



**COUNTRY PROFILE:  
FGM IN SUDAN**

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**28 TOO MANY**

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Limited Company: No: 08122211

E-mail: [info@28toomany.org](mailto:info@28toomany.org)

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# Preface

*'The seeds of success in every nation on Earth are best planted in women and children.'*

*~ Former President of Malawi Joyce Banda*

One distinguishing characteristic of the most recent revolution in Sudan is that it was led predominantly by youth and women. In keeping with the spirit of this revolution, it must be recognised that women, particularly young women, hold in their powerful hands the keys to success in achieving social change. The roles of men and youth are also priceless to the success of anti-FGM programmes.

Paving the road to changes in social norms, including the abandonment of FGM, requires quality research and evidence. Actors working to combat FGM in Sudan have realised the importance of evidence in understanding factors influencing the continuation of the practice and ensuring the success of any interventions in Sudan. The few recent published studies have confirmed that Sudan is undergoing several shifts, including increased medicalisation, driven by social, religious, professional and legal norms, economic benefits and increasing awareness of FGM's health impacts.

Despite national, local and community efforts made to date, Sudan still has a very high prevalence of FGM. Unfortunately, the medicalisation of FGM, especially by trained midwives, is predicted to support the continuation and normalisation of FGM in the country. I strongly believe that healthcare providers, regardless of their title, can play a critical role in combating FGM, particularly in communities, where they are highly respected and have great influence. They can promote the abandonment of all types of FGM, leading to zero tolerance for it. The practice of reinfibulation demands intensive and focused awareness programmes for all medical personnel, especially trained midwives, who have direct contact with women of reproductive age.

The time is now opportune in Sudan to harvest the fruits of decades' worth of advocacy and activism and endorse a national law criminalising FGM. This requires sensitisation of and dialogue with policy makers, legislators, religious leaders and the media, using data from Sudan and lessons from other countries that have succeeded in criminalising FGM. The series of country reports by 28 Too Many provides exactly the resources needed for such an effort.

Moreover, the efforts and reports by 28 Too Many offer pertinent support and direction for all actors on the ground and provide them with the necessary evidence and best practices to bring about changes in policy, legislations and interventions that can make our countries and continents free from all forms of FGM.

**Nafisa Mohamed Bedri**  
**Professor in Women and Reproductive Health**  
**Ahfad University for Women**





# Foreword

In 2003 in West Darfur, I met a 10 year old girl, displaced from her home, orphaned by war and heavily pregnant as a result of rape by the militia. She suffered complications in labour as a result of FGM and needed to have a caesarean section, and shortly afterwards she was relocated to relatives far from her home. As an aid worker, I felt an overwhelming burden to help her and other girls and women affected by FGM. 28 Too Many was born out of that encounter.

As the world watched the political protests unfold in Sudan this year, the young activist Alaa Salah addressed the crowds adorned in white and spoke about the strength of women. This iconic moment in history is significant because it demonstrates that the continuing challenges faced by the Sudanese people, and especially women and youth, are complex and go far beyond the political platform.

One such challenge continues to be the very high prevalence of FGM. 86.6% of women aged 15–49 have undergone FGM, and it is most commonly Type III (infibulation). That shows that the practice is still deeply entrenched in communities across the country and impacts the lives of millions of women and girls.

In this new Country Profile, 28 Too Many brings together the available data and knowledge to demonstrate where Sudan stands in 2019 in efforts to end FGM and what impact recent events have had. We consider the opportunities the change in the political environment offers moving forward and highlight the real hope and optimism among those working tirelessly on anti-FGM programmes.

During this research we have been honoured, once again, to connect with key organisations and activists who are working to end FGM. The network in Sudan is a good example of cooperation, and we call upon the new administration to work closely with it to develop and accelerate activities that are making a real difference. These activities include the Saleema awareness campaign, which is now recognised by the African Union as a key tool in ending FGM, and the community dialogue programmes across Sudan that are leading to FGM abandonment. There also now appears to be a very real opportunity to pass national legislation banning all forms of FGM, and we support all partners and activists who are working so hard to bring the law back to the table.

As well as winning protection for women and girls through the law, there are still many challenges to overcome in Sudan, including medicalisation and the continued support for the sunna cut from some stakeholders. Additionally, there is a need to empower midwives to maintain their important role in communities while advocating for an end to FGM and tackling the continued practice of reinfibulation, which is so devastating to mothers' health. There is still a pressing need for more up-to-date and accurate data to inform programmes. All these challenges are being tackled in Sudan, and, 16 years on from my first visit, it is pleasing to see the positive progress being made and the appetite for change.

We look forward to reporting on continued progress as the country, and particularly women and young people, are empowered to say no to FGM.

**Dr Ann-Marie Wilson**  
**28 Too Many Executive Director**



# Information on Country Profiles

## Background

28 Too Many is an international research organisation created to end FGM in the 28 African countries where it is mainly practised and in other countries across the world where members of those communities have migrated. Founded in 2010 and registered as a charity in 2012, 28 Too Many aims to provide a strategic framework where knowledge and tools enable influencers and in-country anti-FGM campaigners and organisations to make sustainable change to end FGM. We are building a global information base, which includes detailed country profiles for each country practising FGM. Our objective is to encourage all those working in the anti-FGM sector to share knowledge, skills and resources. We also campaign and advocate internationally to bring change and support community programmes to end FGM.

### *Theory of Change*

28 Too Many effects change by:

#### **1. Collating and Interpreting Data (Research)**

We present data in a number of ways, primarily through Country Profile Reports and Thematic Papers, with additional research products as required. To support our aims, we make this research available globally.

#### **2. Influencing Influencers (Top-Down Approach)**

Using the data we have collated, we engage influencers, encouraging them to advocate for change (of policy, legislation, etc) within their spheres of influence.

#### **3. Equipping Local Organisations (Bottom-Up Approach)**

Based on our research, we develop and distribute advocacy materials and training tools that local organisations can use to bring effective change at a community level. We also support community organisations by highlighting their work and sharing examples of best practice through both our research products and global communications.

Ultimately change happens when policy and legislation (top-down) aligns with community action and education (bottom-up). Our approach is to play a catalytic role in both and to base our interventions on solid, evidence-based research.

## Purpose

The prime purpose of this Country Profile is to improve understanding of the issues relating to FGM in the wider framework of gender equality and social change. By collating the research to date, this Country Profile can act as a benchmark to reflect the current situation. As organisations continue to send us their findings, reports, tools and models of change, we can update these reports and show where progress is being made. While there are numerous challenges to overcome before FGM is eradicated in Sudan, many programmes are making positive, active change.

## Use of This Country Profile

Extracts from this publication may be freely reproduced, provided that due acknowledgement is given to the source and 28 Too Many. We invite comments on the content and suggestions on how the report could be improved as an information tool and seek updates on the data and contact details.

When referencing this report, please use: **28 Too Many (2019) Country Profile: FGM in Sudan.** Available at <http://www.28toomany.org/Sudan/>.

## Acknowledgements

28 Too Many is extremely grateful to everyone who has assisted us in accessing information to produce this Country Profile, as it would not have been possible without their collaboration. The research for this report was undertaken against a particularly challenging political and domestic environment, which means it has not been possible to connect with as many organisations and activists as we would normally hope to. However, we would particularly like to extend our thanks to the following for sharing their knowledge and insight into the current work to end FGM in Sudan: Ahfad University for Women, including Dr Nafisa Bedri and the team at the Gender and Reproductive Health and Rights Resource and Advocacy Centre, the UNFPA Sudan, UNICEF Sudan, DFID Sudan, Dr Samira Amin, Mama Igbal and the team in the Tuti community, Peter Verney ([sudanupdate.org](http://sudanupdate.org)) and Professor Tamsin Bradley (International Development Studies, Portsmouth University).

28 Too Many carries out all its work as a result of donations, and is an independent, objective voice unaffiliated with any government or large organisation. That said, we are grateful to the many organisations and individuals that have supported us so far on our journey and the donations that enabled this Country Profile to be produced. For more information, please contact us on [info@28toomany.org](mailto:info@28toomany.org).

## The Team

**Founder/Executive Director:** Dr Ann-Marie Wilson

**Operations Manager:** Sean Callaghan

**Research Manager:** Amy Hurn

**Communications Manager:** Emma Lightowers

**Research Coordinator:** Caroline Pinder

**Lead Editor:** Danica Issell

**Research Analyst:** Dr Jenna Lane

**Research Volunteers:** Nicole Arnold, Tichafara Chisaka, Terri Harris and Rita Sakari

**Volunteer Proof Reader:** Jane Issell

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*Please note that the use of a photograph of any girl or woman in this Country Profile does not imply that she has, nor has not, undergone FGM.*

## List of Abbreviations

AIDS	Acquired Immunodeficiency Syndrome
CBO	community based organisation
CSO	civil-society organisation
FGC	female genital cutting
FGM	female genital mutilation
GBV	gender-based violence
GDP	gross domestic product
HIV	Human Immunodeficiency Virus
ICC	International Criminal Court
INGO	international non-governmental organisation
MDGs	Millennium Development Goals
MICS	Multiple Indicator Cluster Survey
NCCW	National Council for Child Welfare
NGO	non-governmental organisation
OECD	Organisation for Economic Co-operation and Development
PPP	purchasing power parity
SDGs	Sustainable Development Goals 2015–2030
TBA	traditional birth attendant
UN	United Nations
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNJP	UNFPA-UNICEF Joint Programme to Eliminate Female Genital Mutilation
US	United States of America
WHO	World Health Organization



*Please note that, throughout the citations and references in this report, the following abbreviations apply.*

**'MICS 2014'** refers to:

Central Bureau of Statistics (CBS) and UNICEF Sudan (2016) *Multiple Indicator Cluster Survey 2014 of Sudan, Final Report*. Khartoum, Sudan: UNICEF and Central Bureau of Statistics (CBS). Available at [www.mics.unicef.org/surveys](http://www.mics.unicef.org/surveys).

**'SHHS 2010'** refers to:

Federal Ministry of Health and Central Bureau of Statistics (2010) *Sudan Household Health Survey – Round 2: National Report*. Khartoum, Sudan: Federal Ministry of Health and Central Bureau of Statistics. Available at [www.mics.unicef.org/surveys](http://www.mics.unicef.org/surveys).

**'Secondary Analysis'** refers to:

Macoumba Thiam, PhD (2016) *Female Genital Mutilation/Cutting (FGM/C) and Child Marriage in Sudan – Are There Any Changes Taking Place???* An in-depth analysis using Multiple Indicators Cluster Surveys (MICS) and Sudanese Household and Health Surveys (SHHS). Khartoum, Sudan: UNICEF and Central Bureau of Statistics (CBS).

*All cited texts in this Country Profile were accessed between August and November 2019, unless otherwise noted.*

## A Note on Data

Statistics on the prevalence of FGM are regularly compiled through large-scale household surveys in developing countries, predominantly the Demographic and Health Survey (*DHS*) and the Multiple Indicator Cluster Survey (*MICS*). **For Sudan, a MICS report was published in 2014. A Sudan Household Health Survey was published in 2010.** Both reports contain data on FGM and are referred to as the MICS 2014 and the SHHS 2010, respectively, throughout this Country Profile. Neither includes data on South Sudan.

A MICS report on Sudan (including current South Sudan) published in 2010 contains some basic data on FGM, but does not provide the country-wide prevalence for the practice. A MICS report on the South Sudan area published in 1999 does not provide any data on FGM, nor does a MICS report on Sudan (including current South Sudan) published in 1995. For this reason, the majority of this Country Profile is based on data from the MICS 2014 and the SHHS 2010.

It should be noted that **the definitions of 'states'** in Sudan changed between the SHHS 2010 and the MICS 2014. As a result it is not possible to make meaningful comparisons between the two datasets of the FGM prevalence according to state. It should be noted that large-scale migration has occurred in Sudan over decades, which has the potential to influence the trends that are observed. The country also has a significant nomadic population whose location can similarly affect regional trends over time.

In the datasets, **FGM data was self-reported**, meaning that it was not based on physical examination. In general, UNICEF<sup>1</sup> emphasises that self-reported data on FGM 'needs to be treated with caution', since women may be unwilling to disclose having undergone the procedure because of the sensitivity of the topic or the illegal status of the practice. They may also be unaware that they have been cut, or the extent to which they have been cut, especially if FGM was carried out at a young age. In Sudan specifically, it has been noted that misunderstandings by both women and midwives reporting FGM statuses show that 'statistical research alone cannot tell us the whole story and can in fact throw up an inaccurate picture. Given the huge diversity of Sudan, it is no surprise that this is the case[,] not least because cultural understanding of the practi[c]e varies.'<sup>2</sup>

As for any dataset, it is also important to note that **some results of these surveys may be based on relatively small numbers of women**, particularly when the data is further broken down by, for example, location or age. Therefore, in some cases the trends observed should be interpreted with caution.

A further valuable source of information on FGM in Sudan is the report ***Female Genital Mutilation/Cutting (FGM/C) and Child Marriage in Sudan – Are There Any Changes Taking Place???***, referred to as the **Secondary Analysis** throughout this document. This secondary analysis of the MICS and SHHS data revisits the raw data from the 2014 and 2010 surveys and includes results, analyses and predictions that were not published in the original reports; for example on *adal*, or reinfibulation.

Measuring the FGM status of girls, who as a cohort have most recently undergone FGM or are at most imminent risk of undergoing it, may give an indication of the impact of current efforts to end FGM. Alternatively, responses to this question can indicate the effect of laws criminalising the practice, or a shift in societal attitudes towards the continuation of the practice, which may make it harder for mothers to report that FGM was carried out, as they may fear incriminating themselves.

Additionally, unless they are adjusted, these figures do not take into account the fact that girls may still be vulnerable to FGM after the age of 14.

A key feature of the Secondary Analysis is the calculation of an **'adjusted prevalence'** for the cohort of daughters aged 0–14 at the time of the 2014 survey. The adjusted prevalence addresses the fact that the vast majority of girls in this cohort are still at risk of being cut, and so the measured prevalence in girls aged 0–14 will not be a true reflection of the final FGM prevalence for this age group. The author performed a Kaplan-Meier survival analysis, which is a technique commonly used to compute the cumulative probability of an event occurring when the chances of the event occurring depend on the length of time of exposure. When applied to the risk of a girl undergoing FGM at each age between 0 and 14, the Kaplan-Meier estimate gives the cumulative probability that a girl will be cut between birth and that age. Therefore, for girls aged 14, the Kaplan-Meier estimate gives the likelihood of their being cut between the ages of 0 and 14. The result is a measure of the expected final FGM prevalence for a cohort of girls who are still at risk of being cut. The adjusted prevalence is based on two assumptions: that a negligible proportion of girls will be cut after the age of 14 and that this proportion does not change significantly over time.<sup>3</sup>

A further key result from this study is a **calculation relating to the possible elimination of FGM in Sudan**. The author considers the FGM prevalence (adjusted prevalence in the case of girls aged 0–14) for three age cohorts: 0–14, 15–29 and 30–44. By modelling the drop in prevalence over time using a second order polynomial, they are able to make a prediction of the timescale on which FGM could be eliminated in Sudan. It should be noted that these predictions are based on an assumption that future trends in FGM prevalence will follow the same pattern as in the past. Predictions of this type can only ever be estimates, and, in practice, many factors may influence the rate at which FGM is eliminated. However, it is certainly useful to understand the broad timeline that is currently suggested by the available data.

It should be made clear that any **limitations of the data sources** used in this report do not mean that the data is not useful; they simply mean that one should be careful about drawing 'hard and fast' conclusions, and 28 Too Many has accordingly taken that approach when researching and writing this Country Profile.

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1 UNICEF (2013) *Female Genital Mutilation/Cutting: A statistical overview and exploration of the dynamics of change*, p.24. Available at

[http://data.unicef.org/corecode/uploads/document6/uploaded\\_pdfs/corecode/FGMC\\_Lo\\_res\\_Final\\_26.pdf](http://data.unicef.org/corecode/uploads/document6/uploaded_pdfs/corecode/FGMC_Lo_res_Final_26.pdf).

2 Nafisa Bedri and Tamsin Bradley (2017) 'Mapping the complexities and highlighting the dangers: The global drive to end FGM in the UK and Sudan', *Progress in Development Studies* 17(1). Available at [https://www.researchgate.net/publication/313327749\\_Mapping\\_the\\_complexities\\_and\\_highlighting\\_the\\_dangers\\_The\\_global\\_drive\\_to\\_end\\_FGM\\_in\\_the\\_UK\\_and\\_Sudan](https://www.researchgate.net/publication/313327749_Mapping_the_complexities_and_highlighting_the_dangers_The_global_drive_to_end_FGM_in_the_UK_and_Sudan).

3 Secondary Analysis.

# Executive Summary

**Sudan** was the largest African country until South Sudan gained independence in July 2011. The country is divided into 18 states grouped into five provinces. There are 19 major **ethnic groups** in Sudan, speaking more than 100 languages and dialects. Sudanese Arabs form the largest ethnic group. Intermarriage has blurred boundaries between ethnic groups, but recent conflict has caused those lines to re-emerge somewhat.<sup>1</sup>

Sudan was devastated by civil **war** throughout the 1980s and 1990s. Lieutenant General Omar Bashir led a coup in 1989 and ruled the country until his ousting by the military in April 2019. Since then, however, violence has continued. Women have been at the forefront of **street protests** and, consequently, been targets of **violence** against protesters. A Transitional Government was sworn in on 8 September 2019. New Prime Minister Abdalla Hamdok has stated, 'We have to concentrate on women's participation. Sudanese women played a very big part in our revolution.'<sup>2</sup>

Fundamental Islamist law was introduced in 1983, causing conflict between the Islamic population in the north and the largely Christian population in the south. Currently, a mixed **legal system** of Islamic law and English common law is in place. Sharia law, which includes the Muslim Personal Law 1991, sometimes contradicts and supersedes other laws.

Sudan has signed up to or ratified several **international and regional conventions and treaties** that are relevant to female genital mutilation (FGM); however, it has not signed the Convention on the Elimination of All Forms of Discrimination Against Women (1979) or the African Charter on the Rights and Welfare of the Child (1990).

Despite making some good progress towards the **Millennium Development Goals (MDGs)**, Sudan failed to meet several targets, including those for maternal and child health.<sup>3</sup> Sudan has signed up to the **Sustainable Development Goals (SDGs)**, which go further than the MDGs and make explicit reference to the elimination of FGM, but a 2019 audit found that there have been significant problems related to the frameworks for implementation, oversight monitoring and funding at the federal level. The Government has made new commitments to healthcare and education in order to achieve the SDGs; nevertheless, the audit notes that a clear plan of action must be drawn up if Sudan wishes to achieve them.<sup>4</sup>

The **Constitution** of the Republic of Sudan 2005 (as amended) places various obligations on the State to protect women and children. Specifically, Article 32 obliges the State to 'combat harmful customs and traditions which undermine the dignity and status of women'.

Marriage is legally required before sexual intercourse is allowed, but no legislation prohibits **child marriage**; Article 40 of the Muslim Personal Law 1991 allows the marriage of a child of ten with the consent of their parent/guardian.<sup>5</sup> The Government has recognised the problem of child marriage and is taking steps to eliminate it.

There is currently no national **law against FGM** covering the whole of Sudan. Six states have laws in place that only apply to FGM undertaken within their boundaries: South Kordofan, Gadarif, South Darfur, Red Sea, North Kordofan and Northern. These laws are not enforced and there is no publicly-available information on any cases of arrests or court proceedings in relation to FGM. In September 2016 an amendment to the federal Criminal Act (1991) was approved by the Council of Ministers to

criminalise all forms of FGM under a new **Article 141**; at the time of publication, this is still pending parliamentary endorsement.

Article 15(2) of the Constitution states, ‘The State shall . . . empower **women in public life**.’<sup>6</sup> Women are able to vote and stand for election. The new cabinet of the Transitional Government includes four women, including a female foreign minister and a female chief justice, the first in Sudan’s history. Women have the right to employment and to own property; however, they usually lack sufficient economic resources to purchase land.

On the UN’s **Gender Inequality Index** for 2017, Sudan was rated 139<sup>th</sup> out of 160 countries.<sup>7</sup> **Physical violence and sexual harassment** are grave concerns for Sudanese women, particularly in times of conflict. While rape is outlawed, there is no stipulation regarding marital rape and no domestic violence laws in place.

This Country Profile on FGM in Sudan mostly uses data taken from the Multiple Indicator Cluster Survey of 2014 (*MICS 2014*)<sup>8</sup> and the Sudan Household Health Survey of 2010 (*SHHS 2010*)<sup>9</sup>. A further valuable source of information on FGM in Sudan is the report *Female Genital Mutilation/Cutting (FGM/C) and Child Marriage in Sudan – Are There Any Changes Taking Place???* (the *Secondary Analysis*).<sup>10</sup>

The most recent measurement of **FGM prevalence across Sudan** is from the MICS 2014, which found that 86.6% of women aged 15–49 have undergone some form of FGM.<sup>11</sup> This places the country in UNICEF’s ‘very high prevalence’ category.<sup>12</sup> More than 12 million women and girls are believed to have undergone some form of FGM.<sup>13</sup>

The SHHS 2010 found a prevalence of 88% among women aged 15–49.<sup>14</sup> This suggests that there has been a small reduction in the practice among women in recent years, although progress has been slow. However, understanding how the prevalence of FGM has changed over time is complicated by the mass migration that has occurred in the country’s recent history, meaning that trends arising from direct comparisons between 2014 and 2010 should be treated with some caution.

The data reveals a distinct trend towards lower FGM prevalence among younger women. The highest prevalence (91.8%) is among women aged 45–49 and the lowest (81.7%) is among those aged 15–19. This suggests that the practice is declining at a faster rate than might be apparent from considering only the overall prevalence.

The prevalence of FGM among women living in urban areas appears to be very similar to that among women living in rural areas. In general, states in the centre and north-west have the highest prevalence.<sup>15</sup>

The relationship between a woman’s level of wealth and whether or not she has had FGM is quite complex; however, the practice is most prevalent among women in the richest wealth quintile (91.6%).<sup>16</sup>

Most ethnic groups practise FGM, except for the Fur, Hawsa and Umbarraro.<sup>17</sup> The UNFPA has concluded that ‘ethnicity is the most significant factor in FGM prevalence, cutting across socio-economic class and level of education.’<sup>18</sup> Recent reports have noted that women from non-practising communities in Sudan who have migrated to practising communities have felt pressured to be cut as they feel ‘unclean’.<sup>19</sup>

31.5% of daughters have already experienced some form of FGM.<sup>20</sup> However, this only represents the current FGM status of the girls, many of whom are still at risk of being cut. The Secondary Analysis calculates an ‘adjusted prevalence’ for the cohort of girls who were aged 0–14 at the time of the survey – effectively a projection of the final FGM prevalence in this group once they all reach the age



of 14. This was found to be 66.3%, which, when compared to the prevalence among women aged 15–49, suggests that considerable progress has been made in recent years.<sup>21</sup> Sudanese girls are at their highest risk of being cut between the ages of four and ten.<sup>22</sup>

The Secondary Analysis considers the rate of decline in the prevalence of FGM across three age-groups. Assuming that **future trends** follow the same pattern as in the past, the report predicts that FGM could be eradicated in Sudan for girls born from 2040 onwards.<sup>23</sup> This prediction should, of course, be read with caution.

In Sudan, FGM is referred to in two ways: the more severe form (Type III) is referred to as **pharaonic** or **infibulation**; Types I and II are referred to by the Islamic term **sunna**. The majority of Sudanese women aged 15–49 (77%) have been ‘sewn closed’ (infibulated).<sup>24</sup>

Both the available data and anecdotal evidence demonstrate that FGM has become **medicalised** over the past few decades. 63.6% of women are cut by a trained midwife and 28.7% by a traditional cutter. The medicalisation of FGM in Sudan is linked to the shift from practising Type III/infibulation to practising Types I and II (sunna), which is perceived to be safer. Medicalised FGM is most apparent in women who are wealthier and/or better educated.<sup>25</sup>

Midwives are very well respected in the communities where they work, and their involvement in the practice of FGM offers both challenges and opportunities. In Sudan, though not yet spread across the whole country, a **midwives’ oath** to not practice FGM is now included in the curricula at midwifery schools. The challenge for midwives is that, even though they may understand the long-term impact of FGM because of their training, if they take the oath, they risk a fierce backlash from the communities in which they work. It is important for Sudan to fully utilise the opportunities midwives represent. FGM needs to be included across the curricula for all health workers.

Midwives in Sudan also perform **reinfibulation** (*adal*) a procedure to re-sew the genitals following childbirth. This affects a significant proportion of Sudanese women (23.9% of ever-married women aged 15–49 who have ever given birth). However, in Kassala state, for example, this figure almost triples to 62.5%.<sup>26</sup>

Most women in Sudan know about FGM; however, women with less education are less likely to know about it.<sup>27</sup> The most common **reasons given for the practice of FGM** in Sudan are ‘purification, cleanliness and hygiene, acceptability within the group and reducing sexual desire’.<sup>28</sup> A study of Nyala University students found that male students felt that religion was the most important reason for FGM, whereas female students felt that it was the least important (and that ‘traditional beliefs’ was the most important).<sup>29</sup> While 73% of male students would prefer to marry women who had not been cut, 64.5% would still have their daughters undergo FGM.<sup>30</sup>

There is evidence that **boys and men** feel a conflict, caused by the desire to protect girls and women, between the belief that FGM curbs a woman’s sexual desire and is a necessary part of her growth and development and the understanding of the health risks involved. Greater education in relation to these matters is clearly crucial.

Of women aged 15–49 who have heard of FGM, 40.9% believe that it should continue, while 52.8% believe that it should be abandoned. The lowest **level of support for stopping FGM** is in East Darfur (30.6%) and the highest is in Khartoum (71%). Women who have received a higher level of education

and are in the highest wealth quintile are considerably more likely to favour abandoning the practice than those who have received no formal education or are in the lowest wealth quintile.<sup>31</sup>

Younger women are less likely to intend to cut their daughters, as are those who have achieved higher levels of education and those in the richer quintiles.<sup>32</sup>

Of those Sudanese aged 15 years and over, 79.9% are literate (83.3% of men and 68.6% of women).<sup>33</sup> A child can expect to receive and complete, from primary to tertiary, seven years of **education**.<sup>34</sup> The MICS 2014 data suggests that more young women are becoming literate.<sup>35</sup> Since FGM in Sudan usually takes place at such a young age, it has been suggested that Sudanese girls are less likely to drop out of school due to FGM than girls in other countries where FGM is practised.<sup>36</sup>

The Federal Ministry of Health is responsible for healthcare in Sudan.<sup>37</sup> The **health sector** suffers from underfunding, a lack of human resources and problems associated with the instability of the country at present.<sup>38</sup>

According to the MICS 2014, in the age group 15–19, 11.8% of women have already given birth and 3.3% are pregnant.<sup>39</sup> 71.3% of births take place at home. Women living in urban areas are more likely than those living in rural areas to use a health facility (45.2% and 21.5% respectively).<sup>40</sup> 79.1% of women receive antenatal care from a skilled provider (90.8% in urban areas and 74.9% in rural areas).<sup>41</sup> Pregnancy is a leading factor in deaths among girls aged 15–19.<sup>42</sup>

Approximately 97% of Sudan's population is Sunni Muslim, and the remainder usually adhere to indigenous beliefs or Christianity.<sup>43</sup> **Religion** is still cited, particularly by young men, as a reason to continue practising FGM. Some religious leaders from conservative communities claim that criminalising the sunna form of FGM would be against Sharia law; this is a clear challenge to the passing of comprehensive anti-FGM legislation in Sudan.

Reporters Without Borders ranks Sudan 175 out of 180 countries in its 2019 World Press Freedom Index.<sup>44</sup> While the **media** has long struggled for freedom in Sudan, matters grew worse towards the end of 2018 when Bashir's government began a major crack-down on reporting, particularly in terms of any social or political unrest such as the anti-government protests that began at that time. After Bashir was overthrown, the media was opened up to an extent, but the Transitional Military Council soon put in place new restrictions, including internet shut-downs.<sup>45</sup> There remain 15 'red-line issues' that Sudanese journalists are restricted from reporting on.

As a result, people are turning to the internet and social media for uncensored news or to make their opinions heard. However, the state has the power to block any website that it deems a threat to national security, and activists and internet users have faced arrest over social media posts.<sup>46</sup>

**Access to media** in Sudan is often restricted by costs and the fact that only about half of households (44.9%) have electricity. Anti-FGM messaging targeted at urban areas is likely to reach people via both radio and television, but messaging targeted at rural areas, and the Darfur states in particular, is likely to be more effective and reach a wider audience via radio.

Social media is quickly becoming a powerful tool for activism in Sudan. Anti-government and feminist activists and protesters have coordinated their activities and spread their messages online, and powerful viral images are helping to change opinions and social norms. Successful anti-FGM media campaigns have been run nationally and regionally. The Population Council notes a need for

programmers to understand decision-making processes that lead people to abandon FGM and tailor programmes accordingly.<sup>47</sup>

Sudan has long been recognised internationally as a high-priority country for funding to end FGM. Vast sums of money have been committed to the country, particularly through the **United Nations Joint Programme (UNJP)**, which has entered Phase III (2018–2021), and the UK DFID-funded **Sudan Free of Female Genital Cutting (SFFGC)** programme, which is now in Phase 2 (January 2019–December 2024).

**The National Council for Child Welfare (NCCW)** is the government authority that plans and coordinates child welfare across Sudan, including FGM. It works in collaboration with partners at all levels, including various government departments, UN agencies, international non-governmental organisations, academia and community representatives.

The core strategies being used in the work to end FGM across Sudan are a **community and intergenerational dialogue** approach, facilitated by initiatives such as the Saleema Initiative. **Public declarations of abandonment** in Sudan are also reportedly successful in giving communities the opportunity to speak out against FGM. The **Saleema Initiative** emerged from communities as an innovative way of talking about FGM. It has equipped activists and the media with a new tool to address the social norms that support FGM. The name 'Saleema' (meaning 'pure, intact and unharmed') is being used to give positive connotations to giving up FGM, using a philosophy of 'Every girl is born Saleema; let her grow up Saleema.' Evaluations of the campaign to date show that it is proving effective in changing pro-FGM social norms.<sup>48</sup> Furthermore, the **Almawada wa Alrahma** ('Compassion and Mercy') campaign is being used to address rights and tackle violence against women and girls from a religious perspective.

In the spring/summer of 2019, the protests and subsequent political crisis impacted on anti-FGM work. Sudan has been dealing with a government shutdown, significant economic crisis, curfews and internet restrictions, which have inevitably impacted on programmes and advocacy work across the country. There are many practical issues and challenges to be overcome to resume activities and accelerate progress, and these are highlighted in detail in this new Country Profile by 28 Too Many. Importantly, with the new Transitional Government in place, partners in the anti-FGM network in Sudan now see an opportunity to rebuild momentum on the back of a much stronger emphasis on gender issues and the participation of women in the country's future.

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# Introduction

*'It is now widely acknowledged that [FGM] functions as a self-enforcing social convention or social norm. In societies where it is practiced it is a socially upheld behavioural rule. Families and individuals uphold the practice because they believe that their group or society expects them to do so. Abandonment of the practice requires a process of social change that results in new expectations on families.'*

*~ The General Assembly of the United Nations<sup>1</sup>*

**Female genital mutilation** (sometimes called female genital cutting and female genital mutilation/cutting) (FGM) is defined by the World Health Organization (WHO)<sup>2</sup> as comprising 'all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons.' FGM is a form of gender-based violence (GBV) and has been recognised as a harmful practice and a violation of the human rights of girls and women. At least 200 million girls and women alive today have had FGM in the 28 African countries where FGM is practised, in Yemen and in Indonesia.<sup>3</sup>

## History of FGM

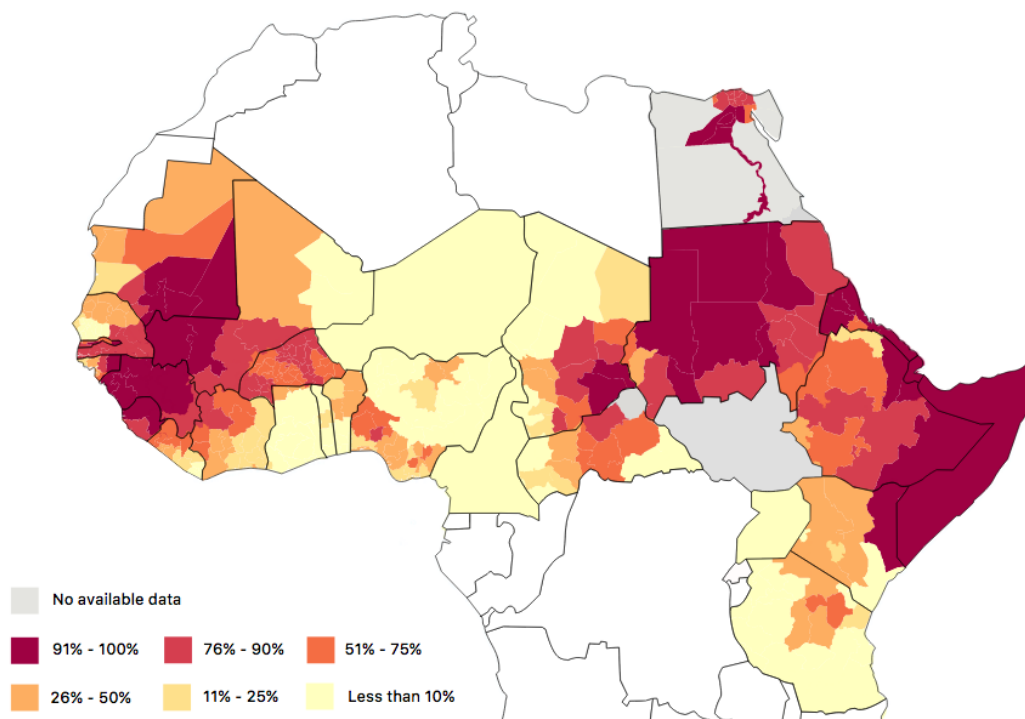
FGM has been practised for over 2,000 years.<sup>4</sup> Although it has obscure origins, there has been anthropological and historical research conducted into how FGM came about. It is found in traditional group or community cultures that have patriarchal structures. Although FGM is practised in some communities in the belief that it is a religious requirement, research shows that FGM predates Islam and Christianity. Some anthropologists trace the practice to 5<sup>th</sup> century BC Egypt, when infibulations were referred to as 'pharaonic circumcision'.<sup>5</sup> Other anthropologists believe that it existed among Equatorial African herders as a protection against rape for young women, as a custom among stone-age people in Equatorial Africa, or as 'an outgrowth of human sacrificial practices, or some early attempt at population control'<sup>6</sup>. There were also reports in the early 1600s of the practice in Somalia as a means of extracting higher prices for female slaves, and in the late 1700s in Egypt to prevent pregnancy in women and slaves.

FGM is practised across a range of cultures and it is likely that the practice arose independently among different peoples<sup>7</sup>, aided slave raids from Sudan for Egyptian concubines and the trading of maids through the Red Sea to the Persian Gulf<sup>8</sup>.

## Global Prevalence and Practices

FGM has been reported in 28 countries in Africa, mainly along a belt stretching from Senegal in West Africa, to Egypt in North Africa, to Somalia in East Africa and to the Democratic Republic of Congo in Central Africa. It also occurs in some countries in Asia and the Middle East and certain diaspora communities in North and South America, Australasia and Europe. As with many ancient practices,

FGM is carried out by communities as a heritage of the past and is often associated with ethnic identity. Communities may not even question the practice or may have long forgotten the reasons for it.



**Figure 1: Prevalence of FGM in Africa (© 28 Too Many)<sup>9</sup>**

The WHO<sup>10</sup> classifies FGM into four types:

<b>Type I</b>	Partial or total removal of the [external*] clitoris (clitoridectomy) and/or the prepuce
<b>Type II</b>	Partial or total removal of the [external*] clitoris and the labia minora, with or without excision of the labia majora (excision). [Note also that the term ‘excision’ is sometimes used as a general term covering all types of FGM.]
<b>Type III</b>	Narrowing of the vaginal orifice with the creation of a covering seal by cutting and appositioning the labia minora and/or the labia majora, with or without excision of the clitoris (infibulation).
<b>Type IV</b>	All other harmful procedures to the female genitalia for non-medical purposes, for example: pricking, pulling, piercing, incising, scraping and cauterization.
<b>Reinfibulation</b>	The procedure to narrow the vaginal opening in a woman after she has been deinfibulated (i.e. after childbirth); also known as re-suturing.

**Table 1: Types of FGM as classified by the WHO [\* added by 28 Too Many for clarification]**

FGM is often motivated by beliefs about what is considered appropriate sexual behaviour. Some communities consider that it ensures and preserves virginity and marital faithfulness and prevents promiscuity/prostitution. There is a strong link between FGM and marriageability, with FGM often being a prerequisite to marriage. FGM is sometimes a rite of passage into womanhood and necessary for a girl to go through in order to become a responsible adult member of society. FGM is also considered to make girls ‘clean’ and aesthetically beautiful. Although no religious texts require the

practice, practitioners often believe it has religious support. Girls and women will often be under strong social pressure, including pressure from their peers, and risk victimisation and stigma if they refuse to be cut.

FGM is always traumatic.<sup>11</sup> Immediate complications can include severe pain, shock, haemorrhage (bleeding), tetanus or sepsis (bacterial infection), urine retention, open sores in the genital region and injury to nearby genital tissue. Long-term consequences can include recurrent bladder and urinary tract infections, incontinence, cysts, psychological problems, infertility, an increased risk of new-born deaths and childbirth complications including fistula, and the need for later surgeries. For example, a woman with Type III infibulation will likely need to be cut open later to allow for sexual intercourse and childbirth.<sup>12</sup>

The vision of 28 Too Many is a world where every girl and woman is safe, healthy and lives free from FGM and other human-rights violations. A key strategic objective is to provide detailed, comprehensive country profiles for each of the 28 countries in Africa where FGM is practised. The profiles provide research into the situation regarding FGM in each country, as well as more general information relating to the political, anthropological and sociological environments in the country, to offer a contextual background. This can also be of use in relation to diaspora communities that migrate and maintain their commitment to FGM.

The country profiles also offer analyses of the current situation, and will enable all those with a commitment to ending FGM to shape their own policies and practice to create conditions for positive, enduring change in communities that practise FGM. We recognise that each community is different in its drivers for FGM and bespoke, sensitive solutions are essential to offer girls, women and communities a way forward in ending this practice. This research report provides a sound information-base that can contribute to determining the models of sustainable change necessary to shift attitudes and behaviours and bring about a world free of FGM.

During our research, we connect with many anti-FGM campaigners, CBOs, policy-makers and influencers. 28 Too Many wishes to continue to build upon its in-country networking to aid information-sharing, education and awareness of key issues, enabling local non-governmental organisations (NGOs) to be part of a greater voice to end FGM locally and internationally.

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# General National Statistics

This section highlights a number of indicators of Sudan's context and development status.

## **Population**

44,043,162 (1 October 2019)<sup>1</sup>

Growth rate: 2.93% (2018 est.)

Median age: 17.9 years

Human Development Index Rank: 167 out of 189 countries<sup>2</sup>

## **Age of Suffrage, Consent and Marriage**

Age of Suffrage: 17

Age of Consent: Marriage is legally required before sexual intercourse is allowed<sup>3</sup>

Age of Marriage: 'There is no legislation in Sudan to prohibit child marriage. The 2010 Child Act, for example, does not mention marriage in this context. Article 40 of the Muslim Personal Law 1991 cites that once a party is 10 years old, they may be married with the consent of their parent or guardian.'<sup>4</sup>

## **Health**

Life expectancy at birth (years): 65.8

Infant mortality rate (per 1,000 live births): 48 deaths (2015)<sup>5</sup>

Maternal mortality rate: 295 deaths/100,000 live births (2017)<sup>6</sup>

Fertility rate, total (births per woman): 4.85 (2018 est.)

HIV/AIDS – adult prevalence: 0.2% (2018 est.)

– people living with HIV/AIDS: 59,000 (2018 est.)

(country comparison to the world: 58)

– deaths: 2,900 (2018 est.)

## **GDP (in US dollars)**

GDP (official exchange rate): \$45.82 billion (2017 est.)

GDP per capita (PPP): \$4,300 (2017 est.)

GDP (real growth rate): 1.4% (2017 est.)

## **Literacy (percentage who can read and write)**

Adult (age 15 and over): 75.9% (female: 68.6%; male: 83.3%)

Youth (ages 15–24): 65.8%<sup>7</sup>



### **Urbanisation**

Urban population: 34.9% (2018)

Rate of urbanisation: 3.17% annually (2015–2020 est.)

### **Religions**

Sunni Muslim, small Christian minority

### **Ethnic Groups**

Unspecified Sudanese Arab (approximately 70%), Fur, Beja, Nuba, Fallata

### **Languages**

Arabic (official), English (official), Nubian, Ta Bedawie, Fur

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Unless otherwise stated, all statistics are taken from Central Intelligence Agency (2019) *The World Factbook: Sudan*, 23 September. Available at <https://www.cia.gov/library/publications/the-world-factbook/geos/su.html>.

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# Political Background

## Historical

Located adjacent to the Red Sea in north-eastern Africa, the Republic of Sudan was the largest African country, with land coverage of 2.5 million square kilometres, until it split to form Sudan and South Sudan in July 2011. It now has a population of 44 million people<sup>1</sup> and land coverage of 1.88 million square kilometres.<sup>2</sup> The majority of its population lives in rural areas, with only a third in urban cities. Its capital, Khartoum, is home to some 6–7 million people, which includes approximately two million who have been displaced by the conflict in the south and drought in the western and eastern parts of the country.<sup>3</sup>

70% of the population is Sudanese Arab. Many Arabs migrated to Sudan in the 12<sup>th</sup> century. Almost all Sudanese are Muslim and speak Sudanese Arabic. The rest of the population comprises numerous tribes having over 400 dialects and languages.

In ancient times Sudan was part of the Kingdom of Nubia, ruled by Egypt. During the 16<sup>th</sup> century, the country was conquered by a people called the Funj who, along with other African groups, moved into the south of the country. Britain and Egypt established a joint protectorate in 1898 and the country was known as Anglo-Egyptian Sudan until it achieved independence on 1 January 1956.<sup>4</sup>

Fundamental Islamist law was introduced in 1983, which deepened tensions between the Islamic Arab population in the north, who occupied the region as the country's seat of government, and the largely Christian African population in the south. Civil war continued through the 1980s and 1990s, and many people from the south were taken as slaves to work in the north. Lieutenant General Omar Bashir led a coup in 1989; he effectively ruled the country from then until the recent ousting of his government by the military in April 2019.<sup>5</sup>

A ceasefire was achieved in 2002 and talks took place throughout 2003, during which power-sharing with the southern states was agreed and a commitment made to hold a referendum on independence of the south after six years. Fighting continued throughout this period, however, and in 2004 included massacres of black villagers in the Darfur region by a pro-government militia called the janjaweed, which displaced more than a million people.<sup>6</sup> A further peace deal was drawn up in 2005 that gave roughly half of Sudan's oil wealth to the south, along with, essentially, complete autonomy and the right to secede in six years.<sup>7</sup>

Part of the deal was power-sharing in the interim, but further fighting broke out following the death in a helicopter crash of the first southern vice president, John Garang, just two weeks after he had been sworn in. The African Union and the UN Security Council sought peace talks between the parties and sent in peacekeeping forces, but these were attacked in late 2007, resulting in Darfur being razed and some 7,000 Darfuris left homeless.

Meanwhile, the Government had refused to hand over to the International Criminal Court (ICC) Ahmad Harun, Deputy Minister for Humanitarian Affairs and militia leader Ali Abd-al-Rahman, who were deemed responsible for the rape and displacement of thousands of civilians in the Darfur region.<sup>8</sup>

The Government and the janjaweed continued to attack the Darfur region into 2008, and in July the ICC indicted President Bashir with genocide of Darfur's main ethnic tribes by using 'rapes, hunger and

fear' to terrorise civilians.<sup>9</sup> In 2009 a further indictment was issued by the ICC against Bashir for war crimes and crimes against humanity. Bashir responded by shutting down the relief camps and agencies working in Darfur with those displaced by the conflict.

In 2010 Bashir won Sudan's first multi-party elections since 1986, taking 68% of the vote, although there were allegations of fraud and several opposition groups boycotted the election. Salva Kir was re-elected president of the semi-autonomous southern region, with over 90% of the vote.

### ***South Sudan Secedes from Sudan***

A referendum on the independence of the south was held in January 2011.<sup>10</sup> In that referendum, 98.8% voted for independence from the north. President Bashir agreed to honour the result, and on 9 July 2011 independence was declared and South Sudan became the 54<sup>th</sup> African State, with Juba as its capital.

Tensions between the two countries continued over oil, which was the main source of revenue to South Sudan. A deal on the oil was eventually reached in March 2013; meanwhile, Bashir had introduced austerity measures in Sudan that had resulted in a doubling of costs for cooking and gas and led to riots.<sup>11</sup>



***A woman supporting the Sudanese political protests***

## **Current Political Conditions**

### ***Bashir is Overthrown***

In April 2019, the army, led by Lieutenant-General Abdel Fattah al-Burhan, overthrew Bashir following months of street protests against his authoritarian rule.

In the immediate aftermath, as leader of a Transitional Military Council, Burhan promised a return to civilian rule in two years. However, despite releasing some of the people imprisoned under Bashir's emergency laws, Burhan has been cited as being in part responsible for the atrocities in Darfur.<sup>12</sup>

As a result of continued street protests, in August 2019, a power-sharing agreement was reached between the Transitional Military Council and representatives of an umbrella group of civilian pro-democracy protesters called the Alliance for Freedom and Change. Under this agreement the country will be run by a sovereign council, comprising six civilians and five generals, until elections are held in three years' time. Prime ministers will be elected and the role of council chair will be rotated between civilians and generals.<sup>13</sup>



*Sudan's Prime Minister Abdalla Hamdok was sworn into office on 21 August 2019*

*(Photographer: Christoph Wu)*

A month after the signing of the agreement, protesters returned to the streets demanding justice for the pro-democracy demonstrators who were killed earlier in the year. They called on the Transitional Government to appoint new senior judiciary officials; again, tear gas was used to break up the protest.<sup>14</sup>

General Hemeti, now vice-chair of the Transitional Council, has defended the violence used against protesters in Khartoum earlier in the year, which resulted in the deaths of 19 children,<sup>15</sup> and several massacres that have occurred in Darfur over the past decade.<sup>16</sup>

As a way of remembering and recognising the contribution of those protesters who were killed, leaders of one of the pro-democracy groups, the Sudanese Professionals Association, have been unofficially re-naming roads in Khartoum after those who lost their lives.<sup>17</sup>

Criminal proceedings for corruption charges against Bashir are expected to commence shortly. He has also been charged with incitement and killing of protesters, and the outstanding charge of genocide issued by the ICC remains.

### ***Women's Participation in the Current Protests***

Women have been at the forefront of the demonstrations – firstly those against Bashir and, more recently, those against the new military regime. There are reports that female protesters have been the main target of government and military forces and that many have been detained in crowded, windowless cells and threatened with sexual violence.<sup>18</sup>

A female student's protest songs about Bashir's regime went viral in April 2019 and became a symbol of the protests. Her white dress, known as a *toub*, has become a symbol for female protesters. (See a clip about women's role in the protests at <https://www.bbc.co.uk/news/av/world-africa-48027451/sudan-protests-the-women-driving-change>.)

It is estimated that 70% of the marchers against Bashir were women who want to see an end to the repressive laws of an Islamic state.<sup>19</sup> There are many stories of violence against them by members of security forces, even though the women have complied with conditions of Sudan's Public Order laws, which require them to wear a headscarf and not to wear trousers.<sup>20</sup> Not only have these women been protesting against Bashir's corrupt regime, but also they have been fighting laws such as these that repress women. It is estimated that each year between 40,000 and 50,000 women are arrested and flogged by public-order police because of their clothing.<sup>21</sup> (For further information on women's protests against repressive laws, see Media, pages 94 and 95.)



Awadia Mahmoud Koko, a grandmother who arranged hot meals for at least 2,000 protesters every day at the height of the demonstrations, said:

*'We want a new Sudan, and everyone has to take part in creating that new Sudan.'*<sup>22</sup>

### **Government Structure**

Until the recent takeover by the Transitional Military Council, Sudan was a democratic republic with an elected president as the head of government. The National Assembly comprised 450 appointed members and the Council of States comprised 50 elected members.<sup>23</sup> Legal decisions are based on Sharia Law.<sup>24</sup> The country is divided into 18 states, each having its own legislature and governor who, since 2015, has been appointed by the president. States are further divided into 133 districts. In addition, there are three autonomous regions: the Darfur Regional Authority, the Eastern Sudan States Coordinating Council and the Abyei Area Administration.

The Transitional Government was sworn in on Sunday, 8 September 2019.<sup>25</sup> Four women are included in the cabinet, and for the first time Sudan has a female foreign minister, Asmaa Abdallah, who is also the first female foreign minister in the Arab world. Madam Ne'imat Mohammad Khair was recently appointed chief justice and is also the first woman in Sudan's history to take the post. Negotiations have ensured that women will be better represented in the legislature in future, with 50% of the 300 seats guaranteed (at least on paper) for women.<sup>26</sup>

One of the stated values for Sudan's National Strategy 2007–2031 is 'Widening the full participation of political and social groups being a right for and duty of all.'<sup>27</sup>

Prime Minister Abdalla Hamdok has stated, 'We have to concentrate on women's participation. Sudanese women played a very big part in our revolution.'<sup>28</sup>



*Sudan's new cabinet (2019)*



*Figure 2: States of Sudan (@28 Too Many)*

## Current Economic Conditions

Oil was the mainstay of Sudan's economy from 1999 until 2011, when South Sudan was formed and took away three-quarters of Sudan's oil production.<sup>29</sup> Most of the population (an estimated 80%) relies on agriculture, and 36.1% live below the global poverty line.<sup>30</sup>

US sanctions were lifted in 2017, but austerity measures introduced by Bashir in 2012, which contributed to the recent protests and his overthrow, led to annual inflation rates of over 40%, only declining slightly to 32.4% in 2017.<sup>31</sup>

The Transitional Government has recognised that the main challenge now is reforming the economy. The new finance minister has said, 'We have a 200-day programme for reviving the economy in a way that could help reduce the cost of living for our people in the near term' as well as 'a long-term plan to restructure the overall economy.' The budget is to be overhauled to reduce the amount spent on war, with more funds going into education and infrastructure.<sup>32</sup>

### LIVING CONDITIONS

Less than half of Sudanese households have access to electricity (94.4% in Northern state, but less than 20% in Darfur and Kordofan and only 8.7% in North Darfur). Houses are constructed from natural materials and are usually unfinished. More people have access to animal-drawn transport than cars or trucks. Only 11.1% of people in urban households and 2.4% of people in rural households have personal bank accounts.<sup>33</sup>



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- 4 Infoplease (undated) *Sudan*, Chapter 1. Available at <https://www.infoplease.com/world/countries/sudan>.
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- 6 *Ibid.*, Chapter 3.
- 7 *Ibid.*
- 8 *Ibid.*, Chapter 4.
- 9 *Ibid.*
- 10 *Ibid.*, Chapter 5.
- 11 *Ibid.*, Chapter 8.
- 12 BBC News (2019a) *Sudan country profile*. Available at <https://www.bbc.co.uk/news/world-africa-14094995>.
- 13 BBC News (2019b) *Sudan conflict: Army and civilians seal power-sharing deal*, 17 August. Available at <https://www.bbc.co.uk/news/world-africa-49379489>.
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- 18 **See:** - Nima Elbagir, Sheena McKenzie, Abdulgader Bashir, Salah Nasir and Salma Abdalaziz (2019) 'They tried to use rape to silence protestors. It didn't work', *CNN*. Available at <https://edition.cnn.com/2019/05/17/africa/sudan-protests-asequals-intl/index.html>.  
**and** - Shannon Ebrahim (2019) 'Women of Sudan transform the paradigm', *IOL*, 19 May. Available at <https://www.iol.co.za/news/opinion/women-of-sudan-transform-the-paradigm-23553178>.
- 19 BBC News (2019e) *Letter from Africa: How 'cheating husbands' are linked to Sudan's protests*, 20 February. Available at <https://www.bbc.co.uk/news/world-africa-47291511>.
- 20 **The law is Article 152 of the Criminal Code and applies to 'indecent acts' in public.**
- 21 BBC News (2019f) *Letter from Africa: How 'cheating husbands' are linked to Sudan's protests*, 20 February. Available at <https://www.bbc.com/news/world-africa-47291511>.
- 22 Hamza Mohamed (2019) 'Sudan's female protesters leading the pro-democracy movement', *Al Jazeera*, 24 April. Available at <https://www.aljazeera.com/news/2019/04/sudan-women-protesters-leading-pro-democracy-movement-190423134521604.html>.
- 23 worldatlas (2019) *Politics: What type of government does Sudan have?* Available at <https://www.worldatlas.com/articles/what-type-of-government-does-sudan-have.html>.
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- 27 The General Secretariat of The National Council for Strategic Planning (2007) *The Twenty-Five Year National Strategy 2007–2031*, p.12.
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- 30 - *Ibid.*  
- African Development Bank Group Statistics Compartment (2018) *Sudan Poverty Profile: Summary Results of the 2014–2015 National Baseline Household Budget Survey*. Available at [https://www.afdb.org/fileadmin/uploads/afdb/Documents/Publications/Brief-Sudan\\_Poverty\\_Profile\\_2014-2015\\_-\\_Key\\_Findings.pdf](https://www.afdb.org/fileadmin/uploads/afdb/Documents/Publications/Brief-Sudan_Poverty_Profile_2014-2015_-_Key_Findings.pdf).
- 31 Countries of the World, *op. cit.*
- 32 Sarah El-Sheikh, *op. cit.*
- 33 MICS 2014, p.15.

**Image page 25:** Sudan Tribune (2013) *Woman holds a picture of the protests in Khartoum, while demonstrating outside the Sudanese Embassy in London.* (Photographer: Izzeldin Taha.) Available at <https://flic.kr/p/goM4fS>. CCL: <https://creativecommons.org/licenses/by-nc-sa/2.0/>.

# Laws Relating to Women and Girls

For information on international and African regional laws relating to FGM, please refer to the **Law Factsheet** on our website.

## International and Regional Treaties

Many of the international human-rights conventions and treaties related to the practice of FGM have been signed and ratified by Sudan. The ratification of these conventions places a legal obligation on the Government to ensure that FGM, as an international human-rights violation, is eradicated by putting certain provisions in place such as anti-FGM laws.

Sudan has ratified or signed up to the following conventions and treaties.<sup>1</sup>

### *International*

- **The Universal Declaration of Human Rights**, 1942
- **International Covenant on Civil and Political Rights**, 1966 (acceded in 1986)
- **International Covenant on Economic, Social and Cultural Rights**, 1966 (acceded in 1986)
- **Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment**, 1984 (signed in 1986 but not ratified)
- **Convention on the Rights of the Child**, 1989 (signed and ratified in 1990)

Sudan has not signed the **Convention on the Elimination of All forms of Discrimination Against Women** of 1979.

### *Regional*

- **African Charter on Human and Peoples' Rights** (*Banjul Charter*), 1981 (signed 1982; ratified 1986)
- **African Charter on Human and Peoples' Rights on the Rights of Women in Africa** (*Maputo Protocol*), 2003 (signed in 2008 but not ratified)

Sudan has not signed the **African Charter on the Rights and Welfare of the Child** of 1990, of which Article 21 requires states to 'take all appropriate measures to eliminate harmful social and cultural practices affecting the welfare, dignity, normal growth and development of the child . . .'.<sup>2</sup>

## National Laws

Sudan has a federal system of government. Following the separation and independence of ten southern states in 2011 to become South Sudan, the country of Sudan now comprises the remaining 18 states, which are grouped into five provinces. It has a mixed legal system of Islamic law and English common law.

### *The Constitution*

The **Constitution of the Republic of Sudan 2005 (as amended)**<sup>3</sup> places various obligations on the State to protect women and children. **Article 15(2)** says that the State shall protect ‘women from injustice, promote gender equality and the role of women in family, and empower them in public life.’ **Articles 28 and 33** state that everyone has ‘the inherent right to life, dignity and the integrity of his person’ and that ‘[n]o person shall be subjected to torture or to cruel, inhuman or degrading treatment.’ Although the Constitution does not specifically mention FGM, **Article 32** refers to harmful practices in relation to the ‘Rights of Women and Children’: The State is obliged to **(2)** ‘promote women’s rights through affirmative action’, **(3)** ‘combat harmful customs and traditions which undermine the dignity and status of women’ and **(5)** ‘protect the rights of the child as provided in the international and regional conventions ratified by Sudan.’

### *Age of Suffrage, Consent and Marriage*

The age of suffrage is 17. Marriage is legally required before sexual intercourse is allowed; therefore, there is no defined age of consent.<sup>4</sup> In countries where FGM is linked with rites of passage into adulthood, girls are usually seen as marriageable once they have undergone FGM. Girls not Brides reports that the Government of Sudan has recognised the problem of child marriage in the country and is taking steps to eliminate it, in line with Sustainable Development Goal Target 5.3. However, there is no law against child marriage at present, and Article 40 of the Muslim Personal Law of 1991 states that a party may be married once they reach the age of ten if his/her parents or guardians consent.<sup>5</sup>

### *Laws Against FGM*

There is currently no national law against FGM covering the whole of Sudan. To date, six states have put laws in place that only apply to FGM undertaken within their boundaries: South Kordofan, Gadarif, South Darfur, Red Sea, North Kordofan and Northern.

Although in 1946 Sudan was the first country in Africa to criminalise Type III FGM (‘infibulation’), the article was subsequently removed from the **Penal Code** following the introduction of Sharia law in 1983. More recently, in September 2016, an amendment to the **Criminal Act (1991)** was approved by the Council of Ministers to criminalise all forms of FGM under a new **Article 141**; at the time of writing it is still pending endorsement by parliament. The UNFPA-UNICEF Joint Programme to Eliminate FGM (*UNJP*) reports that in 2018, following its endorsement by the Council of Ministers, Article 141 was passed to the Health and Legal Committee for revision (although further details are unavailable and political unrest since has caused delay to its progress).<sup>6</sup>

In the absence of national legislation criminalising FGM, there are laws that refer to causing harm to another person and the protection of children that are applicable across Sudan:

- **Criminal Act (1991)**<sup>7</sup> – **Section 138** defines ‘wounds’ inflicted on another person (both ‘intentional’ or ‘semi-intentional’) to include the loss of an organ or any of the senses and sets out the penalties for committing the offence. **Section 142** defines ‘hurt’ as causing pain to another person and is punishable accordingly.
- **Child Act (2010)**<sup>8</sup> – **Chapter II, Article 5** protects children (under 18 years of age) from all forms of violence, harm and physical and psychological abuse; **sub-section (2)(k)** specifically states, ‘This

Act ensures the protection of a male, or female Child, against all types and forms of violence, injury, inhuman treatment, or bodily, ethical or sexual abuse, or neglect or exploitation.’ The drafting of this law was started in 2007, and in 2009 it was proposed to include an **Article 13** that would explicitly criminalise all forms of FGM. However, following subsequent representations by religious leaders claiming this article was against Sharia, the president ordered its removal.<sup>9</sup>

The following states have attempted to criminalise FGM:

- **South Kordofan** (FGM prevalence 88.8%) – the first Sudanese state to adopt legislation. The **Prevention of Female Genital Mutilation Act (2008)**<sup>10</sup> places responsibility on parents and guardians to protect girls (up to 18 years of age) from FGM. Reporting incidents of FGM is the responsibility of all. This law also provides for the payment of compensation to the victim of FGM by the person who performed the act.
- **Gadarif** (FGM prevalence 78.5%) – the second state to introduce a law. Under **Article 13 of the Child Law 2009**, all harmful traditional practices (including FGM) are prohibited. This is applicable to all forms of FGM.<sup>11</sup>
- **South Darfur** (FGM prevalence 88.2%) – under **Article 11 of the South Darfur State Child Act 2013**, all forms of FGM are prohibited.<sup>12</sup>
- **Red Sea** (FGM prevalence 89%) – the Red Sea succeeded in introducing a law in 2007 prohibiting all forms of FGM, only for it to be repealed following protests from the Beja ethnic group.<sup>13</sup> Following the death of an infant girl from FGM in 2009, pressure to criminalise the practice increased again and the **Child Act 2011** reportedly included the potential under **Article 10** for FGM prohibition, although only for the most severe type (infibulation, also known as ‘pharaonic circumcision’ in Sudan). The Ministry of Health, however, has yet to issue a decree; hence, to date, the law has still not been fully enacted.<sup>14</sup>
- Most recently, in 2018, both **North Kordofan** (FGM prevalence 97.7%) and **Northern** state (97.5%) passed laws banning FGM, although content was not available to 28 Too Many at the time of writing.
- According to the most recent UNJP report, **White Nile** (FGM prevalence 93.7%) also submitted to its legislative council a state law banning FGM. Advocacy work around new state laws also continued in **Blue Nile** (68.0%) and **North Darfur** (97.6%).<sup>15</sup>

While there are no **customary laws** surrounding FGM in Sudan, some religious leaders support *sunna* cutting (which includes partial or total removal of the external clitoris) and claim that criminalising it would be against Sharia. This has been a clear challenge to the passing of comprehensive legislation in Sudan.

### **Medicalised FGM**

Medicalised FGM is significant in Sudan; according to the Secondary Analysis of 2014 data, 77.9% of women in urban areas and 56.7% of women in rural areas (aged 15–49) have been cut by ‘trained midwives’. The rate of medicalisation also varies by state, and the analysis shows that it has increased significantly over time.<sup>16</sup>

National legislation does not effectively uphold professional ethics for medical personnel in Sudan. **Medical Council Resolution Number 366 from 2002** prohibits doctors and midwives from performing all forms of FGM<sup>17</sup> and has resulted in the verbal commitment taken by midwives to not practice FGM

(known as the **midwives oath** – see page 87). All involved, including the hospital or healthcare facility, will be subject to punishment if caught performing FGM. The sanctions, however, are only administrative in nature rather than criminal. Punishment for doctors and midwives under this resolution is at the discretion of the Medical Council and can result in the annulment of practicing licences and dismissal from the profession.

It is understood that, in South Kordofan, the Ministry of Health has issued a code of conduct for midwives, instructing them not to perform FGM, and implemented reproductive health programmes to raise awareness of the effects of FGM and why it should not be practised. Furthermore, South Kordofan's **Prevention of Female Genital Mutilation Act** calls for life imprisonment, cancellation of medical licences for doctors and nurses, and confiscation of property for repeat offenders. 28 Too Many is not aware, however, of any cases of doctors or midwives being prosecuted under this law.

### ***Cross-Border FGM***

In some countries where FGM has become illegal, the practice has been pushed underground and across borders to avoid prosecution. Sudan shares borders with other countries where the prevalence of FGM and the existence and enforcement of anti-FGM laws vary, including Egypt, Eritrea, Ethiopia and South Sudan.

It is not known to what extent the movement across national borders for FGM is an issue in Sudan. It is possible that families from other countries are crossing borders into Sudan to avoid prosecution.

## **Law Enforcement**

Nationally, there are no specific penalties in Sudan for practising FGM.

**The Criminal Act (1991)** sets out the following penalties for causing 'wounds' or 'hurt':

- **Section 139** – anyone causing 'intentional wounds' to another person is subject to punishment of up to five years' imprisonment, or a fine, or both;
- **Section 140** – anyone causing 'semi-intentional wounds' to another person is subject to punishment of up to three years' imprisonment, or a fine, or both; and
- **Section 142** – anyone causing 'hurt' to another person is subject to punishment of up to six months' imprisonment, or a fine, or both.

Examples of penalties in individual state laws include:

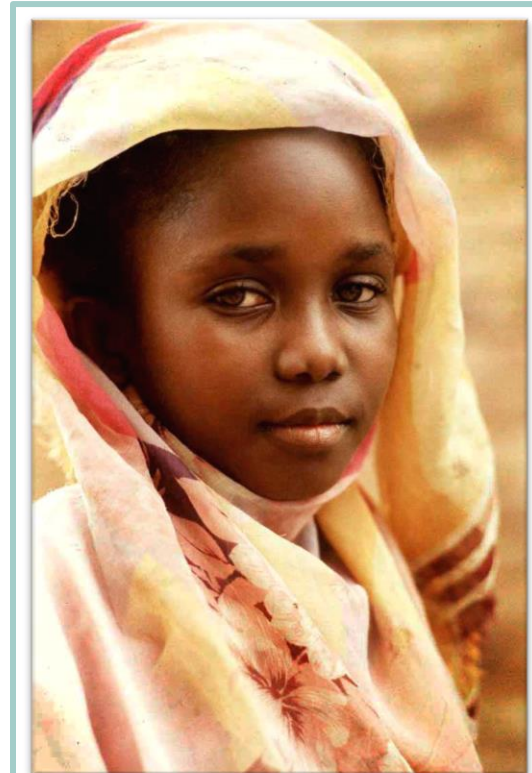
- **South Kordofan** – The Prevention of Female Genital Mutilation Act (2008) includes a range of penalties, from three years' imprisonment and compensation payable to the victim, to up to ten years' imprisonment and compensation payable to the victim's family in the case of the victim's death.
- **Gadarif** – The Child Law 2009 stipulates a maximum of 6 months' imprisonment or a fine of not less than 100 SDG (approximately US\$5.50)<sup>18</sup>, or both, but without prejudice to any civil compensation that may be available. It also stipulates that the court concerned may give part of the fine to the victim.
- **South Darfur** – The Child Act 2013 does not include a provision for penalties.
- **Red Sea** – The Child Act 2011 does not include a provision for penalties.



There are no reported cases of arrests or court proceedings in relation to FGM, nor is there evidence of the **Criminal Act (1991)** being used to prosecute perpetrators of FGM.

Enforcement across the six states that have attempted to criminalise FGM has varied to date. Anecdotal evidence suggests that the laws are either not enforced at all or only to a very limited extent. Even though there are still reports of girls dying following FGM, no high-profile cases have been brought to court under state laws in recent years. Back in 2009, local media reported that a 40-day-old girl died after being cut in the Red Sea state. Although the case was reported to the police, the family refused to give the name of the midwife responsible for the act.<sup>19</sup>

According to the UNJP, advocacy efforts continue across states to ensure that there is political commitment to the enforcement of laws where they are already in place.<sup>20</sup>



*In 2019, Sudanese girls are still not protected from FGM by the law*

## Civil Society Observations

There is a wide network of NGOs in Sudan working to mobilise communities and implement the different strategies of the national campaign to end the practice. These efforts, however, are not being supported by national legislation. Many civil-society organisations (CSOs), for instance, petitioned the president in 2009 against the removal of Article 13 from the Child Act and also to include the prohibition in other acts and byelaws, as necessary, to ensure the success of the national campaign to eliminate FGM. Their efforts to tighten the law were unsuccessful.<sup>21</sup> Most recently, political unrest throughout Sudan has also delayed the progress of laws to ban FGM.

Civil society also reports that, even in states where laws have been passed criminalising FGM, there are many challenges to implementing them, including a lack of knowledge around the meaning and content of the law, even among the police and judiciary. It is suggested that, unless FGM has caused life-threatening loss of blood or actual death, cases are not usually pursued. There is also the challenge that the midwives performing FGM are well-respected practitioners, particularly in rural areas, in terms of maternal healthcare and attending difficult births, and hence there is a reluctance to bring charges against them. The resistance of religious and community leaders to the anti-FGM campaign also restricts victims' access to justice.

It is clear from discussions during this research that there is real hope among those working to end FGM in Sudan that the amendment to the Criminal Code will be back on the agenda and that new government ministers who are speaking out against the practice, such as the minister of social welfare, will recognise the huge significance of passing into law a ban on all types of FGM. There remains opposition to getting the legislation through, however, particularly from religious leaders, and the challenge of mobilising communities so that they are accepting of the law and FGM is not driven underground. Civil society reports, however, that some communities are at a tipping point and the law could encourage them to finally stop the practice.



- 1 **'Signed': a treaty is signed by countries following negotiation and agreement of its contents.**  
**'Ratified': once signed, most treaties and conventions must be ratified (i.e. approved through the standard national legislative procedure) to be legally effective in that country.**  
**'Acceded': when a country ratifies a treaty that has already been negotiated by other states.**
- 2 African Commission on Human and Peoples' Rights (1999) *African Charter on the Rights and Welfare of the Child*. Available at <http://www.achpr.org/instruments/child/#a21>.
- 3 *Sudan's Constitution of 2005* (2005) Available at [https://www.constituteproject.org/constitution/Sudan\\_2005.pdf?lang=en](https://www.constituteproject.org/constitution/Sudan_2005.pdf?lang=en).
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- 6 UNFPA-UNICEF Joint Programme on the Elimination of Female Genital Mutilation (2018) *Accelerating Change: Annual Report 2018*, p.100. Available at <https://reliefweb.int/sites/reliefweb.int/files/resources/19-152-UNJP-FGM-AR2018-Aug2019.pdf>.
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- 11 Ahfad University for Women (2013) *Evidence based advocacy for ending FGM/C in Sudan*, 3 May. The Free Library. Available at <https://www.thefreelibrary.com/Evidence+based+advocacy+for+ending+FGM%2fC+in+Sudan.-a0414006443>.
- 12 United Nations, UNAMID, African Union and United Nations Human Rights Office of the High Commissioner (undated) *Human Rights Situation in Darfur in 2013*, paragraph 27. Available at [http://www.ohchr.org/Documents/Countries/SD/UNAMID\\_OHCHR\\_situation\\_Darfur2013.pdf](http://www.ohchr.org/Documents/Countries/SD/UNAMID_OHCHR_situation_Darfur2013.pdf).
- 13 Liv Tønnessen, Samia El-Nagar and Sharifa Bamkar, *op. cit.*
- 14 *For further analysis on the Red Sea Child Act see* <https://www.cmi.no/publications/file/6229-weak-law-forbidding-female-genital-mutilation-in.pdf>.
- 15 UNFPA-UNICEF Joint Programme on the Elimination of Female Genital Mutilation, *op. cit.*
- 16 Secondary Analysis, pp.24–26.
- 17 United Nations Economic Commission for Africa (2012) *African Women's Rights Observatory: Sudan*. Available at <http://www1.uneca.org/awro/CountrySpecificInformationSudan.aspx>.
- 18 **As at 10 April 2018 (<https://www.xe.com/currencyconverter/convert/?Amount=100&From=SDG&To=USD>).**
- 19 Liv Tønnessen, Samia El-Nagar and Sharifa Bamkar, *op. cit.*
- 20 UNFPA-UNICEF Joint Programme on the Elimination of Female Genital Mutilation, *op. cit.*
- 21 The Female Genital Cutting Education and Networking Project (2009) *SUDAN: Letter To Sudan President On Female Genital Cutting*, 26 March. Available at <http://fgmnetwork.org/gonews.php?subaction=showfull&id=1238088339&>.

**Image page 34:** Steve Evans (2005) *Sudan. Khartoum marketplace. Outdoor food stall. This young girl served our food and captured my adoration...* Available at [https://commons.wikimedia.org/wiki/File:Sudan\\_-\\_young\\_girl\\_in\\_Khartoum.jpg](https://commons.wikimedia.org/wiki/File:Sudan_-_young_girl_in_Khartoum.jpg). CCL: <https://creativecommons.org/licenses/by/2.0/deed.en>.

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# Anthropological Background

There are 19 major ethnic groups and more than 597 ethnic subgroups in Sudan, speaking more than 100 languages and dialects. Minority Rights Group International notes:

While intermarriage and the coexistence of Arab and African peoples in Sudan over centuries has blurred ethnic boundaries to the point where distinctions are often considered impossible, ethnic boundaries have [re-emerged] in response to decades of conflict fueled by political manipulation of identity.<sup>1</sup>

Some of Sudan's ethnic groups are as follows:

- **Sudanese Arabs** form the largest single ethnic group, at 22 million, making up about 70% of the total population.<sup>2</sup> They are generally Muslim and speak Sudanese Arabic.
- About 1% of the population are **Copts**, the largest group of practising Christians.<sup>3</sup>
- The **Fur** largely inhabit western Sudan (particularly Darfur), and speak Fur. They do not practise FGM.
- The **Beja**, of which there are well over a million in Sudan, have, in recent times, lived largely in the Eastern Desert. The Beja were heavily involved in protests in Red Sea state that resulted in the repeal of a 2007 law prohibiting all forms of FGM.
- Various ethnic groups residing in the Nuba Mountains of South Kordofan constitute the **Nuba**. There is believed to be more than a million Nuba in that region.
- Originating from the Nile valley, the Arabic-speaking **Nubians** are largely Muslim.
- The **Zaghawa**, or **Beri**, are semi-nomadic, but mainly found in the Darfur region.

Like the Fur, the **Hawsa** and **Umbarraro** do not practise FGM.<sup>4</sup> Table 2 below shows the ethnic composition of Sudan's states, whether or not those groups practise FGM and at what age girls from each group are usually cut.



*FGM is typically performed on girls from the Halanga tribe in Kassala between the ages of five and seven*

State	Ethnicity/Tribe	Do They Practise FGM?	Typical Age of Cutting (Years)
North Darfur	Masalit, Zaghawa, Fur, nomadic groups	Not all practise; e.g. Fur, Hawsa and Umbarraro do not	11–14
Northern	Nubians, Danagla, Mahas, Copts	Yes	5–8
East Sudan (Kassala, Red Sea)	Beja (Halanga, Hadandawa, Beni Amir), Rashaida	Yes	Majority prior to 5–7 Rashaida (prior to 2–5)
Gadarif	Shukria, Hawsa, Nuba	Yes	5–11
Blue Nile	Anuak, Fellata, Nuba	Yes	5–11
Gezira	Fulani, Hawsa, Ja'aleen, Magharba, Abdallab, Copts	Yes	5–8
White Nile	Hassania, Danagla, Copts	Yes	5–8
North Kordofan	Hamar, Baggara, Messeria, Rizaigat	Yes, all practise	7–12
South Kordofan	Messeria, Dinka, Nuba	Merreriya – yes Dinka and Nuba - no	7–12
River Nile	Ja'aleen, Shawaiga, Abdallab, Copts	Yes	5–8
South Darfur	Masalit, Zaghawa, Fur, nomadic, Ta'isha groups, Rizaigat	Not all practise; e.g. Fur, Hawsa, Umbarraro do not	7–12
West Darfur	Masalit, Zaghawa, Fur, Ta'isha, nomadic groups	Not all practise; e.g. Fur, Hawsa, Umbarraro do not	7–12
East Darfur	Barbo, Rizagat, Ma'alia, Ta'isha	Not all practise; e.g. Fur, Hawsa, Umbarraro do not	Not available
Khartoum	All tribal groups including those from South Sudan	Yes, except for those who have received focused anti-FGM programming and the Hawsa	5–7

**Table 2: Ethnic composition of states, practice of FGM by each ethnic group and typical age-range of cutting (data compiled by the Child Protection Section, UNICEF Sudan)<sup>5</sup>**

The UNFPA has concluded that:

ethnicity is the most significant factor in FGM prevalence, cutting across socio-economic class and level of education. Members of certain ethnic groups often adhere to the same social norms, including whether or not to practice FGM, regardless of where they live.<sup>6</sup>

One study has found that, in Khartoum State, the age of cutting also varies between different ethnic groups. For example, girls from the Gamoeia ethnic group are cut between the ages of six and nine, usually during the school holidays, whereas girls from the Melaoha ethnic group (who are Sudanese Arabs) are cut in the week following their birth, so that the same midwife who attended the birth can perform FGM. One Melaoha mother said:

*'We cut our girls in the Semaya ['naming'] part or in the Sebooa ['seventh day celebration'] so we can have the same midwife to do the birth and the circumcision.'*<sup>7</sup>

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1 Minority Rights Group International, *op. cit.*

2 worldatlas (2019) *Ethnic Groups of Sudan*. Available at <https://www.worldatlas.com/articles/the-ethnic-groups-in-sudan.html>.

3 *Ibid.*

4 Secondary Analysis, p.11.

5 Secondary Analysis, p.16.

6 The UNFPA as cited in the Secondary Analysis, p.15.

7 A. Gamal Eldin, S. Babiker, M. Sabahelzain and M. Eltayeb (2018) 'FGM/C Decision-Making Process and the Role of Gender Power Relations in Sudan', *Evidence to End FGM/C: Research to Help Girls and Women Thrive*, p.14. New York, NY: Population Council.

**Image page 36:** j-pics.info (2010) *Faces and People (Sudan)*. Available at <https://flic.kr/p/8pzQwL>.  
CCL: <https://creativecommons.org/licenses/by-nc-sa/2.0/>.

# The Role of Women in Society

Gender inequality remains a crucial barrier to human development. Globally, women and girls have made a push for equality, but have yet to gain it.

Women and girls are heavily discriminated against in a plethora of ways, which hinder levels of development. The UN uses the **Gender Inequality Index (GII)** to measure three aspects of human development: reproductive health, empowerment and economic status; thus, the GII is used to measure the cost to human development of gender inequality. It is calculated using factors such as maternal mortality, adolescent birth rate, share of seats in parliament held by women, population with some secondary education, and labour-force participation.<sup>1</sup> The higher the GII value, the greater the disparity between men and women (and boys and girls) and the more loss to human development (and, therefore, the lower the likelihood of equal status between women and men).

The GII investigates 160 countries to 'highlight areas in need of critical policy intervention and it stimulates proactive thinking and public policy to overcome systematic disadvantages of women.'<sup>2</sup>

Sudan is currently ranked 139 out of the 160 countries, with a GII value of 0.564 (see Table 3).<sup>3</sup>

Year	2013	2014	2015	2016	2017
Sudan's GII Value	0.598	0.593	0.573	0.564	0.564

**Table 3: Sudan's Gender Inequality Index values 2013–2017<sup>4</sup>**

The OECD Development Centre assigns **Social Institutions and Gender Index (SIGI)** values to countries based on the laws, attitudes and practices that impede women's access to equality.<sup>5</sup>

In 2014, Sudan was assigned a value of 0.555, classifying it as having 'very high' levels of gender inequality, the highest classification the SIGI gives.<sup>6</sup>

These two values in conjunction are evidence that women face a high level of **gender inequality** in Sudan.

Freedom House's 2018 **Freedom in the World** investigation, published in 2019, measured 50 'Not Free' countries, and Sudan's **political rights and civil liberties** were given extremely low rankings. It should, however, be noted that these rankings were given while Bashir was still in power.<sup>7</sup>

## Rights Under The Constitution and International Treaties

Although Sudan has not signed the Convention of the Elimination of All Forms of Discrimination or ratified the Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa, the country has signed the Universal Declaration of Human Rights and the Convention on the Rights of the Child and 'recognizes the international obligations, principles, and standards on gender equality and the human rights of women and girls' in relation to the treaties it has signed.<sup>8</sup>

The **constitutional position** in Sudan is complex. The most recent Constitution, the Interim National Constitution of the Republic of Sudan<sup>9</sup> as amended in 2017,<sup>10</sup> does provide some focus on gender, as follows.

### **Article 31: Equality Before the Law**

- (1) All persons are equal before the law and are entitled without discrimination, as to race, colour, sex, language, religious creed, political opinion, or ethnic origin, to the equal protection of law.
- (2) All persons are equal in rights to hold elected or public positions, in litigations, and judicial or general humanitarian actions, legal or national dealings without discrimination provided that they be eligible.

### **Article 32: Rights of Women and Children**

- (1) The State shall guarantee equal rights of men and women to the enjoyment of all civil, political, social, cultural and economic rights, including the right to equal pay for equal work and other related benefits.
- (2) The State shall promote women rights through positive discrimination actions.
- (3) The State shall combat harmful customs and traditions, which undermine the dignity and the status of women.
- (4) The State shall provide maternity, childcare and medical care for pregnant women.
- (5) The State shall protect the rights of the child as provided in the international and regional conventions ratified by Sudan.

Additionally, **Article 15(2)** states, ‘The State shall . . . empower women in public life.’<sup>11</sup>

Included in the Interim Constitution is a bill of rights, which states at **Article 1(2)** that ‘The State is committed to the respect and promotion of human dignity; and is founded on justice, equality and the advancement of human rights and fundamental freedoms.’<sup>12</sup>

Despite the abovementioned laws, which speak to the equality of women with men, the human-rights situation in Sudan reveals a pattern of subservience and subordination. Women and girls face frequent discrimination, which has escalated during periods of conflict; for example, they require male permission to travel or obtain official identification.

## **Women in Politics**

**Article 41** of the Interim Constitution states:

- (1) Every citizen shall have the right, without unreasonable restrictions, to take part in the conduct of public affairs, through voting.
- (2) Every citizen shall have the right to stand for elections in periodic elections, which shall be by universal adult suffrage and shall be held by secret ballot, guaranteeing the free expression of the will of the electorate.

Women, therefore, are able to vote and stand for election in both national and local elections.

The National Elections Act 2008 required that 25% of seats in the national and state parliaments be allocated to women. This quota contributed to increased political participation by women – 28% of seats were held by women in 2010 compared to 4.9% in 1980.<sup>13</sup>



According to data gathered by the Inter-Parliamentary Union In February 2019, based on elections held in 2015, women held 27.7% of seats in the Lower/Single House and 26.8% of seats in the Upper House/Senate. In September 2019, after several months of political upheaval in Sudan, the new cabinet of the Transitional Government was introduced. It now includes four women, including a female foreign minister and a female chief justice, the first in Sudan's history.



*Many Sudanese women have jobs in the informal sector and are not protected under workers' rights*

## Resources and Entitlements

Under Sudanese law there are three conditions for a **marriage** contract. Firstly, both parties must agree to marriage and its contract. Secondly, the marriage contract must be announced by two Muslim witnesses. Lastly, the couple must be of age (18), because the Sudanese Constitution (at Article 15) attempts to halt early and involuntary marriage.

However, there is a contradiction in the law due to Sudan's adherence to Sharia law. Under Article 40 of the Personal Status Law of 1991, once a party is ten years old, they may be married with their parent's or guardian's consent.<sup>14</sup> Additionally, 'the insane, imbecile, or the special needs' person may be married with the authorisation of their guardian and proof of favourable interest; this may or may not leave the door open to marriage before the age of 18 for such persons.<sup>15</sup>

As the case of Noura Hussein (see Physical Integrity below) demonstrates, **forced marriages** – which are agreed between the father and the husband – do occur in Sudan. Although marriages are meant to be a consensual contract between a man and a woman, the MICS 2014<sup>16</sup> found that 38% of people aged 20–49 were married before the age of 18, 11.9% of people aged 15–49 were married before the

age of 15, and 21.2% of people aged 15–19 are already married. Further, Sudan (according to UNICEF statistics) has the 16<sup>th</sup>-highest number of child brides – 640,000.<sup>17</sup> Child marriage is driven by many factors, some of which include poverty, power dynamics and traditional customs, including FGM. In 2015 Sudan created the African Union Campaign to stop child marriage, in line with its commitment to Sustainable Development Goal Target 5.3 to eliminate child marriage by 2030.<sup>18</sup>

The **marital relationship** between Sudanese men and women is inherently unequal – women are subordinate. The Personal Status Law defines the rights of both husband and wife, in which there are crucial differences. Section 51 details that the wife is to be provided with living expenses and states that a husband must not interfere with his wife’s personal property or harm her financially or emotionally. Section 52 states that it is the husband’s right to be taken care of and obeyed, and that his wife must ‘preserve herself and his property’.<sup>19</sup>

A husband may **divorce** his wife without a court order by way of *talaq*, yet a wife must apply through the courts. Divorce may be granted on certain grounds, including a husband’s cruelty, illness or absence (for a year or more), or if he causes general harm. In the event of a divorce, the custody of any children comes into dispute. Under Articles 234 and 235 of the Personal Status Law, the father is the legal guardian; however, if the children are young, they may stay with the mother until the son is seven and the daughter is nine. The mother may be granted further custody if it is in the best interest of the child.<sup>20</sup>

Women in Sudan are able to take up **employment**, and the proportion of women working rose from 12% to 28% between 1993 and 2008. When women do participate in the labour force, it tends to be within the informal economy; for instance, selling street food. Many women work in sectors where they do not obtain social nor workplace protections, such as agriculture or domestic service.

The protection of female workers has been provided for within the INC, the Labour Act 1997 and the National Civil Service Act 2007. Many acts and regulations aim to enforce equal pay, promotions based on achievement and maternity leave and ensure that women are not subjected to dangerous work. Under the Labour Act, working mothers are granted nursing periods alongside maternity leave, although problems do arise for mothers as there is no legislation against the dismissal of pregnant women.<sup>21</sup>

According to Article 43 of the INC, women have the right to own **property**, and government-owned land is available for rent by both men and women; however, women usually lack sufficient economic resources and therefore cannot in practice purchase land. Alongside this, private land is often registered in the name of the head of the household, which goes to the male of the family, based on longstanding custom.<sup>22</sup>

## Physical Integrity

Physical violence and sexual harassment are widespread problems for Sudanese women. Nevertheless, there are some policy frameworks that seek to protect women and girls from violence.

The 1991 Criminal Act was amended in 2015 as there was no prior definition of ‘rape’. The 1991 Act did not, however, address domestic violence or marital rape. Article 149 defines **rape** as:

whoever makes sexual contact by way of penetrating a sexual organ or any object or part of the body into the victim's vagina or anus by way of using force, intimidation, or coercion by fear of the use of violence, detention, psychological persecution, temptation, or abuse of power against the person or another person, or when the crime is committed against a person incapable of expressing consent because of natural causes or luring-related or related to age.<sup>23</sup>

Article 151 criminalises **sexual harassment** and seeks to provide justice for victims. It defines 'sexual harassment' as an action by someone who:

speaks or behaves in a way that causes seduction or temptation for another person to engage in illegal sex, or to commit indecent or inappropriate behaviour of a sexual nature that psychologically harms the victim or makes the victim feel unsafe . . .<sup>24</sup>

Article 156 of the Criminal Procedure Act of 1991 attempts to protect **women during court proceedings that concern violence** by deterring emotionally harmful questions.<sup>25</sup>

There is no **domestic violence** legislation in place to protect women from their husbands.

Although domestic violence is a prominent issue, the social stigma victims face causes an absence of reporting. Despite the provisions of Article 156 of the Criminal Procedure Act, an overall lack of support and reporting mechanisms means that women do not speak out against their abusers.

Women do have the right to press charges for abuse, yet most are told to reconcile the issue within the private sphere. As domestic violence tends to occur within the home, victims who are told to reconcile are more likely to be subjected to repeated abuse.

Women in Sudan live within systematic inequality and are often silenced. Marital rape is not criminalised. Under the Sudanese Personal Status Law for Muslims, a wife must obey her husband and therefore comply with his conjugal wishes. There is a belief that sexual demands must be met, with or without the wife's consent. Rape within the household thus becomes a complex and 'invisible' matter.<sup>26</sup>

#### **MARITAL RAPE**

Marital rape in Sudan was given international attention in 2018 with the case of Noura Hussein, who was sentenced to death at the age of 19 for murdering her husband after he attempted to rape her.

In April 2017 she was handed by her father to her husband, who she ran away from after their forced marriage when she was 16.

As noted above, Sudanese wives are expected to comply with the sexual demands of their husbands, irrespective of their own consent. Ms Hussein did not want to consummate the marriage, so her new husband had three of his relatives pin her down while he raped her. On the following day, when he attempted to rape her again, she stabbed him.

As marital rape is not legally recognised, Ms Hussein was charged with 'intentional murder' and sentenced to death. Due to international efforts, however, the court of appeal changed her sentence to five years in prison and a fine of 337,500 Sudanese pounds.



## WOMEN IN CONFLICT

Armed conflict in Sudan has had a severe impact on the lives of women in Sudan, particularly in Darfur. Conflict-related sexual violence within the area is a longstanding problem, making civilians, especially women and girls, highly vulnerable.

Reports of mass rape by the Sudanese army were documented in Tabit, North Darfur. Despite a much-criticised assessment by the UN-African Union peacekeeping operation finding no evidence for the allegations, Sternford Moyo, the chair of the International Bar Association, writes that sexual and gender-based violence is systematic and has become part of the conflict strategies.<sup>27</sup> Rape is a devastating weapon that humiliates women. As one Amnesty International campaign declares: 'Rape is cheaper than bullets.'

Due to the instability in regions of conflict and post-conflict, sexual crimes are rarely addressed. Although there are international efforts to tackle rape during warfare, many women are too afraid of the stigma they may face by speaking out – being deemed 'tarnished' or being pushed out by their communities.<sup>28</sup>

An African Union and UN operation in Darfur documented in 2018 more than 122 incidents of sexual violence, which involved 199 women, girls and boys. 80% of these incidents involved rape, 80% of the perpetrators were armed and 31% of the incidents were attributed to security-force members.<sup>29</sup>

Cases of sexual violence and rape appear to be prevalent within conflict areas. Rape within warfare has a detrimental impact on those sexually abused, beyond the act itself. Victims of rape are shamed. In some instances, rape is also seen as suspected adultery. In that case, victims are unlikely to report the incident, as they may be prosecuted for committing adultery, for which there is a death sentence under Article 149 of the Criminal Act.<sup>30</sup>



- 1 UN Development Programme (2015) *2015 Human Development Report*, pp.225-227. New York: UNDP. Available at [http://hdr.undp.org/sites/default/files/2015\\_human\\_development\\_report.pdf](http://hdr.undp.org/sites/default/files/2015_human_development_report.pdf).
- 2 UN Development Programme (undated) 'Gender Inequality Index (GII)', *Human Development Reports*. Available at <http://hdr.undp.org/en/content/gender-inequality-index-gii>.
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- 4 UN Development Programme (2017b) 'Human Development Data (1990–2017)', *Human Development Reports*. Available at <http://hdr.undp.org/en/data>.
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- Freedom House (2018) 'Sudan', *Freedom in the World 2019*. Available at <https://freedomhouse.org/report/freedom-world/2019/sudan>.
- 8 UN Economic and Social Commission for West Asia, UNFPA and UN Women (2018) *Sudan: Gender Justice & The Law*, p.10. New York, NY: UN Development Programme. Available at <https://arabstates.unwomen.org/en/digital-library/publications/2018/12/gender-justice-and-the-law-in-the-arab-region#view>.
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- 10 UN Economic and Social Commission for West Asia, UNFPA and UN Women, *op. cit.*, p.11.
- 11 UN Economic and Social Commission for West Asia, UNFPA and UN Women, *op. cit.*, p.11.
- 12 *Sudan's Constitution of 2005* (2005) Available at [https://www.constituteproject.org/constitution/Sudan\\_2005.pdf?lang=en](https://www.constituteproject.org/constitution/Sudan_2005.pdf?lang=en).
- 13 UN Economic and Social Commission for West Asia, UNFPA and UN Women, *op. cit.*, p.11.
- 14 Girls Not Brides (2002–2019) *Child Marriage Around The World: Sudan*. Available at <https://www.girlsnotbrides.org/child-marriage/sudan/>.
- 15 UN Economic and Social Commission for West Asia, UNFPA and UN Women, *op. cit.*, p.16.
- 16 MICS 2014, p.ix.
- 17 GirlsNotBrides (2002–2019) *Sudan – Atlas*. Available at <https://www.girlsnotbrides.org/where-does-it-happen/atlas/#/sudan>.
- 18 *Ibid.*
- 19 Equality Now (undated) *Sudan – The Muslim Personal Law Act of Sudan, 1991*. Available at [https://www.equalitynow.org/sudan\\_the\\_muslim\\_personal\\_law\\_act\\_of\\_sudan\\_1991](https://www.equalitynow.org/sudan_the_muslim_personal_law_act_of_sudan_1991).
- 20 UN Economic and Social Commission for West Asia, UNFPA and UN Women, *op. cit.*, pp.16–17.
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- 22 Food and Agriculture Organisation (1994) *Fact sheet: Sudan – Women, agriculture and rural development*. Available at [http://www.fao.org/3/V9105e/v9105e06.htm#P83\\_7745](http://www.fao.org/3/V9105e/v9105e06.htm#P83_7745).
- 23 UN Economic and Social Commission for West Asia, UNFPA and UN Women, *op. cit.*, p.12.
- 24 *Ibid.*, p.13.
- 25 *Ibid.*
- 26 UN General Assembly (2016) *Human Rights Council Thirty-Second Session (2016) Report of the Special Rapporteur on violence against women, its causes and consequences on her mission to the Sudan*, p.6. Available at <http://evaw-global-database.unwomen.org/-/media/files/un%20women/vaw/country%20report/africa/sudan/sr%20sudan.pdf?vs=1155>.
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- 29 UN Office of the Special Representative of the Secretary-General on Sexual Violence in Conflict (2019) *Sudan (Darfur)*, 29 March. Available at <https://www.un.org/sexualviolenceinconflict/countries/sudan-darfur/>.
- 30 UN General Assembly, *op. cit.*

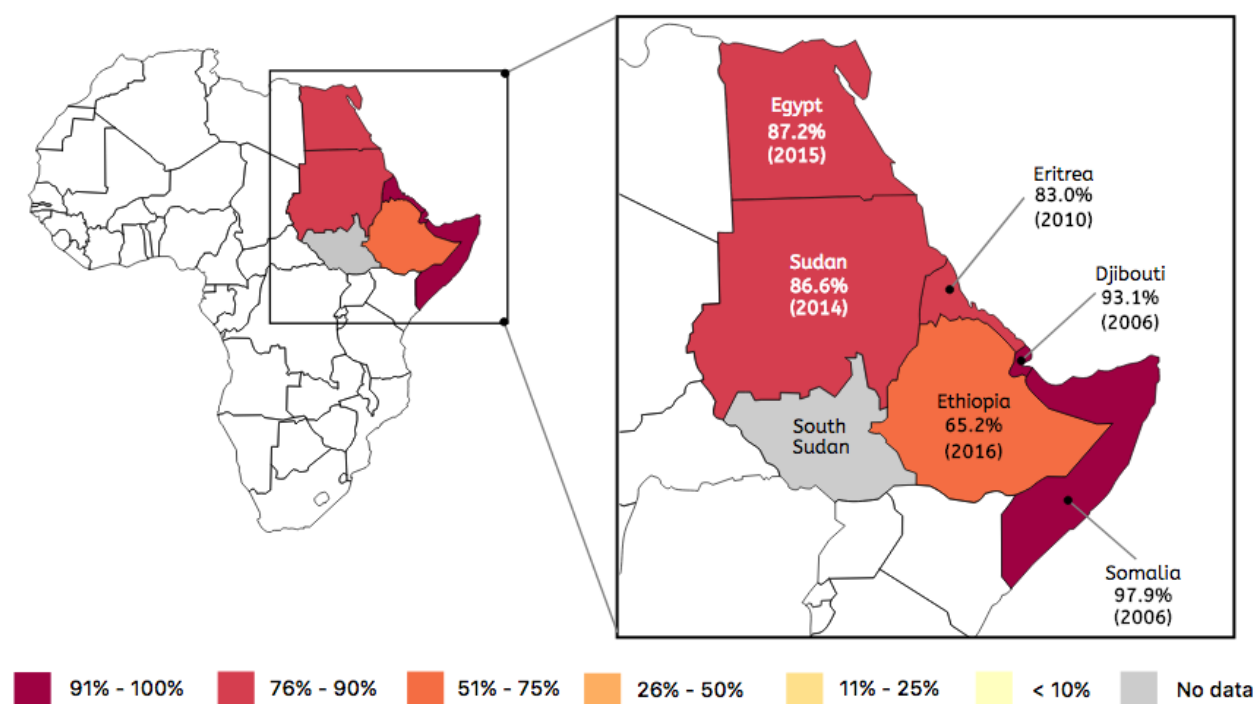
**Image page 41:** [www.j-pics.info](https://www.j-pics.info) (2010) *Selling tea in Khartoum*. Available at <https://flic.kr/p/848CcW>.  
CCL: <https://creativecommons.org/licenses/by-nc-sa/2.0/>.

**Image page 44:** United Nations (2015) *Sudan*. Available at <https://flic.kr/p/Vge9ME>.  
CCL: <https://creativecommons.org/licenses/by-nc-nd/2.0/>.

# FGM: National and Regional Statistics and Trends

This section gives a broad picture of the current state of FGM in Sudan. Other sections of this report give more detailed analyses of FGM prevalence set within anthropological and sociological frameworks, and of efforts towards its abandonment. For example, an analysis of the relationship between FGM and education may be found in the Education section.

None of the recent country-wide surveys for Sudan break down the prevalence of FGM according to respondents' **ethnicity** or **religion**, and there is no evidence from other sources to inform these criteria.

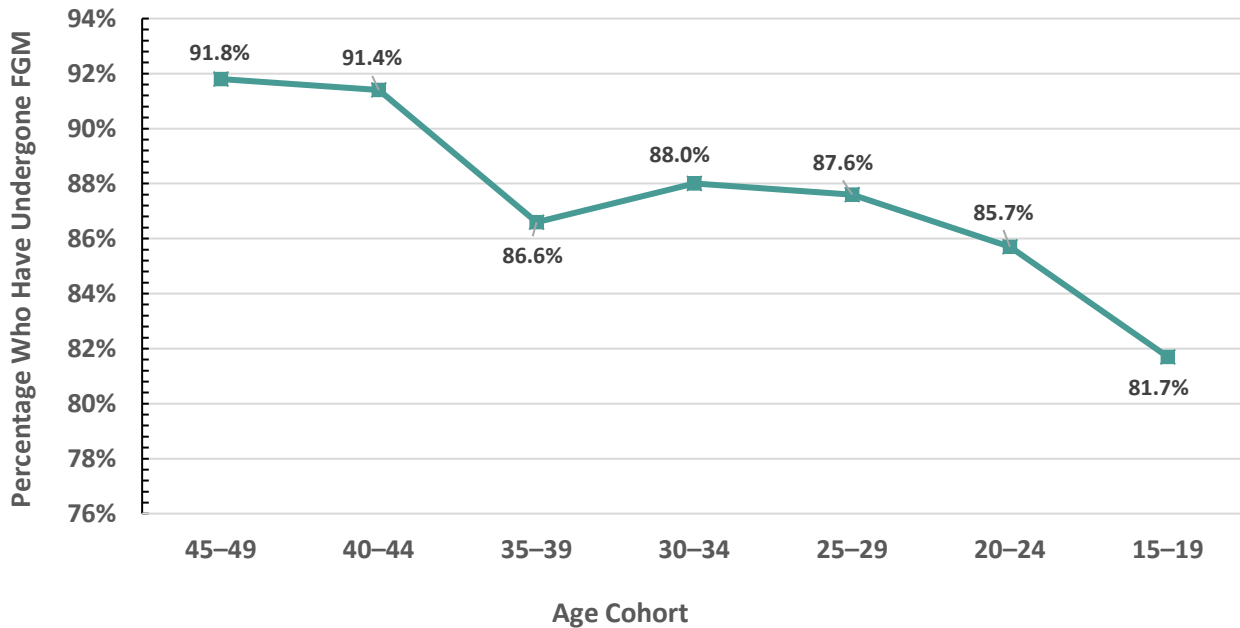


**Figure 3: Prevalence of FGM in north-east Africa<sup>1</sup>(©28 Too Many)**  
Please note that the dates of these figures vary from 2006 to 2016

The most recent measurement of FGM prevalence across Sudan is from the MICS 2014, which found that **86.6% of women aged 15–49 have undergone some form of FGM.**<sup>2</sup> This places the country in UNICEF’s ‘very high prevalence’ category.<sup>3</sup> More than 12 million women and girls are believed to have undergone some form of FGM.<sup>4</sup>

The SHHS 2010 found a prevalence of 88% among women aged 15–49.<sup>5</sup> This suggests that there has been a small reduction in the practice among women in recent years, although progress has been slow. However, understanding how the prevalence of FGM has changed over time is complicated by the mass migration that has occurred in the country’s recent history, meaning that trends arising from direct comparisons between 2014 and 2010 should be treated with some caution.





**Figure 4: Prevalence of FGM according to age of women in Sudan<sup>6</sup>**

Although the overall prevalence of FGM in women appeared to drop very little between 2010 and 2014, a breakdown of the data into smaller age cohorts is the most powerful way to understand what progress has been made.

Data from the MICS 2014 reveals a distinct trend towards lower FGM prevalence among younger women (see Figure 4). The highest prevalence (91.8%) is among women aged 45–49 and the lowest (81.7%) is among those aged 15–19.<sup>7</sup> This suggests that the practice is declining at a faster rate than might be apparent from considering only the overall prevalence.

## Prevalence of FGM According to Place of Residence

A third of Sudan’s population lives in urban areas, where the prevalence of FGM among women aged 15–49 appears to be very similar (85.5%) to that in rural areas (87.2%).<sup>8</sup> This trend is also seen in the SHHS 2010, where the prevalence was found to be 87.6% among women living in both urban and rural areas.<sup>9</sup>

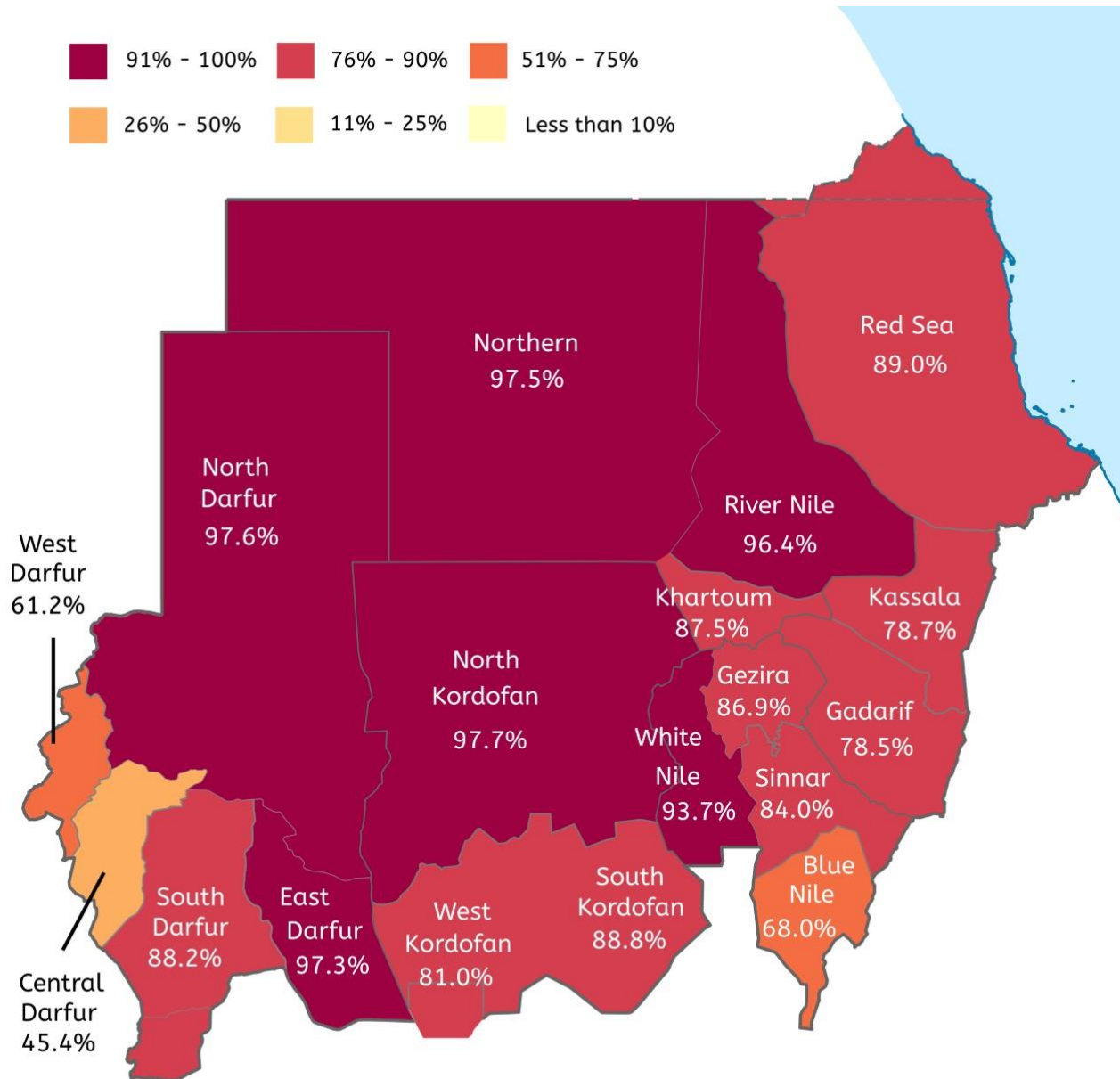
An analysis of prevalence according to the different regions of Sudan reveals a geographical pattern where, in general, states in the centre and north-west have the highest prevalence (see Figure 5). The highest prevalence is in North Kordofan state (97.7%) and North Darfur (97.6%), while in only three of the 18 states is the prevalence below 70% (Blue Nile – 68%, West Darfur – 61.2% and Central Darfur – 45.4%). In the majority of states, the prevalence is above 85%.<sup>10</sup>

These findings were broadly the same in the SHHS 2010, although it should be noted that, due to changes in the regional definitions between the two surveys, any comparisons should be treated with caution.<sup>11</sup>

One major influence on the prevalence of FGM in any given state is believed to be the ethnicity of the local population, since some ethnic groups historically practise FGM while others do not.<sup>12</sup>

It has been noted in recent reports that urbanisation has impacted on prevalence and attitudes towards FGM in Sudan. For instance, the migration to urban Khartoum of non-practising communities

from the Nuba Mountains, South Sudan and parts of the Darfur regions in the far west has resulted in intermarriage and pressure to adopt the practice. It is reported too that some uncut women now living in Khartoum seek FGM as they feel 'unclean' if they are examined by a male doctor, which is more likely to occur in urban areas.<sup>13</sup>

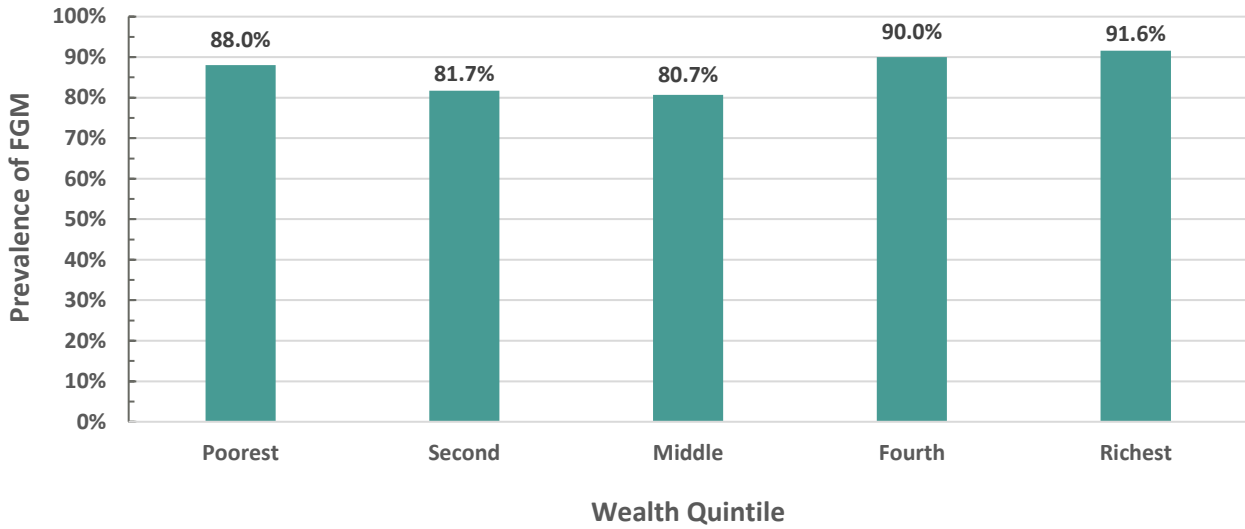


*Figure 5: Prevalence of FGM across Sudan (@28 Too Many)<sup>14</sup>*

## Prevalence of FGM According to Economic Status

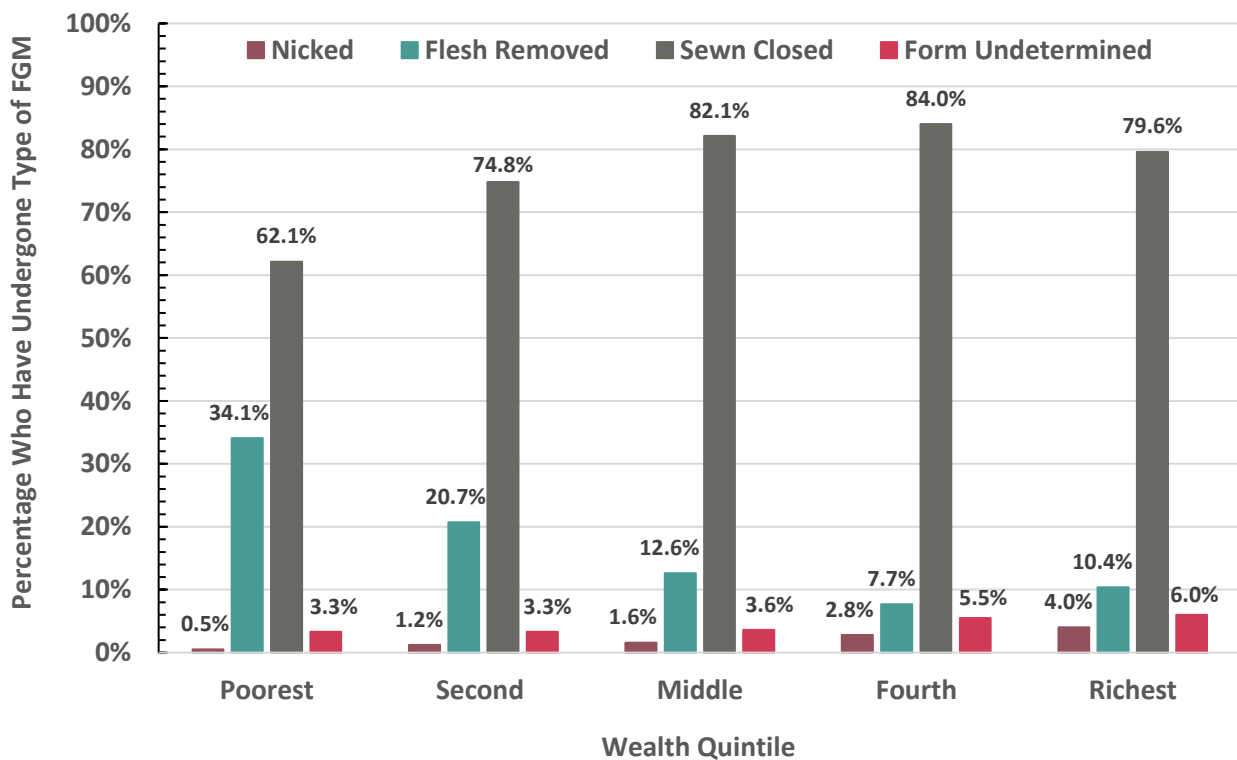
The relationship between a woman's level of wealth and whether or not she has had FGM is quite complex. According to the MICS 2014 (see Figure 6), FGM is most prevalent among women aged 15–49 in the richest wealth quintile (91.6%). Prevalence declines among those in the fourth and third quintiles, then rises again among those in the poorest two quintiles. The prevalence among women

in the poorest quintile is 88.0%.<sup>15</sup> This is noteworthy because in the majority of African countries where FGM is practised, the prevalence is usually higher in each subsequently *poorer* wealth quintile.



**Figure 6: Prevalence of FGM according to Sudanese women's (aged 15–49) wealth quintiles<sup>16</sup>**

Excluding those in the richest wealth quintile, there is a general correlation in the MICS data between a woman's wealth and her likelihood of being 'sewn closed' – that is, having undergone Type III FGM (infibulation) (see Figure 7).



**Figure 7: Prevalence of type of FGM according to Sudanese women's (aged 15–49) wealth quintiles<sup>17</sup>**

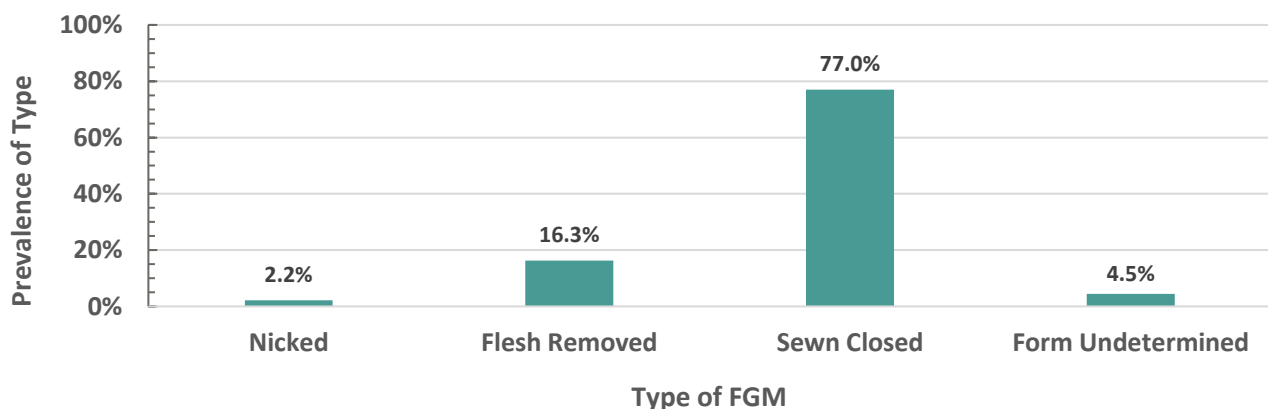
Among women aged 15–49 who have been cut, 62% of those in the poorest wealth quintile have been ‘sewn closed’, while 84% in the second-richest quintile and 79.6% in the richest quintile have been.<sup>18</sup> Again, this broad trend is the reverse of what occurs in most African countries. (Sudanese experts working on the campaign to end FGM have been unable to identify a clear association to date between levels of wealth and types of FGM due to the few studies and limited data available on the topic.) There are no strong correlations, however, between the prevalence of FGM among daughters aged 0–14 and their levels of wealth.<sup>19</sup>



*Sudanese girls are at their highest risk of being cut between the ages of four and ten*

## Types of FGM Practised and Practitioners

FGM in Sudan is generally referred to in two ways: the least severe form is called *sunna*, which is an Islamic term for FGM involving partial or total removal of the external clitoris (equating to Type I or Type II by the WHO definition, depending on the extent of the cutting). The more severe form of FGM is referred to in Sudan as *pharaonic* or *infibulation*, and this equates to Type III by the WHO definition. Some Islamic leaders and religious scholars in Sudan have sought to distinguish between the two forms by issuing a *fatwa* condoning *sunna* and opposing the *pharaonic* cut.<sup>20</sup> The majority of Sudanese women in the 15–49 age group (77%) have been ‘sewn closed’ (Type III FGM/infibulation), 16.3% have had had flesh removed and 2.2% have been ‘nicked’ (Figure 8).<sup>21</sup>



*Figure 8: Percentage distribution of types of FGM in Sudanese women aged 15–49 who have been cut<sup>22</sup>*

There is some difference in the type of cut experienced by a woman according to her place of residence. In general, the prevalence of 'sewn closed' is lowest in the five Darfur states, ranging from 36.7% in Central Darfur to 68.7% in South Darfur among women aged 15–49 who have been cut. However, in these states, the prevalence of 'flesh removed' is consistently above the national average. (It should be noted that in Central and West Darfur around 15% of women who have been cut do not know what type of FGM they have had.) Conversely, the prevalence of Type III is above 90% in four states: Northern, Gezira, Sinnar and West Kordofan.<sup>23</sup>

There are no strong correlations between the types of FGM experienced by women and any other background characteristics, although Type III was found to be slightly less prevalent in the youngest age-group of women (15–19), in those women in the lowest wealth quintile and in women with no formal education. The SHHS 2010 does not provide data on the types of FGM experienced by women.

Both the data and anecdotal evidence demonstrate that FGM in Sudan has become increasingly medicalised over the past few decades.

The MICS 2014 found that 63.6% of women are cut by a trained midwife and 28.7% by a traditional cutter. This data, however, masks some distinct trends. Firstly, 76% of women (aged 15–49) who underwent FGM between 2000 and 2014 were cut by a trained midwife, compared to 69% between 1990 and 1999, 61.6% between 1980 and 1989, and 55.4% between 1966 and 1979. There has been a corresponding decrease in the percentage of women cut by a traditional cutter over the same time period (from 39.1% between 1966 and 1979 to 18.4% between 2000 and 2014).<sup>24</sup>

Women living in urban areas are more likely to have been cut by a trained midwife (77.9% of women aged 15–49 who have been cut) than women living in rural areas (56.7%). The type of practitioner used varies even more widely by state. In central Darfur 71.3% of women are cut by a traditional cutter, while for the River Nile, Khartoum and Northern states this figure is less than 7%.

*'Families believe midwives perform FGM/C more safely than traditional cutters and with fewer complications.'*<sup>25</sup>

Among daughters aged 0–14, traditional cutters are more commonly used when a girl is cut before the age of five.<sup>26</sup> In some states, for instance, FGM is performed at a very young age (as early as the first week after birth); hence, a family will use the services of a traditional birth attendant (TBA) who lives and works in their community and likely attended the baby girl's delivery. Evidence from rural Khartoum, where some communities continue to strongly support Type III/infibulation, shows that TBAs commonly perform FGM on girls at a preschool age. This is done in the belief that, if they cut early, girls will conform to the traditions of the community (and be available for early marriage), but if they go to school uncut, they will be 'influenced' by others' views and practices.<sup>27</sup>

Information on the types of practitioner used according to women's background characteristics (such as education and wealth) was gathered for the SHHS 2010.<sup>28</sup>

Midwives in North Kordofan have expressed concerns that if they and TBAs abandon FGM, mothers and grandmothers will undertake to cut girls themselves, increasing the health risks. The Department for International Development (DFID) recommends 'calibrating' 'surveillance systems' to monitor whether this does in fact happen as more healthcare workers abandon FGM.<sup>29</sup>



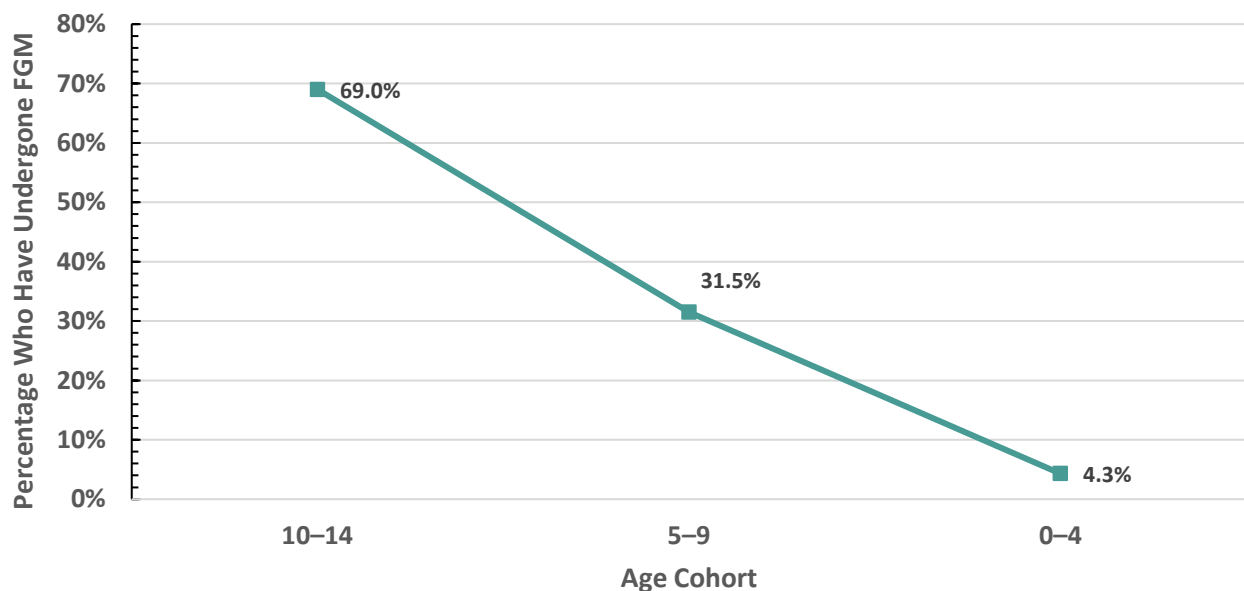
Women with a secondary or higher level of education are much more likely to be cut by a nurse or midwife (59.3% of women aged 15–49 who have been cut) than those with no formal education or a non-standard education (less than 20%), who are more likely to be cut by a traditional midwife.

Similarly, women in the highest wealth quintile are more likely to be cut by a nurse or midwife (58.8%) than those in the lowest quintile (22.7%).

Thus, as might be expected, medicalised FGM is most apparent in women who are wealthier and/or better educated.

For detailed information about the medicalisation of FGM, please see 28 Too Many’s report, which is available at <http://28toomany.org/fgm-research/medicalisation-fgm/>. For a discussion on the oath not to perform FGM that midwives are being encouraged to take, see page 87.

## Prevalence of FGM Among Girls



**Figure 9: Prevalence of FGM according to age of daughters in Sudan, as reported by their mothers<sup>30</sup>**

Data on FGM prevalence among women’s daughters shows that 31.5% of daughters aged 0–14 have already experienced some form of FGM.<sup>31</sup>

A mother’s own FGM status is a significant indicator of her daughters’. Only 2.3% of the daughters of mothers who have not themselves been cut have had any form of FGM, compared with 34.6% of girls whose mothers have been cut.<sup>32</sup>

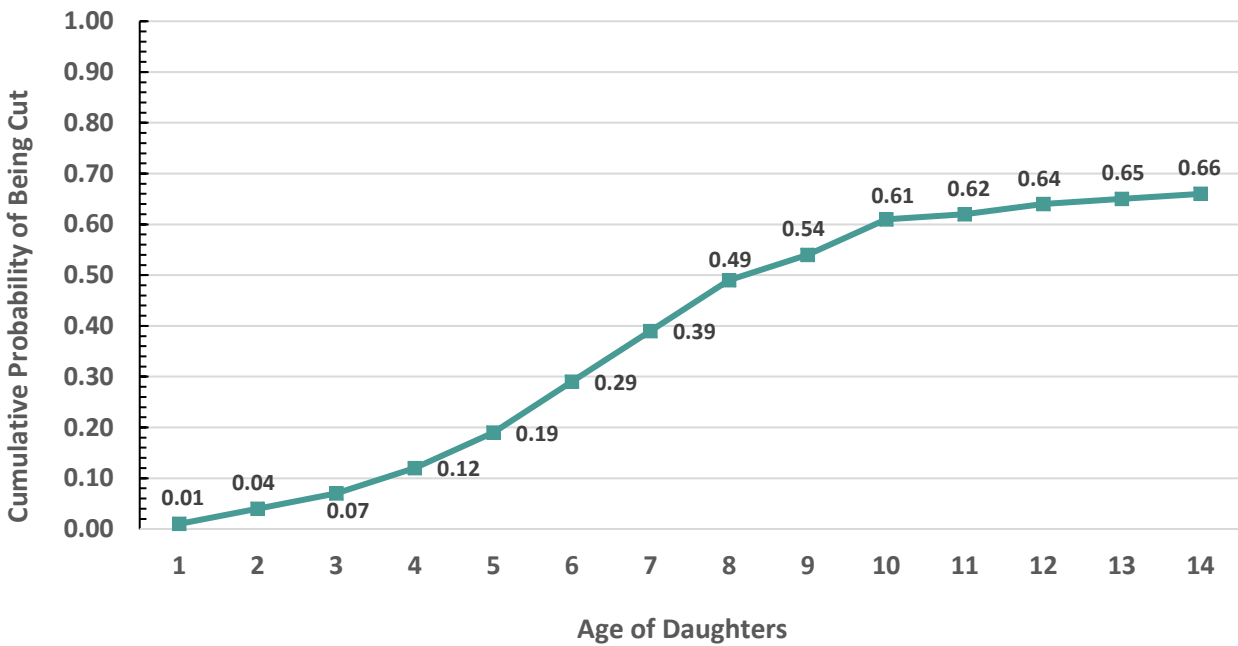
These figures, however, represent only the current FGM status of the girls, many of whom are still at risk of being cut.

Figure 9 shows the FGM prevalence among daughters broken down into three age cohorts. While only 4.3% of girls aged 0–4 are reported by their mothers to have been cut, 69% of 10–14-year-olds are reported to have been cut. This underlines the fact that the deceptively low overall prevalence

of FGM in daughters aged 0–14 (31.5%) should not be used as a measure of the true prevalence of the practice in contemporary Sudan.

This issue is addressed in the Secondary Analysis. Using statistical methods described in the Note on Data on page 10, the author calculated an ‘adjusted prevalence’ for the cohort of girls who were aged 0–14 at the time the survey was taken. This is effectively a projection of the final FGM prevalence for this group once they all reach the age of 14, after which they have a lesser risk of being cut.

The adjusted prevalence was found to be 66.3% (70.9% for girls living in rural areas and 56.2% for girls living in urban areas). For this cohort of girls, Figure 10 shows the cumulative probability of them being cut by each birthday from their first to their 14<sup>th</sup>. A probability of 1 would equate to a 100% prevalence of FGM among girls that age.



**Figure 10: Cumulative probability of daughters aged 0–14 undergoing FGM by certain ages<sup>33</sup>**

The data suggests that, by the age of six, almost 30% of this cohort of girls would have been cut, and by the age of nine, more than half the cohort would have been cut (54%). Figure 10 also shows that girls in Sudan are at their highest risk of being cut between the ages of four and ten.<sup>34</sup>

The results of these statistical analyses are, of course, estimates. However, they do give useful insight into progress made towards eradicating FGM.

Encouragingly, the adjusted prevalence among girls aged 0–14, which is 66.3%, when compared to the overall prevalence among women aged 15–49, which is 86.6%, suggests that considerable progress has been made in recent years. As always, the possibility of under-reporting of FGM should be held in mind when interpreting these results.

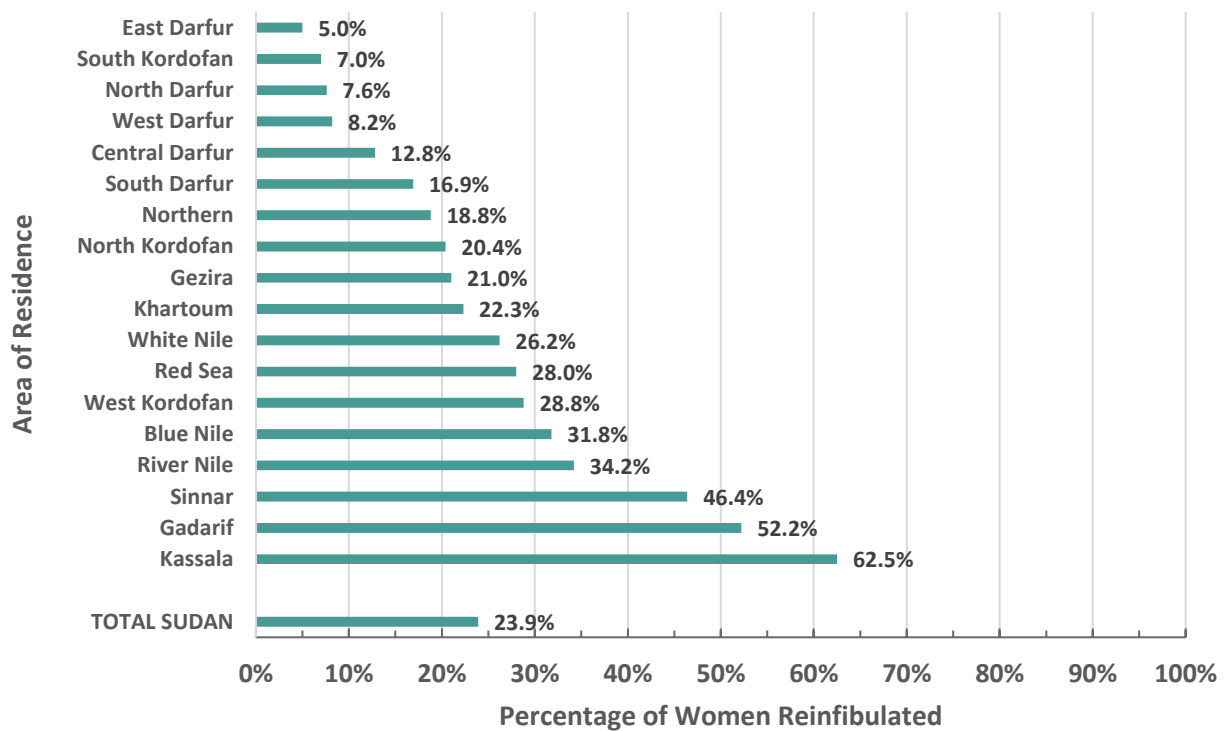
For a complete list of the typical age of cutting of girls from each ethnic group, see Table 2 in the Anthropological Background section.

## Reinfibulation

Reinfibulation (also known as *adal*) is the process of re-sewing the genitals following childbirth, and it may be done repeatedly during the lifetime of a married woman.

While it is not as prevalent as initial FGM, reinfibulation affects a significant proportion of Sudanese women. The MICS 2014 measured the prevalence of reinfibulation in Sudan for the first time in a population-scale survey and found that it is performed on around one in four (23.9%) ever-married women aged 15–49 who have ever given birth. The prevalence of reinfibulation in ever-married women who had given birth in the 12 months prior to the survey was 23.6%, suggesting that, unfortunately, the extent of the practice has barely changed in recent times.<sup>35</sup>

The prevalence of reinfibulation is broadly similar among women living in urban areas (22.6%) and those living in rural (24.4%) areas, although there are wide variations by state, as shown in Figure 11.

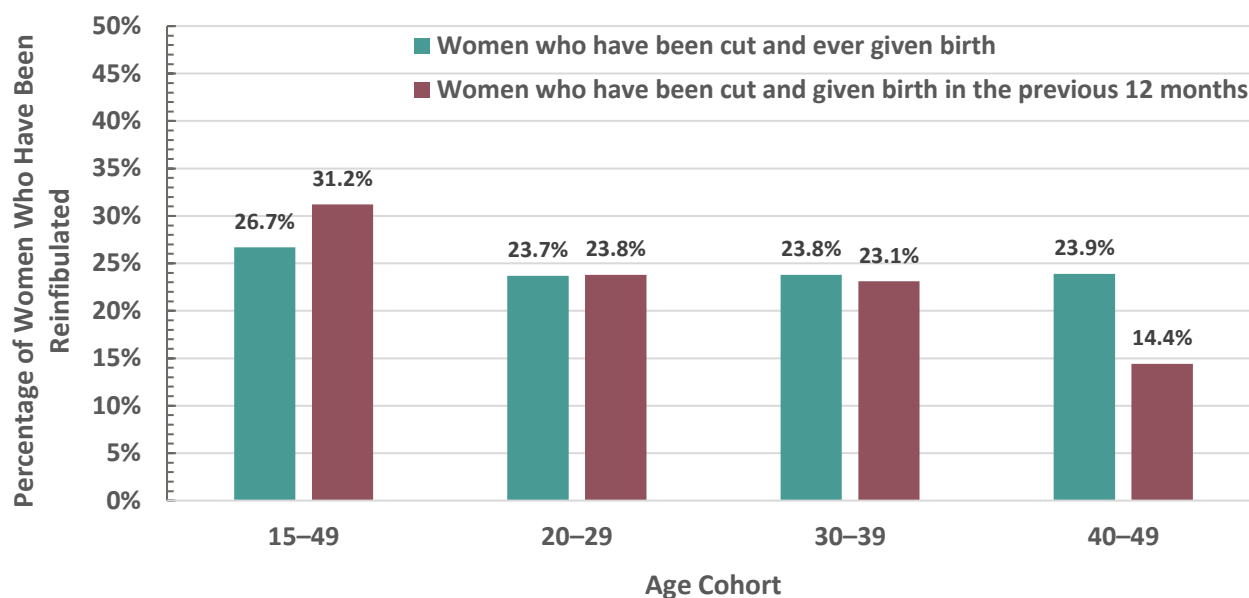


**Figure 11: Percentage of ever-married Sudanese women aged 15–49 who have ever given birth and have been reinfibulated, according to state of residence<sup>36</sup>**

More than half of ever-married women who have ever given birth in Kassala (62.5%) and Gadarif (52.2%) are reinfibulated, while in East Darfur 5% are. In the majority of states the prevalence of reinfibulation is 15–35%. Anecdotal information supplied to 28 Too Many during this research suggests that reinfibulation occurs more in urban areas among wealthier families (see below).

Among ever-married women who have ever given birth, the prevalence of reinfibulation does not vary significantly according to women’s current ages. However, Figure 12 shows that, of women who gave birth in the 12 months prior to the MICS 2014, the younger age cohorts were more likely to have been reinfibulated (as expected following childbirth). 31.2% of those aged 15–19 were reinfibulated, while only 14.4% of those aged 40–49 were.

See page 86 for a further discussion on reinfibulation.



**Figure 12: Percentage of ever-married Sudanese women aged 15–49 who have ever given birth/ have given birth in the 12 months prior to the MICS 2014 and have been reinfibulated, according to their ages<sup>37</sup>**

From discussions with Ahfad University of Women, 28 Too Many understands that there is an important case for more studies and data-gathering to understand the practice and prevalence of reinfibulation in Sudan. Evidence from the few studies that have been done to date, such as the MICS 2014, suggest that the prevalence of reinfibulation, though difficult to quantify, does appear to have remained the same over time and poses a significant challenge to the maternal health and wellbeing of Sudanese women.

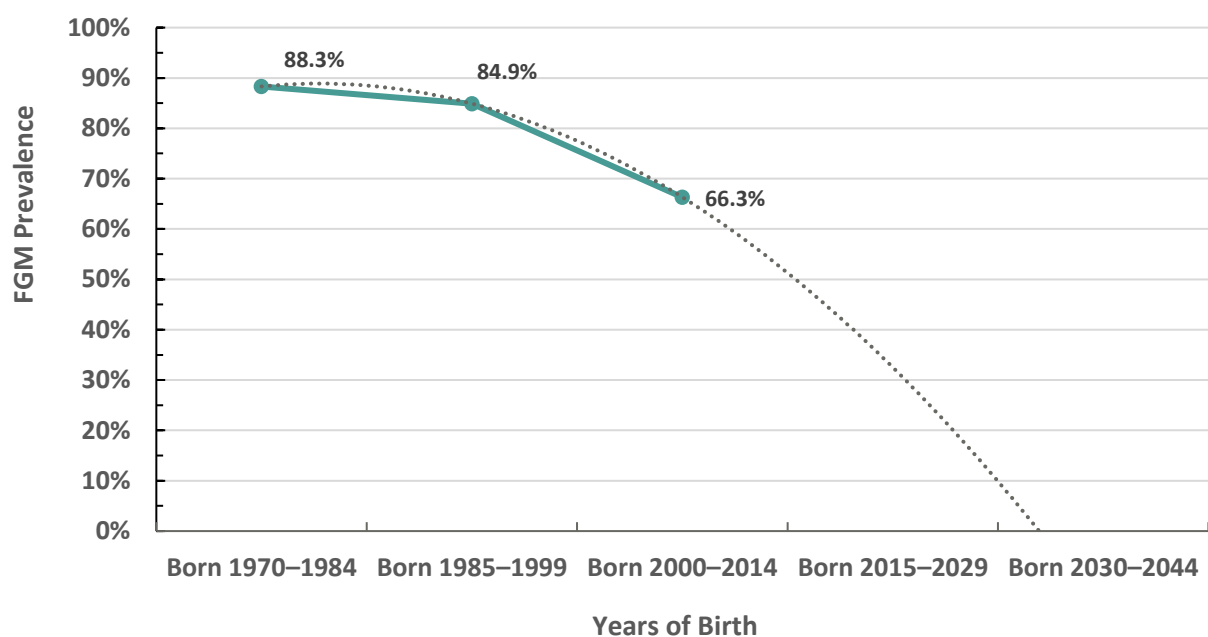
Reinfibulation is not technically against the law in Sudan, but medical doctors and gynaecologists are not supposed to carry out the procedure and should only conduct repairs that are required after childbirth, such as stitching to stem bleeding (for example, to close an episiotomy). 28 Too Many understands that it is usually the midwives who carry out reinfibulation – doctors may attend births due to complications, but will leave the midwives to complete any medical procedures that follow. Once the doctors leave the room, it is reported that midwives might perform reinfibulation either with or without the woman’s consent. Many young women do not understand the implications and are convinced by the midwife that reinfibulation will make them look ‘neat and beautiful’ again for their husbands. Some women also request the procedure because it is thought to be ‘fashionable’ – they believe ‘this is my body; I do it for my relationship with my husband’ – and they expect their husbands to pay midwives well for their services and to buy their wives gifts for making themselves ‘tight like virgins’ again. Hence, it has been observed that reinfibulation is more common among women from wealthier families, although there is no data to quantify this.

Reinfibulation reportedly has a significant negative impact on deliveries and maternal health, and it appears that women who have been reinfibulated show more support for FGM as a practice that should be continued. There is, therefore, a strong case for understanding reinfibulation and its impact in greater detail as part of the overall strategy to protect women and girls.

## Predictions For The Future

The ultimate goal of FGM campaigns and interventions in Sudan, such as the Saleema Initiative, is to eradicate the practice.

The Secondary Analysis<sup>38</sup> considers the speed of decline of FGM prevalence across three age groups (0–14, 15–30 and 31–44), as shown in Figure 13. Assuming that future trends follow the same pattern as in the past, the author of the Secondary Analysis was able to predict that FGM could be eradicated in Sudan for girls born from 2040 onwards, and that the prevalence of FGM could be reduced to below 50% among girls born from 2023 onwards. See A Note on Data for an explanation of the method. These predictions should, of course, be read with caution, since in reality many factors lead to either faster or slower abandonment of FGM.<sup>39</sup>



*Figure 13: Past and future trends in FGM prevalence by generation in Sudan<sup>40</sup>*



- 1 **Click for source document:** Djibouti: MICS 2007; Egypt: EHIS 2015; Eritrea: EPHS 2010; Ethiopia: DHS 2016; Somalia: MICS 2006; Sudan: MICS 2014.
- 2 MICS 2014, p.214.
- 3 UNICEF (2013) *Female Genital Mutilation/Cutting: A Statistical Overview and Exploration of the Dynamics of Change*, p.27. Available at [https://www.unicef.org/publications/index\\_69875.html](https://www.unicef.org/publications/index_69875.html).
- 4 *Ibid.*, p.1.
- 5 SHHS 2010, p.198.
- 6 MICS 2014, p.215.
- 7 MICS 2014, p.215.
- 8 MICS 2014, p.215.
- 9 SHHS 2010, re-analysed by UNICEF.
- 10 MICS 2014, p.214
- 11 SHHS 2010, re-analysed by UNICEF.
- 12 Secondary Analysis, p.16.
- 13 Cited in Nafisa Bedri, Huda Sherfi, Ghada Rodwan, Sara Elhadi, and Wafa Elamin (2018) *Medicalisation of Female Genital Mutilation/Cutting in Sudan: Shifts in Types and Providers*, p.17. New York, NY: Population Council. Available at [https://www.popcouncil.org/uploads/pdfs/2018RH\\_FGMC-MedicalisationSudan.pdf](https://www.popcouncil.org/uploads/pdfs/2018RH_FGMC-MedicalisationSudan.pdf).
- 14 MICS 2014, p.214–215.
- 15 MICS 2014, p.215.
- 16 MICS 2014, p.215.
- 17 MICS 2014, p.215.
- 18 MICS 2014, p.215.
- 19 MICS 2014, p.216.
- 20 Nafisa M. Bedri (2012) *Evidence Based Advocacy for Ending FGM/C in Sudan*. Ahfad University for Women.
- 21 MICS 2014, p.214.
- 22 MICS 2014, p.214.
- 23 MICS 2014, pp.214–215.
- 24 Secondary Analysis, p.26.
- 25 Charlotte Greenbaum (2018) *Understanding the Impact of Medicalisation on Female Genital Mutilation/Cutting. Evidence to End FGM/C: Research to Help Girls and Women Thrive consortium*. Washington, DC: Population Reference Bureau. Available at <https://interactives.prb.org/medicalization/index.html>.
- 26 Secondary Analysis, p.26.
- 27 Nafisa Bedri of Ahfad University for Women in discussion with 28 Too Many, September 2019.
- 28 SHHS 2010, re-analysed by UNICEF.
- 29 Department for International Development Sudan (2017) *Free of Female Genital Cutting Annual Review Summary Sheet*, p.16.
- 30 MICS 2014, p.216.
- 31 MICS 2014, p.216.
- 32 MICS 2014, p.216.
- 33 Secondary Analysis, p.41.
- 34 Secondary Analysis, p.41.
- 35 Secondary Analysis, pp.27–29.
- 36 Secondary Analysis, pp.27–29.
- 37 Secondary Analysis, p.30.
- 38 Secondary Analysis, p.65.
- 39 Secondary Analysis, p.65.
- 40 Secondary Analysis, p.65.

**Image page 50:** Rita Willaert (2008) *Sudan*. Available at <https://flic.kr/p/5EgDWc>.  
CCL: <https://creativecommons.org/licenses/by-nc/2.0/>.

## The Saleema Initiative

The language used to describe FGM has always been an important part of the culture surrounding the practice. The Saleema Initiative began in Sudan in 2008 as a way of addressing the need to change the language and social norms of affected communities in order to eliminate FGM.

Traditionally, FGM was described in Sudan as *tahoor*, which means 'pure' and therefore has positive connotations; women and girls who did not undergo FGM were called *ghalfaa*, which means 'impure' and 'obscene'.<sup>1</sup>

The name 'Saleema' is being used to give positive connotations to giving up FGM. Saleema is a girl who has not undergone FGM. In Arabic, this word means 'pure, intact and unharmed' and relays the image of 'healthy in body and mind' and 'in a God-given condition', all of which are highly rated values in Sudanese society.



*Saleema and her colours are becoming known all over the country (© The Saleema Initiative)*

Although efforts to end FGM in Sudan began in the 1940s, in 2008, following stories in the media about girls dying as a result of being cut, the Government of Sudan endorsed a ten-year, nationwide strategy (2008–2018) aimed at eliminating the practice within a generation. As part of that strategy, Sudan's National Council for Child Welfare (NCCW) consulted stakeholders on activities to initiate collective behavioural change in FGM-practising communities. The Saleema Initiative emerged from stakeholders and communities as an innovative way of talking about FGM. As Dr Samira Amin, one of the founders of the Saleema Initiative, put it, the name 'Saleema' 'created a paradigm shift in terms of acknowledging purity of the girl without compromising the core values of the community.'<sup>2</sup> By

introducing a positive word to refer to uncut women, the Saleema campaign equipped activists and the media with a new tool to address the social norms that support FGM.

The Saleema Initiative receives technical and financial assistance from the UNJP and partners. It has developed attractive materials using colours that are popular in Sudanese society (such as orange, red, yellow and green) to start discussions about FGM in communities. Saleema is presented to participants as a beautiful young girl wearing robes in these colours. She is becoming a household name, reflecting an attractive alternative to the tradition of FGM.<sup>3</sup> At awareness-raising events, men and women wear clothes and accessories in the Saleema colours, and the colour theme and campaign messages can be found on materials such as posters and banners, as well as relayed through popular media and culture, including television animations, songs and poetry.

In 2011, the NCCW and UNICEF launched an extension to the initiative in Khartoum state called 'Born Saleema', which aims to directly protect new-born girls. Trained health workers explain to parents and families in maternity hospitals and health centres the Saleema philosophy: 'Every girl is born Saleema; let her grow up Saleema.' The families are then invited to join the campaign. After signing a pledge, each Saleema family is monitored by a health worker, who visits them at home.<sup>4</sup>

A study on the impact of Saleema was carried out in 2017 by researchers from the George Washington University and UNICEF Sudan.<sup>5</sup> Four focus groups were held in each of Sudan's 18 states, at which participants were shown posters from the Saleema campaign and asked about their reactions to their content. Overall, participants' responses were a positive indication of support for the campaign, suggesting that it should be continued with a particular focus on youth, older women (particularly in rural areas) and those in positions of authority in society, such as religious and local political leaders.<sup>6</sup>

The author of the Secondary Analysis also notes that social change and innovation (such as the Saleema campaign is working to achieve) often begins with 'young, single, well educated' women 'living in wealthier households.'<sup>7</sup>

In March 2019 a further evaluation of Saleema, published by researchers from the Ahfad University of Women in Sudan and the George Washington University, was designed to evaluate the effectiveness of the Saleema campaign in reducing pro-FGM social norms. The evaluation measured a dose-response effect across the 18 Sudanese states and found that, where women self-reported their exposure to the campaign, this exposure was associated with reduced pro-FGM social norms. Additionally, this study found that higher levels of exposure to the Saleema campaign (measured via an independent monitoring system, rather than through self-reporting) was also associated with reduced pro-FGM social norms. Overall, the findings show that social norms are changing in Sudan over time, and that they changed during the Saleema implementation period. The authors assert that this study, therefore, demonstrates that Saleema's social-marketing strategy is effective in reducing pro-FGM social norms in Sudan.<sup>8</sup>

*'Saleema was a starting point, and now younger generations must finish what we started.'*

*~ Dr Samira Amin<sup>9</sup>*

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- 1 Ingy Deif (2018) 'Samira Amin on the anti-FGM Saleema campaign in Sudan', *Ahram Online*, 27 March. Available at <http://english.ahram.org.eg/NewsContent/7/48/293555/Life--Style/Health/Samira-Amin-on-the-antiFGM-Saleema-campaign-in-Sud.aspx>.
  - 2 *Ibid.*
  - 3 *Ibid.*
  - 4 UNFPA (2012) *In Sudan: Changing Labels, Changing Lives*, 15 June. Available at <https://www.unfpa.org/news/sudan-changing-labels-changing-lives>.
  - 5 Andrea C. Johnson, W. Douglas Evans, Nicole Barrett, Howida Badri, Tamador Abdalla and Cody Donahue (2018) 'Qualitative evaluation of the Saleema campaign to eliminate female genital mutilation and cutting in Sudan', *Reproductive Health* 15(30). Available at <https://reproductive-health-journal.biomedcentral.com/articles/10.1186/s12978-018-0470-2>.
  - 6 *Ibid.*
  - 7 Secondary Analysis, p.77.
  - 8 W.D. Evans, C. Donahue, J. Snider, N. Bedri, T.A. Elhussein, S.A. Elamin (2019) 'The Saleema initiative in Sudan to abandon female genital mutilation: Outcomes and dose response effects', *PLoS One* 14(3), March 2019. Available at <https://www.ncbi.nlm.nih.gov/pubmed/30861029>.
  - 9 Cited in Ingy Deif, *op. cit.*

# Understanding and Attitudes

A widespread, correct understanding of FGM is a prerequisite to changing attitudes; thus, exposure to accurate information is essential.

## Knowledge

Most women in Sudan know about FGM – 96.3% of women aged 15–49 have heard of it.

However, women with less education are slightly less likely to know about the practice.<sup>1</sup>

There are also regional differences in levels of knowledge. In urban areas, 97.1% of women have heard of it; in rural areas, 95.8% have. The widest variation is between states: although in 13 out of the 18 states there is not much difference between levels of knowledge, in Central Darfur 71.5% know of it, while in North Kordofan 99.3% know of it.<sup>2</sup>

The Secondary Analysis notes that the reason for the much lower percentage of women aware of FGM in Central Darfur is because the population of that area is largely made up of ethnic groups who do not practise FGM, such as the Fur, Hawsa and Umbarraro.<sup>3</sup>

## Reasons for Practising FGM and Its Perceived Benefits

The most common reasons given to the SHHS 2010 surveyors for the practice of FGM in Sudan were 'purification, cleanliness and hygiene, acceptability within the group and reducing sexual desire'.

Additional reasons included 'desired by men, hence marriageability' and 'adherence to religion'.<sup>4</sup>

Another study notes that, for some, the practice appears to be part of 'raising a girl properly' in that it 'ensures pre-marital virginity and inhibits extra-marital sex, because it reduces a women's libido'.<sup>5</sup>

A 2019 study of Nyala University students<sup>6</sup> found that 59.7% of male students felt that 'religious beliefs' was the most important reason for FGM, while only 10.9% of female students felt that it was – it was, in their view, the least important reason. 64.2% of female students instead felt that 'traditional beliefs' was the most important reason. Therefore, there seems to be a lack of awareness among young men of the fatwa against Type III. Although the male students cited religion as the main reason, Islamic scholars have stated that FGM is not required by Islam and in Egypt the grand mufti issued a *fatwa* against it in 2007.

Notably, while 87.8% of male students and 89.1% of female students were aware that FGM negatively affects women's sex lives and 73% of male students would prefer to marry women who had not been cut, 64.5% of male students would still have their daughters undergo FGM. The study concludes that, despite knowing about the harmful effects of FGM on women's sexual health, men, due to social pressure, are unable to exercise their free will to stop their daughters being cut.



A 2018 Population Council study looked at the pace of change in Sudan.<sup>7</sup> The study investigated how different families perceive FGM and their decision-making surrounding it. The investigation was carried out in urban and rural areas of Khartoum and Gadarif states. It found that:

- decision-making about FGM is a lengthy and complex process and involves many people within the nuclear and extended families, as well as other influencers;
- mothers are key decision-makers, but do not make decisions alone, and they may fear sanctions for disagreeing with other decision-makers;
- a mother is more likely to subject her daughter(s) to FGM if she herself has been cut; and
- men are often involved and influential in the process, although the views of older and younger men are often contradictory. Men tend to be particularly influential when they oppose FGM. Some younger men who were part of the study expressed a willingness to marry women who have not undergone FGM, but they were also concerned about excessive sexual desire in women who have not been cut.

The study concluded that, when parents make the final decision regarding FGM for their daughter, they are

influenced by dominant social norms and by other family members who are also influenced by other people and factors and norms. In general, the widespread support and practice of FGM/C in the research area is perpetuated and sustained by deeply rooted social norms and gender power structures that centre on the need to reduce women’s sexual desire in order to protect them.<sup>8</sup>

The power of this desire to ‘protect’ girls is evident in the study’s additional findings, which include:

- a shift in the type of FGM practised – Type III/infibulation (pharaonic) is being widely abandoned and replaced by sunna, because it is perceived to be less severe;
- a level of awareness of the health consequences of FGM for women and girls, which was a contributing factor to some study participants shifting to forms of FGM that were perceived to be less harmful;
- evidence of medicalisation of FGM – a number of girls and young women had been cut by healthcare providers such as trained midwives; and
- that ‘sociocultural factors, gender norms and power relations drive the continuation of the practice.’ The data indicated that

just over half (52 percent) of those who decided to circumcise viewed it as a cultural practice, a third (33 percent) considered it a religious duty, just over a quarter (26 percent) believed it is necessary for chastity, 16 percent said it was important for marriageability, and 13 percent said it was important for health reasons. Justifications of FGM/C centred on the need to reduce women’s sexual desire.<sup>9</sup>

The authors further concluded

that the widespread support and practise of FGM/C in the research areas is perpetuated and sustained by deeply rooted **social norms** associated with gender power relations **that control women as subordinate and undermine their rights. The norms are justified by the supposed need to ‘protect’ women and girls from their perceived excessive and dangerous ‘sexual desire’.** Such gender views are often projected as social norms and cultural values or religious beliefs.<sup>10</sup>

Table 4 shows the reasons given by study participants for both cutting and not cutting their girls. ‘Custom/culture’ is by far the most common reason given, but there is clearly great concern for the negative impact FGM has on girls’ health.

Reason	Not to Cut Girl	To Cut Girl
Health reasons	57.1%	12.5%
Marriageability	15.0%	16.0%
Custom/culture	8.2%	52.0%
A religious duty	6.8%	32.8%
Chastity	2.7%	26.2%
Religiously preferred	2.0%	10.9%
Economic reasons	2.0%	0.0%
Others	4.1%	9.0%

**Table 4: Reasons and justifications for the FGM final decision in Sudan**

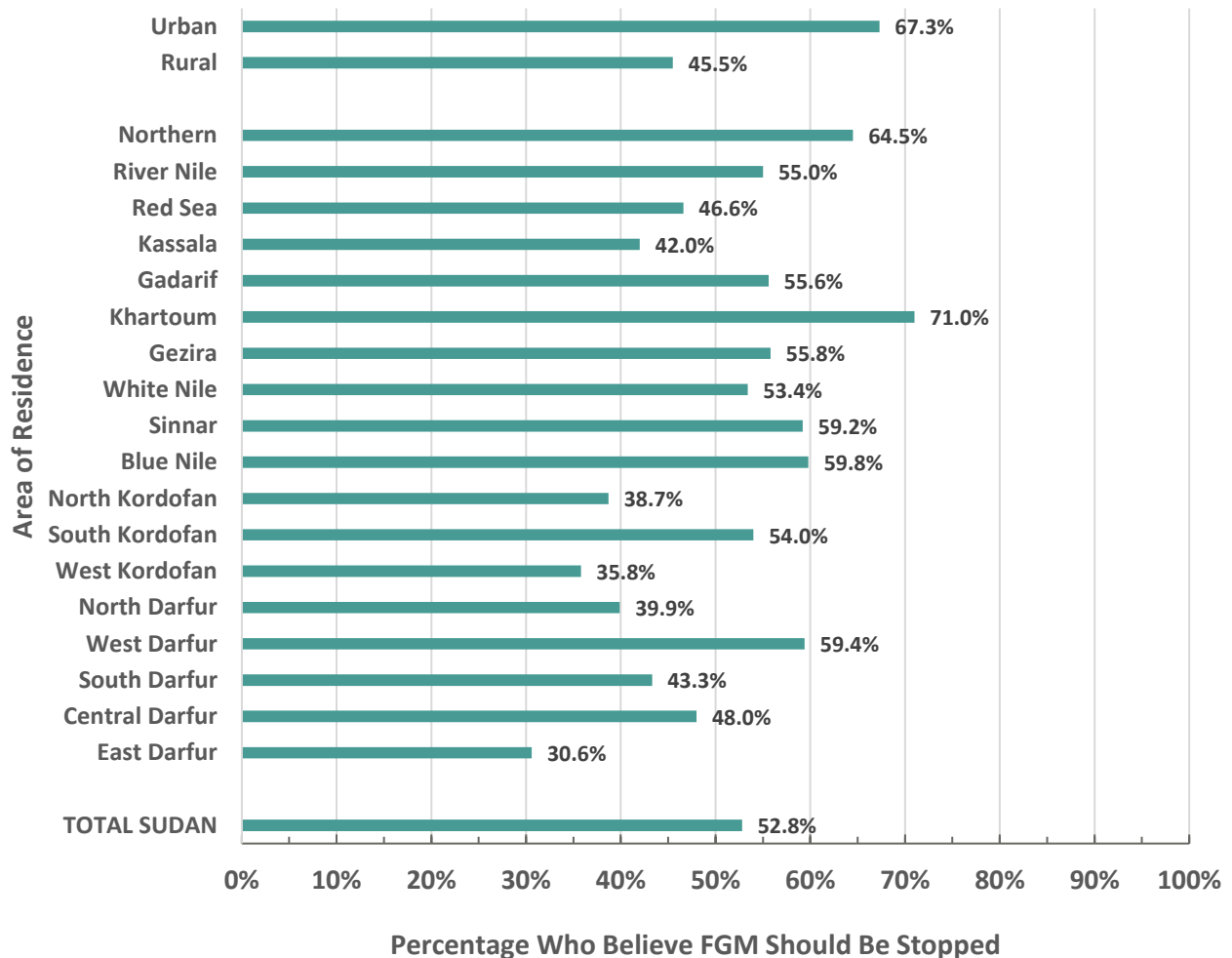
In almost all contexts the reasons driving FGM are deep and complex, and it is necessary, though challenging, to unravel the perceived ‘social benefits’ of the practice for women and girls and what they feel they will lose if they reject it. FGM confers status and belonging to women in many practising communities across Africa. Without addressing these aspects and their underlying beliefs, unhelpful tensions are created between acceptance (in the community) and safety (including health impacts on an individual).

For further information and resources on the role of social norms in the continuation of FGM, please visit <https://www.28toomany.org/thematic/social-norms-and-fgm/>.

## Support for FGM

Across Sudan, **attitudes towards the continuation of FGM** are divided. Of women aged 15–49 who have heard of FGM, 40.9% believe that it should continue, while 52.8% believe it should be abandoned.<sup>11</sup> In 2010, 42.3% believed that the practice should continue, while 53% thought it should be abandoned.<sup>12</sup>

Levels of backing for the abandonment of FGM vary widely by state (see Figure 14): the lowest level is in East Darfur (30.6%) and the highest is in Khartoum (71%). Abandonment is more strongly favoured in urban areas, where about two-thirds of women believe that the practice should be stopped, compared to less than half (45.5%) of women living in rural areas.<sup>13</sup>



**Figure 14: Percentage of Sudanese women aged 15–49 who have heard of FGM and believe that FGM should be stopped, according to area of residence<sup>14</sup>**

The desire for the abandonment of FGM is strongly correlated with both a woman’s level of education and her level of wealth.

Women who have received a higher level of education are considerably more likely to favour abandoning the practice (79.1%) than those who have received no formal education (37.3%).<sup>15</sup>

At first glance, this may seem contradictory to the fact that FGM is more common among Sudanese women with higher levels of education. However, attitudes towards the practice represent the feelings of women currently aged 15–49, whereas the prevalence of FGM is dictated by the attitudes of those responsible for cutting women of the same age-range.

For this reason, the data suggests that, in contemporary Sudan, the links between FGM practice and women’s education are more in line with what is observed in many other African countries – that is, the

more women are educated, the more they believe that FGM should be stopped. The data also supports the widely held belief that education contributes to better health outcomes for mothers and daughters.

71.6% of women in the highest wealth quintile believe that the practice should be abandoned, while only 32.3% of women in the lowest wealth quintile believe the same.

A woman’s current marital status also affects her attitude towards the abandonment of FGM (see Table 5). Less than half of married women (48.3%) think that the practice should be abandoned, while 61.7% of single and 56.3% of previously married women think the same.<sup>16</sup>

Marital Status	Should Continue	Should Be Discontinued	Don’t Know
Never Married	31.5%	61.7%	6.8%
Currently Married	45.7%	48.3%	6.0%
Formerly Married	37.1%	56.3%	6.6%

**Table 5: Percentage of Sudanese women aged 15–49 who have heard of FGM and believe that FGM should continue/should stop, according to marital status<sup>17</sup>**

The SHHS 2010<sup>18</sup> found that, of ever-married women aged 15–49, 48% intended to have their daughters cut; 33.6% did not (3.2% were not sure and 15.3% of answers were missing). Younger women were less likely to intend to cut their daughters, as were those who had achieved higher levels of education and those in the richer wealth quintiles. Women in South Darfur were the most likely to intend to cut their daughters (71.3%), and women in Khartoum were the most likely to say that they did *not* intend to cut their daughters (50.5%).

There is some concern that certain women in Sudan who avoided the practice as girls are coming under **pressure to be cut as adults**. One article in *The Guardian* from 2016 noted that FGM was spreading among minority groups in Sudan and that women from communities that previously shunned FGM were now being pressured to have it done under threat of being ostracised.<sup>19</sup> However, it is unclear how widespread this is (see also the note on urbanisation on page 47).

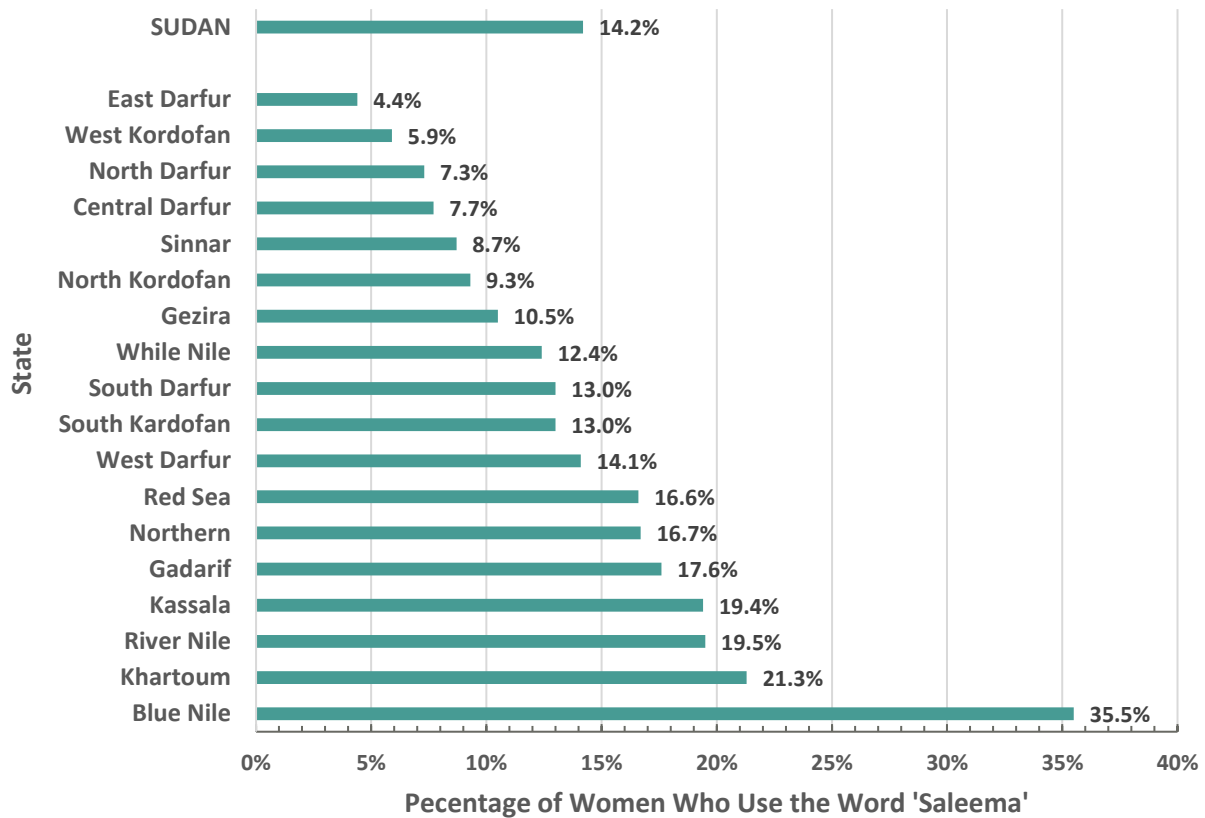
A 2014 study noted that, although some positive changes have been observed regarding attitudes to FGM, ‘these relate primarily to a transition from infibulation to clitoridectomy’. In other words, rather than ending the practice, some communities are continuing it but **shifting to ‘less severe’ forms**.<sup>20</sup> This aligns with findings from other studies such as the 2018 Population Council study.<sup>21</sup>

## The Saleema Initiative and Attitudes towards FGM

Women interviewed for the MICS 2014 were asked, ‘What do you name a girl who is not circumcised?’ ‘Saleema’ was one of the possible answers. The Secondary Analysis of this data attempts to evaluate the link between exposure to the Saleema Initiative (see page 58) and attitudes towards FGM.<sup>22</sup> However, the author notes that, since women may have been exposed to the Saleema Initiative yet choose not to use the word ‘Saleema’, any relationships found between the use of the word and exposure to the Initiative cannot be said to be causal without further data.

Across Sudan as a whole, 14.2% of women aged 15–49 who have heard of FGM use the word ‘Saleema’ to describe uncut girls.

In urban areas, 22.9% use it, and in rural areas, 9.8% do. However, there are large variations by state (Figure 15).



**Figure 15: Percentage of Sudanese women aged 15–49 who have heard of FGM and use the word ‘Saleema’ to describe an uncut girl<sup>23</sup>**

States with the least frequent use of ‘Saleema’ were North, East and Central Darfur and West Kordofan. In these states, less than 8% of women used the word to describe an uncut girl. Use of ‘Saleema’ was most common in Blue Nile (35.5%). Interestingly, East Darfur, with the lowest percentage of women using ‘Saleema’ (4.4%), was one of the last areas to be reached by the Initiative and had therefore received the least amount of outreach in relation to the campaign.<sup>24</sup>

**‘Saleema’ is increasingly being used to refer to uncut girls in Sudan**





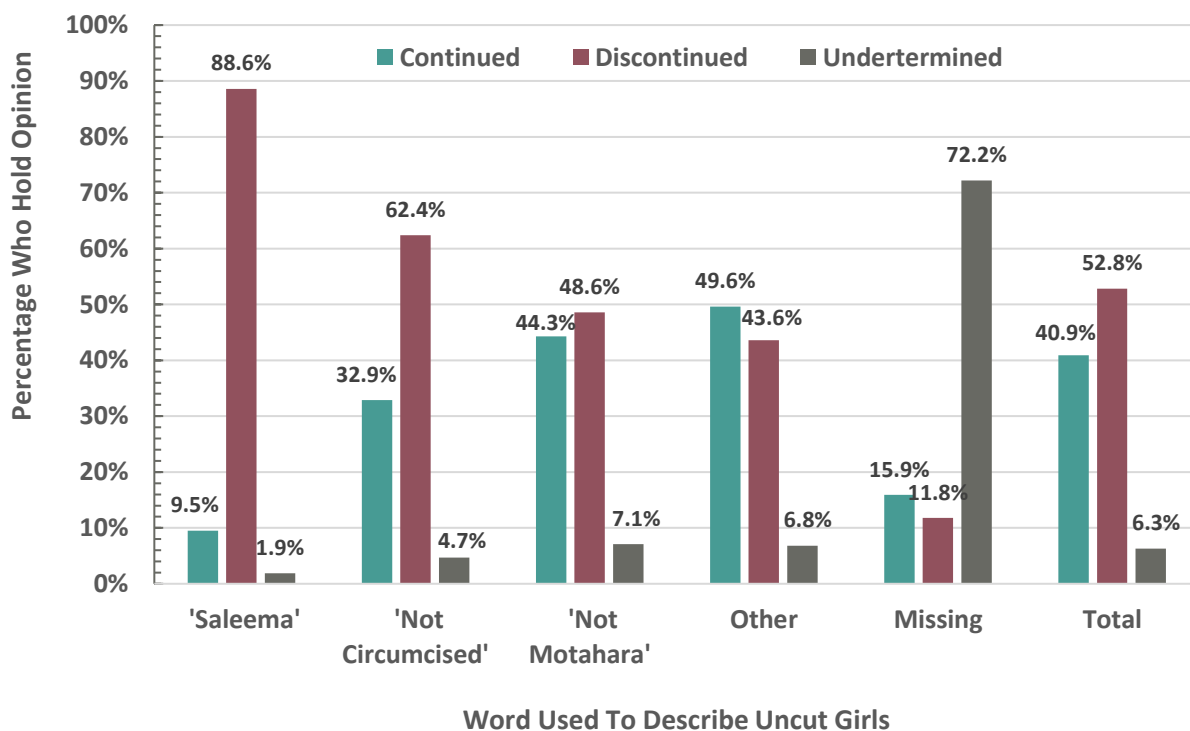
Table 6 shows the usage of 'Saleema' broken down by women's background characteristics. The word is most frequently used by young, never-married, better-educated, wealthier, uncut women.

Background Characteristic	% of Women Using the Word 'Saleema'
<b>Age</b>	
15–19	17.6%
20–29	14.3%
30–39	12.8%
40–49	12.1%
<b>Level of Education</b>	
None	6.4%
Primary	9.5%
Secondary	21.6%
Higher	33.4%
<b>Marital Status</b>	
Never married	20.4%
Currently married	11.3%
Formerly married	14.0%
<b>Household Wealth</b>	
Poorest	5.4%
Second	8.1%
Middle	12.9%
Fourth	14.8%
Richest	25.8%
<b>FGM Status</b>	
Cut	24.1%
Not cut	13.1%
<b>TOTAL</b>	<b>14.2%</b>

*Table 6: Percentage of Sudanese women aged 15–49 who have heard of FGM and use the word 'Saleema' to name an uncut girl, according to background characteristics<sup>25</sup>*

Figure 16 shows the percentage distribution of women aged 15–49 years who have heard of FGM according to their attitudes towards continuation of the practice and whether or not they use ‘Saleema’. An in-depth analysis of women’s attitudes towards FGM shows that a woman’s own FGM status, whether or not she uses the word ‘Saleema’ to describe uncut women (a proxy for exposure to the Saleema Initiative) and her level of education are the factors that have the highest power to predict her attitude towards abolishing FGM. Women who have not undergone FGM are seven times more likely than women who have to think that FGM should be abolished, while women using ‘Saleema’ are six times more likely (88.6%) than those using other words to believe that the practice should be discontinued.<sup>26</sup> The prevalence of FGM among girls aged 0–14 was found to be 30% higher among girls whose mothers did not use ‘Saleema’ (32.5%) than among those whose mothers did (23%).<sup>27</sup>

However, it should be kept in mind that women who are predisposed to favour the abolition of FGM may be more likely to take up the use of the word. Additionally, FGM may have been performed well before the introduction of the campaign; therefore, this cannot be taken as a definitive indicator that exposure to the Saleema Initiative is changing women’s attitudes towards the practice.



**Figure 16: Percentage of Sudanese women aged 15–49 who have heard of FGM according to whether or not they use the word ‘Saleema’ to describe uncut girls and their opinions regarding the continuation of FGM<sup>28</sup>**

The Saleema Initiative is, however, considered by the anti-FGM network in Sudan to be effective in changing attitudes. As a unique grassroots initiative and Sudanese campaign (rather than one imposed by Western campaigners), activists and communities are proud of it and recognise the empowerment and confidence it is encouraging in youth, particularly girls, as positive messaging is increasingly used to tackle FGM. The African Union has recently also adopted the campaign, with the intention of rolling it out across practising countries in Africa.

In Sudan, moving forward, 28 Too Many understands that there is a desire to ensure the Saleema messaging is even more effectively targeted; for instance, by choosing the most appropriate method of communication (social media, word of mouth, etc) to the decision-makers identified in a target community (fathers, grandmothers, etc). There has also been identified an urgent need to better understand the impact of Saleema on future attitudes towards those women and girls *who have already had FGM* (in terms of how they will be viewed and treated by society if they do not 'fit the popular image' of Saleema).

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- 1 Secondary Analysis, p.13.
  - 2 Secondary Analysis, p.11.
  - 3 Secondary Analysis, p.11.
  - 4 SHHS 2010, p.198.
  - 5 A.R. Sharfi, M.A. Elmegeboul and A.A. Abdella (2012; revised 2013) 'The continuing challenge of female genital mutilation in Sudan', *African Journal of Urology*, 19(3), September 2013, p.139. Available at <https://www.sciencedirect.com/science/article/pii/S111057041300060X>.
  - 6 Murat Akbas, Ozer Birge, Deniz Arslan and Ozbey Ertugrul Gazi (2019) 'Opinions of Nyala University students about female genital mutilation', *Eastern Mediterranean Health Journal*, June 2019.
  - 7 A. Gamal Eldin, S. Babiker, M. Sabahelzain and M. Eltayeb (2018) 'FGM/C Decision-Making Process and the Role of Gender Power Relations in Sudan', *Evidence to End FGM/C: Research to Help Girls and Women Thrive*. New York, NY: Population Council.
  - 8 *Ibid.*, p.v.
  - 9 *Ibid.*, p.iv.
  - 10 *Ibid.*, p.34 (emphasis 28 Too Many's).
  - 11 MICS 2014, p.218.
  - 12 SHHS 2010, p.205, re-analysed by UNICEF.
  - 13 MICS 2014, p.218.
  - 14 MICS 2014, p.218.
  - 15 MICS 2014, p.218.
  - 16 Secondary Analysis, p.35.
  - 17 Secondary Analysis, p.35.
  - 18 SHHS 2010, p.203. **(NB: There appears to be a minor misprint in the SHHS 2010, as these figures total 100.1%.)**
  - 19 Zeinab Mohammed Salih (2016) 'FGM spreading to minority groups in Sudan, say campaigners', *The Guardian*, 15 February. Available at <https://www.theguardian.com/world/2016/feb/15/fgm-sudan-female-genital-mutilation-spreading>.
  - 20 Wala M. Elfatih Mahgoub and Ibrahim A. Ali (2018) 'Attitude and Practice of Female Genital Mutilation among Doctors in Khartoum State 2014', *Journal of Gynaecology and Women's Health*, p.2. Available at <https://juniperpublishers.com/jgwh/pdf/JGWH.MS.ID.555797.pdf>.
  - 21 A. Gamal Eldin, *op. cit.*
  - 22 Secondary Analysis, pp.vi and 72–77.
  - 23 Secondary Analysis, p.74.
  - 24 Secondary Analysis, p.73.
  - 25 Secondary Analysis, p.75.
  - 26 Secondary Analysis, p.vi.
  - 27 Secondary Analysis, p.76.
  - 28 Secondary Analysis, p.76.

**Image page 66:** Kertu (2015) *Young Sudanese girl posing for a portrait*. Shutterstock ID 587667914.

# The Sustainable Development Goals

The eradication of FGM was pertinent to six of the UN's eight **Millennium Development Goals (MDGs)**, which reached their deadline in 2015. In September 2015 the UN adopted the **Sustainable Development Goals (SDGs)**, which replaced the MDGs and have a deadline for achievement of 2030. The 17 SDGs focus on five 'areas of critical importance for humanity and the planet' – **people, planet, prosperity, peace and partnership**.<sup>1</sup>



*Figure 17: The Sustainable Development Goals*

A document entitled *Transforming our World: the 2030 Agenda for Sustainable Development*<sup>2</sup>, details the SDGs and states that they

seek to build on the Millennium Development Goals and complete what these did not achieve. **They seek to realise the human rights of all and to achieve gender equality and the empowerment of all women and girls.**

Sudan has signed up to the SDGs, but a 2019 audit by the National Audit Chamber of Sudan found that there have been significant problems related to the frameworks for implementation, oversight monitoring and funding at the federal level. The National Population Council, however, has delivered on the majority of its mandated tasks, such as regular reporting. The audit notes that a clear plan of action must be drawn up if Sudan wishes to achieve the SDGs.<sup>3</sup>

The SDGs go further than the MDGs and **make explicit reference to the elimination of FGM**. This will strengthen the hands of governments, NGOs and multi-lateral organisations when implementing anti-FGM policies and legislation.



**Sustainable Development Goal 5: Achieve gender equality and empower all women and girls**

*Goal 5.3 Eliminate all harmful practices, such as child, early and forced marriage and female genital mutilation.*

Other SDGs have relevance for women and girls who have experienced or are likely to experience FGM, particularly those related to education, health and gender equality, such as **Goals 3 and 4**.

In addition to the SDGs, the African Union has declared the years 2010 to 2020 to be the **African Women's Decade**.<sup>4</sup> This declaration will assist in promoting gender equality and the eradication of FGM and other forms of GBV in Sudan.

For a summary of all 17 SDGs, please go to **The Global Goals for Sustainable Development**.

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1 UN Department of Economic and Social Affairs (2015) *Transforming our world: the 2030 Agenda for Sustainable Development*. Available at <https://sustainabledevelopment.un.org/post2015/transformingourworld>.

2 *Ibid.*

3 International Institute for Sustainable Development (2019) *Sudan Audit Stresses Need for SDG Programme of Action, Indicator Alignment*, 9 April. Available at <https://sdg.iisd.org/news/sudan-audit-stresses-need-for-sdg-programme-of-action-indicator-alignment/>.

4 African Union (2011) *The African Women's Decade*, p.2. Available at <http://pages.au.int/carmma/documents/african-womens-decade>.



# Education

*‘My daughter refused FGM/C and she said to me, “My teacher in school gave us a session about FGM/C and said it’s a harmful practice and has several complications in the future and . . . I want to be Saleema.”’*

*~ A father in Gedaref explaining the importance of empowering girls<sup>1</sup>*

Quality, universal education is a vital step in the eradication of FGM in Sudan, as it is everywhere, and a good level of literacy in the population makes the anti-FGM message easier to spread.

Article 25 of the Child Act, Provisional Decree of 2004, states that education shall aim to ensure a child’s ‘religious, moral, emotional, patriotic and spiritual upbringing.’<sup>2</sup>

Sudan’s Education Planning and Organisation Act of 2001 gives the right to education to all children, without any discrimination. The language of instruction is Arabic, and religious education is compulsory. In 2003, a by-law was passed allowing non-governmental schools to add extra material to the national curriculum and to teach the national syllabus in English.<sup>3,4</sup>

## Literacy

In 2015 literacy among those aged 15 years and over in Sudan was 75.9% (83.3% of men and 68.6% of women).<sup>5</sup> There was, however, a decline in total adult literacy between 2000 and 2008 from 61% to 54%.<sup>6</sup>

The MICS 2014 gives further information about the literacy of young women. The literacy rate among women aged 15–24 is 59.8%. This varies between 79.8% of women living in urban areas (the highest of which is Khartoum at 82.6%) and 50% of those living in rural areas; literacy among women living in Central Darfur is only 27.4%. There is a wide disparity in literacy between women in wealthy households (92.2%) and those in poor households (31.2%). Interestingly, literacy among women aged 15–19 is more common (63.4%) than among those aged 20–24 (55.6%), suggesting that more young women are receiving education and becoming literate.<sup>7</sup>

In 2013 Sudan’s school-life expectancy (that is, the number of years of education, from primary to tertiary, that a child can expect to receive and complete) was seven years for both boys and girls.<sup>8</sup>

## Structure of Education in Sudan

The Federal Government is responsible for educational planning and coordination at central and state levels, development of the general education curricula and exam standards, and coordination of teacher training and higher and technical education.

State governments are responsible for the establishment and management of educational institutions within their areas, in accordance with federal plans and standards; each state has its own minister of education and director-general of education.<sup>9</sup>

Changes in the structure of the education system took place in 1998. It now includes two years at pre-primary level for four- and five-year-olds (which is not compulsory or free and is offered by

kindergartens and traditional Islamic schools)<sup>10</sup> and eight years' compulsory and free basic education for six- to thirteen-year-olds, at the end of which they take an exam to enter secondary school for three years.<sup>11</sup> Secondary education is also compulsory and divided into two programmes, one offering academic study aimed at preparing students for higher education, and the other preparing students for obtaining employment through courses in business studies, agricultural and technical subjects.<sup>12</sup>

## Education and the Development Goals

Goal 4 of the new **Sustainable Development Goals** is relevant to FGM in that it relates to education:

*Goal 4: Ensure inclusive and equitable quality education and promote life-long learning opportunities for all.*

The targets for Goal 4 make specific reference to ensuring girls and other vulnerable people receive equitable early-childhood development, inclusive and effective schooling at all levels, and vocational training and university education; they also include aspirations for adult women and men to receive equal skills training to achieve literacy and numeracy and enable them to take up decent jobs and start businesses.

Of particular importance in relation to the elimination of FGM is Target 4.7:

By 2030 ensure all learners acquire knowledge and skills needed to promote sustainable development, including among others through education for sustainable development and sustainable lifestyles, human rights, gender equality, promotion of a culture of peace and non-violence, global citizenship, and appreciation of cultural diversity and of culture's contribution to sustainable development.



*School attendance rates are generally higher in urban areas of Sudan*

### **Enrolment, Access and Gender Parity**

Although there is no significant gender difference among those attending the first two years of **early childhood education** (22.7% girls and 21.9% boys), according to the MICS 2014, there are differences according to children's areas of residence and levels of wealth.<sup>13</sup>

In 2014, 44.6% of children aged 3–5 living in urban areas received early childhood education compared to only 13.9% of similarly aged children in rural areas. The highest attendance rate was in Khartoum (56.2%) and the lowest was in the state of West Kordofan (4.3%). There was also difference based on socio-economic status: 59.4% of 3–5-year-olds living in the richest households attended preschool compared to 6.9% in the poorest families.<sup>14</sup>

37.5% of girls and 36.1% of boys of **primary-school entrance** age entered Grade 1; however, 56.6% of children living in urban areas entered Grade 1 compared to 29.5% of children living in rural areas, and 77.6% of those living in wealthy households entered Grade 1 while only 14.5% of those from poor households did so.<sup>15</sup>

Across the country 76.4% of **primary-school-aged children** were attending school; in urban areas the attendance rate was higher, at 91.4%, and in rural areas it was 70.6%. There was wide variation between states, however, as only 54.1% of children in West Kordofan were attending school compared to 95.5% living in Northern state. Again, household wealth appears to impact on attendance, with 96.9% of children in the wealthiest quintile attending compared to 57.4% of those in the poorest quintile.<sup>16</sup>

Although there was little variation in attendance by gender at pre-primary level, differences begin to appear during the six years of primary/basic education. At primary level, lower percentages of primary-school-aged girls than boys attended in the rural states, in particular the troubled Darfur states. For example, in Central Darfur, 57.6% of boys attended school compared to 50.9% of girls; in East Darfur the ratio was 66.3% of boys compared to 57.8% of girls; and in West Darfur it was 63.5% to 56.8%.<sup>17</sup>

There are four states where girls' attendance marginally exceeded that of boys: River Nile (90.4% of boys/91.7% of girls), South Kordofan (69.3% of boys/69.6% of girls), North Darfur (76% of boys/77.4% of girls); and South Darfur (65% of boys/67.4% of girls).<sup>18</sup>

The Gender Parity Index achieved for primary education was 0.98 – close to equalisation, which would be 1.0.<sup>19</sup>

Attendance rates for **secondary-school-aged children** continue to show differences by area of residence and level of wealth rather than by gender. In many states girls' school attendance marginally exceeded that of boys, and across Sudan as a whole 29.4% of girls attended compared to 27.4% of boys.<sup>20</sup>

In urban areas there was a significant difference between girls' attendance, at 44.6%, and boys', at 39.7%. In rural areas, the difference was minimal: 21.9% of boys and 22.4% of girls. In Khartoum girls' attendance exceeded boys by 4.6 percentage points (53.6% of boys/58.2% of girls), and in Northern state 57.5% of girls attended while 35.2% of boys did. This was reversed, however, in attendance rates in West Kordofan (17.2% of boys/12.1% of girls) and West Darfur (27.6% of boys/17.8% of girls).

Across Sudan as a whole, only 9.1% of the poorest secondary-school-aged children attended school compared to 68.5% of those in the wealthiest quintile. In Northern state girls were far more likely to

attend secondary school than boys (35.2% of boys/57.5% of girls), while in West Darfur boys were more likely to attend than girls (27.6% of boys/17.8% of girls).<sup>21</sup>

The Gender Parity Index achieved for secondary education was 1.07.<sup>22</sup>

One reason often given for children not enrolling or attending school regularly is that they are in employment. It has been estimated that 4% of Sudan's labour force are children aged six to nine, and that children aged 10–14 comprise 10–12% of the labour force, despite the minimum age for employment being 14 years. In rural areas children make up 13% of the labour force and 5% in urban areas.<sup>23</sup>

In December 2016 the federal minister of general education acknowledged there had been 'an increase in school drop-outs in some areas because of poverty and destitution.'<sup>24</sup>



*Young women who have achieved higher levels of education are less likely to support FGM*

### ***Teacher Training***

Since 1993 the qualification for basic- and secondary-education teachers has been a four-year Bachelor of Education degree. However, in 2008 it was estimated that only 12% of basic-education teachers had achieved this qualification and that half of basic-education teachers were untrained.<sup>25</sup> This is expected to have improved over the past decade as a result of financial support from Global Partnership for Education, which supported the Government in developing an Education Interim Sector Strategic Plan 2012 (*ISSP*) that included the objective 'Improving teaching quality and providing teaching and learning materials.'<sup>26</sup>

The ISSP noted that the student-to-class ratio across Sudan was 47.7 at the time, varying between 63.8 in West Darfur and 31.9 in Northern state. Deployment of teachers was uneven across states, with particularly low deployment in rural areas, because (a) female teachers chose to work near to their spouses and (b) there was no incentive for qualified teachers to work in remote rural areas.<sup>27</sup>

### ***Government Plans for the Education Sector***

In 2008 the Government's spending on education was 2.7%, compared to the 3–7% that was spent by neighbouring countries Chad, Ethiopia and Kenya. The bulk of that spending was on teachers' salaries, leaving little available for the improvement of school infrastructure and facilities.<sup>28</sup>

One objective of The Twenty-Five-Year National Strategy 2007–2031<sup>29</sup> is:

Fostering human resources by training, rehabilitation and provision of basic social services such as health, education and potable water.

Within the overall objectives of the strategy, a cluster of objectives for Higher Education and Scientific Research includes the following:

- To prepare graduates with the appropriate skills and capabilities and to make them responsible citizens able to meet the needs of the country's development challenges.
- To participate in the building of the culture of peace to attain justice based on meeting essential human needs.
- To assist in developing and improving all educational levels especially by training teachers, improving syllabuses and strengthening educational research.
- To cater for students['] social wellbeing including food and accommodation.

UNICEF's country programme 2018–2021 for Sudan includes the following goals in relation to education and learning:

- improve equitable access to quality basic education and improve learning outcomes for all children;
- deliver an integrated package of services to get the most vulnerable children, including girls, into school and keep them there;
- scale up access to education for nomadic and displaced children through strengthened partnerships with NGOs; and
- strengthen teachers' capacities, curricula and facilities to improve education delivery.<sup>30</sup>



## Education and FGM

Population-scale studies of FGM in African countries have typically revealed that the better educated a woman is, the less likely she is to have experienced FGM and to have had her daughter(s) cut. The usual expectation is that better education results in greater exposure to information on health and wider social interactions, leading in turn to a lower likelihood of FGM.

Sudan, however, demonstrates the opposite trend. According to the MICS 2014, 76.8% of women aged 15–49 with no formal education have undergone FGM compared to 91.8% of women with higher education.<sup>31</sup>

This is supported by the Secondary Analysis, which studied the FGM statuses of women aged 20–49 who have achieved a secondary or higher level of education. The study found that 14% of women who have achieved this level of education have not undergone FGM, while 35.2% have undergone FGM.

The same trend broadly persists by location. Of women aged 20–49 who have achieved secondary or higher levels of education and who live in urban areas, 33.7% have not undergone FGM, while 56.1% have. Of those who live in rural areas, 4.4% have not undergone FGM, while 24.9% have.<sup>32</sup>

However, among women aged 15–49, the mean age of cutting was 6.9 years (although reinfibulation may be performed after childbirth). Since FGM in Sudan usually takes place at such a young age, it has been suggested that Sudanese girls are less likely to drop out of school due to FGM than girls in other countries where FGM is practised.<sup>33</sup> This, perhaps, contributes to the relative gender parity in education in most areas of the country.

Therefore, it should be noted that, as the Secondary Analysis concludes, it is not possible to deduce whether or not there is a real *causal* relationship in Sudan between a girl's level of education and whether or not she undergoes FGM.<sup>34</sup>

In relation to the 'transmission' of FGM between generations, FGM is more prevalent among the daughters of mothers who have received *lower* levels of education. 31% of the daughters (aged 0–14) of mothers who have had no formal education have been cut compared to 15.1% of the daughters of mothers who have had secondary or higher levels of education.

This suggests that, in contemporary Sudan, more educated mothers are less likely to cut their daughters.

However, the Secondary Analysis stresses that the main determining factor in whether or not a girl undergoes FGM is whether or not her mother has been cut. 34.6% of girls whose mothers have undergone FGM have been cut, as opposed to 2.3% of girls whose mothers have not.<sup>35</sup>

- 1 Cited in Nafisa Bedri, Huda Sherfi, Ghada Rodwan, Sara Elhadi, and Wafa Elamin (2018) *Medicalisation of Female Genital Mutilation/Cutting in Sudan: Shifts in Types and Providers*, p.15. New York, NY: Population Council. Available at [https://www.popcouncil.org/uploads/pdfs/2018RH\\_FGMC-MedicalisationSudan.pdf](https://www.popcouncil.org/uploads/pdfs/2018RH_FGMC-MedicalisationSudan.pdf).
- 2 UNESCO and the International Bureau of Education (2010/11) *World Data on Education*, 7<sup>th</sup> ed., p.3. Available at <http://www.ibe.unesco.org/sites/default/files/Sudan.pdf>.
- 3 *Ibid.*
- 4 **There are a few private/non-governmental schools in the country, mostly in Khartoum, including international and Islamic schools; for example, see <https://www.schoolandcollegelistings.com/SD/Khartoum/191859/genre/186998168001766/Private+School>.**
- 5 Central Intelligence Agency (2019) *The World Factbook: Sudan*, 23 September. Available at <https://www.cia.gov/library/publications/the-world-factbook/geos/su.html>.
- 6 IndexMundi (undated) *Literacy rate, adult total (% of people ages 15 and above)*. Available at <https://www.indexmundi.com/facts/indicators/SE.ADT.LITR.ZS/compare?country=sd>.
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# Healthcare

## Status of the Healthcare System

The health situation in Sudan is typical of many sub-Saharan African countries. Malnutrition and communicable diseases account for a large portion of illness, with malaria, tuberculosis and diarrheal diseases among them.<sup>2</sup> In addition, Sudan's population is susceptible to non-communicable diseases and drought, flood and conflict.<sup>3</sup>

Life expectancy at birth in Sudan is 62 years for men and 66 years for women.<sup>1</sup>

The health sector suffers from underfunding, a lack of human resources and problems associated with the instability of the country at present.<sup>4</sup> Not only is there great disparity between the health indicators from state to state, but also there is an inequality in the use of healthcare services based on population wealth: those in the richest quintile are four times more likely than those in the poorest to use healthcare.<sup>5</sup>

**The Federal Ministry of Health** is responsible for healthcare in Sudan. It consists of 18 State Ministries of Health. Plans and policies are set at federal (nationwide policy, plans and strategies), state (state plans and strategies, funding and plan implementation) and district (implementation and service delivery) levels.<sup>6</sup> Primary Health Care was adopted by Sudan in 1976 as the main strategy for health care in the country.<sup>7</sup>

Sudan's **public-health structure** consists of three levels – primary, secondary and tertiary. It was reported in 2015 that the primary level was made up of primary health care units run by community health workers with nurses and medical assistants operating dressing units, dispensaries run by medical assistants and health centres run by general practitioners. The secondary level consisted of rural district hospitals with 40–100 beds. The tertiary level consisted of teaching, specialised and general hospitals as well as 21 tertiary-level hospitals. However, at that time, only 13% of the facilities were reported to be fully functioning, often due to a lack of qualified health professionals. The public sector is responsible for around 90% of the health facilities in Sudan.<sup>8</sup> Private-sector healthcare consists of private clinics, health centres and hospitals. In addition to these, a number of NGOs provide health services in conjunction with the Federal Ministry of Health, particularly in unstable regions.<sup>9</sup>

**Medical professionals** in Sudan are split almost equally between male and female. There has been a big increase in the number of medical training facilities over the last two decades. The public sector is the main employer of health professionals. Less than 10% are employed exclusively by the private sector, although many work for both.<sup>10</sup> The distribution of health professionals within Sudan is heavily weighted towards urban settings (almost 70%). This is particularly noticeable with doctors: there are 21 specialists per 1,000 head of population in Khartoum, in comparison to only 0.8 per 1,000 in West Darfur state.<sup>11</sup>

A strategic plan for **Human Resources for Health** was set for 2012–2016, based on a number of existing policy documents, including:

- the Interim Constitution;
- the Twenty-Five-Year Health Strategy (2007–2031);
- the 10-Year Human Resources for Health Projections Plan (2004–2013);
- the National Health Policy 2007;
- the Health Policy South Sudan; and
- the Five-Year Health Sector Strategy (2007–2011).<sup>12</sup>

The Ministry of Health Education provides **training** at 13 universities and 250 allied health cadre schools and institutes. Most of the medical training facilities are based in Khartoum.<sup>13</sup> Although it has increased, the number of doctors, nurses and midwives per 1,000 head of population was reported to be only 1.927 in the 2017 Joint Annual Review,<sup>14</sup> significantly lower than the WHO’s recommendation of 2.28 healthcare professionals per 1,000 head of population.<sup>15</sup>

Much of the problem of **staff shortage** is due to the migration of health workers – more than 60% of Sudan’s health professionals have reportedly migrated to other countries, in particular Saudi Arabia, Gulf States, the United Kingdom, Ireland, and the USA.<sup>16</sup> Part of the reason for this is low salaries compared to other African countries. In addition, there are reports of poor working conditions alongside a lack of training and career-development opportunities.<sup>17</sup> The Government of Sudan has attempted to reduce the migration of medical professionals by introducing compulsory national service for doctors for one year as a condition of acquiring their university qualifications. In addition, monetary and non-financial incentives have been used, although these tended to be limited to certain specialised areas and were often unsustainable in the longer term due to financial constraints.<sup>18</sup> The retention programme has been reported as not being particularly successful, with a high turnover of trained staff.<sup>19</sup>

A number of key **strategy documents** exist for the health sector in Sudan, including the Human Resources for Health Strategic Plan, the Twenty-Five-Year Health Strategy (2007–2031), the 10-Year Human Resources for Health Projections Plan 2004–2013, the National Health Policy 2007, the Five-Year Health Sector Strategy (2007–2011) and the Health Sector Strategic Plan 2012–2016.<sup>20</sup>

Despite these many plans and strategies, the 2016 Joint Annual Review from the WHO and the Ministry of Health<sup>21</sup> highlighted that implementation of these policies tends to be weak, especially at the regional and local levels, with a lack of clarity and overlaps between services.<sup>22</sup> A review of the indicators set showed that, of the 49 indicators, 19 were at 90% or higher of their set target and a further ten were in the range of 75–90%. These ten included antenatal coverage and births attended by skilled personnel. The targets for a further 13 indicators were not achieved, including family planning services and contraceptive needs.<sup>23</sup> Primary healthcare coverage has been increased through the development of community midwives, multifunctional health workers and community health workers, but there are still shortages in training for medical assistance.<sup>24</sup>

Although **regulatory bodies** exist, including the Medical Council, the Allied Health Council and the National Accreditation Committee, it has been reported that laws and regulations are not always enforced.<sup>25</sup> In addition, economic instability in the country has affected health expenditure.<sup>26</sup>

The current **political situation and conflict** in Sudan has greatly affected health services. A report from January 2019 claims that ‘Sudan is on a trajectory towards a health and humanitarian crisis.’<sup>27</sup>

On January 6, the Health Minister Mohamed Abu-Zaid Mustafa was removed from his position by al-Bashir and replaced by Al-Khier al-Nour. Several doctors were reported to have gone on strike during January, and many doctors were involved in the protests against the Government. Health services were reported to be at a state of collapse due to severe underfunding, attempted privatisation of Sudan's public hospitals, and shortages and increases in the cost of essential drugs.<sup>28</sup>

In June 2019, Ms Gwi-Yeop Son, the humanitarian coordinator for the UN in Sudan, made a statement stressing the need to respect international human-rights law and protect health professionals and facilities. She also emphasised the need to get medical resources into Sudan and claimed that half a million people in Khartoum and Darfur were at risk, as well as a quarter of a million mothers, many very young, who were in danger of not receiving vital maternal care.<sup>29</sup> The import of medical supplies to Sudan decreased by 30% from 2017 to 2018.<sup>30</sup>



*Existing hospitals and health facilities in Sudan face huge capacity and staffing pressures*

In June 2019, half of the main Khartoum hospitals were closed or partially closed and two of the main maternity hospitals stopped providing services.<sup>31</sup> The Ministry of Health was working with the UNFPA, the Sudanese Red Crescent Society and other NGOs to keep as many hospitals as possible open and to reduce the impact on maternal and neonatal health. A report from OCHA Sudan in June 2019 stated that most of the public hospitals were now providing emergency maternal care services, but necessary medical supplies were in short supply and access to healthcare limited. The UNFPA provided emergency reproductive-health kits to assist in C-Sections, other obstetric operations and the treatment of other maternal-health complications.<sup>32</sup>

The WHO also called for protection for health workers as well as patients after a member of the Sudanese Doctors Union, Hussam Almuammer, told a conference in London on 4 June that the military had targeted health facilities and professionals in Sudan, particularly in Darfur, the Nuba Mountains and the Blue Nile.<sup>33</sup>

Doctors at the El Geneina Teaching Hospital, supported by the Sudanese Doctors Central Committee, announced plans to strike on 9 August 2019 after claiming that 'administrative irregularities' were the reason for severe shortages of medical supplies and equipment.<sup>34</sup>



## Health and The Development Goals

Despite making some good progress towards the MDGs, Sudan failed to meet several targets, including those for maternal and child health.<sup>35</sup> The Government has, however, made new commitments to healthcare in order to achieve the SDGs, particularly with regards to human resources, and has also pledged to assure healthcare as a right for all.<sup>36</sup>

The SDGs have a deadline for achievement of 2030. The full set of SDGs is available at <https://www.28toomany.org/thematic/law-and-fgm/>.

In addition to **Goal 5.3 (Eliminate all harmful practices, such as child, early and forced marriage and female genital mutilation)**, which makes specific reference to the elimination of FGM by 2030, several other SDGs have relevance for women and girls who have experienced or are likely to experience FGM, in particular those related to education, health and gender equality; for example:

**Goal 3 (Ensure healthy lives and promote wellbeing for all at all ages)** aims to

- (3.2) End preventable deaths of newborns and children under five years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1,000 live births and under-five mortality to at least as low as 25 per 1,000 live births

and achieve

- (3.7) Universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes.

The Countdown to 2030 report in 2015 found the **infant mortality rate** to be 48 deaths per 1,000 live births.<sup>37</sup> One year previously, the MICS 2014 reported it to be 52 deaths per 1,000 live births and the **under-five mortality rate** to be 68 deaths per 1,000 live births. According to the MICS 2014, there are large differences between states for under-five mortality, with the highest rate of 111.7 deaths per 1,000 live births being in East Darfur and the lowest rate of 29.9 deaths per 1,000 live births being in Northern State. Wealth differences are also significant: the rates are 84 deaths per 1,000 live births among those in the poorest quintile and 39 deaths per 1,000 live births among those in the richest quintile.<sup>38</sup>

### **Healthcare Funding**

Before 1990, most health services in Sudan were provided free of charge, but after economic reforms in 1992, user fees were introduced. These appeared to have a negative impact on access to healthcare and use of health facilities.<sup>39</sup>

In 2016, it was reported that 8.8% of **government expenditure** in Sudan was spent on health.<sup>40</sup> Around 5.3% of GDP was spent on healthcare, with private spending accounting for 83% (of which around 79% is out-of-pocket expenditure).<sup>41</sup> The share of public funding for health in Sudan remains lower than the Abuja declaration agreement and international recommendations.<sup>42</sup>

Social **health insurance** was introduced to Sudan in 1997, achieving around 50% coverage across Sudan by 2017. Other health insurance schemes, including those for the police and military, cover around 5.5% of the population, but an estimated 2.3 million families are not covered. For those

employed in the formal sector, membership of the National Health Insurance Fund is compulsory. A further health insurance scheme exists for Khartoum State (Khartoum State Health Insurance HIKS). Additionally, there are some private health insurance companies in Sudan, mainly covering private companies and international organisations.<sup>43</sup>

Although a system of health insurance has been in place in Sudan for more than 20 years, universal coverage has still not been achieved and there are great disparities between urban and rural areas and between formal and informal sectors.<sup>44</sup> Attempts to increase insurance coverage and expand it to include the informal sector will remain a challenge as long as out-of-pocket spending remains so high.<sup>45</sup>

A 2017 review of the health system in Sudan reported that **data** on health financing and expenditure is sometimes lacking, thus hindering effective planning.<sup>46</sup>

### ***Contraception and Family Planning***

According to The World Factbook, the **fertility rate** in 2018 was 4.85 births per woman.<sup>47</sup> According to the Institute for Health Metrics and Evaluation, the rate in 2017 was 4.2 births per woman.<sup>48</sup> According to the MICS 2014, in the age group 15–19, 11.8% of women have already given birth and 3.3% are pregnant. Both women living in urban areas and those with a secondary or higher level of education have lower birth rates than those living in rural areas and those with a primary level or no formal education.<sup>49</sup>

An interesting observation is that **childbearing before the age of 18** is most prevalent in the urban population among older women, but most prevalent in the rural population among younger women.<sup>50</sup>

12.2% of currently-married women aged 15–49 report using **contraception**, according to the MICS 2014, with the pill being the most common form used (9%). The frequency of contraception use varies widely, from 2.9% in Central Darfur to 26.5% in Khartoum state. Of those aged 15–19 who are married, only 6.4% state that they use contraception, but that figure is higher among older women. Higher rates are also found in urban areas than in rural areas and among women with a secondary or higher level of education as opposed to those with only primary education. The level of unmet need for contraception among currently-married women aged 15–49 is at 26.6%.<sup>51</sup>

### ***Reproductive Healthcare***

According to the MICS 2014, in urban areas, 93.2% of women who give birth receive **assistance during delivery from a skilled attendant**, as opposed to 71.9% in rural areas. There is a wide variation by state: only 36.4% of women in Central Darfur give birth with assistance from a skilled attendant, compared to 99% in the Northern state. Rates also vary widely according to women's levels of education: only 58.5% of those with no formal education receive assistance compared to over 90% of those with secondary or higher levels of education.<sup>52</sup>

Although **giving birth in a medical facility** is seen as an important factor in reducing maternal and neonatal risks, only about one-quarter of women aged 15–49 in Sudan give birth in a health facility (27.7%), while 71.3% of births take place at home. Women living in urban areas are more likely than those living in rural areas to use a health facility (45.2% and 21.5% respectively). Again, there are big differences according to women's levels of education: only 11.5% of those with no formal education deliver in a health facility, compared to 75.5% of those with higher-level education.<sup>53</sup>

79.1% of women receive **antenatal care from a skilled provider** (90.8% in urban areas and 74.9% in rural areas). In South Darfur that figure is lower, at 61.8%, while in Khartoum it is 97.1%. Women's levels of wealth also make a difference: 97.2% of those in the highest wealth quintile receive care as opposed to 61.7% in the poorest wealth quintile. Antenatal care in Sudan is provided in 55.4% of cases by medical doctors.<sup>54</sup>

Pregnancy is a leading factor in **deaths among girls aged 15–19**, particularly among those on the younger side of this age-group. Education appears to curb marriage and early pregnancy, as 27.5% of women aged 15–19 with only a primary level of education are married, as opposed to 2.4% of those with higher education.<sup>55</sup>

In August 2017, Sudan officially signed up to the **Campaign to Advance the Reduction of Maternal Mortality in Africa (CARMMA)**, the African Union Commission programme that was launched in 2009 to reduce child and maternal mortality in Africa. The event also marked the first annual celebration of the National Day of Mother and Child Health.

In recent years, Sudan's Government has introduced several **initiatives aimed at improving maternal health**, including 2016's '10 by 5' Reproduction, Maternal, Newborn, Child and Adolescent Health Strategy (*RMNCAH*), the Antenatal Care Scale-Up Program and the Maternal Mortality Reduction Initiative.<sup>56</sup> However, the impact of the political instability in the country has affected delivery of these programmes, and the closure of hospitals and lack of medical supplies have put millions of women at risk.<sup>57</sup> Although the healthcare sector has been particularly affected by the political unrest, some programmes focusing on women's health are still running. For example, Radio Tamazuj started a new radio programme in May 2019, #WomenHealthLifeline, on health issues for women in Sudan and South Sudan.<sup>58</sup> In addition, the UNFPA in Sudan is working with several international partners, among them DFID and SIDA, on issues of maternal and child health, including FGM and child marriage.<sup>59</sup> UNICEF has provided maternal healthcare assistance, including emergency health kits, which contain midwifery and obstetric provisions, to hospitals in Khartoum and Omdurman to help address some of the urgent health needs.<sup>60</sup> The organisation is also actively supporting the Ministry of Health in delivering vaccination campaigns in conjunction with the WHO and Gavi. In addition, it is hosting community-based mother-support groups.<sup>61</sup> The Institute for Reproductive Health and Rights set up the Sudan Sexual and Reproductive Health & Rights Network in 2016 with the aim of creating an advocacy network for individuals and organisations working on sexual and reproductive health rights (*SRHR*) in Sudan.<sup>62</sup>

## Healthcare and FGM

A 2018 study looked at sexual dysfunctions and obstetric complications related to FGM, and concluded that FGM leads to problems during labour and is a significant cause of sexual complications.<sup>63</sup>

An African Journal of Urology study of 1,468 Sudanese women who had been cut revealed the complications related to FGM as shown in Table 7 below. A quarter of the women who experienced immediate complications had severe bleeding; an even higher percentage of women who experienced late gynaecological complications suffered cysts. FGM also clearly caused difficulties for women requiring vaginal examinations and gynaecological procedures.<sup>64</sup>

<i>Immediate complications in 276 women following FGM</i>		
<b>The Complication</b>	<b>Number</b>	<b>Percent</b>
Severe bleeding	67	25.1
Septicaemia	57	21.3
Acute urine retention	45	16.9
Major wound sepsis	54	20.2
Urethral injury	44	16.5
<i>Late urological complications in 618 women following FGM</i>		
<b>The Complication</b>	<b>Number</b>	<b>Percent</b>
Difficulty to perform cystoscopy	242	39.2
Urinary tract infection	138	22.3
Tight urethral stricture	90	14.6
Vesico-vaginal fistula	57	9.2
Post-void urine more than 200 ml	41	6.6
Secondary vesical stones	25	4.0
Urinary bladder diverticulum	19	3.1
Squamous cell carcinoma of the urinary bladder	6	1.0
<i>Late gynaecological complications in 578 women following FGM</i>		
<b>The Complication</b>	<b>Number</b>	<b>Percent</b>
Vulval inclusion cyst	338	58.5
Difficult vaginal examination	189	32.7
Delay in diagnosing cervical cancer (as a result of inability to perform a proper examination because of FGM)	27	4.7
Tubal factor infertility	24	4.1

**Table 7: Complications in Sudanese women who have undergone FGM<sup>65</sup>**

### **Obstetric Fistula**

Obstetric fistula is a condition caused by prolonged obstructed labour, which results in a hole between the vagina and the rectum or bladder.<sup>66</sup> Although FGM does not directly cause obstetric fistula, it can lead to complications in labour that in turn lead to obstetric fistula.

Obstetric fistula is common in Africa, accounting for the majority of the estimated 200 million women who are affected globally, and it is usually the result of poor maternal care or giving birth at a young age.

Working together with the Women and Health Alliance International, the Fistula Foundation Sudan provides funding for fistula surgeries, surgeon training, equipment and community outreach at the Dr Abbo Khartoum Teaching Hospital Fistula Center, the Kassala Hospital and the Nyala Hospital. The Dr Abbo Khartoum Teaching Hospital runs one of the oldest fistula programmes in Africa, but has been affected by the conflict, which has left it with supply issues and a lack of qualified staff. In Kassala and Nyala, where maternal healthcare is a key concern, new projects have been established to treat fistula patients.<sup>67</sup>

The UNFPA in Sudan also works to end and treat obstetric fistula, and the Sudan SRHR Network has launched awareness campaigns for Sudanese women on the problems of obstetric fistula.<sup>68</sup>

### **De-infibulation**

In Sudan, the practice of de-infibulation (i.e. the reopening of the vaginal orifice to allow for sexual relations or childbirth) remains a sensitive subject for both women and men. De-infibulation is never considered before marriage, and, like in other practising countries such as Somalia, it is a matter of shame if the husband needs to seek help after marriage. It is still considered very important for men to have the privilege of and take responsibility for penetrating their 'virgin' wives. There are, therefore, very few cases of husbands in Sudan bringing their wives to the doctor after marriage for de-infibulation. Additionally, upon marriage, young women are often too scared to talk to their husbands about it and too shy to be exposed to doctors or other medical staff.

Regarding de-infibulation for childbirth, in 2005 the Ministry of Health and the WHO released a video to train midwives and healthcare providers on how to prompt women to de-infibulate before delivery. It is reported, however, that, while the service is available, demand for it remains very low.<sup>69</sup>

### **Reinfibulation**

In Sudan, reinfibulation is a common practice for women who have been deinfibulated during childbirth. Approximately one-quarter of women in Sudan undergo reinfibulation following delivery. A distinction is made between *khiata* ('sewing'), which means that the woman is sewn after childbirth for medical purposes (such as tearing) and *adal*, when reinfibulation is carried out. Reinfibulation seems to be concentrated around the states of Kassala (62.5%), Gadarif (52.5%) and Sinnar (46.4%), although it occurs in all states in Sudan.<sup>70</sup> See pages 54 and 96 for more detailed analyses of the prevalence of reinfibulation in Sudan.

A recent study showed that many women do not decide themselves to undergo reinfibulation, but the decision is made for them by their mothers, older female relatives or midwives. The procedure is carried out by a midwife between two hours and 40 days after the baby is born. Those in polygynous relationships also often feel the need for reinfibulation so that they are not seen as different, which



may encourage their husbands to take additional wives.<sup>71</sup> Most men in the study claimed that they had no influence on the decision about whether or not their wife was reinfibulated.<sup>72</sup>

*Many Sudanese women are still reinfibulated after giving birth*



### ***Medicalised FGM and the Role of the Midwife<sup>73</sup>***

The medicalisation of FGM in Sudan is linked to the **shift from practising Type III/infibulation** to practising Types I and II (referred to as ‘sunna’). While influencers (such as religious leaders) and most families now agree that Type III FGM is wrong, many still do not consider Type I (or even Type II) as being ‘the cut’ or constituting FGM. As such, they feel that these ‘less severe’ types are ‘safer’, particularly so if performed by a health professional. Midwives have become, as a result, the primary group of health professionals that Sudanese families are using to cut their girls.

*‘Medicalised FGM is the “new norm” and it is still increasing. It pays very well and it is in high demand.’*

*~ Nafisa Bedri, Ahfad University for Women<sup>74</sup>*

Midwives are very well respected in the communities where they work, and their involvement in the practice of FGM offers both challenges and opportunities. In Sudan, though not yet spread across the whole country, a **midwives’ oath** to not practice FGM is now included in the curricula at midwifery schools. The challenge for midwives is that, even though they may understand the long-term impact of FGM because of their training, if they take the oath, they risk a fierce backlash from the communities in which they work. A midwife may lose both her social status in the community and her income, but, more importantly, if she refuses to perform FGM, families will not want her to be involved in other maternal healthcare duties, including attending births. This risks mothers returning to the services of (untrained) TBAs, traditional cutters or even family members, and the inherent dangers that involves.

Not all trained midwives receive a salary from the state in which they work. They rely on private payments (of both money and goods) from families for performing maternal healthcare duties. Payment for performing FGM is important to them, and even more so given the uncertain economic

situation in Sudan in recent times. Midwives, therefore, have a lot to lose personally by giving up the practice of FGM and will likely, therefore, try to find ways around the oath. Anecdotal evidence suggests that midwives try to avoid the specific part of the oath that swears not to practise FGM (for example, by not saying aloud the actual words or by lowering their hands at that point).

However, given the respect for midwives in communities, they have a **vital role to play** in the work to end FGM, and it is important for Sudan to fully utilise the opportunities they represent. If midwives can be empowered to keep to the oath but continue their maternal-health duties, they will be important advocates for change.

FGM needs to be included across the curricula for all health workers. This is gradually being rolled out across the medical sector; the challenge will be to also include TBAs in the future. All medical personnel need to be sensitised to the leading role they have and their responsibilities to sensitise communities and protect women and girls. Further research is needed in relation to midwives and their role, to feed into the narrative moving forward.

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**Image page 81:** UNAMID (2012) *El Fasher Hospital*. <https://flic.kr/p/dAs7xB>.  
CCL: <https://creativecommons.org/licenses/by-nc-nd/2.0/>.

**Image page 87:** UNAMID (2012) *El Fasher Hospital*. Available at <https://flic.kr/p/dAxA5Y>.  
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# Religion

Approximately 97% of the Sudanese population is Sunni Muslim.<sup>1</sup> The remainder largely adheres to indigenous beliefs or Christianity.<sup>2</sup>

Though freedom of religion is guaranteed under the Interim Constitution of 2005, the Christian community in Sudan has been targeted since the independence of South Sudan (for example, churches have been shuttered). It has also been reported that people who convert to Christianity may face apostasy charges.<sup>3</sup>

## Religion and FGM

FGM is not required by any of the major religious texts, but it is often mistakenly believed by people in certain communities to be one reason for continuing the practice.



*Woman praying in Khartoum*

None of the recent country-wide surveys for Sudan break down the **prevalence of FGM according to religion**, but it is known that FGM is practised by people of all faiths, including Muslims, Christians and Catholics.<sup>4</sup>

The **involvement of religious leaders** in the work to end FGM in Sudan is therefore essential, but remains a challenge in the more conservative of practising communities. As some studies show, religion is still cited as a reason for practising FGM, particularly among young Sudanese men (see page 61).



The **Almawada wa Alrahma** ('Compassion and Mercy') campaign, funded by the UNJP and DFID, has made progress in recent years by introducing dialogue to communities around social norms, relationships between men and women, and GBV issues. Discussions can then progress to issues such as FGM and child marriage. By directly engaging religious leaders, this campaign dispels the idea that FGM is positive (sunna).<sup>5</sup> It has developed a package of training that speaks more directly to faith leaders and men, whereas the wider-reaching Saleema messaging has been more popular in, and understood by, the community as a whole, particularly younger women and girls.

There are **examples of success** across Sudan when religious leaders have played active roles in protecting women and girls by supporting work to end FGM, including in the village of Wad Al Basheer and the Tuti community (see page 101).

*'I support the women in my community — ending FGM is the right thing and we support them.'*

*~ Head Imam Hashim Almubarak Altayeb<sup>6</sup>*

28 Too Many understands from discussions with Sudanese experts that religious leaders are increasingly behind the efforts to abandon FGM in Sudan. There is wide agreement that Type III (infibulation) is harmful, but disagreements continue in relation to sunna. Significantly, the **Religious Advisory Council** has come out in support of the work to end FGM. This is critical, not just to change attitudes and declare that FGM has no part in religion, but also to back implementation of a national law that criminalises all forms of the practice.

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**Image page 91:** Kertu (2015) *Portrait of an old Sudanese woman praying*. Shutterstock ID 587671988.

# Media

*'By giving voice and visibility to all people – including and especially the poor, the marginalized and members of minorities – the media can help remedy the inequalities, the corruption, the ethnic tensions and the human rights abuses that form the root causes of so many conflicts.'*

*~ Former UN Secretary General, Kofi Annan<sup>1</sup>*

## Press Freedom

Reporters Without Borders ranks Sudan  
**175 out of 180 countries**  
in its **2019 World Press Freedom Index.**<sup>2</sup>

While the media has long struggled for freedom in Sudan, matters grew worse towards the end of 2018 when Bashir's government began a major crack-down on reporting, particularly in terms of any social or political unrest such as the anti-government protests that began at that time. Entire editions of newspapers were seized by the National Intelligence and Security Service at an 'unprecedented level'<sup>3</sup>, journalists were arrested and independent or opposition newspapers were shut down. There were also reports of assaults by security agents on representatives of the media.<sup>4</sup>

After Bashir was overthrown, the media was opened up to an extent, but the Transitional Military Council soon put in place new restrictions, including internet shut-downs.<sup>5</sup> There remain 15 'red-line issues' that Sudanese journalists are restricted from reporting on.

As a result, people are turning to the internet and social media for uncensored news or to make their opinions heard. However, the state has the power to block any website that it deems a threat to national security, and activists and internet users have faced arrest over social media posts.<sup>6</sup>

*'The restrictive media environment silences voices, hinders professional development and limits the creativity of journalists.'*<sup>7</sup>

## Media Outlets in Sudan

The Ministry of Information runs all state television and radio through its control of the National Television and Radio Corporation; however, satellite television is popular.<sup>8</sup>

Some of the media outlets in Sudan are as follows:

- **Newspapers:** *Al Ra'y al-Amm* ('The Public Opinion'); *Al-Jareeda* ('The Newspaper') – opposition-leaning; *Al-Dar* – popular tabloid; *Al-Midan* – newspaper of the Sudanese Communist Party; *Al Taghyeer* – independent online paper that has been the target of government crack-downs; *Al-Ryaam* – the oldest newspaper in Sudan.

- **Television:** *Sudan TV* – government-run, also available via satellite; *Sudan National Broadcasting Corporation* – Sudan’s national network; Arabic; *Blue Nile* – the only network not wholly owned by the state.
- **Radio:** *Voice of Sudan* – sponsored by the National Democratic Alliance; *Radio Dabanga* – operated by Dutch NGO (targets Darfur); *Sudan Radio* – broadcasts in several languages; government run; *Mango 96FM* – Khartoum; privately-owned.

## Access to Media

### *Traditional Media: Television and Radio*

Access to media in Sudan is often restricted by the fact that only about half of households (44.9%) have electricity. Interestingly, however, more households (39.6%) have a television than a refrigerator (25.9%) or a finished roof (25%). 35.2% of households have a radio.<sup>9</sup>

In urban areas, 71.1% of households have a television while only 41.5% have a radio. In rural areas, the opposite is true: 26.3% have a television while 32.6% have a radio. Televisions are most common in Northern (86%), River Nile (75.3%) and Khartoum states (77%) but are much rarer in the Darfur states.<sup>10</sup>

Anti-FGM messaging targeted at urban areas is likely, therefore, to reach people via both radio and television, but messaging targeted at rural areas, and the Darfur states in particular, is likely to be more effective and reach a wider audience via radio.

### *The Internet and Social Media*

The **copyright** and confiscations in Sudan of traditional media, such as newspapers, has driven people to the internet, which, by contrast, is ‘a relatively open space for freedom of expression’. While online content blocked by regulator the National Telecommunications Corporation is largely pornographic, forced content removal is increasing. In 2018 a song was released by an Egypt-based musician (but penned by a Sudan-based poet) that criticised the Sudanese Government. The musician was directed by the Sudanese embassy in Cairo to remove the song from YouTube or face reprisals. While it is unlikely that activists posting anti-FGM material would face the same constraints, and it is hoped that matters in the new political era will improve, this situation must be considered when writing content that may be interpreted as criticising government policy.<sup>11</sup>

A **new law** was passed in 2018 against cyber-crime, which includes ‘spreading fake news online’; it also requires online journalists to register with the Journalism Council. Private citizens as well as online journalists have been prosecuted for publishing certain content on social media or even for simply sharing and commenting on other people’s posts.<sup>12</sup>

However, women have found ways of **fighting back against restrictive laws** (such as those that restrict them from being bare-headed or wearing trousers) by setting up Facebook pages to discuss issues (such as identifying cheating husbands).<sup>13</sup>

**Mobile phone and internet usage** has decreased in Sudan in recent years, due to prohibitive costs. For example, a month’s worth of internet connectivity may cost half of the average monthly wage. As of 2016, internet penetration was 29.6% and mobile phone penetration was 71%. The majority of

internet usage comes from mobile phones, although few people have smart phones. WhatsApp is a particularly popular social media platform.<sup>14</sup>

On 10 June 2019 the military council shut down access to the internet for most of Sudan, claiming it was a threat to national security. The **internet blackout** continued for several weeks, negatively affecting the economy as well as the activities of humanitarian organisations.<sup>15</sup>

## The Media and FGM

*'Poetry is a weapon that we use in both war and peace. When we want to tell somebody something, poetry is the best way to convince them.'*

*~ Sudanese poet and songwriter Mahomed Hadraawi*

The media – social media in particular – is quickly becoming a **powerful tool for activism** in Sudan. Anti-government and feminist activists and protesters have coordinated their activities and spread their messages online, and powerful viral images are helping to change opinions and social norms.

For example, a young woman by the name of **Alaa Salah** became the international face of the Sudanese protests because of a viral video and photograph of her, arm raised, leading a chant of 'Revolution!' from on top of a car, her white toub almost glowing against Khartoum's evening sky.<sup>16</sup>

Stages were set up during the protests to display art or for people to sing songs and recite poetry, such as Neuroscience PhD student and poet **Marwa Babiker**, who was also the first woman in about 30 years to appear on national television without her hijab.<sup>17</sup>

*'The West especially has been desensitised to the images of African people in crisis or dying; for them, that is what usually happens in Africa. Art is a way to capture attention, document the history that is being made, and break our fear barrier [around free expression].'*

*~ Alaa Satir, protest artist<sup>18</sup>*

**Anti-FGM media campaigns** have been run nationally and regionally; for example:

- radio programmes including messages and information by leaders and experts, songs and plays;
- dissemination of survey results in daily newspapers;
- appearances by officials on national television to reflect on survey results and talk about the Saleema Initiative (for more information on the Saleema Initiative, see pages 58 and 65); and<sup>19</sup>
- in 2014, the UNJP ran a national television campaign targeted at the 40–55-year-old demographic, in an effort to promote intergenerational discussions and conversations between husbands and wives, as many couples do not discuss FGM. The campaign was believed to help 'break the silence that perpetuates the practice.'<sup>20</sup>

The Population Council's recent paper on designing social marketing campaigns<sup>21</sup> discusses **the role of social media in changing social norms**. Social media campaigns to bring about change in people's behaviours draw on marketing techniques, which many researchers believe are useful for altering culturally embedded practices.

Social marketing has four elements:

- *Product* – the thing offered to satisfy a want or need; in the case of anti-FGM work, this would be abandonment of the practice.
- *Price* – the cost to people of adopting the desired behaviour.
- *Place* – where people perform public abandonment and where they can get support.
- *Promotion* – communications that ‘inspire the target audience to action’.

Academics Bridges and Farland have added the following to these for ‘social media application with social phenomena’ (such as FGM):

- *Policy formulation* – the need for supportive government policies.
- *Partnerships* – the networks that need to be formed to run successful programmes.
- *Purse strings* – the need for funding.

The paper emphasises that the implementation of such theories of change and branding/marketing theories in relation to social media, as well as the integration of research knowledge and evidence, are vital to campaigns’ effectiveness. (Nafisa M. Bedri, Associate Professor in Women & Reproductive Health from the Ahfad University for Women also emphasises the importance of the media’s access to accurate and up-to-date FGM data: ‘The access of media to information and statistics . . . [has] provided legitimacy and strength to work by advocacy groups[,] particularly among NGOs.’<sup>22</sup>)

However, there is a lack of relevant knowledge and skills in Sudan, something that needs to be addressed by NGOs and international organisations that have the capacity to provide training in these areas. The authors note that many campaigns’ shortcomings in this regard are caused by a lack of funding.

The paper discusses the need for social-media programmers to understand ‘the decision process that leads people to adopt the target behaviour’ – in other words, the abandonment of FGM – and tailor programmes in accordance with that understanding. That decision-making process is as follows:

- 1 Be aware and knowledgeable about the options [for example, ‘I have the option of saying no to cutting my daughters.’]
- 2 Embrace the culture and values that permit the behaviour to be considered for adoption [examples of this would be the idea of ‘Every girl is born Saleema. Let every girl grow Saleema’ or the knowledge that many top Islamic leaders do not support FGM].
- 3 Perceive the behaviour as potentially relevant to contextual aspects and their circumstances [‘I don’t want my daughter’s life and wellbeing to be endangered.’]
- 4 Conclude that the positive consequences of the behaviour exceed the negative consequences to a degree that is superior to realistic alternatives.
- 5 Believe they can carry out the action.
- 6 Believe that others who are important to them will support their action.<sup>23</sup>



**Saleema Initiative**  
@BornSaleema

.@BornSaleema #SaleemaInitiative Logo is finally unveiled. Winninf design is from Izzat A. Haile from #Ethiopia. He is an architect & a self-taught visual artist, illustrator, & graphic designer. Watch this space for more on Izzat SOON.

cc @Elfadil\_DSA @ausocialaffairs



*The Saleema campaign reveals its new logo on social media, November 2019  
(© BornSaleema Twitter Account)*

The University of Zurich ran a study in Gezira looking at **attitudes towards FGM from family to family**. Within small areas, they found a huge variation of opinions and reasons for cutting, suggesting that, curiously, social pressures in the local community may not be such a significant factor in bringing about or holding back change as most researchers believe: a family who cuts their daughters may live right next to a family who does not. Based on this research, the University created four films dramatizing discussions within families about different issues related to FGM; for example, one focused on the family members' concerns about the moral development of their girls; in another, the family discusses a girl's marriage prospects if she is not cut. The researchers note, 'Because the debate about cutting is strictly within an extended family, the films situate the antagonism between cutting and abandonment as locally as possible.' The film that was most persistently effective was one that combined many of the issues into the family's discussion, rather than just one aspect. The study concludes:

Using a measure of implicit attitudes, we found that these movies significantly improved people's view of uncut girls. Like other recent studies showing that entertainment can change attitudes and specifically reduce gender bias, our results show that entertainment can lay the groundwork for socially beneficial behaviour change.<sup>24</sup>

The role that the creative arts and the media are playing in Sudan's social revolution offers immense opportunities, and more research in line with the University of Zurich's study would be beneficial, as well as funding for training in social media marketing.



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# Work to End FGM in Sudan

## Relevant Government Authorities and Partners

The **National Council for Child Welfare (NCCW)** is the government authority that plans and coordinates work regarding child welfare across Sudan and, specific to FGM, works in collaboration with the **UNFPA-UNICEF Joint Programme to Eliminate FGM (UNJP)**. The NCCW was established in 1991 in response to the ratification of child-related international and regional conventions such as the Convention on the Rights of the Child.

The **National Strategy to Combat Female Genital Mutilation 2008–2018** was launched as a partnership between government and civil-society organisations to address the religious, health, social and cultural aspects of FGM.<sup>1</sup> The coordination of stakeholders and efforts to end FGM are undertaken by the NCCW at all levels in Sudan. The NCCW was initially formalised at national task-force level in 2014 and then across all 18 states in 2015. Local task forces have been setting up since 2016.

At both the national and state levels, task forces are made up of representatives from the **Ministries of Health, Guidance and Endowment, Welfare and Social Services, Justice, Culture and Media**. There are also representatives from other key bodies, including the **Medical Council**, the **National Centre of Curriculum and Assessment**, academia (including **Ahfad University for Women**), **UN agencies** and **INGOs** (such as **Plan Sudan**). At the local task-force level, representatives include community chiefs and mayors, religious leaders and midwives.

An important centre for research and training on FGM in Sudan is the **Gender and Reproductive Health and Rights Resource and Advocacy Centre (GRACe)**, which is based at the Ahfad University for Women.

GRACe has worked closely with the UNJP agencies and the Population Council to evaluate the work to date on ending FGM and its challenges, such as increasing medicalisation.

As well as jointly publishing a number of key studies, GRACe undertakes training and workshops to disseminate knowledge and strengthen the capacity of women in skills such as public speaking, leadership and community mobilisation around topics such as FGM.

While progress has been made in coordinating ideas and programmes to end FGM, there have also been challenges. Firstly, the NCCW has reported the difficulty of some members believing it is better for them to work independently rather than together, which prevents important streamlining of activities. Secondly, the Ministry of Health has, to date, believed that FGM is solely a health issue and is not best tackled through a multi-sector approach. There are further challenges emerging from those who oppose abandonment of FGM (for example, midwives who fear losing their income) and the need to increase the involvement of grassroots volunteers in dialogues.

The NCCW is taking steps now to overcome these challenges; for instance, increasing dialogue with the Ministry of Health and inviting a member of the National Midwives Committee onto the board to highlight the dangers of practising FGM, develop alternative income-generating projects and working more closely with community volunteers. The NCCW has also set up a **Research Advisory Group** to coordinate research on FGM and avoid duplication. There is a desire to introduce FGM into the primary school curriculum. The NCCW will also continue developing initiatives such as the Saleema campaign.<sup>2</sup>

## Sudan Free of Female Genital Mutilation/Cutting

Sudan has long been recognised internationally as a high-priority country for funding to end FGM. Vast sums of money have been committed to the country, particularly through the UK DFID-funded **Sudan Free of Female Genital Cutting (SFFGC)** programme, which is now in Phase 2 (January 2019—December 2024) and has a budget of £14.4 million. **UNICEF** (as administrative agency), the **UNFPA** and the **WHO** (as Participating UN Organisations) are the main implementing partners through the UNJP, which began in 2008 and now covers 16 countries, of which eight, including Sudan, are targeted for priority ‘Tier 1’ programmes.<sup>3</sup>

As the UN agencies recently entered Phase III of the UNJP (2018—2021), commitments were renewed to continue creating an environment that enabled the abandonment of FGM through policy and legislation; by mobilising and empowering communities to change social norms driving FGM; by supporting access to comprehensive services; and by building a high-quality evidence base to support the work. To this end, the WHO is a key partner in Sudan, identifying gaps in knowledge and tackling key challenges such as medicalisation. Work to end FGM in Sudan funded through the SFFGC and the UNJP is coordinated through the NCCW and includes the following initiatives:

- **The Saleema Initiative** (see page 58);
- the **Almawada wa Alrahma** (‘Compassion and Mercy’) campaign, addressing rights and tackling violence against women and girls from a religious perspective;
- the **Wa Man Ahyaha** (‘And who revived it’) initiative for communities to acknowledge and understand women’s and girls’ rights and harmful practices that affect their reproductive health<sup>4</sup>; and
- the **Khaloha** (‘Leave her’) campaign, launched in 2018 to provide media training and produce songs, television and radio messages, animations, articles and television and radio shows.<sup>5</sup>

The most recent UNJP Annual Report for 2018 notes that, after two decades of work, efforts to reduce FGM in Sudan appear to now be taking hold. More than 100,000 community members were reached through community and intergenerational dialogues, about 68 communities publicly declared abandonment of FGM and a further 57 communities are preparing to make future declarations.<sup>6</sup>

During 2018, working in partnership with NCCW and the National Information Centre and Central Bureau of Statistics, the UNJP launched the **Child Protection Information Management System** to maintain information on FGM, child marriage and gender-based violence. It also supported the Parliamentarian Women’s Caucus to speed up federal criminalisation of FGM by endorsing the new Article 141 of the Criminal Act; this was subsequently presented to parliament and referred to the Health and Legal Committee for revision.<sup>7</sup> The UNJP will build upon these strategies and campaigns across Phase III, having significant funding from international governments, including a DFID-projected spend of approx. £1.4m for 2019/20, which will rise to over £5.2m for 2020/21.<sup>8</sup>

## Approaches to Ending FGM

The core strategies being used by stakeholders across Sudan are the **community dialogue** and **inter-generational dialogue** approaches, facilitated by initiatives such as the Saleema campaign. Activities around community mobilisation, advocacy, training, leadership and capacity-building are conducted according to the target group and community, with specific reference to their social norms and

values. This can be challenging, and it has been essential to undertake activities in appropriate settings according to the focus group in question. For example, work with men and boys in Sudan is taken into mosques, sports grounds, and television clubs. Work with women and girls has been successful through initiatives such as the Afhad University rural extension programme, which takes activities into local social settings (for example, a 'plate and cup' initiative). The Almahada wa Alrahma campaign draws on Islamic values to change attitudes on GBV issues, including FGM and child marriage, and delink these harmful practices from religion. Specific workshops take place to provide space for learning and discussion around FGM for religious leaders.

**Public declarations of abandonment** in Sudan are reportedly successful in giving communities the opportunity to speak out against FGM. The UNJP reports that an increasing number of communities and families are being prepared to make the pledge (see above). There does remain, however, the need for continued support and ongoing monitoring in these communities to ensure that families do not return to cutting their girls. Anecdotal information gathered during the course of this research suggests that there is still a need to put in place more robust and comprehensive monitoring and support for communities post-abandonment.

To date, the success and reach of anti-FGM campaigns has varied across states, often due to the inaccessibility of many villages, which have poor infrastructure and transport links, particularly during the rainy season. High rates of illiteracy also pose a challenge to the advocacy work.

## Case Study: The Tuti Free of FGM Initiative

*'Tuti Island is a shining example of how a community can initiate and sustain an effort to end FGM.'*

*~ Dr Wisal Ahmed, team leader in WHO Sudan's Women's Health Unit<sup>9</sup>*

A community that is widely acknowledged for its successful abandonment of FGM in Sudan lives on Tuti Island, located where the Blue Nile and White Nile rivers meet between the capital Khartoum and the cities of Omdurman and Khartoum North (also known as Bahri). Supported by the UN agencies and working in partnership with both government departments and local civil-society organisations, the Tuti Free of FGM initiative was launched in 2008 with an aim of mobilising the community of 21,000 residents to recognise the negative impact of FGM and the positive impact of abandonment.

*Training and coffee sessions  
with grandmothers*

*(© Tuti Initiative; used by  
permission)*





Success has been achieved through inter-generational dialogues and workshops that have targeted all community stakeholders, including community and religious leaders, grandmothers, parents, medical staff, social workers, teachers, youth and school-age children. The project has celebrated the role of families. Of particular importance to the project's success has been the significant recognition and involvement of grandmothers (who are key decision-makers), through informal trainings and coffee sessions known as *Lamat Gbana*, as well as religious leaders.

The Tuti community is now recognised for its complete abandonment of FGM. Key community members (including health workers, teachers, grandmothers and religious leaders) meet monthly as a protection group to monitor and update on progress. The initiative is now being rolled out to neighbouring communities, including other villages in the Bahri locality.

## Youth Forums

The SFFGC and UNJP partners have successfully established youth forums across Sudan. In 2016 the first national youth conference on FGM was held in North Kordofan with the theme 'Sudan Youth against FGC: inspiring a positive environment for community mobilization'. It brought together young people aged 18 to 34 from 18 states to share knowledge. It resulted in a National Youth Declaration and the creation of a Youth Network to Abandon FGM/C.<sup>10</sup> More than 1,000 young people from across Sudan attended forums in 2018 alone, and the 8<sup>th</sup> National Youth Forum took place most recently in October 2019.



*Youth training in the Tuti community*

*(© Tuti Initiative; used by permission)*

The **Youth Peer Education Network (YPEER)** conducts training and information workshops in partnership with government departments on key topics such as reproductive health, GBV, child marriage and FGM.

The **Institute for Reproductive Health and Rights (IRH&R)**, a not-for-profit organisation, also promotes reproductive and sexual-health rights, with a particular focus on women, girls, youth and minority groups. Current programmes include the **Sudan Free of Female Genital Mutilation/Cutting (Khitani)**, which mobilises and empowers young people to advocate for an end to FGM through the **Analan Sudanese Youth Initiative**, which was launched in 2014. Workshops and discussion forums are used to raise awareness and disseminate information. Analan also uses traditional and social media in its advocacy work.

## Impact of Political Crisis on Work to End FGM

Prior to the political upheaval in 2019, the work to end FGM in Sudan was progressing well. Momentum was building for positive change, there was increasing engagement at all levels from government departments to local communities, and a real growth was being witnessed in the youth movement.

28 Too Many understands that the protests and subsequent political crisis have, perhaps inevitably, impacted on anti-FGM work. Sudan has been dealing with a significant economic crisis (including a shortage of fuel and cash affecting both business and people's day-to-day lives). Curfews were imposed during the protests and internet was severely restricted during the spring/summer of 2019. Activists were distracted with the overthrow of Bashir and it became increasingly difficult to have gatherings (particularly for youth), as well as very challenging to take advocacy work out to rural communities. The government shutdown in early April 2019 also meant a slowdown for many programmes.

With the new Transitional Government in place, partners working on anti-FGM activities have been waiting to see who fills key positions and also what the future structure will be of the NCCW (whether it remains the same or if responsibilities will change). There are many practical issues to overcome to get the work back on track, but the situation is also seen as an opportunity to rebuild momentum on the back of a much stronger emphasis on gender issues and the participation of women in the country's future.

Clearly, FGM needs to be balanced with a whole range of other urgent issues, but civil society is working hard to ensure that the progress to date is not lost. The possibility of more women being placed in key positions at the national level and the opportunity to bring national legislation back onto the agenda are seen as positives and could be genuinely transformative for Sudan.

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- 1 United Nations (2009) *General Assembly Report A/HRC/10/NGO/77*, 26 February. Available at [https://www.ecoi.net/en/file/local/1073132/1227\\_1244999980\\_sudan.pdf](https://www.ecoi.net/en/file/local/1073132/1227_1244999980_sudan.pdf).
  - 2 Presentation provided to 28 Too Many, 'Mainstreaming efforts to end FGM in Sudan 2018', by Alaa Ellidir, NCCW, 27 November 2018, Paris.
  - 3 - UNFPA-UNICEF Joint Programme on the Elimination of Female Genital Mutilation (2018) *Accelerating Change: Annual Report 2018*, p.6. Available at <https://reliefweb.int/sites/reliefweb.int/files/resources/19-152-UNJP-FGM-AR2018-Aug2019.pdf>.
  - UNFPA (undated) *Female genital mutilation*. Available at <https://www.unfpa.org/female-genital-mutilation>.
  - 4 UNFPA-UNICEF Joint Programme on the Elimination of Female Genital Mutilation, *op. cit.*, p.102.
  - 5 *Ibid.*, p.101.
  - 6 *Ibid.*, p.101.
  - 7 *Ibid.*, p.100.
  - 8 UKaid Development Tracker (2019) *Sudan Free of Female Genital Mutilation Phase 2*. Available at <https://devtracker.dfid.gov.uk/projects/GB-GOV-1-300218>.
  - 9 World Health Organization (2018) *Working towards zero tolerance for female genital mutilation in Sudan*, February. Available at <https://www.who.int/features/2018/female-genital-mutilation-sudan/en/>.
  - 10 UNFPA and UNICEF (2016) *Accelerating Change By the Numbers: Annual Report of the UNFPA-UNICEF Joint Programme on Female Genital Mutilation/Cutting: Accelerating Change*, p.67. Available at [https://www.unfpa.org/sites/default/files/pub-pdf/UNFPA\\_UNICEF\\_FGM\\_16\\_Report\\_web.pdf](https://www.unfpa.org/sites/default/files/pub-pdf/UNFPA_UNICEF_FGM_16_Report_web.pdf).



# Ending FGM: Challenges

Challenges faced by anti-FGM advocates fall into two categories.

Firstly, there are cultural challenges related to the structure of society in Sudan that must be negotiated or surmounted, such as traditions, beliefs and social norms that support the practice of FGM.

Secondly, there are practical challenges, such as how to deliver the kind of support needed by those who go against social norms, how to implement and enforce the law in a way that curbs FGM and prevents it being driven underground, and how to maintain a consistent, clear message about FGM when civil society is impacted by political unrest.

## Cultural Challenges

### *Gender Inequality and Violence Against Women*

In Sudanese culture, violence against women is a significant and taboo issue. It leads to a devaluing of women and girls, which in turn contributes to the continuation of women's-rights violations such as FGM.

Given the increasing focus on the role of women in the 'new Sudan', it is important to utilise this momentum and find ways of positioning FGM within the wider GBV agenda; however, at present it may not be clear how best to achieve this without FGM being 'lost' within the wider issues now demanding political attention.

### *Types of FGM*

Support has generally moved away from the most severe type of FGM (Type III/infibulation, or 'pharaonic') towards other types labelled 'sunna'. While sunna is considered 'safer' by supporters of FGM, ultimately, all types of FGM are harmful to women and girls and these misunderstandings need to be overcome for total abandonment to be achieved.

It is difficult in Sudan to gather accurate data on the types of FGM being performed, as there is often a lack of knowledge about, for example, the difference between the different types, even among traditional cutters and midwives. There is also opposition, particularly from some religious leaders, to banning sunna.

Reinfibulation is a problem, as it is seen as the norm for midwives to offer the service following childbirth. Therefore, the attitudes of healthcare workers towards the practice will need to be changed and professionals must be empowered to advocate for an end to a practice that they know seriously impacts on maternal health.

### *Opposition by Religious Leaders*

Although programmes involving religious leaders are shifting opinions in Sudan, some in conservative communities remain at the point of condemning Type III FGM but supporting sunna, believing it is sanctioned by Islam.

Much work still needs to be done, therefore, to change attitudes, and this opposition is a clear challenge to the passing of national legislation that criminalises all forms of FGM.

### *The Risk of 'Underground' Cutting*

According to civil society, there is a danger that the practice of FGM will be driven underground unless people are thoroughly sensitised to new anti-FGM laws prior to their implementation. This will require a vast and coordinated education and awareness programme.

There is also the challenge to empower trained midwives to continue delivering their valued maternal healthcare services and not be rejected by communities for refusing to practice FGM (in preference to using 'untrained' practitioners or family members).



*Millions of girls are still at risk of having FGM in Sudan*

## Practical Challenges

### *Conflict and Political Instability*

Sudan has been devastated by civil war and the recent political crisis. Violence continues to be a problem, particularly against women who protest for their rights and against healthcare workers. Security agents, the military and other aggressors must be held to account for these atrocities.

Political unrest and economic problems have impacted on the work to end FGM and delayed the progress of federal and state laws to ban it. Much effort is now required to get programmes back on track, and there remains a need for government commitment to introduce federal anti-FGM legislation and enforce laws in states where they have already been passed.

### ***Funding and The Economy***

Despite Sudan receiving large sums of international funding for anti-FGM work, its economy is a severe problem for policy-makers and campaigners; for example, funding for the UNJP has been unable to keep up with the rate of inflation, curbing its programmes (however, funding from other sources, such as DFID, has helped).<sup>1</sup> At the local level, too, the shortages of fuel and cash pose day-to-day challenges for CSOs working on outreach programmes in remote areas.

The Transitional Government has recognised that its main challenge is reforming Sudan's economy. While this is, of course, good for the country, it may mean that there is not as much government funding available for NGOs and aid organisations. Therefore, funding that is available for anti-FGM programmes needs to be targeted appropriately, in places where it will have the greatest impact (including focussing the Saleema campaign moving forward).

It is also vital that international agencies continue to partner with and fund grassroots organisations and local activists, who are best placed to know and understand the challenges and social norms still driving FGM and are trusted by communities.

### ***Implementation and Enforcement of Anti-FGM Laws***

At the national level, women and girls remain unprotected by the law because the amendment to the Criminal Act to ban all forms of FGM still awaits enactment. There is a very real opportunity for the new Transitional Government to pass the legislation, but continued opposition from some key stakeholders, including religious leaders, remains a huge obstacle.

Anecdotal evidence suggests that anti-FGM laws that exist at the state level are either not enforced at all or only to a very limited extent. In one case involving the death of a baby girl, her family refused to provide the name of the midwife responsible for cutting her. This appears to be a significant problem because midwives are highly respected in their communities, particularly in rural areas, and people do not wish to bring charges against them.

Civil society also reports a lack of knowledge of anti-FGM laws, where they exist, even among officials.

### ***Infrastructure and Access***

Access to remote rural areas presents difficulties where transport infrastructure is poor, particularly during rainy seasons. The opportunity for anti-FGM programmes to be scaled up and reach the communities where prevalence is highest is also severely challenged in conflict zones and when basic infrastructure (such as a lack of electricity, which requires additional supplies such as batteries and generators) is lacking.

### ***The Health and Education Systems***

A report from January 2019 claims that 'Sudan is on a trajectory towards a health and humanitarian crisis.'<sup>2</sup> Getting appropriate healthcare to mothers who have undergone FGM is a major problem, especially given the number of home births, particularly in rural areas.

The Government recognises that rebuilding these vital systems is a high priority. Its 25-Year National Strategy 2007–2031 states that 'rehabilitating public and higher education' is a key challenge. Integrating education about FGM into school curricula may also prove difficult in practice, given the high number of teachers that are not fully qualified, but it is well worth pursuing.

High levels of illiteracy poses a challenge to advocacy work and requires flexibility and innovation in approach (including utilising different forms of media and advocacy materials).

### ***FGM Research and Monitoring***

There is an urgent need for improved data collection, research and monitoring in Sudan, so that programmes can identify communities where girls and women are most at risk of FGM, how behaviour and attitudes are changing and, thus, how resources can be targeted most effectively.

Apart from the widely recognised problems associated with self-reporting that negatively affect the accuracy of FGM data, there is a lack of data in Sudan on medicalised FGM and reinfibulation and the background characteristics of women who choose to undergo them. It is also unclear why women who are wealthier and better educated appear more likely to have undergone FGM, especially infibulation.

Understanding how the prevalence of FGM has changed over time is also complicated by mass migration, meaning that trends are difficult to discover.

### ***Support for FGM Survivors***

With FGM affecting millions of women and girls across Sudan, the challenge to provide quality universal healthcare and support is a huge one. Women and girls who have access to the main cities may be able to seek the physical and psychological support they need through the few specialist facilities that are in place, but many still remain without any support, which has a severe impact on their careers and families as well as their health and wellbeing.

It will also be vitally important to monitor the impact of campaigns and messaging (such as Saleema) on those women and girls *who have had FGM* and may not fit in with the new, 'popular' image.

### ***Knowledge of Best Strategies***

Further work still needs to be done, both in Sudan and internationally, to identify the best strategies to bring about changes in social norms and behaviours when it comes to FGM. NGOs and government strategists need to use novel approaches and research best practice, rather than using the 'same old ways' simply because skills are lacking in relation to more innovative tools. This is where training for expertise in social media marketing, for example, will be vital.

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- 1 UNFPA-UNICEF Joint Programme on the Abandonment of Female Genital Mutilation (2019) *Joint Evaluation of the UNFPA-UNICEF Joint Programme on the Abandonment of Female Genital Mutilation: Accelerating Change: Phase I and II (2008–2017)*, p.50. Evaluation offices of UNFPA and UNICEF. Available at [https://www.unfpa.org/sites/default/files/admin-resource/FGM\\_Eval\\_Vol1\\_FINAL.pdf](https://www.unfpa.org/sites/default/files/admin-resource/FGM_Eval_Vol1_FINAL.pdf).
  - 2 The Lancet (2019) *Sudan's threatened health and humanitarian crisis*, Vol. 393, 19 January. Available at <https://www.thelancet.com/action/showPdf?pii=S0140-6736%2819%2930074-1>.

**Image page 105:** Rita Willaert (2008) *South-West Liri – Kordofan*. Available at <https://flic.kr/p/5KhF42>.  
CCL: <https://creativecommons.org/licenses/by-nc/2.0/>.



# Conclusions and Strategies for Moving Forward

Sudan's commitment to various international and regional treaties, as well as certain articles of its Constitution and other **laws** that promise protection and integrity of person to all, place an obligation on the Government to ensure that women and girls are protected from harmful practices such as FGM.

This includes introducing federal laws criminalising all types of FGM, both pharaonic and sunna. The continuing lack of legislation undermines the efforts of all parties working to uphold the National Strategy to end the practice in Sudan. There are some states where laws have been introduced, but their enforcement appears to be poor and it is not known if any prosecutions have taken place. The amendment to the Criminal Act (1991) to criminalise FGM under a new Article 141 will be an immense step in the right direction if it is passed into law, and continued efforts to bring this about should be encouraged.

Effective laws would criminalise and punish all perpetrators of the practice (including those who perform, procure, aid or abet FGM), and address incidents of cross-border FGM and the failure to report that FGM is being planned or has taken place. Introducing clear age-of-consent and age-of-marriage laws would also help to protect girls from early and forced marriages, which the Government has recognised are a problem. Civil society notes that some communities are at a tipping point in relation to the abandonment of FGM, and federal laws could encourage them to completely abandon it. Comprehensive **public education and sensitisation** is also essential to success.

There are hopeful signs that the Transitional Government, under Prime Minister Hamdok, will make women's participation in government and decision-making a priority. The new government will also need to consider including human-rights awareness and advocacy in its budgets, as **gender equality and protection** for all citizens from violence, which includes FGM, will improve the overall human-development situation in the country.

Sudan's marital culture is inherently unequal – there are no laws against marital rape or domestic violence, for example – and this inequality extends to the **devaluation of women and girls** in other aspects of society. Although women have been at the forefront of political protests, that has exposed them to harassment and violence. Rape has also become a common tactic during conflict. Women who suffer have little recourse, as there is a stigma attached to domestic violence and rape; rape may even be seen as adultery. This devaluation of women compounds the high prevalence of FGM.

Despite making some good progress towards the **Millennium Development Goals (MDGs)**, Sudan failed to meet several targets.<sup>1</sup> A 2019 audit in relation to the **Sustainable Development Goals** found that there have been significant problems. While the Government has committed to healthcare and education improvements in order to achieve the SDGs, a plan of action needs to be drawn up and implemented to renew progress across the country. One encouraging sign is that **gender parity** in schools has been achieved and in secondary schools is slightly in favour of girls.

The available data on the **prevalence of FGM** suggests that some progress has been made in the work to end FGM in Sudan, and that there is hope for the eradication of the practice in the future.



**Ethnicity** is probably the most significant factor in FGM prevalence. Additionally, women who have not been cut but marry men from another ethnic groups who do practise FGM often feel pressured to be cut. The relationships between a woman's **levels of wealth and education** and whether or not she has had FGM are complex, and further research would be useful.

**Medicalised FGM** and **reinfibulation** are significant problems that can only be tackled if midwives and other healthcare professionals refuse to practise them. Midwives have a tremendous part to play in the elimination of FGM. Training is required in this context, and midwives must be supported to continue their vital maternal healthcare roles in communities while advocating for an end to FGM. Training is also required in relation to the different types of cutting – while most Sudanese women know about FGM, there is evidence that many, including the midwives who perform the cutting, do not fully understand the different types of FGM. There is some concern that, if midwives stop cutting altogether, but demand for FGM does not fall, untrained TBAs, mothers and grandmothers will begin to perform FGM themselves. This needs to be monitored, and tactics to counteract this possibility need to be researched, devised and implemented. There is a need for reinfibulation and its impact to be better understood through research.

There is also a great need for **religious leaders** to speak out against all forms of FGM, not just the pharaonic cut. Regional education, with reference to the Egyptian fatwa, for example, would be useful for this.

There is evidence that boys and men feel a conflict, caused by **the desire to protect girls and women**, between the belief that FGM curbs a woman's sexual desire and is therefore a necessary part of her growth and development, and the understanding of the trauma and health risks involved. There also appears to be a lack of knowledge among young men that FGM is not required by any major religion. Greater education in relation to these matters, especially for boys and men, is clearly crucial. This desire to protect girls and women appears to be the major driving factor behind the continuation of FGM in Sudan.

**Attitudes towards FGM** in Sudan do appear to be shifting, but not necessarily towards abandonment; instead, there is a shift towards 'less severe' or medicalised forms of the practice. Women who have received a higher level of education and those in the highest wealth quintile are the most likely to believe that FGM should be stopped and less likely to intend to cut their daughters.

Unfortunately, **school attendance** across the country, but particularly among less fortunate families and those in rural areas, needs to be improved. The Government is aware of these issues and is taking measures to improve matters. It is likely that much funding will need to be put into infrastructure and welfare before higher rates of attendance can be achieved.



Likewise, drastic measures in relation to Sudanese **healthcare services**, in addition to those the Government has already put in place, are required to avoid an even greater humanitarian crisis. Services have been enormously affected by conflict and the emigration of many healthcare workers. There is an extreme shortage of both personnel and medical supplies, meaning that both critical care and maternal care would not meet internationally recommended standards. The

large number of home births and the lack of antenatal care in rural areas leaves women who have undergone FGM, especially those who have undergone Type III/infibulation, vulnerable to extreme complications and death during labour.

**Creative artists and the media** have important roles to play in Sudan going forward; they have been shown to be effective in influencing public opinions, social norms and behaviours. Anti-FGM messaging targeted at urban areas is likely to reach people via both radio and television, but messaging targeted at rural areas, and the Darfur states in particular, is likely to reach a wider audience via radio.

**Social media** use (particularly WhatsApp) is on the rise in Sudan and has been an extremely useful tool in upscaling social and political activism and in changing behaviours and social norms. It should therefore be harnessed by anti-FGM workers, and organisations with the relevant capacity need to train their workers in social media marketing skills.

It is important for programmers to understand **the decision-making process** that leads people to abandon FGM and tailor programmes accordingly. That decision-making process involves (1) having a knowledge of FGM; (2) embracing anti-FGM values and a culture of ‘Saleema’; (3) recognising the dangers of cutting to their own family members, (4) recognising that the ‘pros’ of not cutting outweigh the ‘cons’; (5) feeling empowered to choose not to cut; and (6) feeling that the people around them will support their choice.<sup>2</sup>

Overall, the findings of recent studies show that social norms are changing in Sudan, and that they changed in some areas during the **Saleema Initiative’s** implementation period. Saleema is becoming increasingly popular, particularly among youth. One study demonstrates that Saleema’s social-marketing strategy is effective in reducing pro-FGM social norms.<sup>3</sup> The anti-FGM network in Sudan also considers Saleema to be an effective initiative, largely because it is viewed as a ‘home-grown’ Sudanese campaign.

The **work to end FGM in Sudan** has made much progress, and the network of national organisations and international partners appears to be strong. However, the events of 2019 have inevitably impacted on momentum; much work needs to be done to get programmes back on track. There is clearly an historic opportunity for the new Transitional Government to work with this network to bring forward and accelerate an ambitious programme to end FGM and protect all Sudanese women and girls. 28 Too Many supports the huge efforts of organisations and activists across Sudan and looks forward to continued cooperation and opportunities to share knowledge and research to inform future campaigns.

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Registered Charity: No. 1150379  
Limited Company: No: 08122211  
E-mail: [info@28toomany.org](mailto:info@28toomany.org)  
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