International Knowledge Sharing Conference on

Women & Girls’ Health in Sudan

International Knowledge Sharing Conference on

Women & Girls’ Health in Sudan Report

Khartoum - Sudan
20th - 22nd October 2015
"Women are not dying because of disease we can treat, they are dying because societies have yet to make the decision that their lives are worth saving"

- Mohammed Fathalla


Gender and Reproductive Health and Rights Resource and Advocacy Centre, Ahfad University for Women. Report by: Dr. Lina Elzain
Conference Overview
2015 was a year when many promises and achievements were measured and examined. A time when countries and actors reflected on the impact and results of efforts made in the past to fulfill the promise of achieving universal access to care and information to a population in need, particularly women.

Ensuring women and girls’ health and wellbeing is crucial in order to empower them. However, high maternal mortality, low access to reproductive health services, and high prevalence of harmful practices, are all challenges facing the health systems in many countries, including Sudan. Protecting women and girls from harmful traditional practices and enabling them to enjoy healthy lives, are by far basic recipes for women to be part of the global and local development agenda. The government of Sudan had already anticipated these challenges, and developed several strategies, as well as, developed national policies to address them i.e. Saleema and “Almawada wal Rahma” Campaigns.

As part of AUW/UNFPA partnership and under the “Sudan free from FGM” project which is supported by DFID, and the UNFPA/UNICEF Joint Program on FGM/C, the "International Knowledge Sharing Conference on Women and Girls’ Health in Sudan", which took place on the 20th -22nd of October 2015 was set to be a scientific knowledge-sharing conference, to promote Sudan’s status in the international developmental agenda and bring the international expertise to Sudan. This conference aimed to promote knowledge sharing, exchange of best practices and experiences between actors, in order to promote local actors’ and policy makers’ abilities in developing suitable plans to execute Sudan’s set goals and national agenda for combating Female Genital Mutilation/Cutting and Girl Child Marriage. It was coordinated and organized through great technical inputs from UNFPA, WHO and UNICEF, National Council for Child Welfare, National Population Council, Federal Ministry of Health, and national experts.

Through 43 national, regional and international papers presented at the conference, the scope covered a number of issues related to women’s health including access to skilled maternity care; training of skilled birth attendants. Also provided an insight into national policies, legal frameworks and interventions and community approaches; awareness to address harmful practices such as Female Genital Mutilation/Cutting and Girl Child Marriage, services and national policies to promote women and girls in Sudan. These were addressed through the themes of the; Conducive Policy Environment, Community Based Interventions and Measuring Change.

The International Conference was an opportunity to bring together various stakeholders from different levels; policy-makers to university student, together to acquire evidence based information, and reflect on previous efforts implemented to address FGC and GCM in nationally, regionally and internationally. A major output of the conference is the production of a Recommendation matrix (P.70), this was produced through daily “Act Now” sessions when attendees were given the opportunity to suggest recommendations based on the sessions they attended during that day. These are hoped to be utilized in the production of national plans, future strategies.
Objectives of the Conference:

a. Provide a platform for Evidence-Based Knowledge and lessons sharing among key actors in Women and Maternal Health, with a focus on Female Genital Mutilation/Cutting and Girl Child Marriage.

b. Engage different National, Regional and International experts in a campaign to meet the unfinished post-2015 developmental agenda.

c. Engage different National, Regional and International experts to come out with concrete evidence based recommendations to inform future interventions and policies on Female Genital Mutilation/Cutting and Girl Child Marriage.

d. Provide opportunity for capacity development and networking for youth and researchers working for Women and Maternal Health, with a focus on Female Genital Mutilation/Cutting and Girl Child Marriage.
Conference Organization
Conference Staff

Dr. Nafisa M. Bedri
General Coordinator

Mrs. Nada Habash
Assistant General Coordinator

Dr. Sara El-Tayeb
Coordinator

Mrs. Sara Mustafa
Coordinator

Ms. Arwa Salah
Media and Logistics Coordinator

Dr. Lina El.zain
Assistant Coordinator

Ms. Manal Idris
Assistant Media Coordinator

Dr. Yussra Mahmoud
Secretariat

Ms. Rania Yassin
Secretariat

Ms. Eiman Mustafa
Secretariat

Ms. Nuha Tambal
Youth Coordinator

Ms. Ghada Rudwan
Workshop coordinator

Ms. Asma Eisa
Workshop coordinator

Scientific Committee

Dr. El.Habib Hamdok
UNFPA-Sudan

Mrs. Lena El-Hindi
UNFPA-Sudan

Mrs. Mawahib El.Hag
UNFPA-Sudan

Dr. Amira Azhary
of FGM Program, NCCW

Dr. Samira Amin
National Consultant

Dr. Samia El.Hadi
National Consultant

Ms. Amna Magboul
NCCW

Dr. Khadija El-Hag
WHO-Sudan

Dr. Tamador Khalid
UNICEF-Sudan

Dr. Wisal Nabag
OBS&GYN Society

Dr. Sami Mahmoud
OBS&GYN Society

Professor El-Falih El-Samani
Ahfad University for Women

Professor Sidigia Washi
Ahfad University for Women

Dr. Somaia El.Sayed,
Ahfad University for Women

National Steering Committee

Director of PHC, FMOH
Dr. Nada Jafer

Dr. Naeema AL.Gaseer
WHO Country Representative

Dr. Khadiga El.Hag
Women Health Technical Officer, WHO

Dr. Tamador Khalid
Child Protection Officer, UNICEF

Dr. Amira Azhary
Director of FGM Program, NCCW

Mawlana Rehab Al.Toum
Ministry of Justice

Dr. Samira Amin
National Consultant

Dr. Atiaiat Mustafa
Head of the VAW Combating Unit

Mrs. Suad Abd-Aaal,
National Council for Child Welfare

Dr. Khadiga Al.Saeed

Dr. Faiza Hussein
Chairperson, Babiker Badri Scientific Association for Women Studies

Dr. Emad Mamoun
Chairperson Entishar Charity Society

Dr. Mohamed Lamine Saleh
Deputy Representative, UNFPA-Sudan

Dr. El.Habib Hamdok
Capacity Building Officer, UNFPA-Sudan

Mrs. Layla Ali
Chairperson, Sudanese Midwifery Association

Dr. Sami Mahmoud,
Deputy Secretary General of the Sudanese OBGYN

Dr. Malik Balla,
Policy Advisor, DFID

Dr. Fathia Ahmed Mursal
Chairperson, Sudan National Committee for Traditional Association

Professor Mustafa Khogali
Ahfad University for Women

Mrs. Lena El.Hindi
Gender Coordinator Officer, UNFPA-Sudan

Gasim Badri
President, Ahfad University for Women

Professor Balghis Badri
Director Regional Institute for Gender Diversity, Peace & Rights

Professor Mutamad Amin
Ahfad University for Women

Dr. Wisal Nabag
Sudanese OBS-GYN Society

Financial Committee

Mrs. Samia Khalifa
Coordinator

Mrs. Rawah Ahmed
Assistant Coordinator
Conference Special Events
**Pre-conference workshop**

“Conducting Culturally Sensitive Longitudinal Studies on Women’s Health”

This one day training workshop was held as part of the International Knowledge Sharing Conference on Women and Girls' Health in Sudan. The workshop was entitled: Conducting Culturally Sensitive Longitudinal Studies on Women’s Health, and took place on Monday 19th of October 2015. It was attended by fifty researches from different national and international institutes and universities and focused on introducing the participants to Culture and ethnographic research in Sudan.

The facilitators, Professor Janice Boddy, department of Anthropology at university of Toronto, Canada; and Professor Ellen Gruenbaum, head of department of Anthropology at Purdue University, USA discussed qualitative research methods, FGM and its symbolic contexts, cultural logic, marriage patterns, mixed methods, longitudinal patterns, life history and reproductive history.

They discussed the development of ethnography as tool in anthropology and its characteristics: its need a long term observation and participation in the community, it uses inductive and qualitative methods and often a longitudinal approach. The participant’s raised some questions like how to sustain the behavior change in the community, how long it requires conducting a longitudinal study or if it is needed to carry out the same research question though out the period of study. The facilitators clarified that, as researchers, they have to adapt to the circumstances and the characteristics of the community.

The workshop included small working group exercise; participants were divided in six groups and the facilitators gave them four hypothetic situations related with FGM, child marriage or maternal mortality. The task of each group consisted in choosing one of those issues and designs a research plan that utilizes the perspectives of culturally sensitive – longitudinal studies. This was followed by group presentations and plenary discussions.

At the end of the work-shop, the facilitators thanked the participators for their assistance and the participators got a certificate for attending the workshop.
Youth Activities

One of the main objectives of the conference was to provide a platform for networking for youth working for Women and Maternal Health in Sudan. That is why the organizers were keen on youth participation, Y-Peer acted as focal point and medium between organizers and a number of national youth based organizations that showed interest for involvement. Together the youth committee developed and executed a number of activities on the 19th of October 2015, these included a Live theater play", Exhibition of promotional materials by the respective organizations and a debate between Ahfad University for women and Khartoum University on the “Role of youth in promoting Women’s Health”. The play was coordinated by Ms. Nagham Hussni Hawash, the executive director for GSER Development Center. She selected the actors in the play and worked together with them to come up with the theme and highlighting the health consequences of circumcision. The debate was coordinated by Ahfad Debate’s Club. Khartoum and Sudan Universities have been invited to participate in this debate because they already have trained debate team. Unfortunately, Sudan University's debate team was unable to participate due to the examination season. The best debater was from AUW, while the winner was University of Khartoum.

Official opening ceremony

The opening ceremony took place at Ahfad University for Women on the evening of Monday 19th October 2015. The objective of the event was to celebrate the launching of the conference, welcome international guests, and appreciate pre- conference activities. It was attended by more than a hundred guests from different national, regional and international organizations and institutes concerned with the wellbeing of women particularly in Sudan. The ceremony was also attended by a number of national policy makers including the governor of Omdurman state and Dr. Mawia Al.Sadiq, who were present to confirm their commitment to the cause. Opening the evening was Sheikh Mohamed Hashim El.Hakim, a prominent religious leader and an active advocate for women and their rights; he recited a few verses of the holy Quran. Following this was a welcome speech by Dr. Khadeiga Al.Saeed, NPC who welcomed to guests on behalf of the organizing committee and the Conference’s National Steering Committee. She spoke briefly about the conference’s scope and objectives, as well as, gave a brief note on the efforts taken to prepare for it.
This was followed by a number of speeches from the donors and the different Sudanese ministers who spoke about the situation of women generally and health specifically. Among the guests and speakers were Gasim Badri, President of Ahfad University for Women, Mrs. Lina Mousa, UNFPA Country Resident Representative, Mrs. Joanna Reid, Head of Office-DFID, her Excellency Masheir Ahmed Dawalab, Minister of Federal Ministry of Welfare and Social Security, Sudan, and his Excellency Bahar Edris Abu Garda, Minister of Federal Ministry of Health, Sudan. They all reflected on the status of women in Sudan and efforts that have been done in order to improve it.

As part of the ceremony, Professor Abdel Salam Gerais, the guest of honor was presented with an award as a token of appreciation for his long history of work in the field of women’s health in Sudan and beyond. Similar gifts were given to the ministers, Mrs. Lina Mousa and Mrs. Joanna Reid as a reminder of the promise to promote women’s health.

There were several promotion products to spread awareness about the issues that the conference addresses. These include a short video on Girl Child Marriage that was
displayed to the audience; the video was created to reflect positive massages so as to attract the community’s attention; what a little girl’s life would be like if she was not wed at an early age, allowed a proper education and other opportunities that better her life. The audience also previewed another video that was developed to promote the conference, showing its objectives, themes and concepts. There were also two songs composed that were performed by AUW’s Choir. Another video that was displayed gave the guests a reflection of the youth activities that had taken place earlier that day. The guests were then invited to visit the exhibition which included IEC materials from different organizations and youth groups working in the field on women’s health.
Conference Program
Social Norms

Abandonment of FGC

Girl Child Marriage

Medicalization of FGC

Maternal Health

Decision Making

Evidence based Interventions
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<th>Time</th>
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<td>9:00-9:30 am</td>
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| 9:30-10:30 am   | Keynote Speech: Sudanese Girls, Women and Maternal Health Promotion: Political Commitment and Partnership | Speaker: Dr. Malik Al.Abbasi, Federal Ministry of Health, Sudan  
Rapporteur: Ms. Tayseer El.Fatih | Lebdah |
| Chairperson: Professor Mohamed Baldo, Obstetrics and Gynecology, Sudan |                                                                                                 |       |
| 10:30-11:00 am  | Coffee Break & Conference Film                                          |                                                                                                 |       |
| 11:00-12:30 pm  | Panel Session: Providing Protection Through Policy and Legal Frameworks  | Chairperson: Dr. Lamya Abdel Gafar, National Population Council, Sudan  
Rapporteur: Ms. Nuha Tambal | Lebdah |
| 1. Sudan experience in addressing female genital mutilation/cutting, challenges and opportunities | Dr. Suad Abdelaal, National Council for Child Welfare, Sudan |       |
| 2. Analytical study reviewing the female genital mutilation law in some states in Sudan | Professor Hassan Salih, MADA Center, Sudan |       |
| 3. Gaps in legal framework of female genital mutilation/cutting and child marriage | Dr. Awatif Abdel Karim, National Consultant, Sudan |       |
| 12:30-1:30 pm   | Lunch Break                                                             |                                                                                                 |       |
| 1:30-3:30 pm    | Parallel Session 1                                                       |                                                                                                 |       |
| Female Genital Mutilation/Cutting as a Policy Issue | Chairperson: Dr. Emad Mamon, Entishar Charity Society, Sudan  
Rapporteur: Ms. Rwida Matar & Mrs. Ghada Rudwan | Lebdah |
| 1. Towards ending medicalization of female genital mutilation/cutting | Dr. Sameh Sadek, Alexandria Regional Center for Women Health and Development, Egypt |       |
| 2. Reconstructive surgery for the female genital mutilation/cutting | Dr. Atif Fazari, Obstetrics and Gynecology, Sudan |       |
| 3. Legal perspective of medicalization of female genital mutilation/cutting in Sudan | Mawlama Rehab El.Tom, Legal Counselor, Ministry of Justice, Sudan |       |
| 4. The role of “Idara Ahlya” (Native Administration) in abandoning female genital mutilation/cutting "looking backward to move forward: Case from Gedarif State " | Uz. Samia Abdaala, University of Gedarif, Sudan |       |
| 5. Teenage/Twenties case studies from the Somali Diaspora UK: how far are new UK policy initiatives supporting 'what works' to address female genital mutilation/cutting and how far this age group’s concerns? | Dr. Hermoine Lovel, Public Health Consultant, UK  
Zeinab Mohamed, Researcher, UK |       |
| 1:30-3:30 pm    | Parallel Session 2                                                       |                                                                                                 | Ghadames &Sebha |
| Child Marriage as a Policy Issue | Chairperson: Dr. Sami Mahmoud, Sudanese Obstetrician and Gynecologist Society, Sudan  
Rapporteur: Amani Tabidi & Sara Isam |       |
| 1. Child marriage and policy for marriage to start at 18 is strongly urged-Sudan 2015 | Dr. Mohamed Baldo, AUW, Sudan |       |
| 2. The impact of early childbearing on maternal health in Sudan | Dr. Awatif Al.Awad, Al Neelain University, Sudan |       |
| 3. Exploring stakeholders and activists perspective on effective interventions for combating child marriage | Dr. Tibyan El.Hussein, AUW, Sudan |       |
| 4. Child marriage strategy in Sudan | Dr. Abbas Korina, National Council for Strategic Planning, Sudan |       |
| 3:30-4:00 pm    | Coffee Break & Conference Film                                          |                                                                                                 |       |
| 4:00-5:00 pm    | Act Now: Policy-oriented Recommendations                                 | Chairperson: Dr. Tamador Khalid, UNICEF-Sudan  
Rapporteur: Dr. TibyanEl.Hussein | Lebdah |
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<td><strong>Keynote Speech: Community-based Initiatives:</strong> Relevance and Lessons Learned</td>
<td>Dr. Mohamed Lamine, UNFPA-Sudan Office Rapporteur: Dr. Sabrine Adil</td>
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<td><strong>Panel Session: Communication and Networking Initiatives on Female Genital Mutilation/Cutting at National and Regional Levels</strong></td>
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<td>Chairperson: Dr. Ellen Gruenbaum, Purdue University, USA</td>
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<td>Rapporteur: Dr. Sabrine Adil &amp; Dr. Wafa Saeed</td>
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<td>1. Almawada wa Alrahma as an umbrella concept for driving social change</td>
<td>Sheikh El. Fatih Mukhtar, Ministry of Guidance and Endowments, Sudan</td>
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<td>2. Saleema initiative: social marketing tools</td>
<td>Dr. Amira Azhari, National Council for Child Welfare, Sudan</td>
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<td>4. Role of virtual regional networks in enhancing social campaigns: Intact Network</td>
<td>Dr. Ian Askew, Population Council, Kenya</td>
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<td>5. Role of the Inter-African Committee in bridging social marketing campaigns</td>
<td>Dr. Zinia Afri and Mrs Sandra Adisa, Inter-African Committee, Ethiopia</td>
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<td>Social Norms and Social Dynamics Affecting Female Genital Mutilation/Cutting and Girl Child Marriage</td>
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<td>Chairperson: Dr. Sidiga Washi, Ahfad University for Women, Sudan</td>
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<td>Rapporteur: Ms. Rania Yassin &amp; Mrs. Rawda El. Dai</td>
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<td>1. Trying to break silence: the Swedish’ experience of promoting the girls’ perspective</td>
<td>Dr. Vanja Berggren, Lund University, Sweden</td>
<td>Ghadames &amp; Sebha</td>
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<td>2. Attitudes towards female genital mutilation/cutting in Sudan</td>
<td>Dr. Hagir El. Jack, Al Neelain University, Sudan</td>
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<td>3. Cursed or Blessed? female genital mutilation in the Gamo cultural landscape, south western Ethiopia</td>
<td>Dr. Getaneh Mehari, University of Addis Ababa, Ethiopia</td>
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<td>4. The social dilemma and dynamics of preference: health risks or Saleema</td>
<td>Dr. Samira Amin, National Consultant, Sudan</td>
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<td>5. The effect of female genital mutilation on sexual satisfaction among Sudanese married women in Khartoum State</td>
<td>Dr. Abdialelah Kuna, Sudanese Obstetrician and Gynecologist Society, Sudan</td>
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<td>6. Obstetric fistula in Sudanese women: social and cultural factors</td>
<td>Dr. Mazar Osman Abu Algasim, Sudananese Obstetrician and Gynecologist Society, Sudan</td>
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<td><strong>Parallel Session 2</strong></td>
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<td>Decision-making Process on Girl Child Marriage</td>
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<td>Chairperson: Professor Janice Boddy, University of Toronto, Canada</td>
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<td>Rapporteur: Dr. Wafa Saeed &amp; Mrs. Ghada Rudwan</td>
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<td>1. Child marriage in emergency setting: protection matters</td>
<td>Dr. Tamador Khalid, UNICEF, Sudan</td>
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<td>2. Knowledge of village midwives about female genital mutilation/cutting in Darfur states and decision making process within their families</td>
<td>Dr. Faiza Hussein, Babiker Badri Scientific Association for Women Studies, Sudan</td>
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<td>3. Decision-making processes in girl child marriage within families of different backgrounds, experiences, and positions in Khartoum State</td>
<td>Dr. Nafisa Bedri, Ahfad University for Women, Sudan</td>
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<td>4. A case study ‘The Arts Factor’ and FGM/Human Rights in Yemen</td>
<td>Dr. Nizar Ghanem, Ahfad University for Women, Sudan</td>
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<td><strong>Act Now: Community-based Initiatives and Communication Oriented Recommendations</strong></td>
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<td>Dr. Ian Askew, Population Council, Kenya</td>
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<td>Panel Session: Evidence-based Interventions for Abandonment of FGM/C</td>
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<td>Chairperson: Dr. Naeema Al.Qaseer WHO-Sudan</td>
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<td>Rapporteur: Ms. Rowida Matar &amp; Ms. Aurora</td>
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<td>1. Maternal death rate as a measuring tool for maternal mortality</td>
<td>Dr. Taha Ahmed Umbeli, Federal Ministry of Health, Sudan</td>
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<td>2. Simple and reliable techniques for measuring changes at the community</td>
<td>Dr. Emad Mamon, Entishar Charity Society, Sudan</td>
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<td>3. Providing evidence to guide interventions</td>
<td>Dr. Sheena Crawford, IMC, UK</td>
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<td>4. Research Agenda to End Female genital mutilation/cutting</td>
<td>Dr. Carolyn Njue, Population Council, Kenya</td>
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<td>5. Setting a national research strategy for Sudan</td>
<td>Dr. Nada Jafar, Population Council, Kenya, Federal Ministry of Health,</td>
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<td>Evidence on Factors and Approaches for Promoting Maternal Health</td>
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<td>Rapporteur: Mrs. Rawda El Dai &amp; Ms. Rania Yassin</td>
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<td>1. Quality assurance (QA) in maternal care at Saudi Arabia improves the</td>
<td>Dr. Mohamed Baldo, AUW, Sudan</td>
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<td>outcome of mothers’ and children’s health in two decades</td>
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<td>2. Availability of midwives and its association to maternal mortality</td>
<td>Dr. Malaz Mazgoub Elmekki, AUW, Sudan</td>
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<td>ratio in northern, River Nile and Sennar States</td>
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<td>3. Inequalities in maternal health in Sudan: the effect of universal</td>
<td>Mrs. Ibtisam Satti Ibrahim, University of Khartoum, Sudan</td>
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<td>low birth weight among full-term, singleton babies born in an</td>
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Key Note Speaker

Dr. Mohamed Ali El Abbassi. is the Director General of Basic Health Services, Federal Ministry of Health, Sudan. He obtained his PhD from Maastricht University, and specialized in the area of Public Health Reform. He initiated, participated and contributed to most of the health reform in the Health Sector in Sudan in the last decade. Dr. ElAbbassi headed many policy and strategies’ development committees in the health sector and beyond. He has represented the country in various regional and international fora. He is a member of several Regional Advisory Committees.

Plenary Speakers

Mrs. Suad Abdelal Eltahir Abdalla: Secretary General of the National Council for Child Welfare at the Ministry of Welfare & Social Security. She was one of the founders and is now chair of the "Women’s Center for Human Rights (WCHR)"
since 2007 and a member of the Advisory Council for Human Rights. She is an activist for women’s rights, leading a large program of legal aid reviewing women’s status in national legislation, building capacity and raising awareness about human rights. In addition to facilitating women’s access to justice through a number of volunteer lawyers representing poor women and inmates at courts. Her concerns are enhancing women’s political participation in elections, political parties and local governance aiming to achieve 50% through national policies and legislation. She led the program for fair political participation of women in the Sudanese 2010 Elections.

Prof. Hassan Mohamed Salih: A Professor in Social Anthropology and Dean of the Dean of the Economic, Administrative and Financial Sciences, National University of Rabat. Designed and implemented many of the bachelor, master and doctoral programs in Sociology and Anthropology and Social Work inside and outside Sudan. Supervised more than a hundred doctorate and master's dissertations. Participated in many scientific conferences and consultancies inside and outside Sudan and carried many theoretical and applied research and studies in the field of sociology.

Dr. Awatif Abdelkarim: A lawyer and Legal Counsel for Legislative Department, Ministry of Justice, a legal expert in the Arab Women Organization and President of the Union of Sudanese Female Lawyers. She has several researches in the area of gender based violence and violence against women and children and human trafficking.

Parallel Session Speakers

Prof. Sameh Saad El-Din Sadek: The current Executive Director of the Alexandria Regional Center for Women Health and Development (ARC) from February 2014. ARC is a training, research and advocacy center active in all areas of women’s health and development. It offers all its activities to women and to all professionals working in health, social, fields in Egypt and friendly neighboring countries particularly Middle East and Nile Basin Countries. Dr. Sadek is Professor of Obstetrics & Gynecology, Alexandria University since 2005. Was the medical director of El-Shatby maternity hospital, and the acting director of feto-maternal unit of El-Shatby Maternity Hospital. Prof. Sadek shared in the edition of [Alexandria Manual of Obstetrics] book and he is an editor advisor of different national & international journals. Dr. Sadek has many national and international publications. He shared in most of the medical activities done in Egypt and conducted by the different international organizations like WHO, Pathfinder, Population council, UNFPA, IIE and others. He attended the training program in Curriculum Design and Evidence Based Medicine in University of California, Irvine College of Medicine. Also, he was a clinical consultant for TAHSEEN – CATALYST – CONSORTIUM in the program of post abortion care (PAC) and the leader of Alexandria PAC training team.

Dr. Atif Bashir Fazari MBBS, Medical Doctorate in Obstetrics & Gynecology. A Senior Consultant of OBSGYN in Omdurman Maternity Hospital. An Advisory Consultant in Reproductive& Child Health Research Unit, University of Medical Sciences& Technology.

Has Fellowship in Obstetrics& Gynecology, a Master Degree in Public Health and Tropical Medicine. Member of Obstetric Medicine, Imperial College London UK and Member of Gynecologic Surgery USA.
Mawlana Rihab Abdel Rahman Eltom  
Legal Counsel Head  
Department of Training.  
Previous posts include  
Head of Criminal cases, Legal Aid Department; Legal Counsel for National Telecommunication Corporation;  
Legal Department for Sudan Airways; Legal Department for Bank of Sudan (Central Bank);  
Member of Sudanese Red Crescent Central Committee. Active in the field of women’s rights and issues concerning women and children with governmental, non-governmental, regional, national and international bodies.

Ms. Zeinab Mohamed Zeinab  
is a Nurse-Midwife Teacher originally from Somalia who has been working as a researcher at Manchester University and in Community Development. She participated in the systematic review of health complications of FGM at the request of WHO leading to her development of the original protocol which formed the base for a 6-country WHO study on obstetric consequences of FGM. She also co-developed community participatory needs research with the Somali diaspora refugee community in response to requests from local Somali religious leaders in Manchester. Zeinab leads community development work with women of the Somali diaspora.

Parallel Session Speakers

Ms. Samia Abd Albarbri  
Dean of Faculty of Community, Gedarif University and PhD candidate at Khartoum University. Was a guest researcher at the Organization of Social Science Research in Eastern and Southern Africa Addis Ababa. (OSSREA), Nordic African Institute, Sweden Cape Town Development Alternative with women for new Era (DAWN), and other international Universities. Has lead the engagement of the University of Gedaref in grassroots development by initiating community based education, gender, Women poverty and livelihoods initiatives that supported the economic development of rural poor women and young girls. A member of the University advisory board as well as other bodies providing policy guidance and technical advice to government authorities, UN and NGO and CBOs on Women land right, empowerment of rural Women, on education in conflict situations, women empowerment, and migration and refugees issues. Currently leading the establishment of a Refugees Studies & Migration center at the University of Gedaref.

Prof. Mohamed Hassan Baldo  
Professor of Obstetrics & Gynecology, AUW; Head of Department 2012-2014 and was a Professor of Obstetrics and Gynecology, Al Zaiem Al Azhari University; founder of AAU ED & R Center & of the Scientific Journal; Editor-in-Chief, and undertook studies on quality, environment & introducing EBM in the faculty curriculum supported by the MOHE& Research. Between 1980- 2000 acted as temporary advisor & short term consultant for EMRO WHO & was reviewer for EMHJ, 1990-2000. A reviewer for SML, KMJ & Gezira J.

Dr. Hermione Lovel;  
is a retired Academic and Consultant in Public Health, who led and developed a systematic review of health complications of FGM at the request of WHO leading to her development of the original protocol which formed the base for a 6-country WHO study on obstetric consequences of FGM. She also co-developed community participatory needs research with the Somali diaspora refugee community in response to requests from local Somali religious leaders in Manchester. Hermione is now an Assessor for the UK

Dr. Awatif Musa;  
An Assistant Professor at Faculty of Mathematics and Statistics, Al Neelain University with a Ph.D in Statistics, Sudan Academy of Sciences. She has more than 15 years expertise in program management & coordination, proposal and report writing in different NGOs and UN agencies, besides research work with relevant government institutions.
Dr. Tibyaan Elhussein a medical doctor graduated from school of Medicine, Ahfad University for Women and holds a Master degree in public health concentrating in health management and policy from the American University of Beirut.

Dr. Tibyaan is a researcher and a reproductive health trainer in the team of the Gender and Reproductive Health and Rights, Resource and Advocacy Center, Ahfad University for Women.

Dr. Abbas Korina; National Council for Strategic Planning Sudan

Chairpersons

**Key note Speech:** Professor Mohamed Baldo, Obstetrics and Gynecology, Sudan

**Panel Session:** Dr. Lamya Abdel Gafar, National Population Council, Sudan

**Parallel 1:** Dr. Emad Mamon, Entishar Charity Society, Sudan

**Parallel 2:** Dr. Sami Mahmoud, Sudanese Obstetrician and Gynecologist Society, Sudan

**Act Now Session:** Dr. Tamador Khalid, UNICEF-Sudan
Sessions at a Glance
Sudanese Girls, Women and Maternal Health Promotion: Political Commitment and Partnership

Presenter
Dr. Malik Al. Abbasi, Federal Ministry of Health, Sudan

Chairperson
Professor. Mohamed Baldo, AUW, Sudan

Key Points Raised
The presentation focused on the status of women and girls’ health which according to the MICS indicators seem lower than the health status of boys. Focusing on women and girls’ health is important for the following general and particular reasons:

- Maternal and child mortality is an alarming issue with significant rate internationally specially in developing countries.
- Tackling women, boys' and girls' health will contributes to the reduction of global poverty.
- The Impact of maternal mortality is seen in a vicious cycle starting with poor child nutrition and educational attainment, as they are the main care providers which in turn may cause local poverty. This contributes to national poverty and low per capita income which again lead to maternal and child mortality.
- Improving women’s health is related to increasing productivity, effectiveness, efficiency and economic development.
- Health system is blind on issues of women needs and priorities.
- Negative traditions and customs constraint women’s health.

Efforts to induce change:
- International commitments towards women and girls health; the United Nations has issued 16 decrees related to women’s and child health.
- Millennium Development Goals (MDGs) address women and girls’ health. Moreover, women's and child health is across cutting issue in MDGs targets. So success of MDGs achievement is a success in achieving promotion on women and child health.

Dr. Malik mentioned the following example of global and national frameworks for maternal, new born and child health:

- Sudan Road map for reducing Maternal Mortality Rate MMR (2007).
- Sudan Reproductive health Program (2010).
- Ministry’s decree for establishing reproductive health partnership committees at the states.

Reasons for state failure on achieving MDGs (4/5):

- Low investment on women’s health
- Health system does not address demands related to promoting women’s health
- Human crisis
- Community’s Harmful traditional practices
Conducive environment and actors:
- The Ministry of Social welfare Women developed a national Women Empowerment policy 2007 which includes the health and environment policy.
- The National Population Council as coordination body for women health issues and as supervisor for ensuring of implementation of MDGs targets related to women’s health and Cairo population and development conference plan of action.
- The National council for Child Welfare contributes to women’s health through its programs on child health in urban, rural and conflict areas. As well play a role in the issuing of the child Act.
- Academic and research institutions such as the initiative of Gazira University for reducing maternal mortality since 2005, Ahfad University for Women’s courses , research and rural extension program.
- Sudanese obstetricians and gynecologists society works through independent initiatives and in partnership with Ministry of Health for implementing programs to promote women’s and girls’ health
- International and national organizations such as JICA, UN agencies and other relevant organizations

The Situation of women and girls health in Sudan
- Only 13.4 % have no access to PHC
- 24% of health services only provide comprehensive package of quality health service.
- The indicator of child health shows little progress. Child immunization is low compared to the target.
- Infant mortality constitutes 45% in urban areas and 55% in rural areas
- In conflict areas, the status of women and girls health is deteriorating due to lack of access.

Challenges and way forward for achieving women’s and child health:
- Strengthening the health system (capacity building for human resources).
- Increasing the health budget and ensring financial sustainability.
- Coordination and unifying national action plans, programs and budgets related to women’s and girls’ health in order to achieve desired outcome.
- Develop monitoring, follow-up and evaluation system for women’s and girls’ health program
- Advocacy for increasing donation from the international community
- Investment in eliminating social determinants for women’s health such as human, poverty, war and conflict.

The presenter concluded by the importance of addressing technical and geopolitical challenges for achieving women and child health in Sudan.
Action Recommendations

- Strengthening the health system (capacity building for human resources)
- Increase in health budget and financial sustainability
- Coordination and unifying of national action plans, programs and budgets related to women's and girls' health in order to achieve desired outcome.
- Develop monitoring, follow-up and evaluation system for women's and girls' health program
- Advocacy for increasing donation from the international community
- Investment in eliminating social determinants for women's health such as human, poverty, war and conflict.
- Engage the civil society in checking the Ministry of Health programs for improving women and child health.
- School curriculum and awareness raising programs are tools for reducing prevalence of FGM in addition to the enactment of law.
- Conduct researches for investigating the link between FGM and maternal mortality prevalence.
- Ministry of Finance to allocate budget for women's health programs and or maternal mortality reduction programs.
- Establish maternal death review
- In collaboration with the Council of child welfare and other relevant bodies to work on implementing programs for combating FGM
- Training for midwives and health workers.
- Support health clinics for provision of quality services.

Chairperson

Dr. Lamya Abdel Gafar, National Population Council, Sudan

Sudan experience in addressing female genital mutilation/cutting, challenges and opportunities

Presenter:

Mrs. Suad Abdelaal, National Council for Child Welfare, Sudan

Key Points Raised

- The presentation reflected the role of the National Council for Child Welfare in accelerating abandonment of FGM/C in Sudan.
- The Joint program and Saleema campaign initiatives are the best examples of NCCW efforts.
- Saleema campaign resulted in social mobilization, where it creates network in each community in each state.
- Strong relationship with religious leaders and, ministry of Guidance, where 700 religious leaders have declared their commitment to abandonment of FGM/C.
- Formulation of Saleema’s ambassadors and the regional forum.
- Resistance of public to the necessary awareness raising and consultation.
Lesson Learned

- Religious leaders’ role is vital as well as media.
- Enacting laws and legislation is crucial in abandonment and criminalization of all forms of FGM/C.
- Networking and collaboration between stakeholders and sectors.

Challenges:

- Opposition of some religious leaders
- Resistance of public to the necessary awareness raising and consultation.

Points Discussed

- The national strategy for abandonment of FGM/C, which was launched 5 years ago. The floor enquired about the extent to which it succeeded in convincing the opposing religious leaders, bearing in mind there’s only 3 years remaining in the implementation period of the proposed strategy. Dr. Suaad stated that the strategy have succeeded in bringing 700 Imams to commit to the abandonment of FGC. She also stated that NCCW is now working on its 10 years strategic plan of 2008 – 2018 which is hoped to eliminate FGC in one generation.
- Saleema campaign initiative capitalizing all the positive aspects of culture, religion, and social in addressing FGC issue it was a successful campaign. In this regard Dr. Suaad emphasized, Saleema campaign initiative was a successful because it depended on the positive messages in advocacy and awareness rising.

Action Recommendations

- Omitting the word “Sunnah” circumcision; because when we say Sunnah we give an impression of a religious background, while it has nothing to do with religion. So, Omit Sunnah from all IEC materials.
- Developing advocacy campaigns using positive messages which are culturally and religiously sensitive.
- Enact state and national laws to abandonment and criminalizing all forms of FGC.

Law creates awareness mechanisms, so the law should go in parallel with awareness

Dr. Suaad Abd Alaal

Analytical study reviewing the female genital mutilation law in some states in Sudan

Presenter

Professor Hassan Salih, MADA Center, Sudan

Key Points Raised

- Decentralized governance allows each state to enact its own law and legislation, hence, this is could be used to enacting law abandoning and criminalize all forms of FGM/C .
- However, many states they aren’t aware that state constitution ensure them to enact their own state’ law, or even that there’s a law abandoning FGM/C.
Un-publishing of the law of Abandonment of FGM/C in mass media an official newspapers contributed to illiteracy of the law’s force who implemented the law.

Enacting of the law to abandon FGM/C in Red Sea, ElGadarif, and South Darfur State.

**Action Recommendations**

- Enacting of national and state law aiming to abandoning FGM/C and hence to bring developmental, political...etc., dimensions at state and national level.
- Men should be targeted because they are the main supporter in addressing FGM/C within the household context and so as the whole community.
- Advocacy campaign targeted legislative council.
- Enact a state law and a national law to abandonment and criminalizing all forms of FGM/C. Mass-media and newspapers should address the issue of FGM/C.

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**Female Genital Mutilation/Cutting as a Policy Issue**

**Chairperson**

Dr. Emad Mamon, Entishar Charity Society, Sudan

**Presenter**

Dr. Sameh Sadek, Alexandria Regional Center for Women Health and Development, Egypt

**Key Points Raised**

- The speaker started the presentation by the medical reasons for partial or total removal/injury of external genitalia. He explained the standard management for FGM.
- Prevalence of FGM/C in Egypt, mentioned there are different figure for women exposed to cutting. Explained reasons for increase in incidence of FGM/C in Egypt increased.
- The presenter discussed the normal anatomy of genital organ of the female, and types and complication of FGM.

In details explained how can we treat FGM/C in points:

- Immediate first.
- Management of FGM Health consequences.
- Medico-legal reporting.
- Psychological & Psycho-Sexual management
- Surgical Reconstruction.
- Prevention of complications.
- Reversal of infibulations (infibulation)
- Also he mentioned the Prevention strategy for every health care providers.

Plenary discussion focused on to forming and strengthening on legal punishment for medical doctors that practice medicalization.
Action Recommendations

- It was suggested to add FGM/C as part of student curriculum.
- To encourage support and counseling for the victims.
- There are needs for a policy maker to coordinate result.

Reconstructive surgery for the female genital mutilation/cutting

Presenter

Dr. Atif Fazari, Obstetrics and Gynecology, Sudan

The presentation started with a historical background of FGM/C practice in Sudan. Dr. Fazari also discussed the normal anatomy and structure of the female genital organs. The discussion included the types of cutting and its complications. He explained the aims of reconstructive surgery for mutilated external genitalia organs which aims to restore some of the mutilated genital Anatomy. The objectives & purpose of this study was to:

- Surgical outcomes.
- Satisfaction for reconstructive surgery for the FRGM/C victims.
- Clients’ acceptability.
- He explained the methods & materials.

The presentation discussed the results, the majority were satisfied (94%) & rest of (4%) of the group were satisfied with the results of the surgery regards the healing, duration of vaginal discharge, the regarding or starting of the sexual activity and the interest. The final 2% of the group was unsatisfied. The discussion was around the activation of laws to combat FGM, explaining what is meant by breaking the silence among the FGM victim, focusing the relationship between FGM and sensitivity of sexual pleasure.

Action Recommendations

- Activation of the laws against FGM in a very strict way.
- Breakdown of silence wall among the awareness & health education about the running FGM complications.
- Reconstructive surgery for FGM victims (RCSFGM) should be performed to restore some of genital Anatomy.

Legal perspective of medicalization of female genital mutilation/cutting in Sudan

Presenter

Mawlana Rehab El.Tom, Legal Counselor, Ministry of Justice, Sudan

Key points raised

The speaker started the presentation by a brief history about legislation; the first one that prohibited FGM was passed since 1925 until the constitution in 2005.
She mentioned that there are different bodies working together to implement the Child Law:

- State Councils for child Welfare.
- Family and child protection police unit ministry of interior.
- Child Attorneys ministry of Justice
- Child Courts, the Judiciary.
- Women Human Rights Centre (Ministry of social Welfare)
- Combating Violence against Women and children Unit Centre (Ministry of social Welfare)

Explained that legislations banning FGM at the regional level were passed in four out of eighteen Sudanese states. These are (Red Sea, Gadarif, South Kordfan South Darfur states, South Darfur) enacted a separate law.

She mentioned the regulation, by which the Sudan Medical council and the Ministry of Health prohibited the practice of FGM/C by any of their members of employees. Emphasizing of the government’s strategy to fight FGM, Mawlana Rehab emphasized on involving community leaders.

**Action Recommendations**

- It’s important to address the people, decision-makers, actors and Islamic leaders.
- Passing a law needs campaigning and advocacy.
- Educational Institutions should be involved.
- The media should participate in fighting the practice.

The role of “Idara Ahlya” (Native Administration) in abandoning female genital mutilation/cutting "looking backward to move forward: Case from Gedarif State"

**Presenter**

**Uz. Samia Abdaala, University of Gedarif, Sudan**

The speaker started the presentation by introduction of figures and facts regarding FGM prevalence in Sudan. She Explained the aim which is:

- Addressing the important role of the Native Administration “Alidara Alahlia” in combating FGM/C practice in their communities
- It also aims at revealing the challenges, opportunities and draw a way forward in enhancing their role in the process of eradicating the practice through the main recommendations shared and discussed by the leaders of Alidaraa Alahliya in the targeted areas themselves.

—Mrs. Samia explained that the methods was used in the study included:

- Desk Review
- Primary data

She also mentioned the international efforts in FGM/C eradication:

- The World Health Organization has been at the forefront of international initiatives for the elimination of FGM since 1979 when it hosted a seminar on “Harmful Traditional Practices Affecting the Health of Women and Children” in Khartoum.

The topic itself drew much attention at other global forums such as:

- Convention on the Elimination of all Forms of Discrimination against Women of CEDAW
She indicated the Role of “Native Administration” in abandonment of FGM/C as:

- Faculty of Community Development became hesitant in taking the step to enter the areas with the highest level prevalence of FGC and highest level of isolation

A workshop entitled: Engaging “Idara Ahlya in abandonment FGM” in Gedarif State 2013. More than a hundred Sheikhs, Khat Sheikhs and Nazirs attended the workshop and assisted Gadarif University in accessing the Leaders of Native. This workshop was the key to gaining access to the targeted Nazaras with the full assistance and collaboration of the Native Administrations without which access to the communities would have been impossible. Despite all the challenges it face and despite the perception of Alidaraa Alahliya as one of the main perpetrators of FGM/C practice as a strong cultural practice, it is very helpful and strongly willing to contribute and participate in the process of FGM/C eradication.

**Action Recommendations**

- The division in the religious discourse that fluctuates between considering FGM/C as a part of Islamic teaching and as a practice that is against the Islamic doctrines perpetuates the existence of supporters of the practice. One religious discourse that confirm that the practice is not a religious principle will eventually effects the government decision and contribution in combating FGM/C
- —Media is another important recommendation since it will help not only in widening the range of awareness raising and knowledge but also in conveying and sharing the experience of the Native Administration in combating FGM and bringing about change .
- Monitoring and follow up are crucial activities that should go parallel to the ongoing efforts in these communities. Follow up should include the results the interventions achieved by the Faculty but more importantly now the communities are taking ownership of the process the follow up should continue in order for the sustainability of this work .

**Teenage/Twenties case studies from the Somali Diaspora UK: how far are new UK policy initiatives supporting 'what works' to address female genital**

**Presenter**

Dr. Hermoine Lovel, Public Health Consultant, UK

Zeinab Mohamed, Researcher, UK

**Key Points Raised**

The session started with a historical background to the self-selected youth case study and divided the youth. The first group was cut youth, while the second group wasn’t cut. She explained the Aims for Youth exploring :

The study hoped to reveal the impact of FGM on:

- Our Lives
- Our Thoughts
- Our Feelings

Also she mentioned the method used to collect data: Case study group and its discussions

**Explained the Somalia prevalence FGM/C % girls/women age 15-49 UNICEF (2013).**

- The results showed those with FGM worry about sex and possible pain
• Worry about childbirth difficulties
• Weighed down by concerns won’t know answers till marriage
• Stress brings anger and blame of mothers, why did they not have the courage to go
against the norm? In UK the community would never know.
• The results showed without FGM ‘scared to tell even one friend
• Scared if did they would tell others
• Scared to be judged
• Scared ruin chances for marriage
• ‘worry the only way able to marry a Somali boy is if I trick him’

Added the lesson was learnt Conceptual model of factors perpetuating and hindering FGM/C
overlaid What Works.

Action Recommendations

• There is a need for technical and financial support.
• Mass media advocacy
• Multi-Sectoral Govt/Cty/NGO support for law

Child Marriage as a Policy Issue

Chairperson

Dr. Sami Mahmoud, Sudanese Obstetrician and Gynecologist Society, Sudan

Child marriage and policy for marriage to start at 18 is strongly urged-Sudan 2015

Presenter

Dr. Mohamed Baldo, AUW, Sudan

Key points raised

• Dr. Baldo emphasized on the danger imposed by Child Marriage and the
importance of allowing young girls completing their education.
• Health personnel should counsel young brides and consider offering
contraception.
• Other consequences mentioned include sexual violence; marital rape and
domestic violence.
• Achieving MDGs 3,4,5 is emphasized; Gs 1,2 are root causes of CM
• HIV G6 is a risk, girls & women being victims (feminization)
• Adolescents (10-24) problems are highlighted.
• Achieving MDGs postponed to 2030 (UN Summit on sustainable
Development 25-27 Sept. 2015)
• WHO statistics for Sudan 2014 reflect increased GR, poor health, cost
burden. FP prevalence has declined high unmet need. Commercial
contraceptives are costly. Breast feeding and natural methods are the main
spacing methods.
Youth are increasing, an affective power of change. Despite increasing university graduates, majority are jobless, specially girls & women. RH to be highly ranked in the political and health agenda.

**Action Recommendations**
- Sexual health is to be integrated component of RH
- Cost effective approaches
- Free primary education for girls and equal job chances
- Creativity in implementation of Saleema strategy
- More research
- Increase awareness

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**The impact of early childbearing on maternal health in Sudan**

**Presenter**

**Dr. Awatif Al.Awad, Al Neelain University, Sudan**

**Key points Raised**

The paper took a look at the community related issues with special consideration at grass root problems. Dr. Awatif discussed the conflict regarding age of marriage in Sudan, she used Blue Nile as an example as an area with a diverse community and a high maternal mortality rate. She focused on religious leaders and a current obstacle as there is still dispute regarding the age of marriage for girls. However, she acknowledged the efforts undertaken by national and international institutes to overcome this issue i.e. MoG&E RH awareness programs targeting Emams. Another issue she discussed was lack of awareness regarding contraceptives use in the states.

**Action Recommendations**
- Tackling child marriage and all factors leading to it as well as its consequences is of huge priority.
- Special awareness programs should be tailored to fit rural communities.
- Efforts should be made to promote girls’ education.

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**Exploring stakeholders and activists perspective on effective interventions for combating child marriage maternal health in Sudan**

**Presenter**

**Dr. Tibyan El.Hussein, AUW, Sudan**

**Key points raised**

The presentation started by a display for the prevalence of GCM in Sudan, this may be due to poverty or lack of education, or in conflict areas early marriage is sought as a solution to meet
the need for protection. She gave a brief overview on the interventions that have been implemented and whether or not they were effective. The study showed that more than 75% of NGOs have projects related to combatting GCM. However, among academic institutes Ahfad University for Women was the only university with projects targeting GCM. Dr. Tibyan identifies mass media as an effectiveness approach for change.

**Action Recommendations**

- Lobbying for the setting of an appropriate age for marriage.
- Involving all sectors of the community to protect children, especially girls.
- Documentation and sharing of experiences.
- Use of multiple and comprehensive approaches.

**Chairperson:**

Dr. Tamadur Khalid, UNICEF-Sudan

**Key points raised:**

- Promotion of girl child education
- Integration of sexual health in RH
- Studies on maternal risk factors
- Integration awareness raising within the existing channel e.g. health services
- Recommendation #1 is very general, in a country promoting privatization how are we going to do it?
- Advocacy to define an age of marriage a 18 years old
- Coordination between organizations working in child marriage

**Action Recommendations**

Recommendations mentioned by the participants included:

1. Strategy emphasis and endorsement.
2. Political will and commitment to be endorsed.
3. Planning of measures to end medicalization of FGM/C and conduction of studies to understand the role of the health sector in the performance of FGM/C.
4. Linking research and policies to the different places with different cultures and contexts.
5. Improving quality and access to health services through; promoting of partnerships and collaboration between private and public services, development of national policies which are to be followed by different health care providers.
6. FGM/C must be added to all medical and midwifery curricula.
7. Linking FGM/C with gender equality and women empowerment particularly in relation to MDG 3,5.
8. Criminalization of all forms of FGM/C and changing the use of the term “Sunna” to cutting.
9. Efforts should target rural areas without losing touch with the work that has been done
in urban communities.
10. Homeless children and labor girls should be included as target groups within the activities and campaigns.
11. Capacity development of community leaders and members in order to enhance community participation.
12. Investigate the reasons behind the continuity of child marriage in the different contexts of Sudan.
13. Use of media channels as a main campaigning tool against FGM/C and GCM.
Key Note Speaker

Mr. Mohamed Lemine Ould Moujtaba; UNFPA Deputy Representative in Sudan, is a national from Mauritania, a Demographer, with large experience in program management and technical assistance in population issues, monitoring and evaluation and gender. He started with UNFPA Mauritania in 2003 as Population and Development Officer and Assistant Representative, before joining Chad Country Office in 2011 as Deputy Representative. He also worked for the National Office of Statistics in Mauritania, as head of social statistics service and with ministry of planning as a research associate.

Panel Session Speaker

Sheikh El.Fatih Mukhtar, Ministry of Guidance and Endowments, Sudan

Dr. Amira Azhari; PhD. in Education Management and the Director of Social Norms Section, and Coordinator of the FGM/C Program at the National Council for Child Welfare Sudan. She has participated in several national & regional fora on the issues pertaining to Social Norms and their impact on Children, including FGM/C and Child Marriage.


Mrs Sandra Adisa, Inter-African Committee, Ethiopia

Dr. Zinia Afri, Inter-African Committee, Ethiopia

Parallel Session Speakers

Dr. Vanja Berggren, Associate professor in Public Health at Lund University, Lund, Sweden. Vanja coordinated (2013-2015) the research in a mission by the Swedish government to elucidate Female Genital Mutilation of girls and women after immigration in Sweden. She did her post doctoral studies in Riyadh, Saudi Arabia and Damascus, Syria in Sexual and Reproductive Health & Rights and in Environmental Health. She

Dr. Hagir Osman Eljack

An assistant professor of Statistics & Demography at the University of AL.Neelan. She received her B.Sc. from Khartoum University, M.Phil in Demography from Cairo Demographic Centre and Ph.D in statistics (demography).

Participated in national & international conferences, and updating national population policy and monitoring process of latest Sudan population census, 2008. Have many publications on demographic issues.

Dr. Getaneh Mehari, Earned his Bachelor of Education Degree (B.E.D) in history in 1998 from Kotebe University College, Addis Ababa, Ethiopia. In 2004, he received his Master of Arts Degree in Social Anthropology from Addis Ababa University, Ethiopia. In 2014, he successfully completed his PhD studies in Social Work and Social Development from the School o Social Work at Addis Ababa University. Getaneh has been working as a graduate assistant at Unity University, the first private University in Ethiopia (2000-2004); as a lecturer (2004-2014), and as an assistant professor (as of 2014) in the Department of Social Anthropology, Addis Ababa University. He has several publications and currently, is a chairman of the Department of Social Anthropology, Addis Ababa University.

Dr. Samira Amin Ahmed Elamin

MSc and PhD in social Anthropology and Sociology, More than 30 years of work in country and outside in Academia Research and Development sector. 15 years with UNICEF Sudan Gained vast experience from work with government, International and National NGOs, UN agencies and civic society. Focus on gender, Child Protection and Social Norms. Chairperson to a national NGO (ROCCS). Currently Consultant with UNICEF Sudan.
runs collaborative projects in Jordan (breast cancer) and in Uganda (HIV-HPV-CC). Vanja conducted her PhD thesis about FGM in Sudan and in Sweden, as collaboration between Karolinska Institute Stockholm, Sweden and Khartoum University and Ahfad University for Women Khartoum/Omdurman, Sudan.

Dr. Abdaalelah Kuna, Sudanese Obstetrician and Gynecologist Society, Sudan

Dr Mazar Osman Abu El Gasim; Graduated from School of Medicine Cairo University 1984 and has MD in Obstetrics and Gynaecology Khartoum University 1991, Diploma in family planning 1994. Obtained her MRCOG (UK) in 1998 and the COG in 2010.

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Parallel Session speakers

Faiza Hussein Abd Alla Osman; An assistant professor in in Zoology, Centre for Science and Technology, Ahfad University for Women and hold a Higher Diploma in Human Rights. Faculty of Law, University of Khartoum. Former Dean School of health Sciences, Ahfad University for Women, and currently is the President of Babiker Badri Scientific Association for women Studies (BBSAWS) and President of Sudanese Women Empowerment for Peace and Development (A network of 50 civil society organizations).

Dr. Nafisa M. Bedri; Associate Professor of Women and Community Health and Director of International & External Relations Office, Ahfad University for Women. Research focus at national and international levels in the fields of gender and women’s health with WHO, UNFPA, UNICEF, UNAIDS and others. An activist in the area of women’s reproductive and sexual rights, maternal health, violence against women, female genital mutilation and HIV/AIDS. Extensive experience in managing programs and chairing of academic committees.

Dr. Nizar Ghanem; A medical academic specializing in Occupational Health and Wellbeing including specialist research interests in ‘Women’s work’. He is also a Musicologist and an eminent performer.

Chair persons

Dr. Vanja Berggren, Lund University, Sweden

Professor Janice Boddy, University of Toronto, Canada

Dr. Sidiga Washi, Ahfad University for Women, Sudan

Dr. Ellen Gruenbaum, Purdue University, USA

Dr. Samira Amin, National expert, Sudan

His experience includes using music, drama and other arts in community settings to open constructive discussion on taboo subjects including FGM. He has inspired many young people to participate in the Third sector in Yemen and innovatively developed and put into practice in Yemen a model of gender equity in governance of NGOs and (Government organizations).

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Chairperson
Dr. Samira Amin, National Consultant, Sudan

Presenter
Dr. Mohamed Lamine, UNFPA – Sudan Office

Key Points Raised

- Demographic characteristics of countries affected by FGM/C is very important because these countries have been observed to have high fertility levels and increased level of the young population.
- When considering a country’s demography urban vs rural, migration of the population and ethnicity must be studied as FGM/C levels are greatly affected by them.
- The common perspective that FGM/C is an issue related to women only and doesn’t require discussion with men needs to be addressed.
- A legally conducive environment is necessary to act at a community level. This provides an opportunity for engaging the international community not for just funding but for international commitment.
- Focus should be on the community, not the individual.
- Human rights should be used as a framework when engaging in a commitment. No practice should be justified by culture but using the human rights framework to make sure that the approach is appropriate.
- Approaches must be holistic in supporting interventions at different levels. The notion of community should be considered when applying the social convention theory.
- The definition of community must be reconsidered with regard to evolution of the society.
- Ethnicity is related to community e.g Mauritians who migrated to Western countries still maintain and practice FGM/C.
- FGM?C should be viewed as a social convention/norm change rather than an individual one.
- The individual perception of human rights must be increased. People now are able to publicly claim their rights. Options must be provided for individuals to speak out. Individuals have more power than ever to bring about change.
- National and decentralized system and services: Communities have their own priorities. There is a need to link programs for abandoning FGM/C to other programs that address community priorities in order to build trust between those who are advocating and the community.
- Social support must be addressed.
- Empowerment of girls. Adolescents and women is very important because girls should be a part of decision making regarding FGM/C. Social norm approach dealing with peers who have the capacity for decision making.
- When addressing social norm change at the community level, public dialogue is necessary but insufficient. In public pledge/declaration, homogeneity of communities is
very important as it is very difficult in heterogeneous communities.

- One of the key elements towards abandonment of FGM/C is not to be coercive and judgmental. Do not challenge people and be positive.

**Action Recommendations**

- Community based approaches towards abandoning FGM must be human rights based and culturally sensitive.
- There should be legal and policy reform allowing for a legally conducive environment making it feasible for people to act at the community level.
- Approaches should be multicourse integrating FGM/C into other programs which are related.
- Special attention should be paid to empowerment of girls so they can be involved in decision-making
- Definitions of community must be reconsidered with regards to the evolution of the society.

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**Chairperson:** Dr. Ellen Gruenbaum

**Almawada wa Alrahma as an umbrella concept for driving social change**

**Presenter**

Sheikh El.Fatih Mukhtar, Ministry of Guidance and Endowments, Sudan

**Key Points Raised**

- Mawadda and Rahma is a moral and compassionate campaign that encompasses the values of all the different types of religions.
- It aims to purify and promote the community to become a peaceful and loving one. It also helps to promote women and children rights and install them in the community.
- It also sponsors high values and promotes good behavior to lead a life that is free of discrimination and violence.
- This is made sure to happen by enforcement of international treaties that reinforce peace and good behavior and fights violence and discrimination.
- By enforcing Mawadda and Rahma we are forcing all the literature to avert from violence and make it compatible with human rights laws generally.
- Many of the ideas from these agreements are respected and esteemed by us.
- The international legal system has made sure that women have equality and has released many agreements, treaties, protocols and advertisements.
The Girl Generation as a regional and international communication initiative in enhancing social change

Presenter

Key Points Raised

- The speaker started talking about the historical background of the Girl Generation (TGG), which is apart of the broader DFID End FGM/C programme that started work in 2014.
- She explained the TGG vision, goal & the expected outcome of the TGG: Accelerated & sustained social change in our focal countries.
- Between 2015-2020 they hope to deliver four outputs & they focus their working in 10 African countries.
- She explained the programme implementation strategy, that have begun in four countries (Nigeria, the Gambia, Sudan & Kenya).
- Their approach to social change communication:
  - Support & accelerates wider behavior-change efforts.
  - Amplify positive stories of change.
  - Increase the public space for dialogue on the issue.
  - Explained also that they are building a critical mass for change, support grass root organizations to strengthen their social change communications to end FGM/C.

Role of virtual regional networks in enhancing social campaigns: INTACT Network

Presenter
Dr. Ian Askew, Population Council, Kenya

Key Points Raised

- A community of practice is not merely a club of friends or a network of connections between people. It has an identity defined by a shared domain of interest. Membership therefore implies a commitment to the domain, and therefore a shared competence.

Elements of CoPs:

- Using rapid low cost communication tools to close the Knowledge-to-Practice Gap
- Initiating Impactful Discussion Forums
- Channeling the information exchanges towards something more concrete (e.g. information products, informed policies and programs)
- The International Network to Analyze, Communicate and Transform the Campaign against FGM/C (INTACT) was born in 2002 in Bellagio, Italy at a meeting that was organized by the Population Council to review the status of FGM/C research, identify important gaps and propose research priorities.
- INTACT’s overall objective is to promote quality research on FGM/C and the utilization of research findings to support the full abandonment of FGM/C.
- The network currently includes more than 2000 researchers, scholars, and activists from around the world who are committed to bringing scientific evidence to bear on the campaign to end FGM/C.
- INTACT communication tools
• Bi-weekly e-newsletters
• Webinars
• Discussion forums
• Facebook page
• Website
• INTACT E-Newsletter
  • A compilation of the latest news on FGM/C from Arabic, English and French-speaking news websites.
  • Recipients of the newsletters include interested individuals, researchers, university professors and consultants who belong to more than 150 organizations

**Webinars:**
• Prominent researchers and practitioners from various backgrounds are invited to an online platform (e.g. Google Hangout) to present their views on an FGM/C-related topic
• Webinars are carried out in Arabic, English and French

**Discussion Forums:**
• Hosted on INTACT’s website, the forums are an opportunity to share experiences, challenges, and lessons learned, with colleagues who are experienced in the field of FGM/C.
• Discussion forums go on for 3-5 days and are held in English and French
• Examples topics in the discussion forums: “Medicalization of FGM/C: A curse or a blessing?” and “Role of various media in communicating messages against FGM/C.”

**INTACT Facebook Page:**
• An awareness-raising medium to build a strong active community of followers online who can be potential change agents.
• INTACT facebook page has 330 followers.
• Creative awareness raising social media material is produced to gauge interest of Facebook users

**INTACT Website:**
• With English, Arabic and French interfaces, the website provides up-to-date documents and information on FGM/C.
• Website has approximately 500 English, 200 French and 350 Arabic documents.
• Along with extensive literature on FGM/C practicing countries and diaspora communities, the website also includes artwork/photos, press releases, up-coming events and training material all related to FGM/C.

**INTACT management and funding:**
• Hosted by the Population Council / Egypt
• Over the last 14 years received funding from:
  • UNFPA/UNICEF Joint Programme
  • UNICEF and UNFPA/ Egypt
  • Diakonia/ Egypt
  • Wallace Foundation

**Challenges:**
• Web-conferences did not receive enough participation despite early and repeated reminders
• Our Facebook visibility and number of followers are limited
• Interrupted funding
• Finding a trilingual local organization to host INTACT
• Organizations to strengthen their social change communications to end FGM
Key Points Raised

- The IAC is a regional NGO created in 1984 in Senegal Dakar, with 29 member states in Africa and 19 affiliates in the Diaspora.
- The mission of the IAC is to promote gender equality and contribute to improvement of the health status of women and children through the elimination of harmful traditional practices and the promotion of beneficial ones.
- IAC enjoys consultative status with the African Union, the United Nations Economics and Social Council (ECOSOC) and official status with the World Health Organization. It enjoys extensive cooperation with several United Nation agencies.
- IAC is also a member of NGO network of international non-governmental organization and of the International Organization of Francophone.
- The Inter-African Committee on traditional practices affecting the health of women and children (IAC) was formed at a time when female genital mutilation was highly controversial and a ‘sensitive’ issue for discussion. There was a critical need for an African Voice at regional and international campaign against FGM, which led to the establishment of the Inter-African Committee.
- In addition, to show case how communication, campaign and networking as important tools in combating FGM and how the IAC has effectively done these using its different communication methods and strategic approaches in combating FGM in the last 31 years.
- Social norms are the rules of behavior that are considered acceptable in a group or community. People who do not follow these norms may be shunned or suffer some kind of consequence.
- Families, communities and cultures in which FGM is performed have different reasons for doing so. A major motivation is that the practice is believed to ensure the girl conforms to key social norms, such as those related to sexual restraint, femininity, respectability and maturity.

According to WHO 2012, the most common risk factors for either undergoing FGM or forcing a girl to undergo the procedure are cultural, religious and social. These influences include:

- Social pressure to conform with peers;
- The perception of FGM as necessary to raise a girl properly and prepare her for adulthood and marriage;

Action Recommendations

- Better visibility for facebook page
- Find a trilingual local organization to host INTACT.
- Sustainable funding
- Get better participation in webinars

Role of the Inter-African Committee in bridging social marketing campaigns
The assumption that FGM reduces women’s sexual desire, and thereby preserves premarital virginity and prevents promiscuity;

The association of FGM with ideas of cleanliness (hygienic, aesthetic and moral), including the belief that, left uncut, the clitoris would grow excessively;

The belief that FGM is supported or mandated by religion, or that it facilitates living up to religious expectations of sexual constraint;

The notion that FGM is an important cultural tradition that should not be questioned or stopped, especially not by people from outside the community.

Methods:

- Operational Research: To measure the impact of the policies, programs and activities of fight for the elimination of the HTPs, To identify the factors of persistence of the practices, To identify and implement the best approaches
- Production of information, education materials: Documentary films, Mannequins (anatomical model), Posters, Books and training manuals, Slides.
- Sensitization and advocacy: Sensitizing of the rural Communities, Advocacy towards the decision makers, Sensitizing of the professionals (health, education...), Mobilization of traditional and modern communicators, Training of peer educator, Sensitizing and Training of Exercise.
- Special Programs for religious and traditional leaders.
- Special programs for the YOUTH:
  - To sensitize and train the youth in school and out of the school
  - To imply the youth in the campaigns of awareness through sport, creation of networks.
- Special programs for media personnel: To sensitize them and to imply modern and traditional communicators in the awareness campaigns. (using the TV, Radio, poem, music, theater, documentary etc.)
- Special programs for Health Professional: To sensitize and train health professionals on the consequence of FGM, to stop medicalization of FGM, to teach how to treat FGM, to imply them in the campaigns against FGM.
- Opportunities of substitution of employment for exercise. (OES) : To become change agent of the community.
- Legislation programs

Strategic approaches:

- The international conference on Zero Tolerance on FGM which was organized by the IAC in 2003 in Addis Ababa brought together all the actors involved in the campaign and came up with a common agenda based on 5 strategic main areas.
  - Advocacy and Sensitization
    - Adoption and enforcement of legislation against FGM.
    - Empowerment of former excisers financially or life skilled training through micro credits system. And become change agent in the community.
    - Care for Victims of FGM.
    - Capacity Building for the institution involved in the campaign against FGM, like operational research, Monitoring Evaluation and Learning.

In addition, the IAC have the Collaboration Strategy on Traditional Practices between the AUC, The African Committee of Experts on the Rights and Welfare of the Child, The Economic Commission for Africa (UNECA), the United Nations Children’s Fund (UNICEF) and the United
Nations Population Fund (UNFPA).

**Action Recommendations**

More:

- Consultation on FGM,
- Information sharing,
- Base line studies or survey should be carried out at intervention areas and there should be a proper ME&L frame work.
- M&E internally and externally.

**Chairperson:** Dr. Sidiga Washi, Ahfad University for Women, Sudan

**Trying to break silence: the Swedish’ experience of promoting the girls’ perspective**

**Presenter:** Dr. Vanja Berggren, Lund University, Sweden

**Key points raised**

- Experience of Swedish reflects the experience of migrants originally from Africa and Asia who are still practicing FGM, Somalia is among the most high population in Swedish practicing FGM/C.
- The study is a situational analysis in its type that aims to provide guidelines for professionals to address such issue. Also is to learning from diaspora and sharing knowledge collaboratively among international arena. Common concern on who to work on combating FGM/C.
- Method of research: Interview and focus group discussion with professional and people concern as youth, mother, leaders, teachers and health care personnel. The size sample is 400 professional in Somalia and Kurdish part of Iraq. 110 seminars all over Sweden.
- What guide the Swedish experience is the common compassion of those who live in the region and suffer from the practice.
- Results: girls and youth in Sweden are suffering from FGM negative health consequences but even do not daring to raise the issue neither to their parent
nor to health professional., professionals concern about FGM and raise their suffering., immigrants undergone FGM during their holidays.

- Challenges: lack of knowledge about this issue and among professional., Taboo is still there in Sweden, How to reach sustainability to combat FGM/C after immigration, professional warred to ask about the issue to seen as racists., How to measure the changes and how to continue support those still trying to change.

**Action recommendations**

- Follow up documentation post mission.
- Professional need to act more professional.
- Political well and economical resources both at central and local level in Sweden to sustain our resolution keep the promise.
- International collaboration to exchange experiences, perspective and keep active.

**Attitudes towards female genital mutilation/cutting in Sudan**

**Presenter**
Dr. Hagir El.Jack, Al Neelain University, Sudan

**Key Points Raised**

- Sudan rank number 5th among the countries practicing FGM, Social pressure is strong motivation for continuation of FGM specially among older women.
- Aims:  a. exploring attitude of men and women toward FGM. B. to examine demographic and socio-economic differentials in FGM.
- Methods: using data of the Sudan Health Household Survey (SHHS, 2010), Sample size women 12264 and men 5296.
- Results: 53% intended to continue practicing FGM, 63%of men's attitude intended to discontinue the practice of FGM, the third result shows the socio-economic characteristics of women who intended to circuncise their daughters, others results shows the statistical ratio of women attitude towards FGM considering different socio-economic characteristics.
- Conclusion: 1. the prevalence of FGM still high in Sudan 87% in 2010. Women between the age (0-50)yrs 65.5% were circumcised, The study proof that there were a relationship between the practice of FGM and socio-economic conditions especially in rural areas and both among women and young men.

**Action Recommendations**

1. Intensive awareness raising campaigns against FGM among rural communities, illiterates and poor people.
2. Enforcement of law of FGM.
3. More researches to study factors behind the high prevalence of FGM.
Key Points Raised

- The problem is that Human Rights Discourse lacks balance. It emphasizes anti-women’s aspect of African cultures and it undermines the contested nature of FGM-related discourses and practices within and across cultures.
- Furthermore, it gives less attention to FGM free cultures: protect women from FGM and cherish the bodily integrity of women.
- The Study Site is Gamo – High land South West Ethiopia
- The Gamo claims unique identity however FGM related taboo has contrary meaning.
- Communities researched were Dorze and FGM free community and Dita and other FGM practicing Communities.

Findings:

- FGM is surrounded by Taboos. Gambo Culture contains complex taboo system
- Gamo embodied indigenous religion include taboo regulating HH and HN relationships categorized of gome (major typology): Layma gome, Tuna Gome and Lanchie gome.
- Gome involve some type of violation, pollution and misfortune. Violating Taboo Gome: is adultery, practicing Sex in farm plots, practicing FGM. Polluting humans) individuals, families and communities). Polluting nature (land, plants, and livestock). Misfortunes: Illness, death, diminishing fertility (e.g. land, livestock and people)
- There is what is called Qexeria gome (QG). It is a set of taboos related to genital cutting. it has different meanings and implications across communities. For example in FGM free communities (Dorze), practicing FGM is a taboo, sex with cut women is a taboo, marriage to cut women is a taboo. While in FGM practicing communities (Dita ) exempting girls/women from circumcision is a taboo, sex with uncut women is a taboo, marriage with uncut women is a taboo.
- The genesis of FGM; FGM had never been practices. It has been a taboo since the ancient time
- FGM was practiced but banned at one time in the past
- The story of Qayishe revolted against FGM
- FGM diverse beliefs and practices: In Dorze, cut women are MUDA(mutilated, amputated, incomplete) , TUNA: Impure, A cut woman is a man (a man marriage to man), FGM brings pollution and misfortune , FGM violates Xoosa – given bodily integrity.
The belief and practice related to FGM in Dita, Uncut woman is seen as a woman with uncut clitoris, uncut penis, Tuna (impure) Gemo (Backward), Uncut woman is a man (a man marriage to man).

Implication of QG in camo setting differs from community to community. IN FGM Free Dereta: protecting women from FGM as protection of Women’s rights and physical integrity. While in across boundaries: Discrimination against uncut woman (Dorze), cut women In (Dita) in addition to restrictions of marriage and mobility.

**Lessons learned:**
- FGM is a polluting practice in Free FGM communities
- FGM is purifying practice in Communities practicing FGM

**FGM at local, national and global level:**
- FGM in the global level is denounced as violation of women’s physical integrity.
- FGM in the state level is denounced as crime. The FGM act is criminalized.
- In Gamo, FGM is contested as a taboo practice and on the other hence as purification practice.
- In Dorze FGM is denounced as taboo practice and violation of God given bodily integrity.

**Action Recommendations**

a. Further research on FGM free cultures to learn from African cultures that cherish the “physical integrity” of human beings
b. African notion of “physical integrity” could be used as an entry point to foster anti-FGM campaigns in African societies practicing FGM.

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**The effect of female genital mutilation on sexual satisfaction among Sudanese married women in Khartoum State**

**Presenter**
Dr. Abdaleelah Kuna, Sudanese Obstetrician and Gynecologist Society, Sudan

**Key Points Raised**

- Sudan is among the 26 countries from the 34 African counties who are practicing FGM.
- Practice of FGM in Sudan is more prevalence in rural areas with a rate of 89%. There is a slowly declining in rate due to education and residence.
- Objectives of the study are to assess the effect of FGM on sexual satisfaction among Sudanese married women in Khartoum. And correlate the type of FGM with sexual satisfaction.
- The method of research is descriptive and cross-sectional. The findings of results examine the distribution of women by stages not satisfies at sexual act, the distribution of married women in Khartoum state by dyspareunia and type of FGM, and distribution of women by time of feeling pain during sexual act.
- FGM is a cultural tradition practices in 27 African countries, as well as part of Middle East and Asia it is performed shortly after birth.
- The research study married women only in Sudan because our culture for discussing sex issue is very sensitive.
Action Recommendations

- Promoting Information sharing, education, specific laws,
- Adequate vocational training of doctors and nurse who cure these women and of the community leaders who prevent these practices.

Obstetric fistula in Sudanese women: social and cultural factors

Presenter
Dr. Mazar Osman Abu Algasim, Sudanese Obstetrician and Gynecologist
Society, Sudan

Key Points Raised

- The study was conducted at the largest fistula center in Sudan (Abbo Fistula Center)
- Perspective, hospital based, non-randomized study (May 2006-2007)
- 164 patients awaiting surgery
- Consent was taken from the respondents. Verbal consent was taken from illiterate
- Standard questionnaire was used looking into the social, cultural, economic and personal history of each patient.
- 40 variables including the background of the respondents, age at interview, age at marriage, use of health services, barriers to medical care, mobility, daily activities as well as marital and social relations were considered,
- Clinical data of the index pregnancy were included in this study.
- Exclusion criteria: fistula of non-obstetric

Results:

- 40.4 were married before 18 years old
- The average age at interview 26 years old.
- 84% of women were of rural origin rural versus urban, taking note that 72% of the Sudan population live in rural areas
- 66.46 were divorced and or separated, 3.65 were widowed, and 29.87% were married.
- Relation with husband, 4.87% has no relation with husband
- 82.3% were illiterate
- 77.47% of the respondents were living in extended family, 6% were living alone
- 75.6 Percent were housewives, 2.43% were employed in the informal sectors as tea and food sellers.
- 53.65% of the respondents admits that their husband marries to another women. Polygamy is experienced.
- 54.41% experience parity from their husbands
- 53.65% indicated that their visit to ANC is none. Because of lack of antenatal care, lack of resources, and distance of health facility
- Outcome of pregnancy is still birth, alive, disabled with minor incidences.
Rating of health is good as 61.5 percent believe that they are in good health. they say Al hamdulilah – Thank God for the good health-

Perceived causes of fistula is difficult labor (78%), circumcision and C/S only 29.42% do not know the cause of fistula

Barriers to medical care mentioned were distance, expensive, ware, poor quality, doctors delay, expensive distance, low socio-economic status

Ability to participate in social activities was affected in 92%

Daily activities affected in 87%

Child care affected in 63%

Usual income earning affected in 51%

59.14 of the Respondents mentioned that they know women with the same conditions prior to admission

100% of women in this study never used any of contraception

The main social and cultural determinants of developing an obstetric fistula in this study were:

- Early marriage, adolescents pregnancies and primiparity
- Rural living, poor education, malnutrition and poverty
- Lack of access to EMOC with resultant poor obstetric outcome, and economic viability.

**Action Recommendations**

- Officer education and schooling for women to raise their economic and social status, thus aiding in the reduction of obstetric fistula
- Fistula center in Sudan should provide literacy training in their premises for those who had successful surgery, to lay grounds for them to find new descent lives
- The MOH should continue to decentralize and improve rural hospitals by encouraging trained doctors to work with remote areas, by improving their living and working conditions.
**Key Points Raised**

Dr. Tamador started by historical background that child marriage practices entrenched in the value of Shame, honor & Sutra. She introduced Article (15) of the draft interim national constitution states. Explained the Aim, which is child marriage is asocial norm that perpetuates violence against women & is a result of the following:

- Gender inequality.
- Abuse of power.
- Lack of respect for human rights.
- Locally perceived attitudes about appropriate for human Rights.

In her presentation explained the result that trends in child marriage in south Darfur (2006, 2010, and 2014). She mentioned the Reasons given for child marriage by the KAP Study that conducted in 2013 / 2014, reveals that responses given as reasons for child marriage are:

- The desire to preserve the girls’ reputation and virginity 72%.
- Financial 5%.
- Religious 2%.
- Others 2%.

The lessons learnt:

- Ending child marriage does require political commitment ,
- Resilient & visionary leadership with technical support NGOs & CSOs
- Native administration community & Religious leaders
- Social groups particular used are catalytic to social norm change.

**Action Recommendations**

- Rapid gender analysis and protection assessment must be completed prior to programmatic interventions.
- Intervention should take precedence over research into child marriage & GBV prevention in emergencies.
- Engagement of NGOs & CSOs in child marriage prevention programmed in emergencies.
• Plan to implement prevention & mitigation programming from the start of an emergency.
• Engage the social media.

Knowledge of village midwives about female genital mutilation/cutting in Darfur states and decision making process within their families

Presenter

Dr. Faiza Hussein, Babiker Badri Scientific Association for Women Studies, Sudan

Key Points Raised

The speaker started the presentation by general definition of FGM/C—along standing ritual in Darfur. She explained that according to the UNFPA/UNICEF (2013) the prevalence was 91% in northern Darfur, 95% in southern Darfur, and 68% in western Darfur. She introduced to the audience the aims & specific objectives and the methods was used (quantitative & qualitative design, using semi-structured questionnaire) in this study.

• The results were explained in charts, diagrams and in percentages.
• The study concluded that the prevalence of FGM /c is high, & the Awareness-raising packages & Advocacy are generally appropriate and important ways to impart knowledge, but are not sufficient to eliminate FGM/C.
• All the discussion was focused on the issue of education being inadequate, we need more curriculums on child health and decision making especially in rural areas.

Action Recommendations

• Improving support to midwives by government.
• Laws must be enacted to address FGM/C and penalize all forms of FGM.
• Merging of community efforts with national efforts to bring a sustained end to the practice of FGM.
• More focus in increasing knowledge, attitude among circumcisers (namely midwives through pre and in-service training and advocacy role of other health care providers as advocates is needed.
• Civil society Organization, CBOs and midwifery associations capacities need to be strengthened and take lead roles in working with community.
• Study of effects of all types of discrimination women face on decisions to schooling vs circumcision is needed.
Decision-making processes in girl child marriage within families of different backgrounds, experiences, and positions in Khartoum State

Presenter
Dr. Nafisa Bedri, Ahfad University for Women, Sudan

Key Points Raised
Dr. Nafisa introduced that FGM provides social status to a group of people who have no other options in their communities. Her study aims to understanding the mother's decision making regarding FGM. It used four stages of the trans-theoretical model of behavioral change (five stages:

- pre-contemplation stage.
- contemplation stage.
- Contemplation stage.
- Action Stage.

She identified the methods was used (A descriptive, exploratory study using mainly qualitative tools & few quantitative components & the groups, there are:

- Mother who decided & practiced FGM in their daughters.
- Mothers with the decision to practice but didn't.
- Mothers who practiced despite the decision not to.
- Mothers who decided not to practice FGM didn't.
- Mothers who weren't sure of their decision to practice FGM & practiced it.
- Mothers who were not sure about their decision to practice FGM & didn't practice.

Action Recommendations

- Further study to explore the decision making process in depth among groups of males & female.
- More studies comparative studies to explore factors influencing the process among different socio-economic & geographical groups.
- Examine male perception of their role in decision making.
- Examine factors of affecting the change in decision making among particular individuals.
- Scaling up of community based interventions targeting all community specially men & young people.
A case study ‘The Arts Factor’ and FGM/Human Rights in Yemen

Presenter
Dr. Nizar Ghanem, Ahfad University for Women, Sudan

Key Points Raised
The speaker started by introduction & background & showed to the audience clinic & Art in same place. Dr. Nizar explained the AIMs & Methods that used that (How did the Arts Help People to start talking about taboo subjects, FGM human Rights & Others. He identified the Result were:

- Islamic Arts context important
- Arts beauty helps sadness.
- Drama is saving for difficult topics.
- Builds on long musical tradition
- Music speaks louder than words.
- Get men talking on difficult topics.
- Arts can help develop gender equity in governance.
- Salon talk led directly to improved data collection by ministry of health.

The paper also discussed to the intervention Arts to save & help gender equality in governance.

Action Recommendations

- Use music, drama and other arts in community settings for starting discussions.
- To open constructive discussion on taboo subjects; including FGM & child marriage.
- Inspire young people to participate the third sector.
Act Now Session

chairperson
Dr. Vanja Berggren, Lund University, Sweden

Key Points Raised

- Community based approaches addressing FGM abandonment must be human rights based and culturally sensitive.
- Consider political constraints when undergoing country assessment.
- There should be legal and policy reform to provide an environment which are conducive for people to act at a community level.
- Networking between different organizations which are working towards abandoning FGM/C at different levels is very important.
- Further research on FGM free culture to learn from African cultures that cherish physical integrity.
- Mainstream Saleema in education and health at national, state and community awareness programs.
- A rapid gender analysis and protection assessment must be completed prior to programmatic interventions.
- Interventions should take precedence over research into child marriage & GBV prevention in emergency settings.
- MOH should continue to decentralize, improve rural health care and encourage trained cadre to work in remote areas.
- Fistula centers should integrate literacy training in their rehabilitation work & premises.
- Addressing the link between marriageability and child marriage.
- Studies are needed on mobility and link to change in gender norms and roles.
- Understanding social protection as a reason for child marriage “contextualizing child marriage”.

Action Recommendations

- Conduct more researches on "ethnography" and "physical integrity" so that research results can better suit African culture with its diversity.
- Promote the conduction of qualitative research.
- Policy makers should consider when planning for decentralization the different contexts of Sudan.
- Provide specialized centers for fistula and other complications equipped with well-trained medical staff.
- Use art to initiate discussions in campaigns.
- The same message should be used in broadcasting media to avoid confusion.
- Health sectors should use easy language and simple words.
- More research to be carried on to investigate why prevalence of FGM is not decreasing.
- Develop and implement indicators to achieve SDG 5 but we need indicators in a timely manner.
- Civil society to alert the government about the importance of the indicators.
- Consider political constraints when undergoing assessment.
Dr. Ian Askew: Director of Reproductive Health Services and Research within the Population Council’s Reproductive Health Program. Dr. Askew coordinates the Council’s research and technical activities globally that support the generation, communication, and utilization of high quality evidence for strengthening reproductive and maternal health services and health systems. He has extensive experience in undertaking research and evaluation around FGM/C in several countries of sub-Saharan Africa and was a founding member of the INTACT Network. Dr. Askew is based in Nairobi, Kenya.

Panel Session Speakers

Prof. Taha Umbeli Ahmed; Professor of Obstetrics & Gynaecology, Faculty of Medicine, Omdurman Islamic University, Senior Consultant Obstetrician & Gynecologist, Omdurman Maternity Hospital; National maternal mortality adviser, FMOH; Convener of Council of Obstetrics and Gynecology, SMSB. Has many publications on women and reproductive health.

Dr Emad Mamoun Abdeen Mohamed; Director of Entishar Charity Society since 2009. Previous posts include Country representative of Tostan international Organization, Somalia 2008-9; Coordinator of UNICEF community Empowerment Program 2003-8. Studies include Qualitative phase of the Knowledge, Attitude and Practice (KAP Study) Survey on Poliomyelitis (as a national consultant) in collaboration with UNICEF and Center for Development Communication (CDC) USA. Implemented a baseline study in 12 communities in two States, Kassala and North Kordufan States. Implemented a pilot situation analysis survey in three villages in three States, Sennar, Khartoum and West Kordufan States.

Dr. Sheena Crawford; Director of CR2 Associates Ltd. Social Anthropologist with over 30 years social development experience in consultancy, research, management and training on rights, gender, poverty, governance, social and human development. Has designed, implemented, & evaluated models of social change, within communities and wider society, to address such issues as extreme vulnerability and exclusion, skills-development, Gender & Age-Based discrimination & violence, Harmful Traditional Practices, HIV, and ineffectual governance. She co-developed a framework for planning, monitoring and evaluation rights-based development, been used now in many different countries. Recently, Sheena has focused on work towards ending FGM/C and Child Early and Forced Marriage, and led a team in a global scoping exercise to enable development of the UK Government funded flagship programme Towards Ending FGM/C in Africa and Beyond. Since 2013, she has been Team Leader for the Independent Verification and Evaluation of the End Child Marriage Programme in Amhara, Ethiopia and, since the beginning of 2015, she has been leading a team for Independent Evaluation of the Sudan Free of FGC Programme.

Thursday 22.10.2015

Dr. Carolyne Njue
Has a PhD in public health from Erasmus University in The Netherlands. She is a senior technical advisor for the Population Council-led research consortium on female genital mutilation/cutting (FGM/C). From 2002 to 2005, Njue worked for the Population Council’s USAID-funded global Frontiers in Reproductive Health program in Kenya, providing technical assistance for implementation of rigorous ARH operations research, managing research in five communities and building partner organizations’ capacities for designing studies of FGM/C abandonment interventions. Her work contributed to the evidence base on SGBV and FGM/C, & as a consultant with many regional and international organizations, she has made numerous contributions to public health research and evaluation. Njue has been published in many peer-reviewed journals, and her professional interests include: M&E systems strengthening and research; improving data on girls and women’s voice and agency; and GBV to laws and norms that prevent girls and women from making decisions about their own lives and having influence in society.

Dr. Seham Amin, Federal Ministry of Health-Sudan
Dr. Wisal Mustafa, World Health Organization-Sudan
Parallel Session

**Speakers**

**Dr Malaz Magzoub Elmekki**
MBBS MPH
Currently Monitoring and Evaluation Officer, International cooperation officer and Focal person for UNFPA in the Academy of Health Science (AHS)/ Directorate General for Human Resources.

**Dr Ibtisam Satti Ibrahim**
Deputy Dean, Faculty of Economics & Social Studies, University of Khartoum; Head of the Executive Committee, OSSREA, Sudan Chapter; Member of Sudanese Environment Conservation Society; Sudanese Social Science Association. Areas of Research Interest: Poverty and development, Medical sociology, Migration, and Child & Gender Studies.

**Prof. Fatih El-Samani**

**Dr. Owolabi Bjälkander**
PhD from, and is an affiliate of, Karolinska Institutet in Stockholm, Sweden. PhD. Member of WHO’s FGM Guideline Development Group for the management of health complications from FGM/C. Currently working on Sierra Leone’s first national strategy for FGM/C abandonment. Previous work includes lecturing at the College of Medicine and Allied Health Sciences, University of Sierra Leone; WHO consultant in the Sudan. Her research has provided evidence on short term complications from FGM/C in Sierra Leone.

**Sara Mustafa El.Hadi**
A graduate of School of Health Sciences, Ahfad University for Women and holds a M.Sc. in Human Nutrition from Ahfad University for Women. She has worked in several positions within the reproductive health field since 2002 with major focus on female genital mutilation and gender based violence up to date. She has held the position of Community Development Research Specialist from 2006-2009. She is a member in some national networks and NGOs and has participated in many RH leadership and management programs. Sara is currently part of the team of the GRACE, AUW

**Chairpersons:**

**Dr. Randa Gindeel**
Assistant Professor of Sustainable Rural Development, Ahfad University for Women (AUW), Sudan. Executive board member of Babiker Badri Scientific Association for Women’s Studies. She is a researcher and consultant in the field of rural development, and some publications in the international journals in education and development and others related to VAW/G.

**Dr. Ibtisam Satti Ibrahim**
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Key Note Speech Description

Measuring change: From Research to Policy to Action

Presenter
Dr. Ian Askew, Population Council, Kenya

Key Points Raised

- Building the picture where? Why? When? FGM practiced and are changing.
- FGM is a rights and gender issue. What is the impact on gender relations?
- We don’t fully understand what change happens when implementing interventions
- There is a difference between work and making a change.
- Generational shifts: there is a difference between mothers, daughters and there is a change in attitudes and practices.
- It must be determined whether changes are happening individually in families or in communities.
- How does gender affect the continuation or abandonment of FGM/C? It is difficult to measure attitudes towards gender equality.
- Understanding the factors that influenced abandonment of FGM/C.
- How can we understand the change in countries where a great change has happened? It is important to learn from their methodology in measuring the effect caused by interventions
- Understanding shifts in the nature of practice: whether FGM/C is practiced at an older or younger age.
- Wider impacts of FGM/C and of abandonment interventions to stop the practice:
  - Adverse health impacts: obstetric, gynecological, sexual and mental health.
  - Potential associations between FGM/C and HIV, infertility and Fistula. There are no clear studies depicting the relationship between them; therefore more research and better understanding is needed in this area.
  - Association between FGM/C and women’s sexuality and psychological wellbeing is a challenging area for researchers.
  - Potential social tension associated with rapid social norms change: Early abandoners and late abandoners and how the society perceives them.
  - The FGM/C focus interventions have wider impaction on gender
relations, early marriage and violence. Measuring change in these factors.

- Measuring change in abandonment interventions. What is working? Where? And Why?
- Changing norms through social networks, community value deliberations and public declarations.
- De-linking FGM/C as a religious obligation and engaging religious leaders as change agents.
- Health system strengthening to engage health professionals as change agents.
- Change new perspectives and expectations of gender norms for uncut girls and women through multi-channel social marketing campaign e.g Saleema campaign in Sudan.

**Challenges to measuring change:**
- Not around asking questions or it is very difficult but it is the design of the study. Before and after studies are very common but not very effective. What would a better design look like?
- Determine the changes on the type and scale of changes.
- Change of the effect of the interventions on Knowledge, Attitudes, Norms, Tensions and Behaviours. Each one of them is different hence should be measured separately.

- Provide evidence that “makes the case” for or against the intervention:
  - Cost
  - Feasibility
  - Sustainability
  - Acceptability

- At what stage of decision-making regarding FGM/C is the community.
  - Has the change started ahead
  - Who is the intervention expected to influence
  - What effects and impacts are expected and can be measured with validity

**Other direct and unexplained influences**

- Social norm intervention: Design and evaluate an intervention in terms of the social norms it is intending to change. E.g in Kenya, different norms maintain the practice depending on ethnicity: Kisi( Cultural/Gender identification), Somali (Religious/ Cultural beliefs, Sexual control), Maasai (Gender, Self-identity, marriage). Despite these differences some organization was implementing the same intervention on all of them.
- At what stage is the community: Pre-contemplation, Contemplation, Preparation, Action and Maintenance? Communities can be at different stages in the change process and this will determine the type of intervention that must be chosen.
- Has the change already started and if it did was it before or after the
intervention e.g Tostan model in Senegal compared with Burkina Faso, the change was observed in some to be before the intervention and was not affected much by the intervention while in the others a great change was caused by the intervention. It is important to make the distinction of timing because it measures if the intervention has changed people’s views. How impactful is the intervention. Where? When?

- Who is the intervention expected to influence? Participants in activities, those influenced by activities, those indirectly influenced by the activities (why?)

- Are the measures valid?
  - Limitations of self-reporting on individual status and change in status. Are people telling the truth?
  - Difficult to measure age-specific changes in girls at a time.
  - Publicly stated intention indicates change in attitudes or in action
  - Denial can be common.
  - Attributable change: is it the intervention that is causing them to change or other things?
  - Measuring FGM/C status and type by genital observation and self-reporting: Self reporting is not yet used to assess the impact of an intervention. It was compared with observed cut and findings generally validated self-report except in urban Nigeria and rural Tanzania.
  - Valid measures of attitudes, intentions and behavior. Statements that they were circumcised then changed after a certain time e.g. Study done in Ghana in 1995 than in 2005 calculating the denial rate of FGM/C showed that a large number of respondents admitted being subjected to FGM/C then denied it in 2005. This change was attributed to that a new law was introduced to Ghana that banned FGM/C in 2000.

- Can other influences be measured?
  - Use an experimental or quasi-experimental design to make comparisons and prevent contamination:
    - Pre and post surveys
    - Control comparison groups
    - Randomization
    - Identify and document other FGM/C interventions.
    - Consider multi-component(“Complex”) interventions to prevent contamination by unplanned influences
    - Between intervention and comparison groups it must be confirmed that they are not interrelated e.g. Nomadic groups in Ethiopia, interrelated families in Senegal.
    - Strong nationwide interventions.
    - Previous interventions with anti FGM/C activities.

- Measuring unplanned effects:
  - Fully understand how the intervention may influence people’s lives
beyond FGM/C. A well designed theory of change is crucial.

- Require project staff to do current reports of all events as they occur.
- Include qualitative research during evaluation to ask how and why unplanned changes happened.
- Report unplanned changes as well as the planned ones.

Examples of various evaluation designs:

- Case studies
- Post intervention only
- Pre-post intervention with comparison
- Two interventions pre and post with comparison

An evaluation intervention should:

- Measure the intervention’s capacity to have an impact based on theory of change.
- Measure the change achievable and attributable to the specific intervention.
- Measure what change (if any) would have happened in the absence of the intervention.
- Systematically document the interventions and its implementation (but feasibility is not effective)
- Measure the cost of implementation.

Measurement of change is more likely to be used for policy and action by:

- Addressing the challenges of ethically and accurately measuring, prevalence and FGM/C status.
- Improving designs to evaluate complex interventions commonly used for FGM/C abandonment.
- Enhancing the Application of “theory of change”
- Improving the definition and measurement of social norms and why changes
- Measuring the rigor, relevance and utility of public descriptions of FGM/C interventions and their evaluation.

There is a need to come up with bi-laws that consider traditional justice system as well as the legal systems. It is difficult to set FGM/C as a priority in disturbed contexts.

- Issue of ownership of research is very vital to link between researchers and policy makers. Ownership must be to the community first. Research ownerships are challenging for the researchers themselves.
- Regarding the organization and funding of researches hopefully this conference can lead the way.
- Transferring experiences. We need to be moderate when considering transferring of experiences and be careful that we don’t go to extremes.
- Encourage families and communities to talk to each other.
Action Recommendations

- We need to measure the change that is caused by abandonment interventions. What is working? Where? And Why?
- Generational shifts and gender must be considered when building the picture on the change happening.
- We need to build a better understanding of countries where great changes happened in them and it is important to learn from these changes.
- We need to understand the shifts in the nature of practice.
- We need to do more research and get a better understanding of the potential associations between FGM/C, HIV, Infertility and Fistula.
- Attention needs to be paid to those families of the portion of the community who have abandoned FGM/C and how the community perceives them.
- Measure changes in the impact of FGM on gender relations. Early marriage and violence.
- De-link FGM/C as a religious obligation and engage religious leaders as change agents.
- Strengthen the health system and engage health professionals as change agents.
- Changing norms through social networks, community value deliberation and community declaration.
- Change new perspectives and expectations of gender norms for uncut girls and women through multi-channel and social marketing campaign
- Measure the impact of legislation and policy reform.
- Before and after study designs are very common and not very effective. Other studies which include control groups need to be considered.
- Change of the effect of the intervention on knowledge, attitudes, norms, tensions and behaviours need to be measured individually.
- When designing an intervention we need to know at what stage the community is in.
- It is important to make distinctions in timing because it measures if the intervention has changed people’s views.
- It is important to determine if the measures are valid.
- Focus on unplanned effects of an intervention as well as the planned.
- Enhance the application of “theory of change.”
- Humanitarian change and context should be considered as forces outside the community can come and install new ideas.
- A link needs to be made between researchers and policy – makers
- Organization and funding of researches need to maintain sustainability.
Evidence-based Interventions for Abandonment of Female Genital Mutilation/Cutting

Chairperson: Dr. Wisal Mustada

Maternal death rate as a measuring tool for maternal mortality

Presenter

Dr. Taha Ahmed Umbeli, Federal Ministry of Health, Sudan

Key Points Raised

There is a growing need, worldwide and especially in Sudan, at all levels for reliable information on estimates of maternal death (MD) to achieve MDG5. Maternal mortality is difficult to measure or to determine because of death accurately even in countries with complete vital registration. That’s why it is a need to highlight:

- Definition of MD
- Causes of MD
- Source of data for estimating MD: the registrations are the most vital data. Others are: Reproductive age mortality studies, population based surveys, national population census, facility based studies and statistical models estimates.
- Maternal Death Review (MDR) as the most useful tool to measure maternal mortality (it is a rapid methods, combines facility and community, asses the current situation, reflect the interventions used and its progress, etc)
- The importance of measuring maternal mortality to set the end of MD as a priority, for planning and advocacy, allocate resources, monitor and evaluate the initiatives and to achieve MDG5

Measuring MD in Sudan is a direct output of SSOG conferences, consequence of the shocking result of NP Surveys (2006) and a way to implement NRH strategy, strength the implementation of road map for MM reduction and to network all the MM reduction stakeholders.

The use of MDR aims to count every Maternal Death, identify common causes of MD, investigate 1st and 2nd delays in communities, increase the knowledge on MD and mobilize the communities. The establishment of it was done through: the decree of notification of every MD (2009), the establishment of NMDRC (State maternal death review committees), the nomination of a focal person for every hospital and locality and the nomination of a review committee in big hospitals. The notifications of the MD are made by telephone daily.
Received data is indexed-coding and its analysis every three months. Furthermore, it’s discussed with NMDRC, used to generate recommendations and disseminated to all the stakeholders & HCP. Between the results of the MDR we find the results of the MMR from 2010 to 2014 and MD causes (the leading is Obstetric Hemorrhage, followed by Hepatitis, Hypertensive disorders, and Sepsis.

The challenges are the limited human and financial resources, a high turnover of trained personnel, that MDR is still a vertical programmer, the slowly implementation of interventions, and the needed of 1st and 2nd delays of collaboration of all partners to improve data collection review.

Dr. Taha mentioned effort to prevent MD such as the establishment of committees in different states that stakeholders are invited to participate in, especially the midwives. Furthermore, there are focus persons in all the areas and institutions. As for remote areas, there are midwives in most of the villages and they are urged to notify if cases occur. However, MM is an issue that needs more attention and as well as resources.

**Action Recommendations**

- More collaboration is needed of all partners to improve data collection of first and second delay.
- Promotion of Family Planning.

**Simple and reliable techniques for measuring changes at the community level (Tostan example)**

**Presenter**

**Dr. Emad Mamon, Entishar Charity Society, Sudan**

**Key Points Raised**

The objective here is to explore and reflect the social change measurements through the Community Empowerment program experience (by Entishar Charity Society, a Sudanese NGO with headquarter in Khartoum).

The Social Change measurement should be done, first of all, by the definition of what and how is going to be measured (establishment of criteria or standards) A clear definitions help to minimize errors in classification of data.

Standards methods of observation and recording are essential before commencing any measurements. Common and deep understanding of monitoring and impact indicators. All the partners help in the validation of measurement and utilization of results and information.
The Basic Necessary information for measurement.

- Indicators: are defined as variables which help to measure changes, often they are used particular when these changes cannot be measured. Some useful indicators are mobility, disability, etc.
- An objective: is precise, either archived or not
- A target: often refer to a discrete activity
- Goal

The measure of changes in the community Empowerment Program Overview through the process of monitoring and evaluations starts by the implementation of the baseline study from the beginning of the program implementation. The data collection in the baseline study include qualitative data collection (with interviews and discussions) and quantitative. We have to be sure that we formulate the questions for measurement of knowledge, skills, attitude and behavior/practice. The success of an intervention is based in the target of the major role (that should be identified before the implementation of the project or program) and the resources.

Providing evidence to guide interventions

**Presenter**

**Dr. Sheena Crawford, IMC, UK**

**Key Points Raised**

The Sudan Free of FGC program, in line with the Sudan Strategy to End FGC in One Generation, aims to decrease the prevalence of FGC in Sudan thereby promoting gender equality and empowerment of women. Its funding comes from DFID-UK.

The Independent Evaluation of this program has been recently settled. It aims to be designed as a process. It will be independent but connected, an outside perspective but supportive, rigorous yet participatory and a resource, not a burden.

At the moment, it is participating in building the Sudan-wide ToC and Logo-Frame for SFFGC. Between its tools, we find: inception visit; Thematic Research; Case Studies documentation and visualizations; baseline, mid-term and end-line data; communications; Mid-Term Review; Ongoing Review; and End-line evaluation.

The expected results of the team are a body of qualitative data available to all; local impact results; in-depth, longer term thematic research; lessons learned to inform future programming; understanding on contribution to social change; contribution to, and sharing with, global knowledge. The challenges include ensuring access to quality data, building good working relationships with all stakeholders, engagement of young people and no sudden growth of the acceptance or intention to continue the FGC.
Action Recommendations

- Increase the independent evaluation processes (specially in “expensive” programs)
- Encourage planning for process and product results.
- Contribute to global evidence and knowledge sharing.

Research Agenda to End Female genital mutilation/cutting

Presenter

Dr. Carolyn Njue, Population Council, Kenya

Key Points Raised

- Overview of DFID program (Towards Ending FGM/C in Africa and Beyond)
- About the program in a brief
- Implementation: engagement of stakeholder
- Generation of quality evidence researches
- Capacity building for researchers and stakeholder

Progress of the program: On track with some production such as: Training programs, Facts sheets, global partnerships and stakeholders, Synthesis products. A lot of researches that aim to bring impact and evidence. Mix research methods are always recommended for better results.

Setting a national research strategy for Sudan

Presenters

Dr. Seham Amin, Federal Ministry of Health
Dr. Wisal Mustafa, World Health Organization-Sudan

Key Points Raised

- National research strategy for Sudan:
- Where we are now?
- Why do we need FGM/C research?
- Aims of the STRATEGIC Research plan: To guide the production of evidence and strength data system on FGM/C
- Vision and Mission and guiding principles of National research strategy
- Timeframe
- The roadmap of the strategy development (activities to do)

Research themes:
1. Behaviour change /empowerment
2. Brining about change in social norms
3. Evidence on harm
4. Service provision
5. Interventions

**Action Recommendations**

- Coordination management and networking is a must.
- Leadership and ownership of different stockholder.
- The importance of pulling of resources.
- Ethics of knowledge sharing.
- Having evaluation as a concept of our programs during all the process (internal and external evaluations)
- Determination of the change that we want to achieve at the end of the program.
- Independent evaluation process increasingly used in “expensive” programs
- Encourage planning for process and product results.
- Ensuring access to quality data
- Building good work-relationships between the stakeholders
- Engagement of youth people

**About Maternal Death:**
- Improving family planning for reduce MD
- It is needed more collaboration of all partners to improve data collection of first and second delay

- Standardized methods of observations and recording are essential before commencing any measurements.
- Multivariate analysis of Sudan DHS/MICS datasets to identify and explain generation shifts in FGM/C and to differentiate individual an community factors in FGM/C
- Finalize, validate and approve national FGM Research Strategy (after the workshop with the stakeholders) and translate it into policy, practices and leadership.
Quality assurance (QA) in maternal care at Saudi Arabia improves the outcome of mothers’ and children health in two decades

Key Points Raised

Dr. Baldo was one of four consultants who developed Mother Child Health component for primary health care, also prepared the maternal health curriculum for primary health care physicians and he was a consultant during the implementation of the program.

The aim was to strengthen maternal and child health as a major component as primary health care. And to shed a light on the implementation of Quality assurance in the context of primary health care between the years 1989 and 2003

Saudi woman’s health and Reproductive health was introduced by a WHO STC and coordination was inter-sectorial between different ministries (MCH was included in girls’ secondary school curriculum.

Civil registration lists provided numbers of female deaths. Vaccinations for six weeks infants and breast feeding status indirectly verified the mother status

Introduction of Primary Health Care improved supportive supervision, information and research.

Adaptation of PHC by Saudi Arabia was a landmark in reorganizing the health care system toward equality. Throughout the presentation Dr. Baldo emphasized that the Importance of the role of midwives in PHC shouldn’t be overlooked.

Action Recommendations

- Researches on safety, satisfaction of clients and providers will guide efforts towards better outcome.
- Audit, evaluation and accreditation are important measures in primary health care.
- Reproductive health services quality, supportive supervision, data management are crucial.
- Antenatal care services which is a primary health care activity that provide a better coverage and outreach.
Inequalities in maternal health in Sudan: the effect of universal health coverage

Presenter

Dr. Huda Mohamed Mukhtar

Key Points Raised

- The study assumes that any new interventions are often associated with increasing health inequalities at the beginning. The trend to reach disadvantage group is last. Transformation from limited health services to a dual system; public and private providers. Strategies and priorities are one of the steps taken to improve the universal health care.

- The main objectives of Universal Health Care are: coverage of quality services and financial protection for all. Priority, strategies & implementation plans for UHC. Moving toward UHC is continues process that require changes.

- Sudan spend 6.5% of its GDP on health which beyond the commitment of government of 15%. Health financing system is weak and mainly supported by household, public sector contribute by is 1/5 of total expenditures. In addition to donors and partners.

- Social Health Insurance compulsory for employees in formal sectors, and voluntary for informal sector. Family is a last beneficiary unit benefiting from all package that cover almost services and in some cases treatment abroad.

- Inequalities demonstrated in health utilization and consequently in health status of the population. General administration of health and insurance together that consume about 4% while 3.35% of health fund are spend on provision and administration of public health programs.

The research examines different variables statistically that conclude the followings: Sudan is one of the most densely populated countries in the region over 37.9 million people. Health care has become more pressing issue especially after split of Sudan in to two countries. Complications during pregnancy affect 1:3 pregnant women and complication during delivery affect 1:2 women. Close to 50% of female death occur during pregnancy, delivery or 2 month after delivery. Sudan is far from achieving MDGs goals and to establish adequate and efficient health care system.
Maternal predictors of the mean birth weight and risk factors of low birth weight among full-term, singleton babies born in an urban setting in Sudan

Presenter

Dr. Fatih El.Samani, Sudan, Ahfad University for Women, Sudan

Key Points Raised

- The statement that saying “women dying more than men” scientifically is not correct, men dying more than women”. But the loss of women affects the whole family.
- Definition of average birth weight is 3.4. Low birth weight is less than 2500 Grams. The prevalence of LBW is 7% in developed countries and 17% in developing countries.
- MDGs and new target in LBW in Sudan reveals little or no success MDG particular goals without reduction in LBW and improvement in the average birth –weight.
- The study focus on the Intera-uterine Growth reduction Retardation as one of the factor determines the birth weight and LBW despite there are other determinants.
- The study mentioned the non-modifiable risk factors of LBW in gender & order of newborn in addition to mother’s own fetal growth. While the modifiable risks factors include mother’s health, exposure to diseases, socio-economic status and primary health care (antenatal care).
- Previous studies showed the association of LBW with in central Sudan with anemia and low ANC, while in western Sudan the LBW associated only with anemia. While in a case-control studies, results reveals LBW association with Malaria treatment.
- Objectives of study include specific objectives as follows: describe the distribution of birth weight, measure the prevalence rate of LBW, estimate the association of maternal health and socio-demographic factors with LBW.
- The statistical analysis for various factors share common variable which is the mother’s age group.

Action Recommendations

- The Presence of skilled birth attendants in order to reduce maternal health is crucial.
- Close monitoring for modifiable risk factors and eliminating it through primary and antenatal care services to improve average birth weight and reduce risk of LBW.
- Public communication, advocacy and relevant national polices should address poverty, teen-age marriage and child birth.
Evidence on Factors and Approaches for Promoting Maternal Health

Identifying priority research gaps in female genital mutilation/cutting for Sudan - a literature review

Presenter
Dr. Owolabi Bjälkander, Researcher, WHO-Sudan

Key Points Raised

- The objective here was to determine what is known about FGM/C from research, and to identify research gaps for Sudan. Electronic database search of peer-reviewed FGM research published over the last 30 years (1984-2014) and physical search for research material in Sudan was used as a method.
- As a result, the following gaps were typified:
  - Research gaps in evidence of harm: a) Complications of labor/childbirth, b) Long term health consequences of FGM/C c) Girls' complication d) Gynecological outcome e) A explication of the association between infertility and FGM/C e) The psychosexual impact of FGM/C on women and their husbands
  - Research gaps in service provision:
    - Care for girls and women with FGM/C
    - Medicalization
    - Reconstructive surgery
    - De-infibulations
    - Role of midwives
- Furthermore, a huge number of questions are needed to be answer related with the interventions and their impact and the research in Sudan.
- Some of the challenges that we find as a result are the discussion about the genitalia and the sex-sensitive because of their taboo status, the lack of knowledge of women about the reproductive health, the FGM status – self reported, the fact that majority of research evidence among women are among African women living in the West and the lack of longitudinal prospective studies to understand socio-cultural drivers.

Action Recommendations

- Assess FGM/C abandonment interventions
- Ascertain what has worked and why
- Identify factors that can contribute to FGM/C abandonment
- Conduct research
Setting intervention study on female genital mutilation/cutting: pilot project in Omdurman

Presenter
Mrs. Sara Mustafa El.Hadi, Ahfad University for Women, Sudan

Key Points Raised

- Overview of the project: the main aim was combating FGM in Sudan by drawing volunteerism and local community action.
- Phases of the project:
  - Recruitment and identification of community workers from the target area
  - Training of volunteers
  - Community based activities
- Methodology: local leaders they were collecting data too. The total of the population that was targeted was about 1000 people.
- Aim of the conduction of the pre and post study: to assess the knowledge of the people, to know the existing types of FGM in the Abu Said area and to identify the most suitable method for intervention to control FGM in the targeted area
- The challenges that the study faced were: being a displaced area, the absence of a clear religious statement to des-link FGM from religious and the fear of social criticism.
- Lesson learned:
  - Coordination at all levels it’s a must
  - Volunteerism is very effective and builds on the spirit of commitment in order to ensure sustainability of the process. The volunteers were the data collectors; they lived in the neighborhood so they knew very well who was moving.
  - Conduction of surveys at different stages is a crucial part of the monitoring process

Action Recommendations

- Asses FGM/C abandonment interventions
- Ascertain what has worked and why
- Identify factors that can contribute to FGM/C abandonment
- Conduct research
- Review of research literature - continual process
- Determine what we know
- Identify research evidence relevant for Sudanese context
- Systematic use of research findings in advocacy, policy formulation and programming
Baseline study to develop indictors for female genital mutilation/cutting abandonment

Presenter

Dr. Hind Bushra, Ahfad University for Women, Sudan

Key Points Raised

- This study aimed to develop a set of indicators that are agreed by all partners to measure the outcomes of FGM programs and interventions in the different states indicated above.
- The activities carried by the IPs are categorized under 8 categories (based on both the objectives and activities done). The 8 categories are:
  - Laws and policies, CBOs creation and strengthening, Different actors working in the area to abandon FGM (numbers, categories, gender), Capacity building for advocates/leaders, Awareness and advocacy activities, Production and dissemination of Information Education and Communication (IEC) materials and media exposure, Research, and Budgetary resources
  - The interventions conducted by UNFPA and its partners have shown positive increase in activities for abandoning the practice and publicly declaring abandonment in some of the five focal states Khartoum (Tuti initiative), Gadaref, White Nile (Gazira Aba), Blue Nile, and Kassala.
  - The rate of change in number of activities, commitment by high level decision takers is slow and more interventions and changes in the program action plans should take place.
  - 2013 and 2014 Plans of actions and activities are below the optimum to achieve and accomplish the diverse output indicators as stated in the baseline.
  - It is important to use these indicator checklists in the future to set-up clear action plans with clear targets and outputs related to the goal.

Action Recommendations

- More training to IPs to understand the indicators.
- Strengthen the link between IPs with state, other partners, and different NGOs and government bodies.
- Increased the number of implemented partners.
- Use the indicators for monitoring and coordination of activities at national and state level to achieve better overall outcomes.
- More monitoring system to grantees coordination is undertaken.
- More funds and clear target plans of action to be developed
Setting intervention study on female genital mutilation/cutting: pilot project in Omdurman

Presenter

Mrs. Sara Mustafa El.Hadi, Ahfad University for Women, Sudan

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  - Conduction of surveys at different stages is a crucial part of the monitoring process

Action Recommendations

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- Identify factors that can contribute to FGM/C abandonment
- Conduct research
- Review of research literature - continual process
- Determine what we know
- Identify research evidence relevant for Sudanese context
- Systematic use of research findings in advocacy, policy formulation and programming
Female genital mutilation/cutting: a statistical overview and investigation of the underlying forces of the practice

Presenter

Dr. Randa Gindeel, Ahfad University for Women, Sudan

Key Points Raised

- In Sudan, FGM/C is widely practiced, however, updated information about the prevalence rate, attitudes toward the practice, the pertaining role of men in the practice, the reasons why women maintain it and the social, cultural and demographic predictors associated with support for it are needed for development of operative eradication strategies.
- The study investigated the prevalence rate of the practice among females, the knowledge and attitudes of males and females towards FGM/C in the Gazira Abba, White Nile State. Purposive sampling technique was adopted to collect data from 231 households (four members were interviewed from each)

Results found that:

- The prevalence rate among the surveyed females is very high (95.1%) although there is a shift in the type practiced to a less severe one.
- The main practitioners of FGM/C were midwives.
- The prevalence of FGM/C is generally highest among daughters of women with no education, and tends to decrease substantially as a mother’s educational level rises.
- Male youth, grandfathers and grandmothers were particularly had insufficient knowledge related to linking FGM/C to girl’s purity, cleanliness, Islam, divorce rates and marriage.
- The main reasons perceived by the community to be the drivers for the practice include a mix of religious (44.2%), cultural and social factors (59.2%).
- On average, fathers reported excellent knowledge compared to young males or grandfathers about different subjects related with FGM/C and the positive sides of keeping girls uncut (Saleema). However, the result sowed that the commitment to work to stop FGM/C are unclear and uncertain for all men groups.

Action Recommendations

- More training to IPs to understand the indicators.
- Strengthen the link between IPs with state, other partners, and different NGOs and government bodies.
- Increased the number of implemented partners.
- Use the indicators for monitoring and coordination of activities at national and state level to achieve better overall outcomes.
- More monitoring system to grantees coordination is undertaken.
- More funds and clear target plans of action to be develope
Act Now Session

Chairpersons:

Mrs. Enshrah Ahmed, UNFPA-ASRO
Dr. Hermoine Lovel, UK

This session served to review the recommendations that were collected through the three days of the conference.

Key Points Raised

- **Measurement of Changes on FGM/C:**
  - Sustainable Development Goals (SDGs) 3 and 5: although FGM/C and GCM are included in their scope, there are no indicators. Local governments, civil society, universities, and researchers to develop indicators should collaborate to develop indicators on FGM/C in order to measure changes and shifts with regard the abandonment of FGM/C.
  - FGM/C has developed to became an international/global concern due immigrations and population movement, hence, there’s an urge to develop global indicators to measure changes around FGM/C.
  - Target and invest in secondary school education because it equips young women with a position to take a decision on her health.

- **Policy Oriented Recommendations in relations to FGM:**
  - Innovative partnerships between midwifery schools and non-profit CBOs and NGOs to address FGM/C.
  - Inclusion of researches on socioeconomic context of the practice and what is the supply and demand i.e. what is going on the FGM/C market? why men preferred to marry underage girls?
  - Sexual education it shouldn’t be age appropriate rather it should be integrated into curriculum with a proper information level.
  - Continued advocacy for age at first marriage and indicating the minimum age of marriage.
  - Men should be involved/targeted in advocacy to stop child marriage; as they might practice C.M. for their daughters due to poverty.

**Action recommendations**

- Work with government, civil society, universities, and researchers to develop indicators for GFM/C and Child Marriage in Sudan
- Create innovative partnership between midwifery schools and non-profit CBOs and NGOs to address FGM/C.
- Researches on socioeconomic context of the practice of FGM/C and Child Marriage.
- Invest in secondary school education.
- Sexual education should be integrated into curriculum with age sensitive information.
- National law addressing minimum age of marriage.
- Enacting national law to criminalize all forms of FGM/C
- Qualitative researches to explore why men preferred to marry underage girls?
Beyond Knowledge and Evidence-sharing
### Beyond Knowledge and Evidence-sharing

#### FGM

<table>
<thead>
<tr>
<th>Conference Themes</th>
<th>Post Conference workshop identified activities implied by conference recommendations</th>
<th>Opportunities and facilitators, useful history and other drivers in similar direction</th>
<th>Obstacles and hindrances</th>
<th>Who to take forward Action</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Legislation</strong></td>
<td>Enacting of National law to criminalise all forms of FGM</td>
<td>FGM legislation already drafted and process in place to complete procedures</td>
<td>Social norms very strong both in community and within institutions.</td>
<td>Civil Society Organizations including NGOs, CBOs academia; Youth and Women organizations and Community leaders</td>
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<tr>
<td>In line with SFFGC.</td>
<td>Advocacy to ensure legislation wording makes it clear that any type of cutting by any person including midwives and doctors is illegal. This will avoid abuse of any FGM law.</td>
<td>Ongoing support of key legal figures, e.g. Ministry of Justice</td>
<td>Dominant culture of FGM so protected social norm; thus in conflict Zones such as Blue Nile new adopters of FGM because felt they would be more accepted if they do it.</td>
<td>Ministry of Endowment (and religious leaders)</td>
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<tr>
<td><strong>Legal and regulatory reforms in place and enforced Gaps</strong></td>
<td>Engage all key organisations to develop advocacy for legal change which will lead to: Advocacy to criminalise all forms of FGM; Regional body to regulate in presence of FGM: ensure regulatory reform within services e.g. health professionals is covered and consistent with Systems strengthening below</td>
<td>Ongoing advocacy avail opportunity to lobby and work with individual States to implement legislation to criminalise FGM, adapting advocacy to each State’s situation.</td>
<td>Diverse religious discourse</td>
<td>Relevant Government institutions at national and state levels (Ministry of Welfare and Social Security; Ministry of Education; Ministry of Interior; Ministry of Media; Ministry of Health; Ministry of Justice, NCCW. Combating Violence against Women Unit)</td>
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<td>Training/awareness raising for Parliamentarians, State CCW (SCCW), Local government staff, law enforcement personnel, local leaders, native administration, community cadres including Health assistants.</td>
<td>FGM (complications, management and counselling) already integrated into curricula for doctors, Midwives and Health Assistants.</td>
<td>Salfists group resistance to abandonment</td>
<td>Parliamentarians, women and men</td>
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<td>Develop local Watchdog to report on contraventions</td>
<td>Regulatory frameworks e.g. for midwives provides framework also for accountability</td>
<td>Risk of practice becoming secret and raising suspicions of religious leaders if have not had time to think it through first</td>
<td>Sudan Medical Council for medical regulation</td>
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<td>Strengthen systems for legal and regulatory reform;</td>
<td>Drafting of FGM surveillance data gathering is ongoing</td>
<td>Police, lawyers and judiciary unaware of and not trained on FGM legislation. Law enforcement is lacking,</td>
<td>Professional organisations including Medical professionals; Midwifery and nursing</td>
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<td>One state has an FGM law (S Kordofan)</td>
<td>Medicalisation</td>
<td>Parent Councils and teacher associations in schools</td>
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<td>4 States have used Child Act as</td>
<td>Difficult for some States to initiate FGM criminalisation legislation but they can adopt a national Federal law</td>
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<td>Social norm changing</td>
<td>Developing FGM indicators for SDG 3 and 5 targets and align with timing suggested for CM indicators, by March 2016 and then develop global indicators by Government collaborating with educators and NGOs.</td>
<td>Realisation of need for change must start from society/community (and has already started)</td>
<td>Youth don’t know physical harm effects of FGM (?research evidence)</td>
<td>Civil Society Organizations including NGOs, CBOs academia; Youth and Women organizations and Community leaders and communities.</td>
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<td>In line with SFFGC Output 2. Target Communities, in particular children and women, are empowered to abandon FGM/C</td>
<td>Link FGM/C with gender equality and women empowerment particularly to link it to SDGs 3,5. Development of multimedia approaches advocacy content</td>
<td>Opportunity now to create a platform to launch social movement for positive change stopping FGM; NCCW or Afhad could invite organisations working for positive change and ask them what support they need to further roll out their work.</td>
<td>Some Religious leaders encouraging FGM</td>
<td>Ministry of Endowment (and religious leaders)</td>
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<td>SFFGC output 3. Social movement, with children, adolescents and youth, active for positive change to end FGM/C</td>
<td>Design Social Norms programmatic interventions that are based a) on rapid gender analysis &amp; protection assessment and that omit the use of terms (especially in community) “Sunna”, Pharaonic, and instead use simply FGM as all cutting; b) a better understanding of contexts where change has happened, to learn from methodology for measuring change; shifts in the nature of practice; link between FGM/C and HIV, Infertility and Fistula; c) understanding of barriers to changing the norms and that the dominant culture is a protected social norm.</td>
<td>Build technical meetings with UNICEF to identify FGM social movements for positive change and FGM related social norms currently.</td>
<td>Conflict may increase FGM?? Poverty may increase FGM</td>
<td>Relevant Government institutions at national and state levels (Ministry of Welfare and Social Security; Ministry of Education; Ministry of Interior; Ministry of Media; Ministry of Health; Ministry of Justice, NCCW. Combating Violence against Women Unit)</td>
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<td></td>
<td>Consider capacity building for strengthening systems of communities empowered to abandon FGM</td>
<td>Multimedia arts, music, dance and drama widespread and can be used e.g. to raise discussion when FGM is taboo subject.</td>
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<td>Parliamentarians, women and men</td>
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<td>Campaigns need to target to grass roots level, men &amp; youth to strengthen their role</td>
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<td>Sudan Medical Council for medical regulation</td>
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<td>Approaches must be human rights based &amp; culturally sensitive. Use (multi)media as a campaigning tool.</td>
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<td>Professional organisations including Medical professionals; Midwifery and nursing</td>
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<td>Parent Councils and teacher associations in schools</td>
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Mainstream Saleema in education & health within community-based programs at all levels

Develop prototypes and pilots (social norms interventions) for use regionally and by diasporas

There is need to consider potential links FGM and fertility and concern about this in Norther Sudan (see Sudan study). (Also draw on evidence FGM is associated with factors detracting from marital relations leading to conception (which inevitably reduces frequency of opportunities for conception) including external pain (e.g. from neuroma); obstruction (e.g. large keloid scar, or any hard scar tissue, also small orifice), dyspareunia, and psychological fear of marital relations following from trauma when FGM done and psychological co-morbidity such as PTSD arising from trauma when FGM done. Also consider role of urogynaecological co-morbidity following FGM potentially interfering with marital relations.)

Consider further evidence of potential infertility due to ascending infection at time of FGM and/or subsequent infection due to e.g. difficulty passing menses through small orifice, difficulty urinating etc.

Further recognise evidence of risk of stillbirth and neonatal death when delivered in presence of FGM (due to risk of FGM associated longer labour). Primary fertility may be OK but baby may be lost due to FGM so net result can be no children

Recognise a social movement for positive change as any effort against the practice.
Strengthen systems for social movement for social change;
Target families in the community who have abandoned FGM, popularize and promote positive perceptions on their achievements.
Continue to recognize the small changes in social norms and list what is known already
Recognize in interventions the barriers to stopping cutting; variation in localities and cultural groups
Harness multimedia for accelerating social change, involving Ministry of Media and local media at community level.
Target individual, family, community, girl, father, grandmothers as decision makers for FGM
Target women and men, family, community as decision makers for re-infibulation (in post-partum and in older women)
Encourage any individual clinicians, religious or other community leader, or any father who refuses to let his daughter be cut to speak out in raising awareness activities.
Recognize how gender relations & generational shifts as a factor for continuation/ abandonment of the FGM/C
Consider Girl Generation communication in interventions

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<td>Systems strengthening of Government and NGOs to provide protection, prevention, care</td>
<td>CB for systems strengthening to provide protection, prevention and care; Develop (FGM capacity building) indicators for SDGs 3 and 5 targets</td>
<td>In-service training is now happening via FMOH Variation in clinical practice, some doctors are against the practice, not supporting it and protecting their daughters from FGM</td>
<td>Risk if progress too quickly before people have had time to think through the issues for themselves, the practice may become more secret and ‘driven underground’, also religious leaders may become suspicious.</td>
<td>Civil Society Organizations including NGOs, CBOs academia; Youth and Women organizations and Community leaders</td>
</tr>
<tr>
<td>SFFGC output 3. Relevant and targeted government and non-governmental systems strengthened to provide prevention, protection and care (PPC) related to FGM/C</td>
<td>Arrange for capacity building for policy development and performance improvement; Consider service integration in training and expose trainees to any other sector than their own. Include FGM complications management and counseling in capacity building Use Girl Generation communication for capacity building Integration of FGM risks in school &amp; all medical and midwifery and medical assistant curricula Integration of sexual health in RH Integrate FGM awareness raising within existing (services and) channels Strengthen accountability &amp; transparency in promotion of women and girls’ health Improving quality &amp; access to health services, partnership between private &amp; public services &amp; ending medicalization of FGM/C Mobilize more financial resources for the health sector Mainstream Saleema in education &amp; health within community-based programs at all levels Consider human rights-based &amp; culturally sensitive</td>
<td>Health Assistant role as important Community leader FMOH has educational role via School Health, Health promotion and MCH programmes Civil Society engagement in providing services in health and education can help integration of FGM issues</td>
<td>Social norm of institutions and mind set of practitioners may be pro FGM as medical norm as well as social norm despite clear guidelines and regulation of specialties such as obgyn that there is no medical reason for cutting. Variation in clinical practice, some doctors are for FGM. Mixed message from parts of health sector, won’t speak out, will do cutting, and stay silent. FGM is income generation for midwives (and majority are not paid by government currently). Misunderstanding by some religious leaders (more than one religion) that FGM linked to religion</td>
<td>Ministry of Endowment (and religious leaders) Relevant Government institutions at national and state levels (Ministry of Welfare and Social Security; Ministry of Education; Ministry of Interior; Ministry of Media; Ministry of Health; Ministry of Justice, NCCW. Combating Violence against Women Unit) Professional organisations including Medical professionals; Midwifery and nursing Parent Councils and teacher associations in schools</td>
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<tr>
<td>Evidence based research</td>
<td>Arrange for measuring change at all levels</td>
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| approaches for service delivery | | | limited ongoing staff training currently except for doctors |
| Develop policy to improve access to health services | | | |
| Continue FMOH decentralization and improve rural cadre | | | |
| Mainstream midwives in government pay roll | | | |
| Using (multi)media as campaigning tool | | | |
| Prioritize gender based violence (GBV) prevention in emergency (e.g. conflict) situations | | | |
| *Include in Service Codes of conduct* | | | |
| Integrate awareness of (harm risks of) FGM in services | | | |
| Consider knowledge transfer and include human resource. | | | |
| Plan for sustainability of resources, | | | |

Left lower grey triangle: Abandonment interventions, what is working, where and why?
Light Blue centre triangle: Valid measures.
Top dark blue triangle: Building the picture, where, when and why.
<table>
<thead>
<tr>
<th>FGM/C? (Where service systems need to be, how to develop and deliver)</th>
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<td>Right lower orange triangle: (Systems with) <strong>wider impacts of FGM/C and of abandonment interventions</strong></td>
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<td>Systems strengthening for the evidence base increase for programming.</td>
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<td>Consolidate existing FGM research in one accessible source</td>
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<td>Studies on mobility and link to change in gender norms and roles</td>
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<tr>
<td>Studies to measure impact of FGM on gender relations, child marriage and violence</td>
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<td>Study link between FGM and HIV, infertility and fistula –</td>
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<td>Study re-infibulation as a social norm.</td>
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<tr>
<td>Consider qualitative studies on FGM and sexuality</td>
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<tr>
<td>Conduct comparative research on FGM free culture to learn from African cultures that cherish physical integrity</td>
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<td>Qualitative studies to understand sexuality (e.g. ‘marital relations’, ‘beautification’, expectations by women of men, and men by women and why) and links to FGM</td>
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<td>Conduct research to understand barriers to changing the norms</td>
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<td>Studying families in the community who have abandoned FGM and how the community perceives them.</td>
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<td>Ensure socioeconomic conditions/poverty included in research on FGM</td>
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<td>Identify small changes in</td>
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</table>
social norms and list what is known already

Conduct research to understand individual man, (specifically husband) and woman, and community roles in decision-making for re-infibulation (post-partum and in older women)

Conduct study to understand individual man (specifically father) and woman, family, and community roles in decision-making for a girl to have FGM considering variations among places, groups

Arrange for studies on prototypes and pilots social norms changes to be used regionally and by diasporas

Studies to understand social norms dynamics in communities empowered to abandon FGM

Conduct research to understand a) the barriers to stopping cutting; and b) understand variation in localities among cultural groups

Strengthen capacities for rapid gender analysis & protection assessment needed prior to programmatic interventions.

Study how coordination can facilitate delivery of outcomes

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<td>Coordination for FGM</td>
<td>Networking between different organisations working towards abandoning FGM and providing services for protection, prevention and care, at different levels and in various sectors including, health, education, care</td>
<td>Common partners already know each other Good relationship currently between UN partners in Sudan</td>
<td>Coordinating body becomes implementation body, no longer coordinating Coordination can become</td>
<td>Civil Society Organizations including NGOs, CBOs academia; Youth and Women organizations and Community leaders</td>
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<tr>
<td>Annual event that fits into annual review and planning cycle of UN, donors, and FMOH</td>
<td>Government agenda and cross government initiatives also addressing FGM and CM controlling at State level. In field can be difficult. Problem of individual NGO contracts with UN agency bypassing State organisations and priorities, may cause duplication and isolation from mainstream government funded long term work. Service integration (and coordination) is omitted from training currently. Often trainees have no exposure to any other sector than their own. The culture of coordination is weak and of low standing. Funding often lacking Brain drain loss of team members so maintaining sustainability of team can be challenging</td>
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<tr>
<td>Strengthen role of NCCW in coordination for planning, monitoring and evaluation and support capacity building for States councils of child welfare. Define Federal rules of engagement between States and federal level donor contracts with NGOs working in those states Coordination is needed for Policy development and performance; It is the way a team can be built; It requires time and joint commitment to agreed goals. Build and strengthen a culture of coordination Use good examples of coordinated work e.g. UNFPA Arab States office Provide support for structures and approaches for abandonment of FGM, synchronising, and harmonising the approaches being used Strengthen the links between government, academia, civil society to facilitate leadership role of NCCW Recognise need for an annual FGM/C meeting led by NCCW to review and plan. Hold meetings with individual States Via NCCW and UN agencies, use financial ring fencing for States when helpful</td>
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<tr>
<td>Ministry of Endowment (and religious leaders) Relevant Government institutions at national and state levels (Ministry of Welfare and Social Security; Ministry of Education; Ministry of Interior; Ministry of Media; Ministry of Health; Ministry of Justice, NCCW. Combating Violence against Women Unit) Parlimentarians, women and men Sudan Medical Council for medical regulation Professional organisations including Medical professionals; Midwifery and nursing Parent Councils and teacher associations in schools</td>
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**Beyond Knowledge and Evidence-sharing**
## Child Marriage

<table>
<thead>
<tr>
<th>Conference Themes</th>
<th>Post Conference workshop identified activities implied by conference recommendations</th>
<th>Opportunities and facilitators, useful history and other drivers in similar direction</th>
<th>Obstacles and hindrances</th>
<th>Who to take forward Action</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Legislation</strong></td>
<td>Advocacy to define age of marriage at 18 years</td>
<td>Ongoing support of key legal figures, e.g. Ministry of Justice broke marriage of 45 years of an old man and child</td>
<td>Social norm very strong</td>
<td>Civil Society Organizations including NGOs, CBOs academia; Youth and Women organizations and Community leaders</td>
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<td></td>
<td>Engage all key organisations to develop advocacy for legal change which will lead to:</td>
<td>Ongoing requirement to update Sudan laws to match Convention Rights of the Child (including amendment to Personal Status Law 1991 Art40)</td>
<td>Diverse religious discourse</td>
<td>Ministry of Endowment (and religious leaders)</td>
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<td></td>
<td>Enforcement of Child Act (18 years marriage)</td>
<td></td>
<td>Salfists' groups</td>
<td>Relevant Government institutions at national and state levels (Ministry of Welfare and Social Security; Ministry of Education; Ministry of Interior; Ministry of Media; Ministry of Health; Ministry of Justice, NCCW. Combating Violence against Women Unit)</td>
</tr>
<tr>
<td></td>
<td>Amendment to Personal Status Law for Muslims, 1991 Article 40 age of marriage</td>
<td></td>
<td>Cultural variation</td>
<td>Parliamentarians, women and men</td>
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<td></td>
<td>Enactment of Law for sexual abuse of children</td>
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<td>Parent Councils and teacher associations in schools</td>
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<td>Enactment of Laws for neglected children</td>
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<tr>
<td><strong>Social Norm Change</strong></td>
<td>Design raising awareness interventions considering that: variation in localities and cultural groups; ‘social protection’ is a reason for child; link of child Marriage to marriageability; parents’ roles and family decision making and variation in localities and cultural groups.</td>
<td>Multimedia arts, music, dance and drama widespread</td>
<td>Youth don’t know educational loss and physical harm effects of CM</td>
<td>Civil Society Organizations including NGOs, CBOs academia; Youth and Women organizations and Community leaders</td>
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<td></td>
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<td></td>
<td>Religious leaders encouraging CM</td>
<td>Ministry of Endowment (and</td>
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<td></td>
<td>Conflict may increase CM</td>
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<tr>
<td>Systems strengthening of Government and NGOs to provide protection, prevention, care</td>
<td>FMOH should continue to decentralise, improve rural health care and encourage trained cadre to work in remote areas to address health complications of child mothers.</td>
<td>Education sector primary and secondary schooling</td>
<td>Lack of coordination</td>
<td>Civil Society Organizations including NGOs, CBOs, academia; Youth and Women organizations and Community leaders</td>
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<td></td>
<td>Address risks and prevention of GBV in conflict situation</td>
<td>Educational role of FMOH via School Health, Health promotion and MCH programmes</td>
<td>FMOH</td>
<td>Ministry of Endowment (and religious leaders)</td>
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<td></td>
<td>Advocacy of marriage 18+ within services</td>
<td>Child protection services</td>
<td>Health sector limited ongoing staff training currently except for doctors</td>
<td>Relevant Government institutions at national and state levels (Ministry of Welfare and Social Security; Ministry of Education; Ministry of Health; Ministry of Justice, NCCW. Combating Violence against Women Unit)</td>
</tr>
<tr>
<td></td>
<td>Integration of family life education/life skills education should have age appropriate content channels e.g. health services</td>
<td>Civil Society services in health and education (can also support public services)</td>
<td>Religious leaders encouraging CM</td>
<td>School parents councils and teachers associations</td>
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<td></td>
<td>Include family life education/life skills in curricula for schools and age sensitive information</td>
<td>Farmers’ Unions (male)</td>
<td>Conflict may increase CM</td>
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<td></td>
<td>Delay (protect from) girls from first pregnancy e.g. wait till 150cm tall to reduce obstruction and risk of damage/death to girl and to baby and provide special care for child if becomes</td>
<td>Ministry of Justice case, broke marriage of 45 yr old man and child</td>
<td>Poverty may increase CM</td>
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<td></td>
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<td>Village midwives</td>
<td>Youth don’t know educational loss and physical harm effects of CM (research evidence)</td>
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Address child marriage and gender based violence (GBV), in conflict zones

Understand effects of CM on loss of education and damage to health of girl including risk of loss of fertility fistula, death etc., and damage to children (fetal death, still birth, low birth weight etc.)

Harness multimedia for this social change

Poverty may increase CM religious leaders)
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</table>
| Evidence base increased for programming | Use research framework triangular diagram presented in measuring change as above  
Rapid gender analysis and protection assessment are needed prior to programmatic interventions  
Develop CM indicators for SDGs 3 and 5 (by March 2016) and then develop | South to South training & exchange  
Application of skills to new setting  
Research skills may exist (or need building) to identify projects that may already | Research Institutes and academia |
<table>
<thead>
<tr>
<th>Global indicators by Government collaborating with educators and NGOs</th>
<th>exist showing what works best.</th>
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<tr>
<td>Develop (CM research) prototypes and pilots for use regionally and by diasporas</td>
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<tr>
<td>Studies on mobility and link to change in gender norms and roles</td>
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<td>Identify and study success stories can be shared and lessons learnt.</td>
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<td>Studies on variations in CM practices among diverse cultural groups</td>
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<td>Study to understand ‘social protection’ as a reason for child</td>
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<tr>
<td>Study parents’ roles and other members decision making roles for M considering variation among cultural groups at locality level</td>
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<td>Understand child marriage in context of gender based violence (GBV), in conflict zones</td>
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<td>Study effects of CM on loss of education and damage to health of girl including risk of loss of fertility fistula, death etc., and damage to children (fetal death, still birth, low birth weight etc.)</td>
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<td>Study the link between marriageability and child marriage to feed into advocacy in schools</td>
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<td>Identify drivers of CM, including historical variation (and roles of conflict (and GBV); poverty; urban/rural; varying ethnic groups; mobility)</td>
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<td>Study why men marry girl child</td>
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<tr>
<td>Research girls’ expectations of their lives, action research maybe, raise alternatives</td>
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including knowledge of health risks/harm; change in social position; marriage course etc.

Studies on maternal risk factors as result of child marriage
If essential for Sudan develop rapid assessment method using the extensive scientific literature on young age and short height and maternal mortality and morbidity and also fetal and infant mortality, morbidity, impairment, and low birth weight morbidity, impairment, and low birth weight

Consolidate existing CM research in one accessible source
Integrate ethics in knowledge sharing
Arrange for multivariate analysis of existing survey data
Action research and intervention studies on CM
Study how coordination can facilitate deliver of outcomes

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<td>Identified activities implied by conference recommendations</td>
<td>Coordinate service organizations working on CM (e.g. health, education, care)</td>
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<td>Strengthen the links between government, academia, civil society to facilitate leadership role of NCWW</td>
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<td>Obstacles and hindrances</td>
<td>Strengthen State and Locality levels of CWW</td>
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<td>Who to take forward Action</td>
<td>Coordination is needed for Policy development and performance; Use good examples of coordinated work e.g. UNFPA Arab States office</td>
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<td>Opportunities and facilitators, useful history and other drivers in similar direction</td>
<td>Common partners already know each other</td>
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<td>Obstacles and hindrances</td>
<td>Good relationship between UN partners in Sudan currently</td>
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<td>Who to take forward Action</td>
<td>Importance of coordination recognized by all actors</td>
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<td>The culture of coordination is weak and of low standing.</td>
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<td>Funding to promote and strengthen often lacking</td>
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<td>Relevant Government institutions at national and state levels with leadership of NCCW</td>
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<td>Who to take forward Action</td>
<td>Parliamentarians, women and men</td>
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## Flayers

<table>
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<td>Conference</td>
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<td>Female Genital Cutting</td>
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<td>Girl Child Marriage</td>
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Background
This conference aims at providing a platform for knowledge sharing exchange of successful practices and experiences amongst local, regional and international actors and an opportunity for capacity development and networking for youth and researchers. It also aims at providing evidence to guide policy and facilitate the development of plans to meet the yet incomplete post 2015 development agenda.

Conference Objectives
- Provide a platform for the sharing of evidence-based knowledge from the key actors in women, girls' and maternal health with a focus on Female Genital Mutilation/Cutting and Girl Child Marriage.
- Engage different national, regional and international experts in a campaign to meet the yet incomplete post 2015 development agenda.
- Engage different national, regional and international experts to come out with concrete evidence-based recommendations to form future interventions and policies on Female Genital Mutilation/Cutting and Girl Child Marriage.
- Provide opportunity for capacity development and networking for youth and researchers working in women and maternal health, with a focus on Female Genital Mutilation/Cutting and Girl Child Marriage.

Theme
- Keeping the Promise for the Promotion of Girls', Women's & Maternal Health.

Sub-Themes
The conference addresses three major pillars that determine women's state of health, these are:
- Conducive Policy Environment: setting conducive policy environment for promoting women's health with a special focus on Female Genital Mutilation/Cutting and Girl Child Marriage.
- Community Based Approaches: to accelerate the abandonment of Female Genital Mutilation/Cutting and combating of Girl Child Marriage and

The conference hopes to draw evidence-based approaches that integrates gender, perspective, when refining national policies and programs to keep the promise.

Venue: Corinthia Hotel – Khartoum – Sudan
Date: 20th - 22nd October 2015

For more details visit website: www.graca.ahfad.sd.edu
or call: +249-157907312
Definition:

Female genital mutilation (FGM) comprises all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons. It has no health benefits and harms girls and women in many ways (WHO).

Statistics on FGM:

- The WHO (2010) estimates that 100-140 million women and girls around the world have experienced the FGM/C procedure including 92 million in Africa, where national prevalence rate of FGM among 15-49 years Sudanese women is 86.6% (MICS 2014).
- 9 out of 10 Sudanese women aged 15-49 have undergone some form of FGM.
- 31.5% of the girls aged 0-14 underwent any form of FGM/C (MICS 2014).
- 48% of women in reproductive age support the continuation of FGM in 2010 compared to 42% in 2014 (SHHS, 2010; MICS, 2014).
- 2 out of 3 men do not support the continuation of FGM/C (MICS, 2014).
- Almost 60% of FGM is performed by traditional midwives, 39% by a nurse or trained midwives (MICS, 2014).
Child marriage is a dilemma that many individuals and organizations have been fighting and trying to prevent for many decades.

Approximately 1 out of 5 girls across the Middle East & North Africa (MENA) are married off before the age of 18. According to UNICEF (2014), the MENA region has made the fastest progress in reducing child marriage, from 34 to 18% over the last three decades.

According to UNICEF, child marriage is defined as “a formal marriage or informal union before age 18” (UNICEF, 2012). UNFPA estimated that by the year 2020, 140 million girls will become “Child brides” (WHO, 2014).

Globally, 64 million women were married before the age of 18.

In Sudan, about 2 in 5 women marry before age 18 years (MICS, 2014).

In Sudan, the percentage of women married before age 15 ranged from 5.2 per cent in Northern State to 19.1 per cent in Blue Nile State (SHHS, 2010).

One in every ten women age 15-49 (11.9%) married before age 15, and (38%) of women age 20-49 were first married before age 18.

One in every five (21%) women currently married at age 15-19 (MICS, 2014).