Knowledge, Attitude and Practice of Female Circumcision in Faris Village, South Gezira Locality, Gezira State, Sudan (2013)

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Submitted to the University of Gezira in Partial Fulfillment for the Requirements of the Award of the Degree of Master of Science in
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Department of Community and Family Medicine
Faculty of Medicine

August, 2013
Knowledge, Attitude and Practice of Female Circumcision in *Faris* Village, South Gezira Locality, Gezira State, Sudan (2013)

Fatima Elhag Mohammed Salim

**Supervision Committee**

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Date of Exam.: 17/6/2015
Knowledge, Attitude and Practice of Female Circumcision in Faris Village, South Gezira Locality, Gezira State, Sudan (2013)

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Date of exam.: 17/6/ 2015
Dedication

To my family
Acknowledgement

I would like to express my gratitude to all those who aided, supported and inspired me in this academic venture. Although trying to list them all would be almost out of the question, I would like to mention a few of those all who have contributed to this thesis.

First of all I would like to thank the women and the professional midwives, physicians and hospital managers in Faris Area and Wad Elhadad Hospital.

I would like to thank my supervisor, Dr. Salwa Elsanosi, University of Gezira Department of Community Medicine, for the valuable advice and support.

I would like to thank staff and students of Faris Technology College for participation and support.

Also I would like to express my gratitude to primary and secondary schools and youth centres in Faris Area.

I would like to express my deep gratitude to teacher AbdElmonem IzzEldin.

At last not least, my deepest gratitude to my family, to my parents Elhag and Amina, for love and support and for taking care to my children during periods of research.

Most of all, I have the greatest gratitude to my beloved husband Anwer Osman for his valuable support and love and our wonderful children, Mohammed and Mohenned.
Knowledge, Attitude and Practice of Female Circumcision in 
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Abstract

Worldwide at least 130 million now living women and girls have under gone female genital mutilation (FGM). Reinfibulation (RI) is a secondary form, mainly performed after delivery. Inspire of documented complications, the procedures continue. The objectives of this study generally explore FGC and RI in Faris Area more specific (i) to determine magnitude and patterns of FGM/C and RI InFaris Area, (ii) To identify immediate and long complications of FGM and RI. (iii) To plan health program to end FGM/C and RI in Faris Area. This study in which a cross-sectional study was done. 100 participants were selected randomly to represent females in reproductive age (15-49). The data collected by questionnaire and focus group discussion. Analysis by SPSS. The questionnaire results showed that 87.4% of study group were circumcised. The younger generation changed their practice from Pharaoh's (44.49%) to Sunna (55.6%). The focus group discussion results were 61% of the women included had under gone RI after delivery. The midwives who practice RI they do it response to the social request, tradition and alleged male sexual satisfaction . This study indicates high prevalence of FGC and RI in Faris Area and health complications associated with practices. The study recommended coordination and involvement of students and other sectors in Faris Area to minimize FGC rate.
دراسة عن ختان الإناث بقرية فارس، محلية جنوب الجزيرة، ولاية الجزيرة، السودان (2013)

فاطمة الحاج محمد سالم

ملخص الدراسة

يوجد ختان الإناث في جميع أنحاء العالم، 130 مليون على الأقل من النساء والفتيات يتعرضن للتعريش الاتصالية. كما يوجد آخر للختان بعد الولادة. بالرغم من وجود مضاعفات وأوضحة لختان الإناث إلا أن ممارسة الختان لازالت مستمرة. الهدف العام من هذه الدراسة توضيح المضاعفات الصحية الناتجة عن ختان الإناث في منطقة فارس. أما الأهداف الخاصة بتحديد حجم وأنماط ختان الإناث في منطقة فارس، تحديد المضاعفات الفورية وطويلة المدى الناتجة عن ختان الإناث، تخطيط برنامج صحي لإنهاي ختان الإناث. إجريت هذه الدراسة في منطقة فارس ريكي ود الحداد وهي عبارة عن دراسة مجتمعية. تم اختيار 100 مشارك عشوائيا لتمثيل الإناث في سن الافتراض (15-49) سنة. تم جمع البيانات بواسطة الاستبيان ومناقشة مجموعات، تم تحليل البيانات بواسطة. أظهرت نتائج الاستبيان ومناقشة الموضوعات 90% من النساء مختوتين، 44.4% فرعوني و 55.6% سن، 61% تخضع للختان بعد الولادة تقوم به القابلات للعادات والتقاليد وإرضاء الجنس لدى الذكور. هذه الدراسة تشير إلى ارتفاع معدل انتشار ختان الإناث في منطقة فارس والمضاعفات المرتبطة عليه.
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## Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
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<tbody>
<tr>
<td>ANC</td>
<td>Antenatal Care</td>
</tr>
<tr>
<td>DI</td>
<td>Deinfibulation</td>
</tr>
<tr>
<td>FC</td>
<td>Female Genital Cutting</td>
</tr>
<tr>
<td>FGD</td>
<td>Focus Group Discussion</td>
</tr>
<tr>
<td>FGM</td>
<td>Female Genital Mutilation</td>
</tr>
<tr>
<td>IEC</td>
<td>Information, Education and Communication</td>
</tr>
<tr>
<td>M and E</td>
<td>Monitoring and Evaluation</td>
</tr>
<tr>
<td>NGO</td>
<td>Non-Governmental Organization</td>
</tr>
<tr>
<td>RI</td>
<td>Reinfabulation</td>
</tr>
<tr>
<td>TBA</td>
<td>Traditional Birth Attendant</td>
</tr>
<tr>
<td>UNFPA</td>
<td>United Nations Population Fund</td>
</tr>
<tr>
<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
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</table>
CHAPTER ONE

1. Introduction

Female circumcision is held responsible for multitude of health risks. According to WHO, it is defined as all procedures that involve partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons. (3)

Female genital mutilation is very common in Sudan and are subjected to the most severe form i.e. infibulations.

Factors such as religion, tradition and sexuality are used to explain and justify the practice of genital mutilation. However, it is important to note that, women affected by GM do not uniformly regard it as mutilation and may react negatively to be referred to as damage (Almoroth 2005, lecture by Barre, March 2008). Girls who do not experience chronic pain, serious bleeding or blood poisoning after the procedures often suffer complications during pregnancy, experience great pain during sexual intercourse, gynaecological problems of life. It is of course difficult for young girls to understand that their closest family allows this to be inflicted upon them. The tradition is upheld for fear that the child will not be accepted for marriage, which can have serious social consequences. Genital mutilation is also a manner in which men exercise control over women’s sexual lives (Land info, 2007).

Currently in Sudan there is a number of government and voluntary organization working towards the elimination of female genital mutilation, but despite these long term efforts genital mutilation continue to be widespread in Sudan. Whereas few positive changes have been observed, these related primarily to transition from infibulations to clitoridectomy and not eradication. (9,10)
Justification of FGC/RI study in Faris area:

Increase incidence of immediate and late complications related to FGC and RI, e.g. bleeding, menstrual problems, sexual and psychological trauma from the procedure.

Decrease community awareness towards these complications.

Definitions:

Deinfibulation: Splitting the vulvar scar after an infibulation to widen the vaginal orifice.

Reinfibulation: The repair of an infibulated vulva after delivery and in addition resuturing on the sides of vaginal orifice to recreate the size of primary infibulation, often in a pinhole size.
Rationale:

The persistence of FGC stems from deep-rooted traditions within the societies where these are practiced and reasons can vary according to ethnic group, type of FGC and the time when they are performed. For some groups, FGC serve as a rite of passage into womanhood, without which a girl can’t marry or assume the responsibilities of a woman. It also ensures the preservation of daughter’s virginity, which in turn the families honors and improves a daughter’s marriage prospect. (4,8)
General Objectives:

To review the strength of evidence that links many health hazards to female genital cutting in Faris area:

Specific Objectives:

1. To determine magnitude and patterns of female circumcision in Faris area.
2. To identify physical and psychological effects of female circumcision.
3. To promote gender equality and empower women to reduce child mortality and to improve maternal health.
4. To plan health program through health education and community awareness towards end of female circumcision in Faris area.
5. To explore the experiences and perceptions of RI after delivery among Faris midwives.

Who perform FGC in Faris area?

100% of those performing genital mutilation are traditional midwives assistant. Prior to the operation girl’s mothers or grandmother determines which kind of procedure the girl should be suspected. Payment is made before the procedure in order to insure the best possible service. The payment represents an important source of income of these women.
CHAPTER TWO
LITERATURE REVIEW

2.1 Terminology:

The focus of this is an important reproductive health issue, but it is also a sensitive topic. Attention should therefore be paid to the terminology chosen when approaching the issue. (9)

The term “Female Circumcision” has been used historically. As the harm that the practice causes became increasingly recognized, the term gave way to “Female Genital Mutilation”. The term Female Genital Mutilation (FGM) has been adopted by many women’s health organizations such as the Inter Africa Committee on traditional practices affecting the health of women and children, and intergovernmental organizations such as World Health Organization (WHO).

More often and more often the term “Female Genital Cutting” is used in an attempt to find a language that is value-neutral, but which adequately describes the nature of procedures in a joint statement by WHO, UNICEF and UNFPA, it was described that FGC comprises all procedures involving partial or total removal of the external female genitalia or other injury to female organs, whether for cultural or other non-therapeutic reasons. (8)

2.2 Types of Genital Mutilation

In 1997, the World Health Organization (WHO), classified four categories of genital mutilation, type V follows on CEF (Land info 2007):

I. Clitoridectomy: Partial or complete removal of the clitoris and/or the prepuce.

II. Clitoridectomy: Partial or complete removal of the clitoris and the labia minora without excision of the labia majora.

III. Infibulations: Narrowing of the vaginal orifice with creation of a covering seal by cutting and appositioning the labia minora and/or labia majora with or without excision of the clitoris (Infibulation).

Before the women can have sexual intercourse, the vaginal orifice must be expanded, and before birth the vaginal orifice must be completely opened. This form is also referred to as Pharaonic. Resealing after birth is known as reinfibulation.
IV. This is related to pricking, piercing and incising, burning or cauterising all or parts of the clitoris and the surrounding area, scraping in the area surrounding the vaginal orifice (known as angurya cuts), cutting the vagina (gishiri cuts), placing corrosive substances or herbs into the vagina to create bleeding for the purpose of tightening or narrowing it.

V. Symbolic Genital Mutilation: pricks or small cuts in the clitoris in order to induce drops of blood, where the purpose is symbolic as opposed to creating lasting harm to the genitals (Land info).

2.3 The global aspect of female genital cutting:

Worldwide above 130 million females, now living, have been subjected to some kind of genital cutting (3). The origins of FGC are obscure, but some researches (4-8) claim that FGC, particularly infibulations, originates from the time of the pharaohs in ancient Egypt and then diffused to the Red Sea Costal tribes with Arab traders, and from there into eastern Sudan. Later also describes how infibulations was practice by ancient Arab before Islam to protect the shepherd girls against rape while they were out unescorted with their sheep.

Today FGC is reportedly practiced in 30 African countries in the Sub Saharan and North-Eastern regions (3), in parts of the Middle East, in Indonesia and Malaysia (5) and among migrants in Europe (4,6). It is most commonly practiced in the African region, in abroad, Triangular east-west band that stretches from Egypt in the north-east and Tanzania in the south-east and to Senegal in the west.

2.4 FGC in Sudan

Approximately 90% of the women in the northern Sudan have experienced FGC in girl hood, infibulations being the predominant form. Studies from Sudan, published both locally and internationally report a change of practice from infibulations (Pharaoh) to clitroidectomy (Sunna), at least among young educated urban people. (1,3). Efforts to compact FGC in Sudan have been going on, since several decades before the Second World War. Religious leaders, politicians, activists and medical practitioners have been concerned with finding ways and means to abolish the practice of FGC. (8)
2.5 Attitude towards FGM/C practice in Gezira State:

The improvement in the anti-FGM/C attitude among both women and men in Gezira State.

For examples:

Table (1): Attitude of women aged 15-49yr towards whether the practice of FGM/C should be continued or discontinued, Sudan House Hold Survey – 2010 (SHHS-2010)

<table>
<thead>
<tr>
<th>State</th>
<th>Continued</th>
<th>Depends</th>
<th>Don’t know</th>
<th>Discontinue</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gezira</td>
<td>28.2</td>
<td>0.6</td>
<td>1.9</td>
<td>69.1</td>
</tr>
</tbody>
</table>

Table (2): Attitude of men aged 15-49yr towards whether the practice of FGM/C should be continued or discontinued, Sudan, 2010 (SHHS-2010)

<table>
<thead>
<tr>
<th>State</th>
<th>Continued</th>
<th>Depends</th>
<th>Don’t know</th>
<th>DisContinue</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gezira</td>
<td>10.9</td>
<td>6.9</td>
<td>6.7</td>
<td>75.3</td>
</tr>
</tbody>
</table>

Table (3): Percentage of ever married women aged 15-49 yrs who intend or not intend to FGM/C their daughters, Sudan, 2010 (SHHS-2010)

<table>
<thead>
<tr>
<th>State</th>
<th>Yes</th>
<th>Don’t know</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gezira</td>
<td>28.3</td>
<td>2.1</td>
<td>48.8</td>
</tr>
</tbody>
</table>

Table (4): Person who performed the FGM/C by state, 2010 (SHHS-2010)

<table>
<thead>
<tr>
<th>State</th>
<th>Traditional Midwives</th>
<th>Nurse or Midwife</th>
<th>Doctor</th>
<th>Other health professional</th>
<th>others</th>
<th>Don’t know or missing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gezira</td>
<td>66.1</td>
<td>31.7</td>
<td>0.2</td>
<td>0</td>
<td>0</td>
<td>2.0</td>
</tr>
</tbody>
</table>
2.6 Reinfibulation:

Reinfibulation has been defined as the re-stitching after delivery of the scar tissue resulting from infibulations (4), but is also described as additional tightening mimicking the narrow introitus of a virgin (4). The definition of RI is not always clear in the literature. It should, however, be distinguished from episiotomy repair, which signifies the reconstruction of a normal vulvar anatomy after delivery. The need for a more extensive tightening beyond episiotomy repair is the basis of the practice of tightening vulvar operation and RI.

The English translation of Arabic name, El Adel, literally means “putting right and improving” (6).

RI is performed in women who have previously undergone infibulation or other severe forms of FGC and who have given birth, are widowed or divorced with the purpose of recreating the narrow vulvar introitus of a virgin (4,5). Because of the alleged male sexual satisfaction, the practice has been referred to as “Adlat El Rujal”, men’s circumcision (1). RI is also carried out in a case where the original infibulations of girl was unsuccessful. Defibulation or deinfibulation consists of an enlargement of the enclosed vulva. (3)

2.6 Medical aspects of FGC and reinfibulation:

The health risks and complication of FGC depend mainly upon the gravity of the mutilation (4). According to El Dareer (5), there are difficulties in estimating the extent and the prevalence of complications, for many reasons.

Since FGC is illegal in Sudan, many tried to hide the complications, fearing enquiries about the operator and why they let it be performed.

Several physical health complications following FGC have been documented through different studies, ranging from infections to severe bleeding, shock, infertility (6), menstrual problem and complication at Micturition (6,7), prolonged labour (4,6) and Maternal Mortality (7). Sexual and psychological problem have also been documented, related to the psychological trauma, from the operation itself and previous research indicates that RI causes the same health hazards as primary infibulations repeatedly putting the women at risk of severe sequelae (4,5,6).

Inspite of all the documented complications, the procedures continue and it seems essential to future reveal the underlying motives in order to increase the understanding of their persistency.
CHAPTER THREE

Methodology

3.1 Study Area

Faris is a big village located in South of the Gezira state of Sudan, about 60 Km from Wad Medani. It's surrounding, Blue Nile in the east, main road of Medani-Sennar in the west, Wed Elhadad town in the south and Mezagella village in the north. It has a population of about 4000, most of them farmers and merchants. There are four primary schools, secondary schools, four mosques, Faris faculty of technologies, three youth centers and health center.

The state religion is Islam, there are different ethnic groups all of them speak Arabic. In Faris antenatal care deliveries or supervised by skilled attendants, most of them midwives in Wed Elhadad hospital.

3.2 Study Population

Female at reproductive age (15-49) in Faris Area.

3.3 Study Design

This is a community based study in which a cross-sectional study was done.

3.4 Data Collection Methods

1. A total of 100 participants were selected randomly representing female in reproductive age (15-49). A questionnaire with fixed questions and open answer possibilities were used. The data collection upon age, circumcised or not, type of circumcision, whom decide circumcision, preferability of getting circumcised and presence of problems related to circumcision.

2. The sample consist of 20 women selected systematically upon being admitted to the delivery ward in Wad Elhadad hospital, observation with digital examination before and after delivery were carried out, during which data on age, no. of deliveries, types of FGC, estimated width of vaginal orifice before delivery, type of delivery, midwife who perform the delivery and re-stitching after this delivery were collected. The data collected supervised by obstetrician working in Wad Elhadad hospital.
3. Also interview with six midwives working in Faris and Wad Elhadad hospital was done, the midwives experience of her profession towards FGC and RI. 

4. Two focus group discussion were done, one with men and the other with women and three interviews with 10 men and women. The analysis of the interviews formed by basis for experiences of men and women towards attitudes and practice of FGC and RI.

3.5 **Sample size:**

According to Steven Sampthon equation:

\[
\begin{align*}
    n &= \frac{NP(1-P)}{((N-1)(d^2 + z^2) + P(1-P))} \\
    &= 100 \\
    &\text{n} = 750 \times 0.5 (1-0.5) \\
    &= 100 \\
    &\text{((750-1)((0.07)^2 + (1.96)^2)+0.5(1-0.5))}
\end{align*}
\]

\[
\begin{align*}
    n &= \text{Sample Size} \\
    N &= 750 \\
    d &= 0.07 \\
    P &= 0.5 \\
    z &= 1.96
\end{align*}
\]

The study applied both quantitative and qualitative methodologies.

3.6 **Analysis:**

Analysis of data was done by SPSS.
Figure (1); Age distribution of the study group: (n = 100)

Figure (2); Circumcised Percentage. (n = 100)
Figure (3); Types of circumcision. (n = 100)

Figure (4); Problems with circumcision. (n = 100)
Figure (5); Age for circumcision. (n = 100)

![Age for circumcision](image1)

Figure (6); Circumcision decision maker. (n = 100)

![Circumcision decision maker](image2)
Figure (7); Preferability of getting circumcised. (n = 100)

![Bar chart showing frequency and percent of yes and no responses](image)

Figure (8); Preferability of study group to circumcise their expected daughters. (n = 100)

![Bar chart showing frequency and percent of yes and no responses](image)
CHAPTER FOUR

4. Results

The questionnaire results shows 90 of 100 female respondents had undergone FGM and 10 of them not undergone FGC.

All grand parents had let their first daughter undergo some form of FGC. The level of education played an important role in the young women’s decisions. Significantly more of those who believed in religions support for FGC would let their daughters undergo the procedures than of those who didn’t believe in this support, so there had been significant shift from infibulations (Pharaoni 44.4%) to clitoridetomy (Sunna 56.6%), preferred by the younger generation. A girl’s mother was the major decision maker.

According to the young men, the father of the girl was more involved when decisions were made not to perform FGC.

On the personal level, the major answer of all respondents was that FGC is performed because it is socially important.

Grand mothers and grandparents most frequently answered that tradition was the motives. All groups mentioned that FGC is important for the future husband, implying marriage ability. The motives for those who did not want their daughter to undergo FGM was mostly that they wanted her to avoid the suffering that FGC causes.

The prevalence of tightening vulvar operations after delivery was 61% among 20 newly delivered women.

According to the group discussions, most of the participatory midwives has undergone infabulation and RI themselves, for the women with infabulation or an intermediate form of FGC, DI was perform before every birth, DI involves the cutting of the scar of FGC to allow access and spitting the scar to widen the opening for birth.

Reinfibulation (El Adel) was mentioned as the (normal) thing to do after delivery, tradition and anecessity which had to be performed for the husband’s which sexual satisfaction. Some midwives even mentioned that the practice of re-tightening is a fashion and mentioned groups who had not formerly practiced El Adel after delivery, but had recently taken up this practice.
All women interviewed had personal experience, except one who had undergone an intermediate form of FGC. All the interviewed men had wives who had undergone infibulations. A majority of the interviewed women had undergone RI after delivery and some also in between deliveries. Half of the men interviewed had wives who had undergone RI.
CHAPTER FIVE

5.1 Discussion

The aim of this study was to determine the magnitude of FGC and RI in Faris area. FGC and RI cause harm to the individuals to become victims. Respondents in this study described experiences of suffering of health complications related to FGC and RI. Harmful health complications as direct consequences of primary from FGC have been thoroughly documented in the local international literature. Female as well as men respondents blamed the older women and the midwives for the persistence of the practices, midwives blamed their performance of the operation on their wish to satisfy the demand of the community. The younger generation of women and men viewed themselves and un-willing to continue with either FGC or RI. The respondent also spoke of deficient communication concerning FGC and RI between women and midwives in Faris area. This study shows that FGC and RI could be perceived as resulting in both victimizations and benefits for women as well as men. A consistent pattern in this study was balancing between conflicting attitudes related to motives for the practices of FGC and RI on the one hand and on the other hand awareness of the harm full health complications. From an ethical perspective, this could be interpreted as ethical dilemmas between the principles of beneficence and the principle of non maleficence. This kind of balancing was shown concerning the daughters among men and women and among midwives regarding the harm might inflict on the newly discovered women in relation to their perceived demands from the family. This dilemma was also shown concerning the women decision whether they should submit to RI or not. The midwives recognized that the women physical well being was at risk in the close perspective as a procedure caused pain and suffering, but perceived that in the long run the women status would benefit. Midwives also gain benefits from the performance of FGC and RI, however, it is pointed in this study that the economic incentives were not decisive for their motives, since previous researches has mentioned economic as the only motive FGC and RI were viewed as protection against a legal social stigma of not having FGC and RI. This social argument/pressure is frequently described in previous literature but only considering primary FGC.
Primary FGC was also seen as protection against premarital sex, and thus as protection of the virtue of the girl and the honor of her family.

Finally we still have much to learn about human caring with respect to people, families, institutions, communities and cultures in Faris area.
CHAPTER SIX

6.1 Conclusion

This study confirms a high prevalence of FGC and RI. That also women without any primary FGC had been subjected to a tightening operation cost delivery means that RI might be more prevalent. Midwives are important stakeholders in perpetuating FGC and RI, but the issue is more complex than previously described.

By recognizing midwives for their important role in the community related to the whole well being of the women, society ought to acknowledge the midwives to be the group most able to affect people to the prevention of both FGC and RI.
6.2 **Recommendations:**

1- Logistic support needed.

2- Training for health educators.

3- Linkage of FGM/C program to school health program.

4- Introduction of FGM/C into educational curriculum.

5- Increase training commitment.

6- Continuous training for health visitors.

7- Targeting the PHC, with high patient load as priority.

8- Provision incentive for medical providers who deliver FGM/C services.

9- Targeting states and rural areas where there is weak restriction on FGM/C practice.

   Some mothers take their daughters for circumcision to rural area with fewer restrictions on FGC.

10- Improve on M & E system for all FGM/C activities clear M&E system.
6.3 Activities at community level:

1. Sensitization and education: the approach of taking to community about benefits (positive) of not practicing is better than negative consequences of FGM/C. Targeting elderly population has shown to be effective e.g. grandmother.

2. Coordination and involvement of students and other sectors in Faris area to minimized FGM rates.

3. Educate midwives in Faris area to be sensitive and modified according to the target population in different setting.