

**Towards a New '*Silif*':
Breaking the Silence on FGM Among
the Beja Pastoralists of Eastern Sudan**

Development Practice Series 1

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Acronyms in the text

| | |
|-----------|---|
| ACORD: | Agency for Co-operation and Research in Development |
| AI: | Amnesty International |
| CBOs: | Community-based Organisations |
| DRC: | Democratic Republic of Congo |
| EC: | Executive Committee |
| FGM: | Female Genital Mutilation |
| HIV/AIDS: | Human Immuno Deficiency Virus/Acquired Immune Deficiency Syndrome |
| IGAs: | Income-generating Activities |
| NGOs: | Non-governmental Organisations |
| Pbuh: | Peace be upon Him, i.e. the Prophet Mohamed |
| SEA: | Social Exclusion Analysis |
| TBAs: | Traditional Birth Attendants |
| TOT: | Training of Trainers |
| UN: | United Nations |
| USA: | United States of America |
| VDC: | Village Development Committee |
| WHO: | World Health Organisation |
| WID: | Women In Development |

Vernacular terms

| | |
|------------|---|
| Diyah: | An Arabic term which refers to the blood money paid when a person is killed |
| Ewash: | Squalor or dirt in the Beja dialect |
| Jinn: | Evil spirits in the Arabic language |
| Khifadh: | An Arabic term which means reduction and is used to refer to females' circumcision |
| Khitan: | An Arabic term means cutting and is used to refer to males' circumcision |
| Kushabi: | Girls' circumcision in the Beja dialect |
| Pharaonic: | Refers to the era of Pharaohs in ancient Egypt |
| Sakanab: | The Beja communication system |
| Sharief: | Someone who is believed to be a descendant of the Prophet Mohamed (pbuh) |
| Sheikh: | A religious leader or the third position in the tribal system in Sudan |
| Silif: | A traditional customary law governing aspects of life among the Beja in Eastern Sudan |
| Sunna: | A term used by Muslims to refer to sayings/practices of the Prophet Mohamed (pbuh) |
| Umda: | The second position in the tribal system in Sudan |

Abstract

Female Genital Mutilation (FGM) refers to both partial and total removal of the external female genitalia. This practice leads to serious health problems. These include severe pain, haemorrhaging, abscesses, maternal morbidity and adverse effects on reproduction, as well as the potential for tetanus and HIV/AIDS transmission due to the lack of sterilisation of instruments. It can also lead to lasting psychological trauma. Apart from the above hazards, FGM has some serious long-term health consequences throughout a woman's life, starting with the pain associated with the procedure itself, difficulties during marriage and health complications during delivery. The practice is a common threat affecting children's and women's rights among the Beja pastoralists in Eastern Sudan and is a habitual practice caused by many socio-cultural beliefs. It is particularly harmful because it is conducted during the first week of birth, when the female infant is only 7 days old.

This publication reflects on some of the socio-cultural aspects related to the practice among the Beja using a 'social exclusion' approach of analysis. Since the practice is deeply rooted in the Beja *silif* (traditions), the paper argues that there is a need for a new *silif* that would legitimise the call for abandoning this harmful practice.

The publication also contends that fighting FGM needs to be addressed within an overall developmental strategy for Eastern Sudan, a strategy that addresses the deplorable living conditions and high levels of illiteracy. This is why the ACORD's FGM Reduction Project has been working in partnership with others, especially with local government authorities.

This paper is the first of a Development Practice Series pursued by ACORD. It is not purely an academic work. Rather, it largely focusses on best practices and lessons learned in development, based on ACORD's practical experience in working with the Beja pastoralists. The paper starts off with an articulated analysis of the main findings of the research carried out, documents research-based activities, draws on the approach applied, assesses the achievements and impact generated, and finally, makes recommendations for future plans.

1. Introduction

Female Genital Mutilation (FGM) refers to both partial and total removal of the external female genitalia. This practice triggers serious health consequences which include severe pain, haemorrhaging, abscesses, vaginal bleeding, difficult labour, psychological problems, urinary track infections, difficulty in catheterisation, maternal morbidity, tetanus, and adverse effects on reproduction. Furthermore, FGM is one of the practices that increases the risk of transmission and spread of HIV/AIDS through damage to the genital area during intercourse and also through the use of one instrument on multiple circumcision operations without sterilisation (cf. Sahl & Ibrahim, 2002; Amnesty International, 1998).

FGM is currently practiced in 28 countries all over Africa. Many females who have undergone genital mutilation also live in Asia and Middle East, and are also increasingly found in Europe, Australia, Canada and the USA, primarily among immigrants from countries where mutilation is practised (WHO, 2000; Amnesty International, 1998). Its prevalence in Africa varies between countries, ranging between 98% in Somalia and Djibouti, to 5% in Uganda and DRC, and 89% in Sudan (see Annex 1).

The practice in Sudan dates back to Pharaonic history, relying on the name associated to it as Pharaonic circumcision. Although the fight against the practice in Sudan dates back to the 1940s during the colonial era, it is only during the last two decades that the country has witnessed a nationwide campaign against the Pharaonic type, commonly known as infibulation. Those most actively involved include a wide range of government authorities, UN agencies, NGOs (local, regional and international), activist Sudanese nationals, dedicated politicians, academics and research institutions (see annex 2). Interventions by these actors have created a tremendous impact which is, however, yet to be assessed and evaluated.

According to Amnesty International (1998), "Sudan was the first country in Africa to outlaw FGM". The 1946 Penal Code prohibited infibulation, but permitted a lesser radical form of mutilation known as *Sunna*. In 1957, one year after independence, the law was ratified again. In 1991, the government reaffirmed its commitment to eradicating Pharaonic infibulation, but no mention was made of this commitment in the 1993 Penal Code where the matter was left unclear.

Eastern Sudan, in particular, represents a special case where the FGM practice is still widespread, especially among the Beja pastoralists in the Red Sea State. The harsh environmental conditions and marginalisation contribute to the poverty and numerous challenges faced by the Beja.

The Red Sea State is classified among the poorest States in Sudan (Sudan NHDR, 1998). The biting poverty and underdevelopment are attributable to various factors (see Abdel Ati, 1999):

- a** The vast area of the province (10% of the area of Sudan), coupled with low population density (3.3 person/km²), high population mobility and scattered mode of settlement in the area, have discouraged the government from providing basic social services.
- b** The conflict between Sudan and Egypt on the Halaib Triangle has had a destructive impact on the already beleaguered public service centres, especially schools.
- c** The economic reform policies and the federal governance system in Sudan implied lifting of federal support to social services and giving that role to the resource-poor local authorities, especially Halaib Province.
- d** The general decline in the value placed on education among the Beja community has also impacted on the labour market with high dropout rates at 60%.
- e** All those with university and most of those with secondary education have left their home villages in search of employment in the urban centres, such as Port Sudan town.
- f** The above-mentioned development challenges in the area have been exacerbated over the years by cyclical drought spells and famine outbreaks, which have led to environmental depletion, loss of livestock, displacement, and rural-urban migration. It is the most vulnerable who have suffered most as a result, especially women. They have found themselves having to cope with disaster, yet are constrained by socio-cultural barriers, coupled with illiteracy and lack of marketable skills.

ACORD has during the last five years been putting great efforts in the fight against FGM and has developed a special approach of addressing the issue through intensive surveys and analysis to demystify the root causes and design proper combating interventions.

2. Survey methodology

This publication outlines the socio-cultural aspects of the FGM practice among the Beja pastoralists of Eastern Sudan in Halaib and Sinkat provinces. It is the product of a survey aimed at analysing the socio-cultural factors involved (assumptions, attitudes, stereotypes, prejudices and values) so as to identify the root causes of the practice. The outcome of the analysis is to allow ACORD to revise its work, update its gender strategy and devise a full-fledged FGM eradication programme.

The baseline survey was carried out in five villages, namely Mohamed Gol, Norait, Gebiet Almaden, Darah and Sinkat (see Table 1). The main data collection tools used were a quantitative survey using a core questionnaire and discussion groups using Social Exclusion Analysis (SEA). This publication summarises the qualitative outcomes of the discussion groups only.

SEA is a tool adapted by ACORD (Elkarib and Sahl, 2002; 2001) to understand the association between the causes, manifestations and consequences of exclusion arising from various forms of discrimination by groups and/or individuals. It helps in carrying out a multidimensional analysis of the factors that are responsible for discrimination, thus further leading to exclusion. These factors are mostly entrenched in the historical context (e.g. economic situation, socio-cultural legacy, political history, etc.).

Generally, the SEA model is self-explanatory (see the model in Annex 3). It starts off with the negative attitudes that are revealed in the prevailing values, assumptions, stereotypes, and prejudices in a given context. When these attitudes are combined with the power to act, they ultimately yield discrimination, which can be direct, indirect, inaction or victimisation. The direct consequences of discrimination are the denials of certain opportunities, services, resources, rights and self-respect.

When discrimination is combined with an ideology of superiority that is underpinned by certain values (reflected in the system of education, language, legislation, etc.) and is internalised by both parties (the oppressed and oppressor), it transforms into a social exclusion that can take different forms depending on that ideology (sexism, ethnocentrism, tribalism, elitism, etc.).

Based on the principles of the SEA mentioned above, various discussion groups were carried out in the community. However, because of the gender ideologies¹ among the Beja, it was not possible to arrange mixed discussion groups, and, therefore, discussion groups were arranged for men and women separately, except in one village where men and women came together in one discussion group (see Table 1 below).

Table 1: Survey participants (by gender) in the five villages

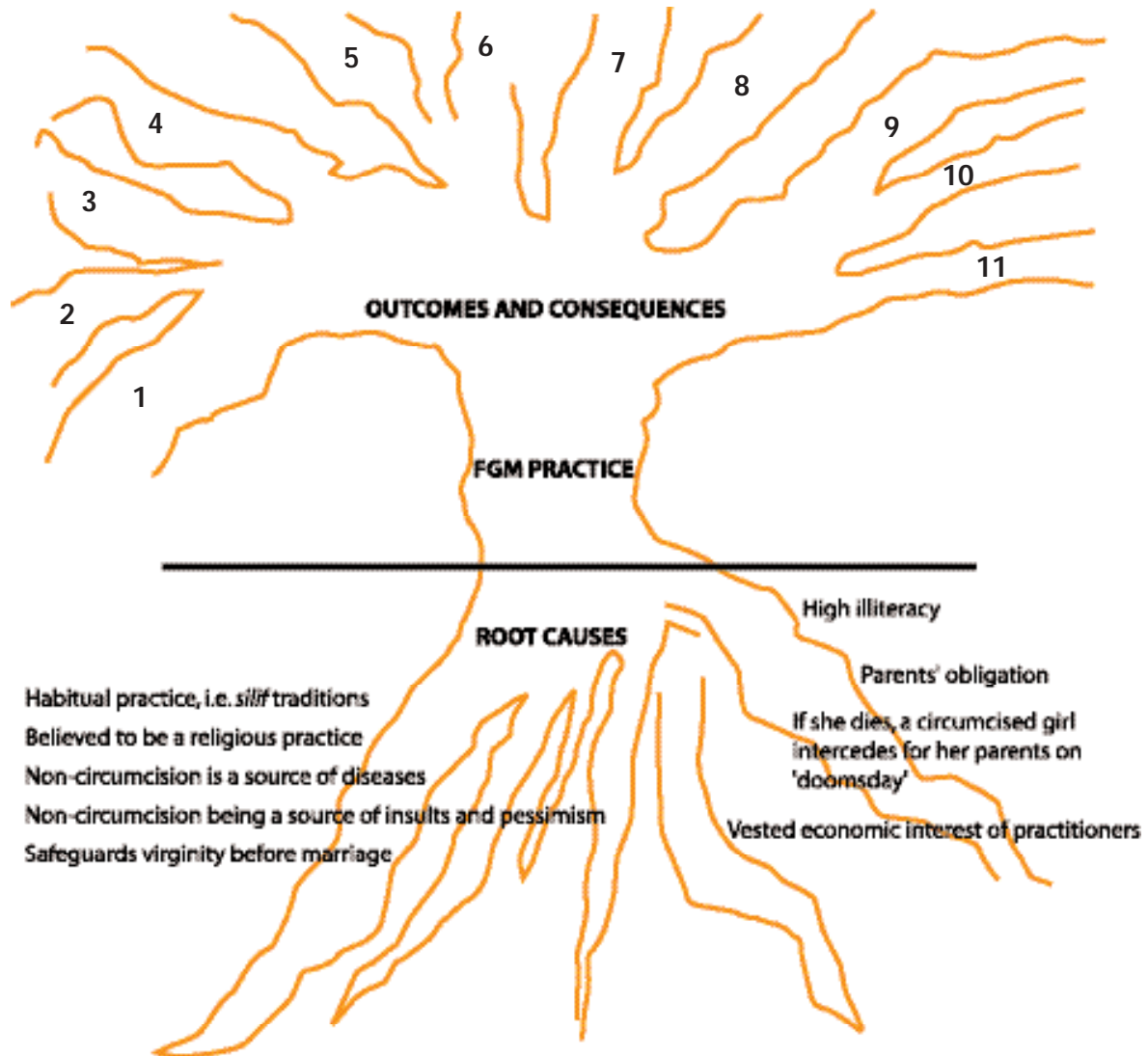
| Village | Mixed discussions | Women | Men | All |
|----------------|-------------------|-----------|-----------|------------|
| Mohamed Gol | Yes | 08 | 03 | 11 |
| Noraite | No | 51 | 25 | 76 |
| Gebeit Almaden | No | 17 | 08 | 25 |
| Darah | No | 10 | 08 | 18 |
| Sinkat | No | 10 | 00 | 10 |
| Total | | 96 | 44 | 140 |

Based on the objectives of the research and the principles of SEA, specific inventory questions were asked on socio-cultural aspects relevant to the FGM practice among the Beja pastoralists. Discussion with the villagers was initiated by using the 'problem-tree'² as an entry tool to demystify the root causes and consequences of the practice, as is believed by the Beja pastoralists. Results of the problem tree analysis and discussion groups are summarised in the sections below.

¹ Gender ideologies are defined as "the system of values which underpins gender roles and identities and which validates gendered power structures in a system of social relations, framed within a particular culture." (El-Bushra, et. al. 2002: 4; see also El-Bushra, 2003).

² The principles of the problem-tree used were as follows: (i) the 'roots' of the tree represent the root causes of the FGM practice; (ii) the 'stem' represents the FGM practice itself; (iii) the 'fruits' represent the outcomes and consequences of the practice. Results of the analysis are exclusively the perceptions of survey participants, who may not necessarily represent the community as a whole but give an indicative reflection on the FGM practice.

3. Results of the problem-tree analysis:



KEY ON OUTCOMES AND CONSEQUENCES

1. Gives the Beja woman her identity
2. High marriage opportunities
3. Better acquired immunity
4. Purifies women
5. A source of relief for parents
6. Safeguards virginity before marriage
7. Protects against evil spirits and spiritual disease
8. Girls grow as normal persons and become ideal wives
9. Difficult labour and maternal morbidity
10. Health complications: urine retention, haemorrhaging, infections
11. Hampers marriage of old men to young women

4. Analysis of Findings

4.1 Socio-cultural stimulus of the FGM practice among the Beja

The practice of FGM among the Beja community is embedded in the various socio-cultural traditions, beliefs, power inequalities, gender relations, and the ensuing compliance of women to the dictates of their traditional communities. The practice is common across the Beja and thrives partly because of their geographical isolation and the high illiteracy rates. While any form of circumcision presents a danger to the women involved, the use of a method called “Pharaonic” circumcision is particularly harmful. It involves cutting of the labia majora, labia minora and the clitoris, as well as both an external and internal stitching of the genitalia after the cutting process is completed.

Although the law in Sudan prohibits the “Pharaonic” circumcision, its practice among the Beja groups is still pervasive and encouraged by the local culture. There is very limited gender awareness and little knowledge on legal rights, especially those of children among the Beja. Vested interests also serve to perpetuate the practice since it is a source of income for its practitioners, who are mostly specialised circumcisers, TBAs (traditional birth attendants) and midwives.

The high illiteracy rate and low level of general awareness among the Beja often lead the local community to confuse religious and cultural practices. Although local religious leaders managed to generate a considerable awareness among their communities, perception of girls’ circumcision as a religious belief is still prevalent among men and women on an equal footing.

(i) A widely accepted customary law

All the Beja groups ACORD has interacted with do not see girls’ circumcision as an abnormal practice, but rather view it as a habitual practice that became a *silif* in their life. The *silif* is a tribal convention and/or a customary law that is immensely respected by all members of the community. Traditionally, no single community member can violate *silif* rules unless a new rule is formulated to replace the old one. It is the degree of reciprocity under the *silif* rules in both rural and urban areas that determines the strength of people’s relationships (Pantuliano, 2000). The different aspects of the life of the Beja (economic, political and social) are regulated by the *silif*. Such aspects include access to resources, conflict resolution, environmental protection, social solidarity, preserving intergenerational memories, gender aspects, women’s roles and cultural taboos.

The *silif* is, therefore, a customary law that governs all aspects of life for individuals, groups, and tribes of the Beja. Because it is considered as part of an individual’s identity, respect and adherence to the *silif* system is not negotiable. Since community relations are still tribe-based, it is the tribe that is accountable for the behaviours of its members and not the individuals themselves. Each tribe is

empowered to question its members regarding the different aspects of the *silif* in case of any violation. The behaviour of members of each tribe is blamed on their tribes and not the individuals who have broken the *silif*. The tribe then announces that the individual is no longer socially committed to it and, consequently, has no right to claim any further treatment under the *silif* system.

The *silif* mechanism is a chain process of responsibilities starting from individuals, heads of families and ending up at the broad tribe level. Individuals are expected to watch their behaviour and to live according to the *silif* norms. Fathers are responsible for their families and traditional leaders are responsible for representing the affairs of their tribes to the public. This process affirms one's tribal identity affiliation within the *silif* system.

ACORD is committed to fighting the FGM practice. Previously, before the interventions of ACORD, religious leaders shied away from addressing the issue of FGM because it was considered shameful to talk about. Recent involvement of some local religious leaders, whose opinions are well-listened to by their respective communities, has made it easier to break the long silence towards the practice (See Box 1). This has generated a general awareness among the Beja to accept bringing the issue in public and even contesting the socio-cultural validity of the practice.

Box 1: Experience of a religious leader: Sheikh Mohamed Tahir Nakasoab

Sheikh Mohamed Tahir Nakasoab is a well-known Beja enlightened religious activist who has been committed to fighting girls' circumcision among his community for more than 30 years. He holds a distinction between the type of circumcision applicable for men and women alike. For him *khifadh* is for females while *khitan* is for males.

Sheikh Nakasoab explained that according to Shari'a law, the removal of the labia implies paying *diyah* (blood money), equivalent to what a person's relatives are paid when that person is killed. In the Shari'a law that blood money is equivalent to a value of 100 camels. So this implies that removing such female genital organs is no less than killing a person. He mentioned that females infibulations is a crime but it is that the circumcision of males which is a *sunna*. He believes that girls are the victims.

Sheikh Nakasoab declared that he has been working on fighting FGM among his Beja community for more than 30 years without any significant impact. It is only, he said, after the starting of the campaigns of ACORD, which he has been part of, that he has seen a change. His approach to work with the community is based on key principles:

1. Convincing the male youths not to marry circumcised females because they are persons without genital organs. So the work should be collectively made on the demand side rather than the supply, i.e. on men before women.
2. Documentation and use of video shows.
3. Awareness creation using the following methods:
 - (a) Use of local language/dialect of communities.
 - (b) Sharing the same life of the community (dress like them, eat like them, etc.).
 - (c) Listening to communities while involving them.
 - (d) Choice of the most suitable entry points to the community.

(ii) FGM, religion and health beliefs

Being exclusively Muslim, the beliefs of the Beja adhere to the *silif* rules where customary rules are in many ways mixed up with the religious values, resulting in their becoming legitimate practices. Indeed it is believed that the “combination of Islam and animist elements and the predominance of customary laws over Islamic code are (sic) common to all the different Beja groups” (Pantuliano, op.cit: 67).

The FGM practice is locally referred to in the Beja language as *kushabi* and treated as a religious practice known to them as *sunna*. Mistakenly citing Islam as a reason for the practice, the largely illiterate Beja community believes that girls’ circumcision is a religious practice. Though the Holy Qur’ān does not contain any call for FGM, many Muslims supporters of the *sunna* type of circumcision refer to few sayings by the Prophet Mohamed, who in response to woman FGM practitioner (Ummo A’ttiyah) was quoted as saying to her “reduce but not destroy” (Amnesty International, 1998).

The Beja believe that an uncircumcised girl is vulnerable to ‘evil spirits’ (referred to in the local language as *jinn*) and diseases. Hence newborn girls are closely guarded and observed until they are circumcised. The community believes that circumcision is a removal of an undesired part of the body and the presence of an uncircumcised girl herself represents a source of ‘evil’ to her family. The community refers to the removable parts of the girls’ genitalia as an *ewash*, loosely translated to mean squalor or dirt. They believe that the *ewash* must be mutilated at the earliest opportunity if a child is to grow up healthy. Hence, the Beja carry out the Pharaonic circumcision within the first week of delivery, as soon as the baby is 7 days old. This practice takes place before the naming ceremony and as a result, it is the circumcision that gives children their identity rather than their being named. An analysis within the community indicates that 90% of girls are circumcised before the end of their first birthday and the rest before their second birthdays. The cutting is done by circumcisers who are paid for their services. In some cases, some girls are re-cut once or several times while growing up.

Although local people admit that circumcision causes problems, like bleeding, urine retention, dyspareunia and difficult labour, they also believe that weight loss, itching, eye infections, and abdominal distension are direct results of the state of non-circumcision.

(iii) Parents’ fear

Usually, when a Beja girl gets sick, relatives will immediately ask questions like ‘Tu *sunna* ti frana? - *ewash* hoi ti frana?’ meaning, “Has *sunna* been performed on her?” The first option then becomes the practice of circumcision. If the disease continues after conducting the circumcision, parents will then start to look for another cause and seek treatment for it. These beliefs have led parents to be terrified to keep their girls uncircumcised and those who choose to let their daughters escape the knife are often taunted and insulted by the community during social occasions, mostly through songs. It is also believed that if an uncircumcised girl dies, she will not intercede for her parents on ‘doomsday’.

(iv) FGM and subordinate gender status

Largely as a result of high levels of illiteracy, most Beja women have fully resigned themselves to a subordinate status in the community. Since FGM is part of an agreed *silif* and habitual practice,

women find it shameful to talk about their suffering during marriage or delivery, even when they are divorced. As a result, Beja women do not talk about the impact of circumcision on them, even if they are experiencing health problems associated with circumcision. The suffering that results from FGM are closely guarded personal secrets that are not disclosed to others.

These misconceptions make the Beja view those who do not practice circumcision as being inferior and liken them to animals. *“The inferior people do not circumcise and, therefore, they are unhygienic, look dirty and smell nasty”*, said a Beja man who was interviewed. Even those who do not circumcise are believed by the Beja to have other alternatives to protect their girls against ‘evil spirits’ and diseases, such as wearing charms, use of special tree roots, and frequent cleaning of the genitals. The common perception among the Beja is that without the practice of circumcision, other mechanisms for protecting girls against physical and spiritual diseases must be instituted.

(v) Men’s beliefs perpetuate FGM

Men play a major role in encouraging the practice. Fathers view it as one of their obligations towards their daughters if they are to be accepted and identified within the community. They believe that girls must be circumcised in order to grow normally and have good marriage opportunities. Men prefer to marry circumcised women because they believe that the removal of the sensitive tissue of the outer genitalia increases sexual desire in the female, maintains chastity and virginity before marriage and fidelity during marriage, thereby, increasing sexual pleasure to the man. The external female genitalia are also considered dirty and unsightly and are to be removed to promote hygiene, increase marriage opportunities and enhance fertility and child survival. These male beliefs and misconceptions are at the core of the root causes that stimulate the practice and sustain its perpetuation.

(vi) Existing communication channels

Absence of media programmes in the local dialect (especially on radio) has been accentuating the silence towards the practice. The only sources of knowledge and awareness about FGM include religious leaders and institutions concerned about the impact of FGM such as ACORD.

4.2 Who is the FGM decision-maker?

Contrary to expectations, parents are the main decision-makers on issues of FGM followed by grandmothers who are key decision-makers in other parts of Sudan. Grandmothers often exert pressure on their married daughters to ensure all their female children are circumcised. The mothers, in turn, pressurise their husbands to look for FGM experts to come and perform the ritual. In many cases, husbands travel for days in search of a woman practitioner to come and carry out the task. Female children have no say since the procedure is normally performed on them during the first week of delivery.

Unlike other parts of the Sudan, FGM among the Beja is unique as it is conducted during the first week of delivery. Both parents support the practice, as they believe it will ensure that their daughter is not attacked by ‘evil spirits’ and genital diseases. After the ritual has been performed, parents feel a sense of relief since they have fulfilled their *silif* commitment and obligations towards their daughter.

4.3 Recent attitudinal changes:³ Towards a new *silif*

As a result of the awareness-raising interventions and campaigns by ACORD, the Beja of Halaib have recently begun to distinguish between what is religious and what is a traditional/cultural practice. They have started to embrace the idea of instituting change and now feel less inhibited about openly discussing the challenges of FGM issues with outsiders. In addition, in their discussions, the community is increasingly accepting the involvement of women who were previously completely excluded from attending or participating in such discussions.

The Beja have begun practising what they label as *sunna* circumcision, which they believe is less harmful than the Pharaonic kind as it does not involve stitching of the labia but instead is a partial cutting of the clitoris.

The enlightened and educated Beja, who mostly live in towns, have started rethinking the practice and many have completely stopped practising it. To compensate for the dispensation of the practice, a key strategy that was developed by the enlightened community members was the idea of an alternative circumcision ceremony. Here, families organise a ceremony for their daughter, thereby, providing psychological support for the girl herself and for the relatives and enabling them to announce a 'fake circumcision'. They resort to such a scenario because education among the Beja is not a factor or an excuse to violate the tribal *silif*. Everyone is expected to act and live within the boundaries of the *silif*.

Notwithstanding this, it is evident that peoples' attitudes are changing in spite of the rigidity of the *silif*. During the discussions that followed, men acknowledged that in the past they viewed women who had not been circumcised as 'animals' as they delivered naturally and without any surgical intervention. They were even more surprised to learn that uncircumcised women are not unhygienic, as they had previously been led to believe. More recently, some male interviewees have asserted that after recent attitudinal changes, they had started engaging in informal discussions with men who are married to uncircumcised women on the misconceptions about the hygiene and sexual pleasure of their wives.

The direct result of the new critical awareness among the Beja is that they want to stop the practice. They have now agreed to formulate a new *silif* that prohibits the FGM practice across the whole community. To this end, community members and their leaders have to come together to make a communal decision on producing a new *silif*. That is the only way, they said, to eradicate the practice.

While the Beja have generally recommended communal action to be taken by their community to reach a new *silif*, one village, Mohamed Gol, has already taken the initiative in this respect. Mohamed Gol is a village where ACORD has field-based offices and has been working since the beginning of its interventions. The Mohamed Gol community has already begun abandoning the FGM practice and in its place adopting an alternative *silif*.

³ For details on impact assessment and project results, see section 5 below.

The new initiative will gradually phase out the Pharaonic circumcision and apply a less harmful type so as to accommodate the social needs of the community and protect girls. The alternative type of circumcision does not involve major cutting and hence does not give rise to wounds. The village community has taken this step as a starting point until a consultation process on how to reach a total banning of the practice is complete in other areas.

Furthermore, the local leader of Mohamed Gol Village, Sheikh Ali, agreed with his village sub-leaders to ostracise any woman who continues to practise FGM. They agreed that those who want to circumcise girls should do it outside the village (see Box 2). Following the experience of Mohamed Gol, other villages, such as Dongonab and Gebeit Alma'adin, have also taken the initiative to ban the practice.

Box 2: The case of Mohamed Gol on FGM

Mohamed Gol is one of the villages covered by the ACORD FGM Project. The community used to circumcise newborn girls on their seventh day. In response to awareness campaigns and debates on the dangers of circumcision, the village leader Sheik Ali met with his sub-tribal leaders and discussed the issues with them, seeking to know their stand on such a harmful habitual practice.

All leaders agreed on an implementation plan to combat the practice in the area. Sheikh Ali was entrusted as the principal leader to implement the plan and inform people in the outskirts through their sub-leaders. Two women who were able to deliver the message properly were selected to address other women during local ceremonies. The leaders agreed that any woman who continues to practise the habit would be deported from the village. In addition, no traditional assistance or support would be given to the fathers and mothers who intend to circumcise their daughters.

When Sheik Ali informed his people about their plans, the majority agreed to suspend the practice. By the time of writing this report, 25 girls (more than 80% of girls born six months after the agreement) were left uncircumcised. However, 7 cases were reported to have been circumcised outside the village in Port Sudan town. Sheikh Ali explained that the debate is still ongoing with the unconvinced minority. Otherwise, social sanctions are going to be applied on those who refuse to stop the practice.

4.4 Steps towards a new *silif*

Introducing any change to the *silif* system is possible but has to evolve slowly and gradually through tribal consensus building. Any radical change would otherwise bring about resistance and confrontation, as it would be viewed as an infringement on the already existing *silif* system. Religious leaders and other key persons can only suggest the required changes through a process of consultation with traditional leaders who are the actual implementers of the *silif* system. The traditional leaders then consult with the sub-leaders who will then lead the consultation process with members of their tribes and others who share the same *silif*. Such a *silif* change can never be

imposing and should evolve through persuasive ways. Sub-leaders are asked to feedback their consultative findings to the principal tribal leader who then plans accordingly. If, for instance, all groups accept the proposed change with a few that reject it, the leader will bring together those who accepted with those who rejected in an attempt to reach a consensus. In all cases, a final decision is not taken until a consensus among all groups is reached.

It is clear that all tribe members or their representatives, traditional or religious leaders, should agree if a new *silif* is to be introduced. According to the findings of the analysis, the introduction of a new *silif* that would eradicate the FGM practice needs to be initiated by a religious leader (known as *Sharief*). Since the Beja are exclusively Muslim, the Sharief is entrusted by the community members in convincing them of the illegitimacy of the FGM practice in Islam. The Sharief's initiative should then be supported by a specialist medical doctor who is able to convince the people about the disadvantages and harmful consequences of the practice and the fallacies about it as a cure for some diseases, as is currently believed by the community. The third person in the initiative, to follow the Sharief and the medical doctor, is a traditional leader (sheikh or *umda*), who has a respectful *silif* status among the community.

When the Sharief starts the new *silif*, the villagers, especially women, should agree to practically endorse it by means of declaring the practice illegitimate. For the process to succeed, the well-known efficient communication system of the Beja, which is locally known as *Sakanab*, should be used. Currently, all news of death, funerals, birth, social/cultural events, rains, grazing, etc. are effectively transmitted through the *Sakanab* system whereby one person breaks the news and the information is communicated through a chain process from one person/village to another. Therefore, the moment the new *silif* rule is announced, it should be automatically transmitted to the rest of the community, irrespective of the distance and within a relatively short period of time.

Even when the new *silif* is agreed upon, still there is a danger that TBAs/midwives and circumcisers will continue to secretly carry out the practice as it represents a source of income for them. Some villagers have suggested the need to provide an alternative source of income for those women practitioners so that they do not violate the new *silif*. Both NGOs and concerned government authorities are expected to play this role and make a contribution towards it.

Given the large-scale poverty, physical isolation and high illiteracy rate among the Beja, fighting FGM should not only be addressed by introducing a new *silif*, but also within an overall developmental strategy for Eastern Sudan. There is need to develop an integrated strategy that addresses the deplorable living conditions, beleaguered social services and high levels of illiteracy.

4.5 Survey concluding remarks

Almost all community members who participated in the discussion groups were aware of and convinced about the adverse effects of the FGM practice but they continued to practise it because it is part and parcel of an inevitable tribal *silif*. Unless a new *silif* is formulated, the FGM practice will continue and remain a source of misconstrued beliefs and subjugation of women.

The community members asserted that the entry point to establish a new *silif* and stop the practice should be through a religious leader whom they know and entrust. This should be supported by a

professional medical doctor who convinces them of the fallacy of some of their health perceptions towards circumcision. The efforts of these two persons are to be supported by a respected traditional leader whose opinion is held in high regard by the community and is binding.

In terms of the impact of religion on the FGM practice and the ongoing awareness campaigns, it is clearly evident that the community is now aware of the illegitimacy of the FGM practice in Islam. However, the community still clings to the health misconceptions regarding the genital parts, perceiving their existence as the main sources of certain physical and spiritual diseases, or even a conducive environment for attracting 'evil spirits' to the girl child.

Future interventions should, therefore, concentrate on the health misconceptions about the practice. The community itself is ready to abandon the practice if it is provided with practical medical evidence on the claim that the practice does not cure the diseases currently associated with circumcision.

The following sections shed light on the FGM activities carried out by ACORD in line with its research findings and analysis of the local context.

5. FGM-based activities: Work approach and impact assessment

5.1. The past experience on FGM

Several unsuccessful attempts by local and international NGOs were made to try and tackle the FGM problem. The lack of success is attributed to the approaches and methodologies adopted by activist groups, which were treating the practice in isolation from the local reality and context. Old approaches were concentrated on the harmful effects of FGM through public sessions which focussed solely on women while completely ignoring the role played by men in perpetuating the practice. Some of these actors have now joined hands with ACORD and contributed to the positive work that is going on.

In the past, ACORD too used the same approaches but without success. However, after carrying out various researches and analysing the findings, the organisation implemented a drastic change in its programming. The new approach saw a shift in emphasis with men being brought on board from the start as an entry point since they were found as one of the main reasons behind circumcision.

5.2. Approaching FGM among the Beja pastoralists: The current experience

ACORD Red Sea Hills programme started operation in 1987 in a limited remote area in Halaib Province called Suffaya, targeting agro-pastoralists (see site map, Annex 6). In response to requests from the community and official pressure, the programme expanded its activities in 1992. It was again expanded in 2000 as a "Rural-urban Linkages Programme", covering 14 rural villages with about 14,500 inhabitants in Halaib Province and approximately 3,000 Beja migrants in Port Sudan town.

The goal of the new phase of the programme is *"To improve the quality of life and future prospects of its beneficiaries through enhancement of food security, provision of alternatives for sustainable production and support to local communities by building their capacity to plan, implement and manage their resources."*

The new phase of the programme has involved working with both women and men with special focus on education and awareness on women's participation in development. The specific issue of FGM was tackled after having thoroughly studied causes and perceptions about the practice in 1998 and in 2001/2. One of the main current interventions of the programme involves implementing activities that contribute to combating the deep-rooted harmful practices, chief among them being the circumcision of girls (FGM). The major constraint to the development of the Beja women is health hazards arising from the practice of FGM and low life expectancy resulting from extreme poverty, poor nutrition, and lack of preventative and reproductive health services.

The overall objective of ACORD's FGM Reduction Project is *"To eliminate the FGM practice in the Red Sea State, transform people's attitudes through direct campaigns, networking and awareness-raising methods, and to address denials in particular with regard to women's rights."* Such an ambitious project aiming at banning old and deep-rooted habits had to be planned carefully so as to fulfil its long-term objectives. The strategic planning on how best to approach all the concerned groups was primarily based on findings of the various participatory research and analysis carried out.

ACORD approaches FGM as a community development issue through its Gender Component using the old Women in Development (WID) approach. This is because there is still a growing gender gap imposed on women by the local culture. However, ACORD does not seek to antagonise the community by directly attacking the culture but rather seeks to gradually change attitudes and practices.

ACORD recognises the seriousness of FGM not from a health perspective but rather from a developmental and human rights angle. The organisation views FGM as a threat to human rights and social justice. The organisational strategy to eradicate the problem aims at tackling the root causes of the problem, whether they are stigma-related, linked to alternative income options or associated with religious or social attitudes. There is a direct link between the FGM practice and power relations between genders in the family and the community as a whole. For that reason, addressing these gender relations is as important to fighting FGM as is transforming people's attitudes and traditional practices.

Both men and women attach strong significance to FGM as an inevitable social practice among the Beja. Men hold strong misconceptions about the practice related to sexual pleasure, women's hygiene and virginity. As such, women were left with no option other than to cling to men's desires. This is one of the strong factors that encouraged ACORD to target men as an entry point although the victims of the practice are exclusively women.

ACORD's anti-FGM initiative started with a UNICEF-funded pilot project in Halib Province in 1999. The approach was based on mobilising key persons in each village. These persons were then used as entry points to approach the community leaders and religious sheikhs, which was key to breaking the religious and social stigma. The encouragement of these influential two poles of the village was a silent blessing to the progress of the project. This provided a platform for mobilising men, women and girls to take part in the initiative. It also prevented and pre-empted husband-wife conflict within the families.

Individual discussions were then followed by campaigns through open sessions and workshops involving the whole community and midwives from the villages and the Midwifery School in Port Sudan. Health awareness campaigns and open health days were conducted. This approach proved very fitting within the socio-cultural context of the Beja.

Unlike other similar initiatives in Sudan, the project was unique in that it started by creating awareness among men. It was also boosted by the fact that it started with a baseline survey before approaching the villages. It was further strengthened by the trust built between ACORD and the local community, having been involved since 1989 through other interventions. This foundation of mutual trust and co-operation was instrumental in the success of the project (see Section 5.4.3).

ACORD uses local staff in all its operational areas. The fact that almost all staff members are Beja themselves opened dialogue on issues like FGM, which were never thought of before; not only with men but also with women and mixed groups as well. However, opening up of such space for discussions was an objective in itself for ACORD.

Success factors of ACORD's approach

ACORD's strategic approach detailed above can be summarised as follows:

- 1 Capitalising on participatory research as a tool to inform interventions and empower the community. The research was mostly a joint qualitative analysis with the community.
- 2 Collecting quantitative information for reference and comparison over time since qualitative information alone is not sufficient to measure qualitative social change. Qualitative information is merely a useful tool for participatory planning with the community.
- 3 Tackling the root causes of the problem rather than just addressing the consequences. The project approached men from the onset since they are directly and indirectly the reason behind circumcision.
- 4 Tackling the core objectives of other interested actors behind the practice, especially circumcisers, TBAs and midwives who circumcise for financial gains. In this regard, finding economic alternatives for midwives was key in the fight against the practice.
- 5 Capitalising on the training of leaders and trainers as a key sustainability strategy, as well as a strategic entry point to religious and socio-cultural issues of sensitivity.
- 6 Utilising awareness about FGM as a human rights issue over time. The approach was neither imposing nor confrontational, and utmost care was taken to ensure that the community did not feel that outsiders were imposing their ideas and attempting to forcefully change their culture. The whole approach was based on equal participation, consensus and trust building and partnership between ACORD and the community.

5.3. Project-based activities and ways of working

5.3.1. Awareness campaigns

The various research findings were shared and discussed with the community leaders to identify the best methods of planning and implementing campaigns. It was agreed that the campaigns had to be realistic, comprehensive, alive and participatory. As a result of this consultation, a one-week awareness campaign was run in 2001 in seven villages⁴. The campaign involved a multi-disciplinary team which included health workers, religious leaders, staff of ACORD, sociologists and communication specialists. The objective was to handle the FGM issue from the different angles and perspectives offered by the team. These perspectives included socio-economic cost for the community, women rights, religious prescriptions, and health complications. All sessions used the local language of the Beja.

⁴ These were Mohamed Gol, Dongonab, Fodicwan, Eit, Arakyay, Salal Asir, Gebiet and Yamomt villages.

During 2002, the team facilitated more than 54 sessions in the target villages and Port Sudan town where there are migrants from these rural areas. To encourage attendance in these sessions and establish better relations with the community, campaigns included provision of clinical services and drugs. The use of video films as warm-up methodology and original ideas like organising competitions on gained knowledge on FGM with financial prizes for the winners, stimulated lively discussions in public places and homes where the debate went across gender and age divides. The major result of the repeated sessions was that it has led to a breaking of the silence around FGM with community members slowly beginning to talk about the FGM issue in public.

In 2003, the anti-FGM activists carried out a 10-day campaign where more sophisticated and elaborated strategies were applied. Villagers were hired as campaign team members to share their experience and gained knowledge about the FGM practice with the team. Specialist villagers in animal health and pastoral issues also joined the team to attract a wider audience in the remote areas. New topics were added in the sites already covered by the previous campaigns, such as HIV/AIDS and rights-awareness for women.

5.3.2. Involvement of religious and tribal leaders

As religious and traditional leaders are well respected opinion leaders in their communities, both Ashraf and Beja traditional leaders were asked to participate in campaigns by making public declarations that Islam prohibits FGM and that it is by no means a religious practice.

Both the *Ashraf* and tribal leaders who were already convinced and aware of the harmful effects of FGM were asked to render their support to the campaigns so as to germinate a seed in the pursuit of adopting a new *silif*. ACORD offered the leaders training courses with in-depth analysis on the negative effects of FGM. The religious leaders, particularly, underwent extensive interpersonal training, aimed at transforming communities from just listeners into proactive participants together with the religious/traditional leaders. Women were present in these meetings.

5.3.3. Establishment of community structures

The planning of the FGM Project was participatory and entailed mobilising all community groups. Since men are the traditional decision-makers, targeting women alone for behavioural change would have led to failure. Women's participation was guaranteed through women's centres, and village and FGM committees. Through these centres, women had an opportunity to meet informally and discuss the FGM issue using income-generating activities, such as sewing, tailoring and handicrafts as entry points.

5.3.4. Offering alternative income-generating activities

The project provided income-generating activities to community members directly involved in the FGM issue, for example, TBAs who use circumcision as a source of income. Each FGM village sub-committee was responsible for the identification of FGM practitioners to be supported through the IGAs without making the support conditional to the abandonment of the practice. This approach has promoted the on-going dialogue between the Project and the beneficiary FGM practitioners.

Between 2001 and end of 2003, 21 TBAs who used to practise FGM were reported to have abandoned the practice and taken on new approaches of maintaining their livelihoods. Currently there is only one TBA who is still practising FGM in the rural area of Gebiet Almaden. This has been

attributed to the fact that Gebiet Almaden is an extremely remote area, therefore, it has been difficult to get in touch with her.

5.3.5. Organising training of trainers

All training courses for trainers during the campaign period included FGM related topics and rural extension skills for community volunteers (men and women) in villages. The aim of these training courses was to create a local cadre of anti-FGM activists who are aware of the negative effects of FGM from the different dimensions (health, social and psychological) and have the right communication skills to reach the community using their own mechanisms. A key target for this group was the remote and scattered settlements around the main villages where the ACORD programme had difficulties reaching. A series of Training of Trainers' sessions were carried out in various villages and in Port Sudan town. These training activities included:

- Community workers training
- Basic and advanced training on FGM issues and interpersonal skills
- On-the-job training during the awareness campaigns for FGM workers in each village (learning by doing)
- Leadership training for committees, especially for women

5.3.6. Training of Traditional Birth Attendants

The lack of trained midwives is a life-threatening factor for pregnant circumcised women in remote areas. In response to this need, a nine-month midwifery training course was organised for 11 women selected from seven villages. Out of these women, seven admitted that they had been practising circumcision in their villages.

The training took place in Port Sudan town Midwives' School, a governmental institution run by highly skilled professionals. Bringing these women together for a long period of time was a great opportunity to equip them with technical and professional skills and enlighten them on the harmful nature of FGM and how to deal with emergencies. After completing the course, the trained women received recognised certificates from the Midwives' School and a complete 'tool kit' to perform their jobs more efficiently and effectively upon return to their villages.

5.3.7. Using the media

The project used the local radio and television stations to facilitate awareness amongst the Red Sea State community. This involved open debates facilitated by specialists deliberating on various FGM-related issues, such as the health and religious aspects. The ensuing debate attracted the attention of other NGOs and local workers. Many interested governmental and non-governmental institutions contacted ACORD programme in the Red Sea Hills seeking to deepen collaboration.

One of the great achievements of the use of local media was the FGM quiz held during the month of Ramadhan in 2002 and 2003. Every day during the holy month, FGM-related questions were broadcasted on the local radio with the locals urged to attempt to answer them. Every day, a winning participant was chosen and received cash prizes. About 900 people participated in the quiz, of which approximately 66% were women. The ultimate objective of the quiz was to publicise the issues, raise awareness on it and attract attention of a wider segment of the community both in rural and urban areas.

5.3.8. Building partnerships for change

Project partners

FGM is a complex issue and no single organisation or individual can effectively address it without building partnerships with others. The stakeholders who were incorporated in the campaign included:

- Concerned local authorities
- Law enforcing bodies
- Tribal and community leaders
- The 'elite' and 'enlightened' community members
- Activists and social workers, including the staff of ACORD and their networks
- Medical doctors (mostly belonging to the community)
- Local and international NGOs working in the area
- Networks at local, state and national levels
- Donors and external supporters

Project beneficiaries

Key target groups for the project were men (fathers, brothers and husbands) and religious leaders. Other targeted beneficiaries included:

- Young girls and women
- Traditional birth attendants and midwives
- Community leaders
- Women activists
- Legal authorities
- People working in the health field
- Other partners concerned with social and developmental issues
- The community as a whole

5.4. Project results, impact, lessons, recommendations and future plans

5.4.1. Project results

The direct aim of the project was to eradicate the deep-rooted FGM practice among the Beja pastoralists. The overall long-term aim was to improve gender relations, further women rights, change the attitudes and behaviour of the community towards FGM, improve the physical and psychological well-being of women and girls, and enhance the decision-making of women in the community.

ACORD's interventions in the Red Sea Hills over the last few years have led to increased openness and attitudinal changes amongst the Beja community. Prior to these interventions, religious leaders shied away from addressing FGM issues. Recent involvement of some indigenous religious leaders, who are listened to and recognised by their communities, has made it easier to break the silence about the FGM practice. The Beja of Halaib have recently started to make a distinction between religious obligations and traditional practices. They have begun accepting the idea of discussing the issues of FGM openly with outsiders and with the involvement of women who were previously completely excluded from attending or participating in discussions.

As a starting point, people are gradually abandoning the Pharaonic type of circumcision and instead undertaking the *Sunna* circumcision, which is less harmful because it involves a partial cutting of the clitoris without the stitching of the labia. Many enlightened and educated Beja, who mostly live in towns, have taken the extreme decision and completely abandoned the practice. Men are increasingly accepting to participate in open discussions on the myths that perpetuate the practice and the consequences of FGM with men from other communities who have married uncircumcised women.

On the issue of religious misconceptions, the community is now more aware of the illegitimacy of the FGM practice in Islam. They, however, still cling to the belief that the existence of the removable genital parts is a main source of certain physical diseases as they create an environment for attracting 'evil spirits' to girls. After lengthy consultations, the community agreed to stop the practice if it is provided with a medical evidence that the practice has nothing to do with the diseases they currently believe are associated with non-circumcision.

So far, ACORD's intervention has generated general awareness among the Beja and resulted in the FGM issue being brought to the public domain, thereby, leading to a demystification of the socio-cultural roots of the practice. A key achievement was the fact that since the beginning of the FGM campaign, 39 girls who were in the right age bracket have not been circumcised to date. (See Annex 4 for details).

Box 3: Summary of Project results:

1- Short-term results (as a basis for the long-term results)

- Bringing the issue to the open and public
- Raising awareness about the repercussions of FGM
- Reducing the incidence of severe types of FGM
- Economic empowerment of midwives through IGAs
- Clear awareness between what is religious and what is a traditional practice

2- (Expected) Long-term results

- Change in the attitudes and behaviour of the community towards FGM
- Improvement in the physical and psychological well-being of women and girls
- Enhancement of the decision-making of women in the community
- More balance in the gender relations at all levels
- Issue a new law to consider the practice as a crime and enhance procedures to abolish it
- Add point on the risks of FGM in birth certificates
- Adopt administrative decisions to sanction midwives who undertake FGM

A new era of community engagement

The local community has started to deal with FGM more objectively, rather than viewing the practice as part of a traditional *silif* that they have to follow blindly. The continuous dialogue on the issue has helped to challenge the stereotypes on gender-relations. Bringing women and men together through open sessions has facilitated the interaction and exchange of views between them.

Men are now listening to women participating in discussions on general community affairs, especially FGM, breaking with the previous practice where women were traditionally not allowed to attend or contribute to such community meetings. Affected women have now begun speaking openly about their individual suffering, describing the horrifying consequences of the practice inflicted upon them and seeking solutions to the root causes of the problem.

Religious leaders and the educated people are now leading voices in the campaign, breaking with the past tradition where they perpetuated the conservative nature of the society. A growing attitudinal change has provided a platform for leaders to proactively engage in campaigning against the practice within their villages.

The open debate and discussion on FGM in the local language has helped the community to critically rethink their reality and recognise the need for changing their living conditions through rational analysis and self-assessment. This new approach has empowered the community to seek necessary resources from the local authorities and other agencies like ACORD.

5.4.2. Establishment of the Red Sea State FGM Network

A key strategy of ACORD is to guide the communities themselves to steer a transformation process within the community to counter the practice of FGM. ACORD aims at encouraging local initiatives while strengthening them to achieve that objective through the *silif* systems as a local transformation mechanism.

Accordingly, an FGM sub-committee has been formed in each of the 14 villages covered by ACORD with representation of both men and women volunteers who willingly decided to join. Village committees have been linked to the traditional and religious leaders to co-ordinate and monitor the practice in their villages, and then report back to ACORD.

The various activities carried out by the project could not have been sustained and pursued in isolation without the involvement of other stakeholders. To ensure maximum benefit/impact of the project activities, there had been a close collaboration and networking with other organisations (NGOs, CBOs) and governmental institutions.

In August 2002, ACORD initiated a seminar that resulted in the establishment of a voluntary network to combat all forms of FGM at the State level. The seminar, attended by many national and international NGOs, community-based organisations and government agencies, decided to create the FGM Network in the Red Sea State with an elected Executive Committee (EC).

The seminar came out with several recommendations. They recommended that:

- A new law to outlaw FGM be formulated and mechanisms created for abolishing the practice
- New birth certificates include a note on the risks of FGM
- The Ministry of Health to adopt a decision to sanction midwives who undertake FGM (eg. withdraw the toolkit and revoke the license)
- Midwives and TBAs be employed by the government
- Relevant technical bodies (doctors, midwives) be assisted to integrate FGM prevention in the health system

- Support be provided to different actors working to combat the practice
- Public sessions and workshops be intensified
- Continued awareness programmes for Imams and other religious leaders
- Children be protected according to the Child Rights Convention
- Ministry of Education to be urged to include FGM in the school curricula
- Encourage volunteers to work in campaigns
- ACORD to evaluate and document other experiences on combating FGM in order to publish good practice
- Midwives to be continually trained through refresher courses and urged to participate in FGM eradication activities
- Research on FGM to be continually carried out (eg. collect any relevant FGM data on successful and unsuccessful experiences)
- Enhanced networking and follow-up of information among different partners to be carried out, according to priorities
- Resources to be mobilised amongst partners to support the campaign

5.4.3. Keys for the project success and lessons learned:

Since the launch of the campaign three years ago, more than 39 girls have been saved from the knife. Eight villages have declared complete abandonment of FGM and currently FGM is a key issue discussed by the public in all the villages. (See Annex 4)

The key factors for the success of the FGM Reduction Project were:

- The project beneficiaries are relatively small and ethnically homogeneous groups
- The in-depth analysis and research carried out on the root causes of the practice
- Tackling the root causes of the problem, rather than addressing the consequences throughout the project interventions
- Whether they are fathers, elder brothers, or to-be husbands, the project approached men from the onset since they are directly and indirectly the reason behind circumcision
- Tackling the core objectives of other interested actors involved in the practice, especially circumcisers, TBAs and midwives who circumcise for financial gain. Offering economic alternatives was a key in the fight against the practice
- Capitalising on training of leaders and trainers as a key sustainability strategy, as well as a strategic entry point to religious and highly sensitive socio-cultural issues
- Using an awareness approach that was neither infringing nor confrontational, since the long-term objective is to change the attitude and eradicate a deep-rooted habit. The whole approach was based on equal participation, consensus/trust building and partnership between ACORD, the community and the concerned organisations
- Most of the FGM campaign groups and project staff belong to the Beja groups
- Long trust building process between the project and the community. ACORD staff normally spend 2-3 weeks a month in the villages
- Involvement of all groups of the society by making strategic choices with influential persons (convincing decision-makers)
- Involvement of governmental authorities of the Red Sea State, the formation of which is a community-based one

5.4.4. Recommendations

a) Abolishing the practice

The long-term aim should be to abolish all types of FGM and not only reduce its prevalence. This means that any form of circumcision should be abolished, even the fake ceremonial type. Anti-FGM advocates must counter the myth and the belief that FGM provides protection against evil spirits. Parents should be helped to feel at ease when making a decision not to circumcise their daughters.

b) Encouraging public declarations

Public declarations by leaders and traditional birth attendants that they have abandoned the practice should be encouraged, and special ceremonies organised to provide platforms for such declarations. This would have a strong psychological effect because such an official declaration would make it difficult to resume these practices.

c) Improving the networking

The Red Sea State FGM Network is currently not a branch of the national Sudanese Network for the Abolition of FGM, created in 2002 in Khartoum. It considers itself as an autonomous structure and there is a need for it to enhance networking through communication and exchange of experiences in order for it to have a bigger impact nationwide.

d) Focussing on health aspects

Future interventions should concentrate on the health misconceptions about the practice to provide medical proof that the practice has nothing to do with the diseases. As almost all women are circumcised, they need to be provided with protective measures to reduce the risk associated with delivery, i.e. provision of maternity, reproductive health and ambulance services accessible for all villages.

e) Initiating a new *Silif*

According to research findings, unless a new *silif* is established, FGM will never be completely eradicated and communities will continue to mistakenly believe that it cures certain diseases. All tribe members should agree if a new *silif* is to be established.

There are three key persons in the process of establishing a new *silif*:

- i) A religious leader: The new *silif* to abolish FGM needs to be initiated by a religious leader (*Sharief*).
- ii) A medical doctor: The *Sharief's* initiative and viewpoints should be supported by a specialist medical doctor who is able to convince people about the various implications of FGM and the fallacies about its curative nature.
- iii) A traditional leader: The third person in the initiative should be a traditional leader (*sheikh* or *umda*), who has a respectful *silif* status among the community.

When the *Sharief* initiates the new *silif*, the villagers, especially women, should agree to practically endorse it by discontinuing the FGM practice. This process is expected to use the efficient communication system of the Beja that is locally known as *Sakanab*.

However, fighting FGM among the Beja pastoralists should not be limited only to the introduction of a new *sillif*, but addressed within an overall developmental strategy for Eastern Sudan; a strategy that addresses the deplorable living conditions and fights the high level of illiteracy.

f) Addressing legal/policy aspects

The efforts to stop FGM within communities would bear more fruit if the laws prohibiting FGM are introduced and implemented.

5.4.5. ACORD's future strategic plans

In Halaib Province, where ACORD is operating, there has been significant progress on community awareness. But, there is still a long way to go to reach a full abolition of FGM. To strengthen and build on what has already been achieved, the following are the future planned interventions:

- Continue to consolidate the on-going work through awareness campaigns, which will be tailored according to the level of awareness in each village
- Facilitate the process of creating a conducive atmosphere for community transformation through mobilisation of villages based on their collective reaction to the practice, which has already started in some villages, like Mohamed Gol and Dongonab
- Ensure that other tribes do not disturb the evolving new *sillif* by extending the project outreach to include areas that have not been covered in the previous phase of the project. Other communities in neighbouring areas will be approached to join the project, either directly or through local partners involved in the FGM Network
- Continue the dialogue with FGM practitioners who are based outside Halaib Province, particularly Port Sudan town, through opening up of channels with them through IGAs and awareness through home visits
- Equip the partners and community activists with professional skills through advanced TOT courses so as to be able to properly deliver the message
- Provide institutional and moral backup for the FGM Network to allow for better co-ordination of the grassroots work and significant impact on policy and decision-making, particularly education, health, and legislation
- Reach a stage of public declaration in Halaib Province for complete eradication of the FGM practice, both at community and State levels. While ACORD will lead on the community-level declaration, the State level declaration will be led by the FGM Network and will probably be witnessed by the State Governor or the Deputy State Governor

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7. Annexes

7.1 Annex 1: Prevalence of FGM in Africa (alphabetic ordering)

| Country | FGM Prevalence | Type practised |
|-------------------------|---|---|
| Benin | 50% | Excision |
| Burkina Faso | 70% | Excision |
| Cameroon | 20% | Clitoridectomy, excision |
| Central Africa Republic | 50% | Clitoridectomy, excision |
| Chad | 60% | Clitoridectomy, infibulation |
| Cote d'Ivoire | 60% | Excision |
| DRC | 5% | Excision |
| Djibouti | 90-98% | Clitoridectomy, infibulation |
| Egypt | 97% | Clitoridectomy, excision, infibulation |
| Eritrea | 90% | Clitoridectomy, excision, infibulation |
| Ethiopia | 90% | Clitoridectomy, excision, infibulation |
| Gambia | 60-90% average (100% the Fula and Sarahuli women) | Excision, infibulation |
| Ghana | 15-30% | Excision |
| Guinea | 70-90% | Clitoridectomy, excision, infibulation |
| Guinea-Bissau | 50% average (70-80% in areas inhibited by Fula and Mandinka; 20-30% in urban areas) | Clitoridectomy, excision |
| Kenya | 50% | Clitoridectomy, excision, infibulation |
| Liberia | 50-60% | Excision |
| Mali | 90-94% | Clitoridectomy, excision, infibulation |
| Mauritania | 25% average (95% among the Soninke and Halpulaar; 30% among the Moor) | Clitoridectomy, excision |
| Niger | 20% | Excision |
| Nigeria | 50% | Clitoridectomy, excision, infibulation |
| Senegal | 20% | Excision |
| Sierra Leone | 80-90% | Excision |
| Somalia | 98% | Infibulation predominates, some excision reported |
| Sudan | 89% of northern Sudanese women | Infibulation, excision |
| Tanzania | 10% | Excision, infibulation |
| Togo | 12% | Excision |
| Uganda | 5% | Clitoridectomy, excision |

Source: Amnesty International (1998).

Notes on Annex 1: the types of mutilation

1. Clitoridectomy: Removal of all, or part of, the clitoris
2. Excision: Removal of all, or part of, the labia minora
3. Infibulation: The most severe form known as Pharaonic circumcision. Includes both clitoridectomy and excision, and cutting of the labia majora to create raw surfaces to be stitched together, while leaving a small hole for urine and menstrual blood to escape.

7.2 Annex 2: List of some key actors engaged in anti-FGM programmes in Sudan

International agencies:

1. Agency for Co-operation and Research in Development - ACORD, P. O. Box 986 Khartoum, Sudan; Tel. +249 183 244 556-8; Fax +249 183 244 560; acosud@hotmail.com; FGM contact person: Ilham Osman (Ilham_osman@yahoo.com)
2. Care Sudan, P. O. Box 2702 Khartoum, Sudan; Tel. +249 183 471 140 or +249 183 489 481; Fax +249 183 471 106; info@sudan.care.org; FGM contact person: Lena El-Sheikh (lena@sudan.care.org)
3. Plan Sudan, Tel. +249 183 231 905; Fax +249 183 227 041; plansudan@sudanmail.net; FGM contact person: Hasnaa Alsyofi (hasnaa.alsyofi@plan-int.org)
4. Save the Children Sweden, P. O. Box 3134 Khartoum, Sudan; Mobile +249 9 121 161 401; FGM contact person: Hanan Ishag (hanan.ishag@sudanmail.net or hananishag@yahoo.com)
5. Save the Children USA, P. O. Box 3896 Khartoum, Sudan; Tel. +249 183 241 588; Fax +249 183 241 591; scusa-sudan@sudanmail.net.sd; FGM contact person: Gihan Salah Eldin (gigi_abdalla@yahoo.com)
6. Norwegian Church Aid, P. O. Box 494 Khartoum, Sudan; Tel +249 183 471 989; Fax +249 183 249 11; ncasudan@sudanmail.net; FGM contact person: Fatima Abdel Aziz (fatimaaziz@hotmail.com)
7. UNICEF, P. O. Box 1358 Khartoum, Sudan; Tel. +249 183 471 835-7; Fax +249 183 471 836; FGM contact person: Samira A. Ahmed (samahmed@unicef.org)

Local actors:

8. Ahfad University for Women, Omdurman, Tel. +249 187 573517
9. Babiker Bedri Scientific Association for Women Studies (BBSAWS), Ahfad University for Women; Tel.+249 187 554870
10. Organisation for the Eradication of Traditional Harmful Practices Affecting the Health of Women and Children (ETHP)
11. Rapid Operational Care and Scientific Services (ROCSS), Tel. +249 9 12372228
12. Khartoum Centre for Human Rights, Tel. +249 9 12378157
13. Elmanar Group, Khartoum, +249 183 469848
14. Bawadina, Khartoum, +249 183 632876
15. Asma, Khartoum, +249 183 622957
16. Training and Law Reform, +249 9 12244748
17. Community Development Association (CDA), Khartoum, +249 183 482906
18. Friends of Children Society (Amal), Khartoum, +249 183 467644
19. Child Rights Watch, +249 9 12350337
20. Mutawinat Group, Khartoum, +249 183 784300

21. Gender Centre for Research and Training, Khartoum, +249 183 474588
22. Society for Women and AIDS IN Africa (SWAA), +249 9 12349962
23. Journalist for Children Society, Khartoum, +249 183 477453
24. Azza Women Association, Khartoum, +249 183 467034
25. Nutrition and Development Centre, Omdurman, +249 187 558624
26. Entishar Charity Society, +249 9 1236252
27. Human Rights and Legal Awareness Network, +249 9 122290015
28. Caf Community Development Association, Omdurman +249 187 560094
29. Sudan National Committee on Traditional Practices, Khartoum, +2459 183 781421
30. Environmentalists Society
31. Sudanese Association for Breast Feeding Encouragement (SABA), +249 187 551159
32. Shaka for Social Development Association, +249 9 12207339
33. Women Initiative Group, +249 183 774515
34. Nutrition and Rural Development Center (NARD), +249 187 557624
35. Child Rights Watch, +249 9 12350337 and +249 183 467848
36. Community Development Organization (CDO), +249 183 482906
37. Sharia Support Fund, Port Sudan, +249 3118 26095
38. FGM Network, +249 183 474588 – 593752
39. Future Centre, samara@hotmail.com
40. Ajaweed Counselling Society, +249 183 7866950
41. Sabah Child Care and Development Association, +249 183 468322
42. Sudanese Society in Care of Older People, +249 183 492282
43. Sudanese Development Association (SDA), +249 183 467957
44. Sudanese Family Organization, +249 183 462332
45. Sudanese Family Planning Association, +249 183 227872
46. Women Development Organization, +249 183 778439

7.4 Annex 4: Villages' awareness level about FGM

| Village | Number of families | Date of first public session | Level | Number of uncircumcised girls | Comments |
|---------------|--------------------|------------------------------|-------|-------------------------------|--|
| Mohd Gol | 120 | 1999 | A | 2 | There is community action to abandon the practice. |
| Gabet Almaden | 250 | 1999 | A | 6 | There is active anti-FGM committee. |
| Salal Asir | 50 | 2001 | A | 2 | Has an active anti-FGM committee. |
| Fodicwan | 110 | 1999 | A | 6 | There is community action to abandon the practice. |
| Eit | 45 | 2001 | B | 6 | Started to talk on the issue in public. |
| Arakyay | 50 | 2001 | B | - | There is community action to abandon the practice. |
| Suffya | 30 | 1999 | A | 7 | Remote area, community accepted the idea, TBA stopped the pharoanic practice but practicing <i>Sunna</i> type. |
| Noraite | 120 | 2002 | B | 8 | Among men and women, there is growing awareness to abandon the practice. |
| Osief | 300 | 2002 | C | - | Still in the entry stage to normalise talking on the issue. |
| Yomomt | 35 | 2001 | C | - | Still at entry stage. |
| Hadaiwa | 30 | 2002 | C | - | Still at entry stage. |
| Dongonab | 100 | 1999 | A | 2 | There is community action to abandon the practice. |

Note: There are 3 levels of FGM awareness (A = good; B = medium; and C = fair)

7.5 Annex 5: List of the main founders of the Red Sea State FGM Network

Government

Shari'a Support Fund (Chairperson of the EC)
Child Care Council
Midwife Training Centre
Port Sudan Broadcasting (for permanent media observation)
Ministry of Health
Sudanese Family Planning Association (Member of the EC)
Ministry of Social Welfare (Deputy Chairperson of the EC)
Humanitarian Aid Commission
SNCTP (Member of the EC)

NGOs

ACORD (Secretary of the EC)
OXFAM UK
Okenden International
Sudanese Red Crescent
Port Sudan Small Scale Enterprise Society
SOS Sahel (Member of the EC)

CBOs

Mohamed Gol Area Committee
Abuhedia Society

7.6 Annex 6: Site Map of ACORD Programme in Halaib Province, Eastern Sudan

