Final Report

Evaluation of Norwegian Church Aid's (NCA) support to GBV projects implemented by SNCTP in Mayo Farm (2004-2010)

Figure (1): Map of Sudan.

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Contents

List of Acronyms

AIDS	Acquired Immunodeficiency Syndrome
CBOs	Community Based Organizations
CPA	Comprehensive Peace Agreement
DBs	Duty Bearers
FC	Female Circumcision
FGM	Female Genital Mutilation
KAP	Knowledge, Attitude, and Practice
HAC	Humanitarian Aid Commission
HIV	Human Immunodeficiency Virus (HIV)
HTPs	Harmful Traditional Practices
IDPs	Internally Displaced Persons
MDGs	Millennium Development Goals
NCA	Norwegian Church Aid
NGOs	Non-Governmental Organizations
RH	Reproductive Health
RHs	Right Holders
SNCTP	Sudan National Committee Against Harmful Traditional Practices
UN	United Nations
UNICEF	United Nations Children's Fund

Glossary

douda	Worm
fatwa	A legal pronouncement in Islam, issued by a religious law specialist on a specific issue
khifad Ferouni	A term used to describe FGM type III
khitan	Circumcision in Arabic eq. tahara
ghalfa	A term used to insult a girl, or a woman, if she is not circumcised
hakamat	Female community leaders
gattaa' al reesha	Throat cutting is a form of HTP practiced on parts of Sudan to clear any throat infections in children.
toub	Traditional dress worn by Sudanese women
sheloukh	Tribal marks or tattooing on the face
tahara	Circumcision in Arabic eq. Khitan
wannasa	General chit-chat

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Executive Summary

Background & rationale

1. Within its gender based violence GBV thematic priority area in Sudan and since 2004, the Norwegian Church Aid (NCA) has been working on combating HTPs/FGM and HIV/AIDS among IDPs in Mayo camp area through its national partner Sudan National Committee on Harmful Traditional Practices (SNCTP). SNCTP pioneered the campaign against FGM in the area.
2. The purpose of this evaluation is to assess the relevance and effectiveness of the SNCTP program in Mayo including investigating to what extent the program has contributed to changing knowledge and attitude towards FGM. Examining the impact and methodology applied within the program will provide important guidance for future models of implementation; particularly since SNCTP has sought the support of NCA to start working in a new location.
3. The design of this evaluation entailed developed both qualitative and quantitative methodologies such as FGDs, SSIs and KAP survey. The total number of the RHs and DBs who have participated in the evaluation was 184. The number of women outnumbered that of men.
4. The IDP population represents the largest section of the urban poor in Khartoum. High rates of illiteracy, inadequacy of health services, and GBV are salient characteristics in the community. The IDP camp in Mayo represents a melting pot where Sudanese from across the county co-exist. There are demographic shifting taking place in the camp due to the separation of the southern part of the country and the repatriation of IDPs from the south – who once represented the largest ethnic groups in the camp - to their new state. The number of the IDPs has been dramatically decreased but IDPs from the west are seen to dominate in numbers.
5. In 2003, a study was launched by SNCTP/SCC and NCA. It looked at HTPs practices among Mayo's IDP population conducted by. Several issues of concern emerged in the study, amongst the FGM has started to be practiced by communities, who do not traditionally practice FGM, such as Nuba and Southern Sudanese. In addition, it was found that IDPs had limited knowledge on the methods of transmission of and protection from HIV/AIDS.
6. The programme was developed by SNCTP focused on targeting several groups, who had influence and access to the target communities and decision makers. These groups are mothers and midwives, community and religious leaders, school pupils, teachers, and youth.

Summary of the Findings

The main findings of the evaluation generally suggest the following:

a. *FGM's knowledge, attitude and practice:*
   - Knowledge on negative consequences of FGM/HTP's and violence on women's health and rights shown in the target area

- An increasing number of women and men have no intention to circumcise their daughters or continue to support circumcision
- Men are less likely to have preference for future partner to be circumcised
- A slight reduction in FGM/HTP's is observed in the target Mayo Farm
- Young girls are less likely to be circumcised
- *Sunna* type of circumcision is more common among younger generations.

b. SNCTP program relevance and effectiveness:

- The findings suggest that that the pedagogical methods used by SNCTP were appropriate to raise awareness amongst the population in the area and to enable broad accessibility for stakeholders particularly amongst the hard-to-reach groups such as religious leaders and policy makers.
- Workshops, school debates, midwives training, ToTs, FGM international day and posters produced and distributed by SNCTP were described as the most effective tools in the campaign.

Recommendation

For SNCTP:

1. Continue using a comprehensive approach which addresses FGM/HTPs as violations for the rights of women and children.
2. Expand the FGM campaign in the other regions beyond Khartoum State.
3. Diversify funding sources in order to avoid interruptions in the program activities.
4. Design a clear long term strategy and establish an exit plan from the onset.
5. Improvements to current program monitoring tools and practices and in particular impact measurement and conduct a prevalence survey especially on young girls.
6. Reach out to mothers, grandmothers and fathers as a priority in future project and design a family approach.
7. Promote local ownership and local leadership
8. build capacities and leadership inside the organization
9. Establish leadership resource centre in order to enable an increasing knowledge sharing among the stakeholders.

For NCA

1. Continue using a rights-based approach but avoid the division of RHs and DBs which might create tension and aid dependency.
2. Ensure faster transfer of funds to SNCTP to avoid delay in the implementation of the programme.
3. Set-up regular monitoring visits to the field and design regular and periodical monitoring activities for the program.
4. Carry out capacity building trainings for all SNCTP staff, and not just those working on the project.

1. Introduction and background to the evaluation

Within its gender based violence (GBV) thematic priority area in Sudan and since 2004, the Norwegian Church Aid (NCA) has been working on combating FGM (Female Genital Mutilation) through its national partner Sudan National Committee on Harmful Traditional Practices (SNCTP). Over the past seven years, NCA supported SNCTP in its work to address FGM/HTP issues – primarily among the internally displaced communities living in Mayo Farm area in Khartoum. As such it is considered that an evaluation of the impact and methodology applied within the program will provide important guidance for future models of implementation; particularly since SNCTP has sought the support of NCA to start working in a new location.

NCA is one of the largest Norwegian international development agencies. It is a church based diaconal organization, which works with long-term development assistance, emergency relief and advocacy across the globe. NCA had become active in Sudan since 1969. NCA shares a vision of a just world and work respectively with people and organizations of all faiths. As such, NCA empowers right holders (RHs), and strives to achieve human dignity for all regardless of race, nationality, gender, political persuasion or religious beliefs.

One of NCA's five thematic Priorities is — Men and women address gender-based violence. Gender-based violence is defined as physical, sexual and psychological violence specifically directed against people due to their gender roles or identities, especially violence against girls and women. It is a gross human right violation, a criminal act, and a human security threat. It happens in a wide range of settings, in the family, in the community, by the state, in conflict and refugee situations; examples being domestic violence, intimate partner violence, sexual abuse, and rape, trafficking in children and women, new forms of slavery, female genital mutilation (FGM) and other harmful traditional practices (HTPs). GBV represents one of the most serious global health problems for women and girls.

Based on this, NCA endeavours to contribute to an environment free from gender-based violence and support partners in their efforts to expose and take actions against all forms of gender-based violence. NCA focuses on prevention of and responses to gender-based violence and promoting the rights and dignity of survivors of violence through advocacy work and challenges perpetrators to accept their duties as duty bearers (DBs).

Considering that people need to own the processes of their own change and development and benefit from them - and informed by a right-based approach which recognizes Right Holders (RHs) and Duty Bearers (DBs) as vibrant actors and partners in development; NCA is aware that national leadership and ownership in all stages of program design and implementation should be fostered and promoted. In light of this, NCA implements national projects mainly through establishing partnerships guided by a right-based approach with local institutions in the respective country such as SNCTP in Sudan.

SNCTP is a Sudanese women non-governmental organization established in 1985 and has been campaigning against FGM and other traditional practices that are harmful to the population. It is

one of the pioneering organizations in the field of social development in Sudan with a long history of contribution and a well recognized role that places the organization in a highly privileged position on the national, regional and international levels – particularly in the area of HTPs/FGM. The stupendous efforts that SNCTP has been leading in Sudan in order to eradicate the practice of FGM are crucial especially in a country like Sudan where FGM is widely practiced and the prevalence rates of FGM represent the highest in the world- along with Somalia and Egypt.

1.1. Evaluation Objectives

The overall objective of evaluation is to assess the relevance and effectiveness of the SNCTP program in Mayo Farm. The evaluation is meant to establish a guidance base for future planning for NCA and its partners SNCTP. Drawing on the lessons learned, it aims to inform the policy design, planning and programming of future interventions in the area of FGM. The specific objectives of the evaluation are:

1. To establish to what degree the program has achieved its overall goal and how it has contributed to the national work on policies and legal frameworks against FGM/HTP
2. To establish to what degree has the program been sustainable, relevant, efficient and effective.
3. To establish to what degree the program has addressed the agendas of participation, equity and protection and contributed to tangible results as expressed in the NCA GSP. To what extent RHs and other stakeholders have participated in planning and implementation of the program and duty bearers been addressed (e.g. legal issues, campaigns etc).
4. To identify constraints and challenges in the program.

Based on the objectives listed above, the evaluation project aims to explore the achievements and challenges of the SNCTP activities and programs in addressing HTPs (Harmful Traditional Practices) specifically FGM - on the national level in general and among IDPs (Internally Displeased people) in the Khartoum's Mayo Farm area in particular. It explores how these activities were a catalyst for raising awareness on the hazards and consequences of FGM and hence reducing its incidence among IDPS in Mayo Farm. It particularly looks at the relevance and effectiveness of SNCTP programs and activities and whether these activities have contributed to shifting ideas and perceptions against FGM within the target area. It further endeavours to assess the relevance and constraints of the approaches and pedagogical methods used by SNCTP in its campaign against FGM among the displaced people in Mayo. It also aspires to provide opportunities for RHs, DBs and other stakeholders for creating future visions and planning for next steps in order to ensure the sustainability of the program and the gains that has been accomplished.

In order to implement the SNCTP Program evaluation in Mayo, NCA has recruited two international consultants who carried out the evaluation research. In addition to the review of relevant program materials and documents, the evaluation process relied on combined

methodologies of both qualitative and quantitative research in order to collect and analyze data. This included focus groups discussions (FGDs) and semi-structure interviews (SSI) with key research participants as well as a survey method – based on the use of Knowledge, Attitude, and Practice (KAP) methodology. The evaluation was carried out over the period from November 2011 until January 2012.

1.2. Structure of the report

This report focuses on the evaluation rationale, process and findings. It provides description and analysis of findings related to the objectives of the evaluation. The evaluation findings and the data which were gained through various sources and methods were all integrated and synthesized in order to compose this evaluation report.

The report begins with an introductory section. The introductory section provides an executive summary which highlight the main purpose, process and outcomes of the evaluation. This is followed by two sections (2 & 3) in which the contextual information on the evaluation objectives and on the context in Sudan, IDPs, reproductive health, FGM, and SNCTP Mayo program's objectives and key achievements are highlighted. Section (4) describes the overall methodology of the evaluation including the implementation of the interviews, FGDs, surveys, and the SNCTP program's objectives and key achievements in Mayo. Section (5) highlights the findings of the evaluation research. It highlights the changing knowledge, attitudes, and practices of FGM and demonstrated the prevalence rates of females' circumcision in the area. It also assesses the relevance and effectiveness of the SNCTP program in raising awareness on FGM and whether the pedagogical methods and approaches employed by the program were appropriate and effective. This will be followed by three other sections (6, 7 & 8) which demonstrate the lesson learned, the concluding remarks and the recommendation for the program on how it can be strengthened further.

2. The Context of FGM and IDPs in Sudan

2.1. Socio-economic and political contexts and their impact on the situation of reproductive health in Sudan

2.1.1. IDPs in a 'new' Sudan

As of 9 July 2011, Sudan is no longer the largest country in Africa; South Sudan succeeded and became the youngest country in the world dividing the country along fault lines. Sudan was embroiled in two prolonged civil wars for most of its post- independence period. These conflicts were rooted in northern economic, political, and social domination, whilst many of those living in the periphery have been largely sidelined and marginalized. The first civil war started in 1957 and ended in 1972, but broke out again in 1983. The second war and famine-related effects resulted in more than four million people displaced and led to more than two million deaths[1]. After much international pressure to end the conflict, the Comprehensive Peace Agreement (CPA) was signed in January 2005, granted the South Sudan autonomy for six years, followed by a referendum on independence for South Sudan. The referendum was held in January 2011 and indicated overwhelming support for independence, and July 2011, South Sudan seceded. A separate conflict broke out in the western region of Darfur in 2003, which displaced nearly two million people and caused an estimated 200,000 to 400,000 deaths, according to the UN[2].

As a result of decades of civil strife and multitude of conflicts, Sudan faced some serious challenges including the largest number of Internally Displaced Persons (IDPs) in the world, with figures before the succession being quoted at 6 million, with some 2 million in Khartoum state alone[3]. Many of those who are displaced in Khartoum have resided in four official IDP camps[4] as well as unauthorized settlement areas. Most of the populations in the camps had fled the conflict in South Sudan, however, in the last couple of years most of the influx has been from Darfur. Despite the paucity of statistical data on IDPs in Sudan, it might be suggested that the number of IDPs arriving from Darfur and other western regions in Sudan might now overweigh the number of Southern Sudanese IDPs who once dominated[5] the landscape of IDPs Camps in Khartoum including Mayo Camp and whom repatriation to the newly-formed South Sudan State is taking place collectively at a rapid pace.

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[1] Christian Aid- UK, http://www.christianaid.org.uk/whatwedo/in-focus/sudan-referendum/two-civil-wars.aspx (accessed 16 December 2011).
[2] UNICEF, http://www.unicef.org/infobycountry/sudan_darfuroverview.html (accessed 16 December 2011).
[3] LandInfo, Thematic Report: Sudan- Internally Displaced Persons in Khartoum (http://www.landinfo.no/asset/748/1/748_1.pdf), 3 November 2008.
[4] These four camps are: Mayo, El Salaam, Wad El Bashir and Jebel Awlia.
[5] In 2006, the predominant in the displaced camps came from the largest Southern Sudanese tribe: Dinka Save the Children Sweden . Future scenarios of IDPs in Mayo and El Salam camps. 2006. Save the Children Sweden and Agency for Co-operation in Research and Development. 2006 Save the Children Sweden and Agency for Co-operation in Research and Development – page 10 & page 13 .

The strenuous socio-economic conditions of IDPs in Khartoum are exacerbated by lack of access to essential services, as well as the continuation of Harmful Traditional Practices, such as FGM, which on occasion has been introduced to communities which did not practice it in the past[6]. For example, a study carried out by Ahfad University for women and revealed that among internally displaced southerner Sudanese living in Khartoum state, 6.8% of the women/girls have been circumcised (SNCTP Report, 2010:3).

Mayo farm, one of the official camps and the focus of this evaluation, where the number of IDPs recorded at 65,000 in the most recent study[7], these numbers have drastically dropped following the separation of South Sudan, however, there are no recent assessments or studies to show the specific figures. Many IDPs from the South live in a legal limbo, waiting for their status to be determined and for their repatriation[8].

2.1.2. IDPs in Mayo[9] Farm (Mandela)

Mayo Farm displaced camp (or what is commonly called Mandela) is one density populated camp in greater Khartoum. It lies south of Khartoum town about 15km. It was established in 1990 and is called so (Mayo Farm) because the area was an agricultural Farm that belongs to a certain merchants. These displaced people came to settle in the camp in groups. The first group is IDPs directly from the south and the western part of the country who first settled at SOWETO displaced camp near central market known as al-Souk el-Markaz.

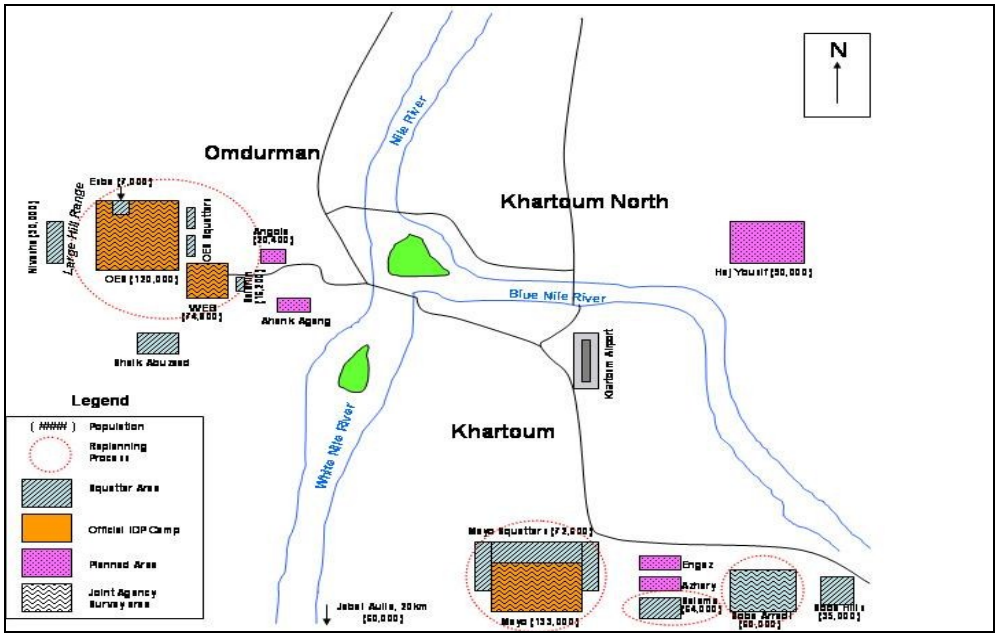

Figure 2: Map of Khartoum IDP areas[10]

[6] For more information on the socio-economic and political conditions of IDPs in Sudan, see for example SCS 2006.
[7] SNCTP narrative report, 2009
[8] Issues of citizenship for southern Sudanese in this interim period, etc …. See SIHA Report
[9] Literally means May in Arabic – the name of the month used in the Georgian calendar.

These groups of displaced people had tribal clashes among themselves and were taken to settle in Mayo Farm displaced camp in 1990. The second groups were the town squatter settlers or finally displaced from the southern Sudan. Others were from Dar El-Salam Mayo, when their area was demolished by the government in 1991[11]. They went and settled in Mayo. These groups were followed by the third group of displaced coming from Warrap state in south Sudan in 1997. The forth groups were the people displaced from the area between Kalakla and Mayo called Asian at bank El-Aghari residence, they were forced by the government to desert this residential area. So, this group started to live in this displaced camp. These groups is composed of tribes named Dinka, Nuer, Bari, Shulluk, Zande, Moru, Balanda from South, El-Rezegat, Nuba, Gasama from south west Kordofan and Darfur. Also some refugees from Uganda, Chad and DRC (Zaire) live as refugees in these camps.

Figure (3): Pupils playing at their school in one of the IDP camps- Credit: The Guardian. http://www.guardian.co.uk/

[10] Khartoum State Joint Rapid Assessment Report – Inter-Agency Rapid Assessment Report. Nov/Dec 2004

[11] The re-planning of towns initiatives carried out by the government, led IDPs to be relocated. The relocation was often carried out without allowing the people concerned a reasonable period of grace and as such had negative impact on the people such as deepening the feeling of insecurity and instability among IDPs. Also, relocation might end in the destruction of community cohesion and neighborhoods, lack of coordination with UN agencies and NGOs working with the IDPs, and the reduction of IDPs accessibility to services. The situation is aggravated by the fact that IDPs had to pay, out of their own meager resources for construction expenses. There are two studies namely Food and Power in Sudan: A Critique of Humanitarianism and African Rights (1998) and Displaced populations in Khartoum: A Study of social and Economic Conditions: Channel Research (2000) underlined other rationales of the relocation policies. These rationales include financial, socio cultural rationales, and security related ones. Source: Save the children Sweden, 2006:11.

The estimate population of Mayo in general is 28,000 including 13,000 of Mayo Farm, it falls under El-Nasr council (present Mayo). Mayo Farm is divided into seven (7) sub-blocks. Each locality has a popular committee and three are about (42) popular committee which represent the government in Mayo in general. The popular committee includes youth, women union and chives. However, there is dominance of certain tribes in each residential area (Save the Children Sweden, 2006:14).

The Mayo Farm community reflects different cultures, traditional beliefs, values, attitudes and religious beliefs. In order to 'properly' integrate in the new society, some of the IDPs communities, adapted cultures which is not of their origin such as female circumcision (FC) or Female Genital Mutilation (FGM) – classified as one severe form of the Harmful Traditional Practices (HTPs), child rights violations, and Gender based Violence (GBV) – and widely prevalent in the Sudanese culture along with early marriage, milk tooth extraction, *sheloukh* (tribal marks and tattooing), etc.

The IDPs represent the largest section of the urban poor in Khartoum (Save the children Sweden, 2006:11). With regard to the socio-economic profile of IDPs in Mayo Farm, the level of education in the camp is generally low (Save the Children, Sweden, 2006). For many of these displaced people, education does not constitute a priority which results in staggering rates of school dropouts. However, for many of those who decided to send their children to schools boys' education is generally perceived to be more important than that of the girls.

High illiteracy rates coupled with widespread poverty and dearth of services and employment opportunities put IDPs in arduous life conditions. This situation results in power quality of life and low income for both women and men. Many women depend on brewery, tea-selling, domestic work, etc as source of income to sustain themselves. While for the men, many of them spend the whole day working typically in manual jobs such as construction, street vending, etc and many others remain just unemployed. Levels of crimes, prostitution, and alcohol and drugs abuse are very high among IDPs which in turn provides an ideal environment for behavioural risks and for other serious hazards such as the spread of HTPs and fatal diseases including HIV/AIDS.

2.2. The context of Reproductive Health (RH) in Sudan: An overview

The health outcomes, compared with Millennium Development Goals (MDGs) for Sudan, are generally low and progress towards achieving them is slow. Maternal mortality ratio is 1,107 per 100,000 live births (638/100,000 in the Northern states), infant mortality was 81/1000 live births (71/1,000 in the Northern states), and the under-5 mortality rate was (102/1,000 in the Northern states) in 2006[12]. One of the main reasons is that only 20 per cent of Sudanese women deliver in a health facility (in South Sudan only 13.6 per cent of women deliver in health facilities). Overall, the accessibility and quality of health care is poor (SCS 2006). The national maternal mortality rates are also very high at 1107 per 100,000 live births. Outside urban areas, little health care is available in Sudan, helping account for a relatively low average life expectancy of 57 years and an infant mortality rate of 71 deaths per 1,000 live births - low by standards in Middle Eastern but not African countries. Furthermore, communicable diseases

[12] National Strategy for RH in Sudan 2006-2010 (page2)

including vaccine preventable constitute a major burden of disease, and the health system, after years of conflict, is disrupted and inadequate to provide essential Primary health services to the population, especially those who are vulnerable[13].

Health indicator	Northern states/Urban	Rural
Maternal mortality rate	638/100,000	1.107/100,000 live birth
Infant mortality rate	71/1,000	81/1000 live births
the under-5 mortality rate	102/1,000	-
Life expectancy	57 years	-

Table (1): RH indicators in Sudan 2006

For most of the period since independence in 1956, Sudan has experienced civil war, which has diverted resources to military expenditure that otherwise might have gone into health care and training of professionals, many of whom have migrated in search for better opportunities. Substantial percentages of the population lack access to safe water and sanitary facilities. Malnourishment is widespread outside the central Nile belt because of population displacement from war and from recurrent droughts; these same factors together with a scarcity of medical supplies render diseases difficult to control. Child immunization against most major childhood diseases, however, had risen to approximately 60 percent by the late 1990s from very low rates in preceding decades[14]. With regard to HIV/AIDS, the years of civil war and limited epidemiological data makes it difficult to generalise about HIV and AIDS prevalence in Sudan. The estimated HIV prevalence rate is 1.6 per cent among the adult population in northern Sudan and 3.1 per cent in South Sudan[15] (UNAIDS Reports 2008 cited in Al – Nagar et al, 2011:11-12).

Under these circumstances, access to health services especially for children, has been especially difficult in Khartoum's IDP camps and for other groups who reside in illegal settlements. As many NGOs are phasing or have phased out their operations and IDPs have to pay fees for treatments[16]. This accompanied by the spread of HTPs such as FGM, milk tooth extraction, and tattooing which are all prevalent and identified by medical experts as high risk factors for the transmission of HIV/AIDS and for causing other major health hazards.

2.3. The context of Female Genital Mutilation (FGM) in Sudan: An overview

The roots of FGM are tangled deep in the social and cultural traditions of many parts of Sudan. They reflect stark inequalities in the status of women and girls. FGM is closely linked with a girl's modesty, and morality and family honour; girls who are circumcised are considered

[13] Gamal Khalafalla Mohamed Ali, Accessibility of medicines and primary health care: The impact of the revolving drug fund in Khartoum State, African Journal of Pharmacy and Pharmacology Vol. 3(3). pp. 070-077, March, 2009.
[14] WHO, The State of Midwifery Report 2011: Delivering Health, Saving Lives, (http://www.unfpa.org/sowmy/resources/docs/main_report/en_SOWMR_Part4.pdf)
[15] UNAIDS Reports 2008 cited in Al – Nagar at al, 2011:11-12
[16] Save the Children- Sweden and Agency for Co-operation in Research and Development, *Future Scenarios of IDPs in Mayo and El Salam camps*, 2006, P20.

decent, chaste and morally pure. These are all important qualities for men while deciding on their future wives, hence FGM has been greatly considered to make girls suitable for marriage. Pejorative terms are used to disgrace uncut girls, including the word *ghalfa,* which is associated with low status and prostitution (UNICEF, 2009:40).

The prevalence rates of FGM in Sudan present one of the highest in the world along with Egypt and Somalia. Statistics on the prevalence rates of FGM in Sudan have been steadily indicating a decrease in the practice. To illustrate, successive national surveys between 1979 and 1983 recorded that 96% of women have undergone FGM. A study carried out by SNCTP between 1996 and 2000 showed that the prevalence rate of FGM among Northern Sudanese women is 84% and 91% among rural women (SNCTP-NORAD, 2006). Data from the 2006 Household Survey indicated that FGM was reducing but still widespread in Sudan and about 89% of women aged 15–49 in the northern part of the country have undergone some sort of FGM[17]. The most recent statistics offered by the Sudanese Survey for Family Health and the Millennium Development Goals (2010) also points to a drop in the prevalent rates of FGM by 65.5%. The same survey suggests that 42.3 of women aged 15-49 still support the practice of FGM.

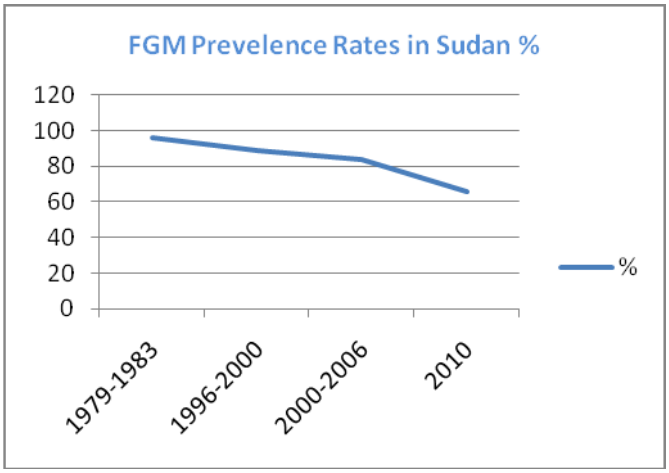

Figure (4): FGM prevalence rate in Sudan 2010

Despite these improvements, the persistence of the practice is still common in many parts in Sudan; however, the prevalence varies on basis of geographical locations, religion, age, level of education, etc. For example, FGM is practiced to a wide extent in Northern Sudan and in rural areas, compared to the Southern parts and the urban centres. For instance, support for FGM is weakest among women in Khartoum (32%) and highest among women in Kassala (69%) and south Darfur (66%) - (Al-Nagar at al, 2011:12). Furthermore, it was shown that better educated women and women in the wealthiest quintile are less likely to favour the continuation of FGM (28%) compared to women who are uneducated and in the poorest quintile (63 %). This steady drop of the rates of female circumcision in Sudan is reflected not only in the total number of incidents but also in the practice of 'milder' form of FGM – i.e. from the severe form of infibulations commonly known in Sudan as *Farouni* (type III) to *Sunna* circumcision (type II) [18].

[17] Sudan Household Survey 2006. http://www.unicef.org/sudan/health_4284.html
[18] Female genital mutilation is classified into four major types.

Interestingly, some studies revealed that against the expectations younger women were more inclined to support the continuation of female circumcision. For example, 58% of women aged 15–19 support the practice compared to 49% of women aged 15–49 (Ahmed et. al 2009). Similarly, a recent study among the students of the Khartoum University suggests that the number of female students supporting the continuation of the practice is exceeding that of their male counterparts (University of St. Andrew, Scotland, UK. 2011).

For example, in the past two years, the National Council for Child Welfare[19], has carried out joint activities with SNCTP, as well as other relevant national NGOs, in 2009 to formulate a new Child Rights Act, which included provisions criminalizing all forms of FGM. The article, referred to as article 13, had provisions criminalizing all types of FGM, and allows for the persecution and imprisonment of the person, or persons, who carry out the procedure, as well as the guardians and anyone who was aware of the act. However, the attempts to criminalize all forms of FGM failed, after senior government officials, guided by a fatwa supporting the use of FGM type I and II, blocked article 13 and threatened to scrap the whole of the Child Act. The Child Act was finalized and came into force in 2010, without clear language regarding the criminalization of FGM. This was a major setback for the campaign, as it encouraged the continuation of the practice. In addition, it leaves room for interpretation what type of FGM can be carried out. Furthermore, this has given the green light for the continuation of the practice, as there are no consequences for those who carry out circumcision or allow it. This can also set precedents in other countries where FGM is still being practiced, such as Somalia, Djibouti, Yemen, Ethiopia, Eritrea, and Chad and in parts of West Africa could implement the fatwa that the Sudanese government used to reject the full criminalization of FGM (SNCTP Report, 2010:3).

Nevertheless, however slow; the gradual shift in public attitudes toward female circumcision in Sudan has been largely driven by intensive efforts of advocacy and policy led by the government, NGOs, individuals, and other stakeholders (LandInfo, 2008). Historically, political and religious leaders, with the support of medical doctors and Britishh colonial officials, initiated the first efforts to ppromote the abandonment of FGM in the Sudan during the 1930s. Toward the end of 1970s social movement llargely driven by local NGOs and motivated by individual cases of girls who had died while being cut ha d begun to campaign against FGM (UNICEF, 2009:41). Today in Sudan, there have been several developments and FGM abandonment programs and activities are promoted at all levels – community, state and national. As civil society organizations became involved and drew attention to the dangers of

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- Clitoridectomy: partial or total removal of the clitoris (a small, sensitive and erectile part of the female genitals) and, in very rare cases, only the prepuce (the fold of skin surrounding the clitoris).
- Excision: partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (the labia are "the lips" that surround the vagina).
- Infibulations: narrowing of the vaginal opening through the creation of a covering seal. The seal is formed by cutting and repositioning the inner, or outer, labia, with or without removal of the clitoris.
- Other: all other harmful procedures to the female genitalia for non-medical purposes, e.g. pricking, piercing, incising, scraping and cauterizing the genital area.

WHO. Female Genital Mutilation, Factsheet No 241, February 2010, http://www.who.int/mediacentre/factsheets/fs241/en (accessed 15 December 2011)

[19] a department within the Ministry of Social Welfare, Women and Child Affairs, works to monitor and implement the Convention on the Rights of the Child nationally in the Sudan

FGM, the Government of the Sudan also began to show greater interest in the subject and hosted a number of rregional conferences that framed FGM within the broader context of protecting the rights of children (UNICEF, 2009:41). As an example for the government commitment, the state minister for health, Amira Fadil has been outspoken even in religious debates and very committed to bring an end to the practice. The Ministry of Health has maintained its line, prohibiting the practice by any medical officials. At the state level there have been more success stories: FGM has been banned, and criminalised, in Gadarif State, Red Sea State; South Kurdufan and Sinnar. The punishments vary, but significantly midwife risk having their work bags and IDs confiscated.

These efforts would not be fully successful or sustained unless the FGM practice is completely banned and the perpetrators are held accountable. The body of legislations that addressed HTPs and child rights are largely ambiguous, and is not enforced. In addition, in some occasions activists and NGOs combating FGM can be subject to pressure from the authorities to stop their activities; whilst there are well organized pro-FGM campaigns (LandInfo, 2008).

SNCTP has been playing an instrumental role on many levels in the FGM campaign, as well as in the wider awareness campaigns on Harmful Traditional Practices (HTP). While recognized as a significant contributor in brining positive change in attitudes and an end to FGM, there are numerous challenges for SNCTP- internal and external- which reduces and weakens its impact and its ability to meet the goals it has set for itself.

2.4. SNCTP program in Mayo: goals and key activities

SNCTP's privileged position:

Despite the fact that Harmful Traditional Practices (HTPs), such as FGM, causes physical and mental pain and suffering to millions of people and can be life-threatening, it remains deeply entrenched in certain social value systems. Changing this reality to bring about positive and protective social behaviour requires a holistic and integrated approach with harmonized programmes of action to achieve the common goal of eradicating these practices. Based on many years of experience working in this area, SNCTP believes that the practice can and should be eradicated. It also recognizes that this can be achieved in a short space of time if all stakeholders join efforts and act in a concerted manner.

SNCTP had numerous advantages that has allowed it to succeed when it has embarked on the project on FGM in Mayo camp, these include:

- No other organization was conducting work on FGM in Mayo.
- SNCTP has a long history and experience as a pioneer in the national and regional campaign against FGM.
- SNCTP's leadership is widely recognized in the FGM campaign and highly respected by other activists, organizations and local communities. Widely recognized and highly respected leadership
- Experience and ability to reach out to various stakeholders, including religious leaders and senior policy makers.

- SNCTP enjoys regional and international coverage and networking. It is a member and an active in a number of campaigns and forums, including the Inter-African Committee against Harmful Traditional Practices (IAC)
- SNCTP has long experience of working directly with IDP communities, also in different parts of Sudan, building trust over the years.

Why FGM in Mayo?

In 2003, SNCTP launched a study[20]- with support from Sudan Council of Churches (SCC) and NCA – which looked at HTP practices amongst IDPs in Mayo farm. Several issues of concern emerged in the study, amongst the FGM has started to be practiced by communities, who do not traditionally practice FGM, such as Nuba and Southern Sudanese. Also, some of the women in these communities started to perform circumcision as a source of income[21]. Some of the other key findings in the report include:

1. Among IDPs in Mayo, FGM is increasing within ethnic groups that did not have the tradition before in view of a false understanding of acculturation for IDPs to their new Arab environment in north Sudan. This misconception leads to the fact that girls from southern Sudan undergo the practice to become more easily accepted for marriage.
2. The knowledge of adult people in Mayo Farms about FGM is poor and needed to be improved.
3. A pro FGM group, composed mainly of conservative and Islamic forces, began to openly support the practice of FGM type I and II. One of their proposals was the establishment of centres across the country, which offers circumcision of girls by trained health officials. There was an international outcry against such a move, and the government quickly moved to distance itself from the group and issued statements condemning these proposals.
4. A high percentage of Mayo Farms adult population had no knowledge of HIV/AIDS or its transmission.

Target groups – Beneficiaries

The programme was developed by SNCTP focused on targeting several groups, who had influence and access to the target communities and decision makers.

One of the main groups targeted are the midwives and women who carried out the circumcision on girls and home births. Training programmes were developed to convey clear messages on the health risks associated with FGM and conveyed in a language that was easily understood.

Symbolically, midwives are sworn to never practice FGM; however, some are reported to have returned to doing the same thing due to economic reasons, mainly. The fact is that once they lose their status, once they admit that what they are doing is wrong, no woman will go back to them or trust them. A strategy that has also proven very successful is a combination of these

[20] SNCTP Study, 2003, title
[21] SNCTP Report, 2010

approaches to have better outreach, and has given the local communities to have ownership of the campaign.

Emphasis on youth leadership development in the community has been a major objective for SNCTP, because they are the future parents. Training programmes for youth and school pupils were designed to help them understand the danger of FGM and HIV/AIDS. But it also encouraged young people to be agents of change through education, information, workshops and informal networks to educate others as well.

Religious and community leaders also play an important role, because there misconceptions, and were identified as a key target by SNCTP. Workshops and lectures were organised on regular basis, and they were engaged in major events, such as the International Day against FGM.

Charts for NCA beneficiaries:

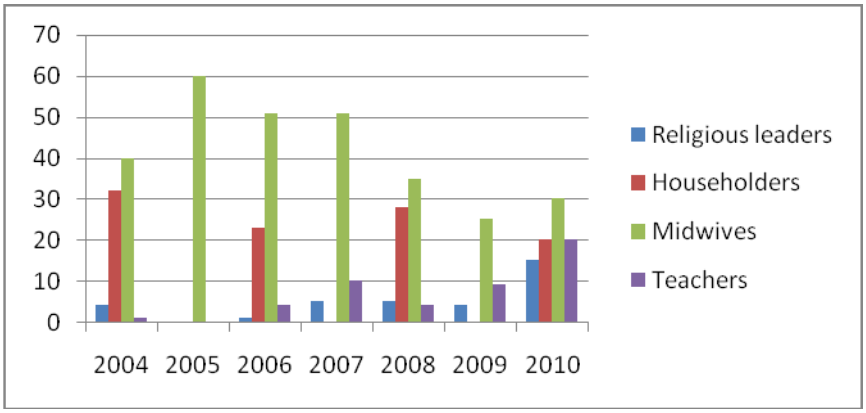


Figure (5): Total ToT workshops, 2004- 2010

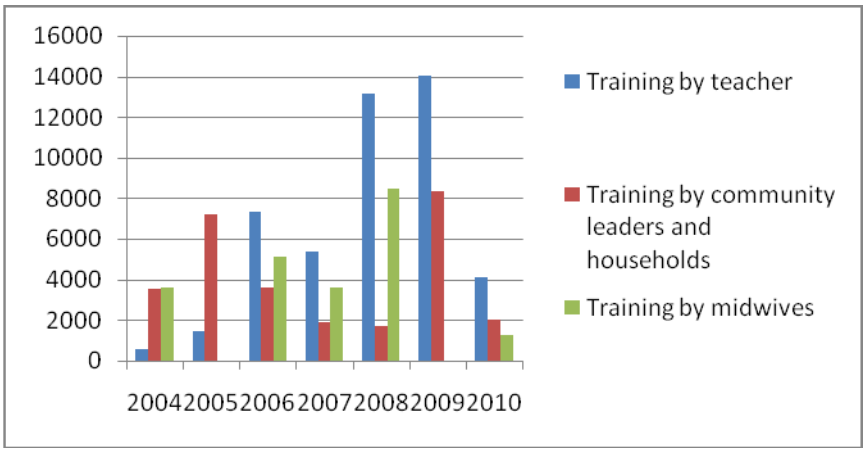


Figure (6): beneficiaries who benefited by sessions organised by ToT trainees

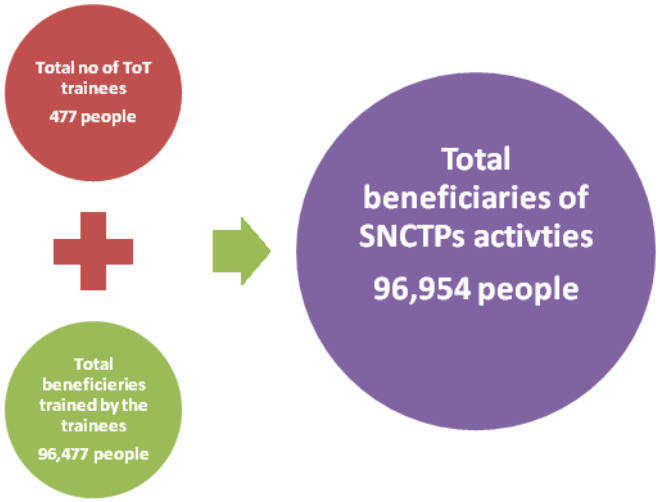


Figure (7): Total number of TOT and Total beneficiaries benefits from community (Awareness rising programs)

Campaign strategies and pedagogical approaches:

SNCTP believes that the elimination of harmful traditional practices has to be approached through training, and advocacy. It employs a multi-pronged approach that seeks to match the appropriate strategy to specific community characteristics, with its work consisting primarily of carrying out educational and "sensitization" campaigns. SNCTPs staff members visit schools and health centres, organize workshop for midwives, mothers, teachers, school pupils, religious leaders, and youth, which are nuanced accordingly.

The evolving interests and voices against FGM are manifested not only in the quantity of actors and campaigns but also in the approaches and methods adopted in advocacy. In other words, many groups shifted their approach from focusing on the medical aspects (which is deemed to limit the impact of these campaigns) of the practice to a rather broader one which emphasizes FGM as a form of GBV and a human rights violation against women and children and an impediment to effective and sustainable development.

At the start of the project, SNCTPs messaging was nuanced towards highlighting the health risks associated with FGM, with emphasis on HIV/AIDS. Recently, the organization has shifted its approach, which is geared towards FGM campaign being seen in a context of women, child and human rights.

SNCTP along with other NGOs propose new and creative ways in their efforts to reach out to local communities and advocate for eliminating the practice of FGM. For example, the national Saleema campaign which was launched in March 2008 uses an 'appreciative approach' in which women's - body as they were born - is perfect and should remain intact. The Arabic word

saleema, meaning whole, undamaged, unharmed, complete, was eventually chosen to describe the uncut female. An added advantage was that saleema could also be used as a girl's name[22].

With the media, some TV and radio programmes have been used to campaign against FGM and there is a network of traditional media campaigning with us against FGM. As far as schools and health centres are concerned, SNCTP used posters and leaflets, with clear graphics language, to provide information about FGM and other HTPs.

There have also been activisms in relation to reforming current laws to criminalise FGM through regular lobbying and advocacy. Also, SNCTP has been closely engaged in the negotiation and drafting if the Child Rights Act 2010, however, a key article which criminalises FGM was taken out.

Methods of education and advocacy:

SNCTP has developed methodologies, based on its experiences, to carry out its campaigns. One of the more proactive has been the use of community dialogues, which allows it to build closer ties with local communities, and engage them on regular basis.

The main methods used by SNCTP include community dialogues, fast education via participation, as well as rights-based approach, and later on, psychological intervention. The planned activities are based on a five years strategy – currently SNCTP is implement ting 2008-2012 strategy- and its methods are reviewed to address the subsequent strategies, and related policies and research needed. One of the more effective tools used by SNCTP has been the presentation of visual materials, such as leaflets.

2.4.1. Summary of major activities and contributions in the area of FGM – 2004-2011

NCA Activities: 2004- 2010

In term of NRCs training activities and monitoring, this was the core of the FGM campaign. The table and chat below which activities were the focus for SNCPT.

Activity /year	Training Workshops	TOT	Sensitization of mothers/women	Community Debates sessions	Sessions in Schools	Home Visits sessions	Meetings	Monitoring Missions	psycho-social counselling
2004	2	2	240	72	384	-	-	-	-
2005	2		480	55	316	-	6	2	-
2006	3	1	265	30	312	192	8	2	-
2007	3	1	318	35	462	192	6	2	-
2008	2	-	182	23	857	-	6	2	-
2009	1	1	199	23	913	192	8	1	-
2010	2	2	48	23	116	-	6	2	1

Table (2): SNCTP activities 2004-2010

[22] UNICEF, 2009

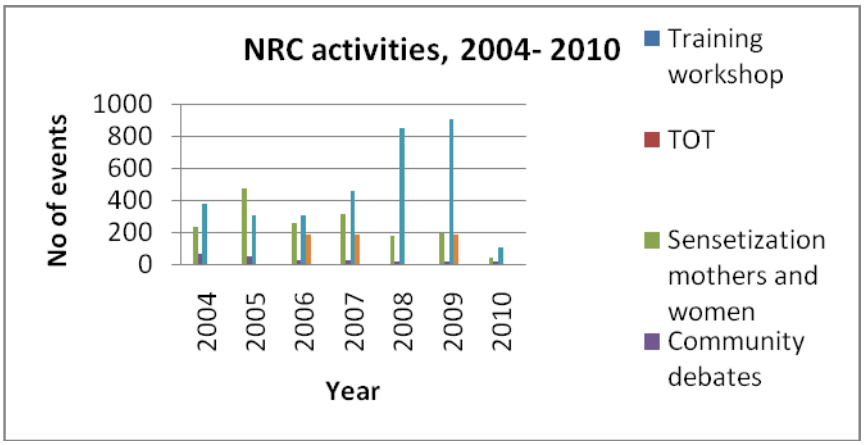


Figure (8): SNCTP activities 2004-2010

Public events participation: 2004- 2010

With regards to visibility and public events, SNCTP has attracted huge crowds. The charts below that there was considerable attendance, especially for football competitions, which brings a large number of youth and the messages on FGM are conveyed.

Event/year	Football Competition (spectators)	6th Feb event (participants)
2004	-	-
2005	1,800	500
2006	1,200	609
2007	500	
2008	-	1500
2009	300	450
2010	250	1000

Table (3): SNCTP public events participation 2004-2010

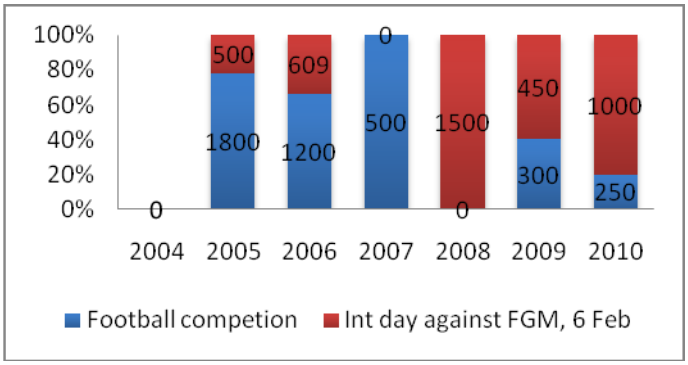


Figure (9): SNCTP public events participation 2004-2010

3. Methodology

With guidance from NCA and SNCTP, the design of this evaluation was developed on a right-based approach principle in accordance with NCA Global Strategic Plan 2005-2009. Hence, a participatory research that used a combination of qualitative and quantitative methodologies was implemented. As the evaluation relies principally on the RHs and DBs who have been involved in the program, relevant data has been collected through focus group discussions (FGDs) and semi-structured interviews (SSI) with individuals. In addition, a research questionnaire was set up in line with KAP study methods in order to measure changes in IDPs knowledge, attitudes and practices in response to the interventions made by SNCTP in addressing FGM. KAP is a useful tool to facilitate the exchange of opinions and experiences, which are essential in the process of changing attitudes towards FGM.

The evaluation sample was selected in a systematic manner based on engaging an even number of participants affiliating to the five focus groups i.e. mothers and midwives, religious and community leaders, teachers, school pupils, and youth. Furthermore, the evaluation data has been gathered through reviewing relevant program materials and documents such as program proposals, SNCTP reports to NCA and national and international reports on FGM, HTPs and woman and child rights. Finally, a meeting will be held in Khartoum (on 22 December) where the preliminary findings of the evaluation were discussed and analyzed. The background information extracted from the documents and the data which were gained during the fieldwork were all integrated and synthesized in order to compose the final report for this evaluation.

According to NCA, the indicators of achievement which are common objective level indicators for SNCTP since 2006 are generally derived from:

1. A reduction in FGM/HTP's is observed in the target area (Mayo Farm)
2. The role of men and male children in activities that used to be traditionally assigned for girls and women increased in the target area
3. Increased knowledge on negative consequences of FGM/HTP's and violence on women's health and rights shown in the target area
4. Changes in parents, grandmothers, midwives behavior towards gender roles and sensitivity realized in the target areas
5. Increased knowledge on women's legal rights and leadership

In order to conduct the evaluation, an international consultant (Dr. Amira Ahmed) was selected to lead the evaluation. She then identified a co consultant (Ms. Bashair Salaheldin E. Ahmed) and they have been both working closely together with NCA and SNCTP teams. Both consultants were skilled researchers and their entrenched knowledge and familiarity with the context and the official language of Sudan as well their experience working with refugees and IDPs have all presented an important advantage for the evaluation. In consultation with NCA and SNCTP, the consultants developed the evaluation plan and design including the evaluation methodology and data collection

tools. The work plan and the evaluation methodologies set by the consultants were thoroughly discussed and were approved during a workshop which took place in the NCA Khartoum Office on 14 November 2011 (please see Annex II). The workshop involved Mr. Tarig Ali (NCA), Mr. Samuel Kabi (SNCTP), and the two consultants mentioned above. It is important to mentions that during the workshop, it was decided that the evaluation should attempt to underpin the above listed five indicators, but should give particular attention to indicators number (1) and (3) due to their relevance to the scope of the evaluation. Upon the approval of the work plan and the evaluation methodology, a data collection phase was launched and continued until almost the end of the month of November 2011.

The research sample reflects a diversity of internally displaced people who are living in Mayo Farm. The evaluation research participants were identified by SNCTP and represented five main groups or categories of RHs and DBs as follows: mothers and midwives, religious and community leaders, teachers, school pupils, and youth.

3.1. Fieldwork in Khartoum (November 2011): Data collection tools

As it was mentioned earlier in the report beside the review of the pertinent documents and materials, relevant data for this evaluation were gained through FGDs and SSIs.

3.1.1. Focus Group Discussions (FGDs)

Overall, a total of 75 RHs and DBs were invited and participated in five FGDs in accordance with the various groups of RHs and DBs identifies above. The number of females (59) outnumbered that of the males (16). The structure and activities of the FGDs sessions were developed in a creative way in order to engage both the participants and evaluator and to allow for proactive engagement and interaction (please see Annex III). All FGDs took place in SNCTP Office in Khartoum-Gabra. The first FGD was held with the group of 'mothers and midwives' and it took place on 16 November 2006.

Category	No of women participants	No of men participants	Total no of participants
Mothers & Midwives	**20**	**0**	**20**
Community & Religious Leaders	**0**	**8**	**8**
School Pupils	**20**	**0**	**20**
Teachers	**16**	**2**	**18**
Youth	**3**	**6**	**9**
Total	**59**	**16**	**75**

Table (4): A Summary of FGDs conducted by Category

3.1.2. Semi-Structured Interviews (SSIs)

SSIs were based on guiding questions which were crafted in line with the evaluations objectives and indicators. The guiding questions were always revised and adjusted depending on the person who will be interviewed (please see Annex V). The interviewees were selected by both NCA and SNCTP. The identified key participants in these interviews reflected persons who had an interest in the area of HTPs/FGM and/or the NCA-SNCTP program including midwives, teachers and youth as well as representatives from NCA staff, SNCTP staff, NGO's working on women and girls rights issues and cooperating with NCA, relevant UN Agencies, Sudanese Federal Ministry of Health and other relevant national and international organizations. Most of the interviews were conducted in Arabic; each interview took an average of 1 hr 15 minutes and they were interactive and conversational. The followings table demonstrates the names and affiliations of people who have been interviewed:

S/No.	Name	Position	Date of interview
1.	Mr. Amin El Fadil	Country Director, Save the Children Sweden.	22 Nov. 2011
3.	Ms. Elisabeth Mustorp	NCA Country Director	22 Nov. 2011
4.	Mr. Tarig Ali	NCA	21 Nov. 2011
5.	Dr Amna A. R. Hassan	Executive Director SNCTP	16 Nov. 2011
6.	Mr. Samuel Kabi	Project Officer for SNCTP and Project Coordinator for FGM project in Mayo	19 & 21 Nov. 2011
7.	Ms. Wafa Kamal Alamin, Journalist and Board Member since 2010	SNCTP: SNCTP board members	20 Nov. 2011
8.	Ms. Samira Suliman Da'oud, Activist and Board Member since 2010; was a founding member of SNCTP in 1985	SNCTP: SNCTP board members	20 Nov. 2011
9.	Dr. Omer Abdelmtalib	Director of Omer Ibn Alkatab Medical Centre in Mayo	20 Nov. 2011
10.	Ms. Fatma Abdallah Agir	Mothers/Midwives	16 Nov.2011
11.	Ms. Munira Suliman	Mothers/Midwives	16 Nov. 2011
12.	Ms. Mariam Haroun	Teachers	23 Nov. 2011
13.	Ms. Amira Azhari	FGM Programme Coordinator, National Council for Child Welfare	23 Nov. 2011

Table (5): Names and affiliation of SSIs participants

3.1.3. Surveys

In addition to FGDs and SSIs, a survey technique in the form of a research questionnaire was designed and distributed evenly (20 questionnaire per each group) among the five categories under focus. A total number of 100 RHs and DBs responded to the survey. The questionnaire's design was informed by the KAPs[23] approach and was structured to cover three main sections as follows: a) demographic and Socio-economic background data, b) Knowledge, Attitude and Practice of FGM, and c) SNCTP community-based activities. The content in all categories of questionnaires resembled each other; however some questions were adjusted and customized in order to suit the specific category of respondents. Hence, five sets of questionnaires were developed and were translated into Arabic before distribution. In order to use time effectively, five data collectors were recruited by NCA/SNCTP in order to carry out the survey, each data collector was in charge of one of the identified five categories (please see Annex IV). The five data collectors met with the evaluators in an orientation session whereby the data collectors and the evaluators discussed the structure, content and the expected outcome of the survey

The following graphs illustrate the demographic and socio-economic profile of the IDPs:

a) <u>Gender:</u>

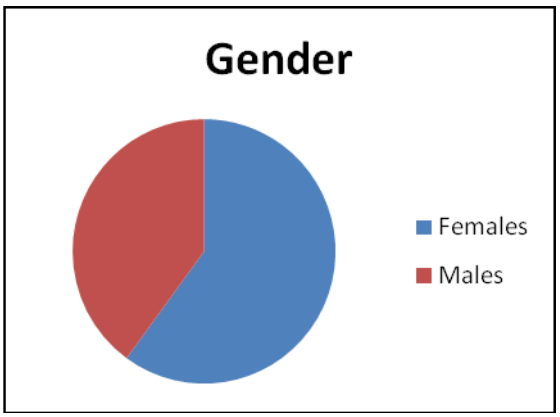
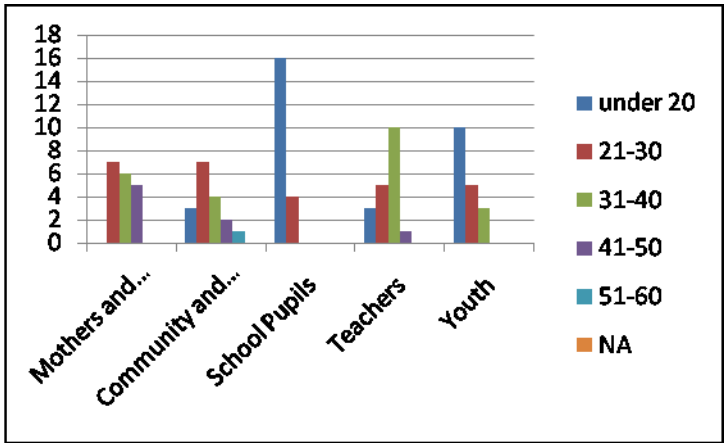


Figure (10) a: Evaluation survey: gender distribution

Category/sex	Females	Males
Mothers & Midwives (20)	20	
Community & Religious Leaders(20)	6	14
School Pupils (20)	11	9
Teachers (20)	13	7
Youth (20)	10	10
Total (100)	60	40

With the exception of the category of mothers and midwives and like the mothers and wives FGD, the survey respondents represent both female and males across the five groups of RHs and DBs. As illustrated above, the total number of females exceeded that of the males, 60 to 40 respondents respectively.

b) Age distribution:

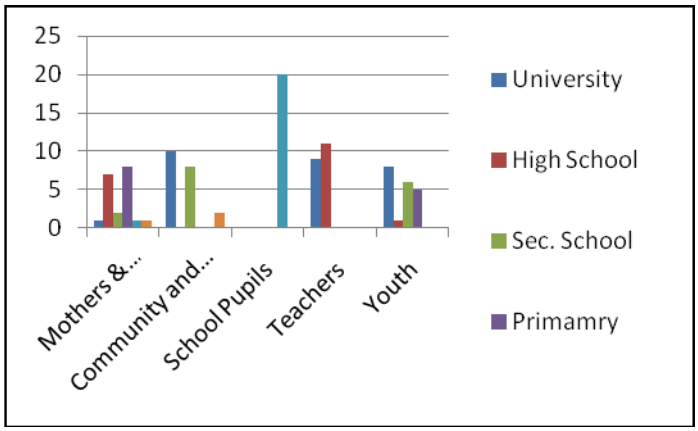


Under 20	**27**
21-30	**35**
31-40	**23**
41-50	**8**
51-60	**1**
(NA)	**6**
Total	**100**

Figure (10) b: Evaluation survey: age

In terms of the age of the survey respondents, the largest age group represents IDPs whose ages bracket spans over 21-30 years old (35 respondents). Overall, 85 respondents fall under the age of 40 years old.

c) Education status of respondents:



University	**28**
High School	**19**
Secondary School	**16**
Primary	**13**
Still at School	**21**
never	**3**
Total	**100**

Figure (10) c: Evaluation survey: level of education

With regard to the level of education of the survey respondents, the above illustrations demonstrate a dominance of students within the sample. These are university, high, secondary and primary school students. Thus, against the demographic characteristics of IDPs in Khartoum indicated in many studies and organizational reports and which suggest that the level of education is low among IDPs in Khartoum; almost 30% of the respondents (28 participants) reported that

they either completed or are still in the university. This might be explained by an easier access to these educated people in order to show willingness and take part in the survey.

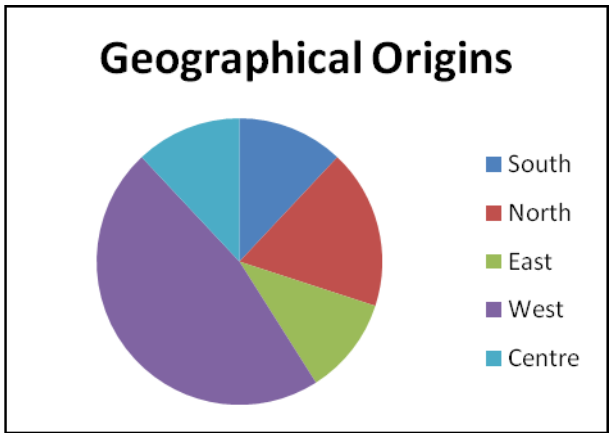
d) Marital Status:

single	married	divorced	widower	Total
47	**44**	**2**	**7**	**100**

Table (9): Evaluation survey: marital status

Early marriage is one of the widespread HTPs among IDPs. However, as the above table demonstrates the number of single IDPs (47) in the survey sample has slightly exceeded the other categories of married (44), widowers (7) and divorcees (2) respectively. Yet, the number of married participants (44) is still significant especially when considering that the number of single participates was boosted by the 20 school pupils who took part in the survey.

e) Geographical origin:

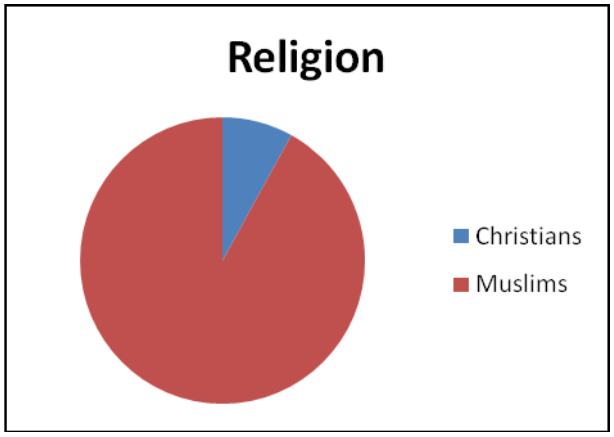


South	**12**
North	**18**
East	**11**
West	**47**
Centre	**12**
Total	**100**

Figure (10) d: Evaluation survey: geographical origin

As the above illustrations indicate, the vast majority of the survey respondents were IDPs from the Western regions of Sudan. This might be interpreted in the increasingly dropping numbers of Southern IDPs, many of whom are taking routes towards the South as citizens of a new independent state. The dominant presence of IDPs arriving from western Sudan (predominantly Muslims) in the evaluation sample is also reflected in an overwhelming representation for Muslim IDPs as the following graph demonstrates.

f) Religion:



Religion	Christians	Muslims
Mothers & Midwives (20)	**2**	**18**
Community & Religious Leaders (20)	**3**	**17**
School Pupils (20)	**2**	**18**
Teachers (20)		**20**
Youth (20)	**1**	**19**
Total (100)	**8**	**92**

Figure (10) e: Evaluation Survey: Religion

The findings indicate that the majority of the respondents are Muslim 92 as opposed to 8 Christians out of 100. Table 11 above presents the distribution of the respondents according to their religious affiliation.

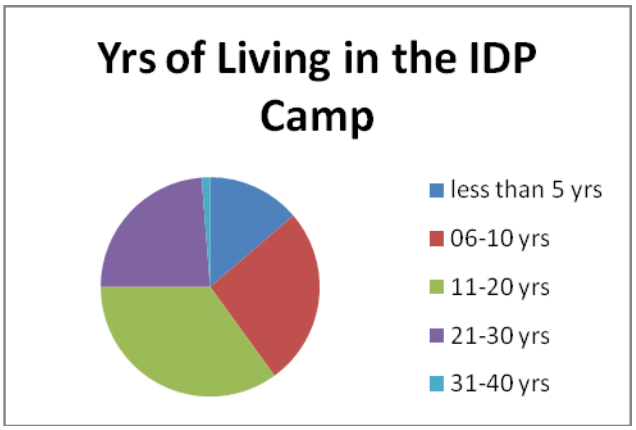
g) Occupation:

House-wife	Nurse or midwife	Tea seller	Domestic worker	teacher	student	Religious leader	Tribal leader	clerk	worker	Other	Total
10	**6**	**4**	**5**	**30**	**35**	**6**	**3**	**3**	**3**	**8**	**115**

Table (12): Evaluation Survey: Employment

The above table provides an overview on the source of income which IDPs depend on in making their living. It indicates that the majority of the IDPs who participated in the evaluation survey are students (30) and teachers (35). This disproportionate representation for students and teachers in the sample might be explained in light of the emphasis which SNCTP has placed on schools during their campaigns. Therefore, students and teachers were important RHs and DBs to be given voices during this evaluation; they were identified under two separate groups within the five focus groups of the evaluation but were also approached as potential participants under the other three categories (i.e. mothers and midwives, community and religious leaders, and youth). It should be also realized that there might be an overlap among the various categories. For example, a housewife who works as a tea seller might not perceive herself as a working woman and might identify herself as a housewife or as a tea seller only or both. Due to the fact that some respondents provided more than one answer in regard of their source of income, the total number of responses (115) as cited in the table above has exceeded the actual number of the evaluation survey sample which is originally 100 IDPs.

h) Years of living in Mayo Camp:



0-5	**11**
6-10	**21**
11-20	**28**
21-30	**19**
31-40	**1**
Total	**80**

Figure (10) f: Evaluation Survey: number of yrs lived in the camp

During the survey, the respondents were asked to reveal the number of years they have spent in Khartoum living as IDPs. The above illustrations which summarize the response of the IDPs indicate that most of the respondents have lived more than five years and less than 30 in the camp. A significant number of the IDPs (28) have lived in the camp between 11-20 years followed by 21 and19 who lived between 6-10 and 21-30 years respectively. Although the total number of the evaluation survey sample was 100 respondents, we received only 80 responses as school pupils due to their young ages were exempted from answering this question on the number of years lived in the IDP camp.

In summary, the design of this evaluation was developed using a right-based approach in accordance with NCA Global Strategic Plan 2005-2009 and with continuous consultation and considerable support from both NCA and SNCTP. Both qualitative and quantitative methodologies were implemented and methods such as FGDs, SSIs and KAP survey. The total number of the RHs and DBs who have participated in the evaluation was 184. The number of women was significantly higher than that of men, i.e. 59 (out of 75) women participated in the FGDs while 60 women have responded to the evaluation survey (out of 100). The IDP Camp is now experiencing a shifting demographic composition due to the departure of Southern Sudanese; many of whom were mainly Christians. This was reflected in the sample as the majority of the survey respondents were Muslim IDPs who come from the western regions of Sudan. In general, the sample encompassed people who were young and educated. Overall, the methodology has been implemented fairly well and both NCA and SNCTP helped to make the process of the evaluation smooth and very efficient. There were many opportunities which made this evaluation possible but on the other hand, there were some constraints during the implementation of the evaluation.

For example, the period covered by the evaluation was long and the time offered for the evaluation is too short and as a result there was few who people have been involved or know about the project since its inception in 2004. For instance, some of those who participated in the FDGs were not

aware of the organisation or its activities; this rendered some of the discussions irrelevant. It also reflected that SNCTP was somehow probably trying to fulfil number requirements for participants, rather than the quality of information. This was even exacerbated by the quality of the notes which came out from the FGDs which could have included more details and captured the key issues in the group discussions more accurately.

In addition, access to Mayo has been always a problem for NCA which makes it difficult to evaluate and monitor the work on regular basis. The lack of access has affected the evaluation as beneficiaries had to be transported to the SNCTP's Office in order to participate in the FDGs. This made the process more complicated and probably less transparent. To give an example only 9 people participated in the youth focus group and 8 for the religious and community leaders group. Most importantly, Southern Sudanese who were at a time the majority of IDPs and who were targeted by the SNCTP program were not available as many of them have already been taking a move towards the South.

Furthermore, there was ambiguity on the definition of the five groups of RHs and DBs under the focus of this evaluation. For example, the grouping of mothers and midwives in one category and the differentiation between school pupils and youth at least in term of age, etc. This might have resulted in reducing the chances for each group to voice their views and their concerns independently (as in the case of the mothers and midwives groups) or in duplicating or mixing responses (as in the case of school pupils and youth).

Finally, time keeping was another constrains encountered during the implementation of the evaluation. Thus, continued delays and public holidays have interrupts the program; several meetings had to be cancelled or postponed due to lack of time-keeping or due to holidays.

4. Evaluation findings

This section outlines and discusses the main findings for the evaluation. The findings will be clustered under two main sections. The first section reflects the knowledge, attitude and practice towards FGM among Sudanese IDPs in Mayo Camp including the prevalence of female circumcision among these groups of IDPs. The second section will discuss the specific impact of SNCTP efforts and activities in combating FGM among IDPs in Mayo Farm area.

4.1. Knowledge and attitude towards FGM among IDPs in Mayo Camp

This section provides information on how IDPs understand the practice of female circumcision. It aims to explore how IDPs perceive FGM within their communities and to establish whether the practice of FGM has negative consequences on women and child rights and on the community as a whole.

Knowledge on negative consequences of FGM/HTP's and violence on women's health and rights shown in the target area

Category	yes	no	I do not know
Mothers & Midwives (20)	2	18	0
Community & Religious Leaders (20)	1	16	0
School Pupils (20)	1	19	0
Teachers (20)	0	19	1
Youth (20)	0	20	0
Total (100)	**4**	**92**	**1**

Category	yes	no	I do not know
Mothers & Midwives (20)	0	18	2
Community & Religious Leaders (20)	0	18	1
School Pupils (20)	0	20	0
Teachers (20)	0	20	0
Youth (20)	1	10	0
Total (100)	**1**	**86**	**3**

Table (14): Responses for whether FC is a good practice

With regard to the perception towards FGM, the evaluation survey respondents were asked to reveal their views on whether female circumcision is a good practice and whether it should continue. It was reported that the majority of the respondents (92) perceive female circumcision as a negative practice and hence should not continue (86) – as illustrated in tables (14) and (15). It should be noted that since this section addresses perceptions and attitudes, some respondents might have given more than one answer in their responses to the various questions under this section.

Those who have reported that FGM should discontinue, elaborated that there are a number of factors that can stand as solid grounds in the efforts to eradicate such practice. For example, there was an overwhelming consensus across the five groups of the evaluation survey respondents (77) on the hazardous consequences that FGM might cause for women's health. In addition, a significant number of respondents (39) reported that FGM is not based on - or has nothing to do with religion and that it is banned under the Sudanese national law (71) - as shown in table (16).

Reasons for why FGM should not continue	Not good for women's health	Has nothing to do with religion	Illegal
Mothers & Midwives (20)	16	7	18
Community & Religious Leaders (20)	18	12	16
School Pupils (20)	17	2	3
Teachers (20)	15	10	16
Youth (20)	11	8	18
Total (100)	**77**	**39**	**71**

Table (16): Responses to why FGM should not continue

Similarly, the qualitative data collected during the FDGs corresponds with the findings above and reflect an increasing awareness among IDPs on the negative consequences of FGM. For example, in the mothers and midwives FGD, one of the midwives accounted that ***'not many people circumcise their girls nowadays, they know that their daughters will have so many problems; they will have problems recovering, they can have bad period pain, then they get problems while giving birth after get are married….the problems for the girls are going to be continue, and their mothers have also suffered from It'.***

In addition, there was a high level of awareness amongst pupils who have participated in the school pupils FGD. One of the girls explained that '***People do know about the problems of FGM, and the girls experience its problems all the time, for example, you can have bad period pains, and when older, you have problems giving birth'.*** The school pupils were also aware of the health hazards that FGM might impose on girls who have gone through the practice of FGM as indicated by one of them ***'If there are infections following circumcision, the families use natural herbs rather than go to the doctor as they are scared they will be prosecuted'***.

Further, the participants in the community and religious leaders' focus groups have described FGM as a problem which affects not only girls but rather the whole community. For example, one participant articulated that: '***FGM is practiced on girls, but it affects everyone in the community, so everyone should know about the problems it causes – it is a community problem and it is difficult to discuss it in the Sudanese society'.***

On the other hand, the small minority of respondents who believed that FGM should continue based their choices on the grounds that female circumcision is a good practice and it is considered one of the old and good traditions; it protects girl's chastity and keeps female genital organs clean. That was explained by a midwife who participated in the focus groups as follows: '***Some of the people are still confused about circumcision; some still think it is a religious duty to do, and others think it is a tradition and that is why it has to continue'.*** Another participant added that ***'some of the reasons why people continue to practice FGM include tradition, and concern that girls/women will be sexually active and will not get married'.***

Likewise, another participant in the teachers' focus group explained the FGM is still widespread in the area and it is mainly maintained by mothers and grandmothers. The persistence of FGM is particularly dominant among certain ethnic groups and among those with low levels of education and income among IDPs. A teacher was quoted as follows ***'Yes, circumcision is still being practiced, even by those who are educated but still hold on to old customs and traditions. Circumcision is more widespread amongst those who are not educated, but those who are educated also still do it. I think the main people in the area who still maintain the practice circumcision are the mothers, grandmothers and some of the midwives especially those who come from tribes in western Sudan such as Baggara'.***

In addition to the reasons related to the girls' honour, prospective of marriage and the persistence of some mothers and grandmother to continue the FGM practice which are cited above; there are confusing religious messages, which are dictating support for this attitude. This was not the case only among the IDPs it is rather a prevailing misconception country-wide regarding the way female circumcision is addressed in Islam. For example in a study conducted among Khartoum University students, it was found that because of reasons related to religion, almost 20% of all students supported the practice of FGM, even though averages of 90% were aware of the complications associated with it (E Herieka, J Dhar 2003).

An increasing number of women and men have no intention to circumcise their daughters or continue to support circumcision

Table (17) illustrates that, more than 50% (51) of the survey respondents reported that they have no intention to circumcise their own daughters or any females under their care in the future. On the other hand, 6 respondents indicated that they are going to support the FGM practice for their daughters or any female under their care, 17 were reluctant to provide a specific answer and 6 respondents did not know about their intention towards FGM in the future.

Category	NA	yes	no	I do not know
Mothers & Midwives (20)	9	0	8	3
Community & Religious Leaders (20)	4	2	14	0
School Pupils (20)				

Teachers (20)	4	0	13	3
Youth (20)	0	4	16	0
Total	17	6	51	6

Table (17): Responses to whether the respondents will support female circumcision in the future

In addition, the intention of the respondents towards female circumcision in the future was addressed in another question exploring whether the IDPs will support FGM in case they decided to return back to the regions which they originally come from. Again the responses – as indicated in table (18) were encouraging since 67 of the respondents decided that they have no intention to support the practice of FGM upon return to their home region.

Category	yes	no	I do not know
Mothers & Midwives (20)		10	1
Community & Religious Leaders (20)	1	18	1
School Pupils (20)			
Teachers (20)		20	
Youth (20)	1	19	
Total	2	6 7	2

Table (18): Responses to whether the respondents will support female circumcision upon return to their regions

Overall, the intention of women and men across the groups about their daughters' circumcision indicates positive changes. To give an example from the qualitative data, a religious leader revealed that he strongly refused to expose his own daughter to female circumcision despite the mounting pressure that he had to encounter from his family. He gives his own account as follows '***I refused to get my 9 years old daughter circumcised. My family thought I was crazy as I am a man of religious. Because I know the intention of my family, I will not let my daughter go back to my home area on holiday because I am 100% sure they will circumcise her, regardless of what I say'.***

Demonstrating a firm opposition against the performance of FGM, some of the FGDs participants indicated that they would anything in their capacities to stop the suffering of girls in the name of tradition i.e. female circumcision. Relevant to this and based on her own experience with FGM, one of the midwives expressed her position as follows '***I am completely opposed to FGM, and if I know of any family members who are planning to do it, then I will call the police on them. To this day, I am suffering from my own experience when I was circumcised as a child. It was a bad circumcision done by a woman who was not properly trained. I bled so much and I had to stay***

in hospital for days…I nearly died. Why should I do the same to my daughters? My daughters will never get circumcise. I will never allow anyone to circumcise them'.

It should be noted that school pupils were exempted from answering the questions whose answers illustrated in tables (17) and (18). However, in the FGDs involving school pupils, some of the young children believed that FGM is decreasing. While others thought that female circumcision is still practiced in the community. Pupils participating in the focus group generally agreed that FGM is still supported especially by people who are illiterate and by grandmothers. One of the pupils indicated that '***FGM has so many bad effects, but some mothers and grandmothers insist on it. They say it will keep you clean, and if you have a worm (douda) circumcision will treat it'.***

Men are less likely to have preference for future partner to be circumcised

In the past, girls who were not circumcised were demoralized and were degrading names such as '*ghalfa'*. The practice of female circumcision was partially undertaken and maintained by the family in order to protect the girl from these negative images and hence boost her chances in the marriage market. In order to assess whether attitudes have changed towards girls who remain uncircumcised, we asked the survey participants the following questions: is there a difference between circumcised and uncircumcised girls? The answers to this question are illustrated in the table cited below.

Category	yes	no	I do not know
Mothers & Midwives	16	1	3
Community & Religious Leaders	16	1	2
School Pupils	17	3	1
Teachers	18	1	1
Youth	17	1	2
Total	**84**	**7**	**9**

Table (19): Responses to whether there is a difference between circumcised and uncircumcised girls

As the responses in table (19) indicate, a vast majority of the respondents replied that there was no difference between girls who circumcised and between those who are not. Likewise, most of the male youth who have responded to the survey (10) expressed their willingness to marry uncircumcised girls in the future (9 versus 1).

The qualitative responses have been also revealing positive changes. One of the teachers who participated in the FGDs described the changing attitudes of boys towards uncircumcised girls as follows: ***'Boys are really open and inquisitive when we are discussing FGM in class, whilst the girls tend to be very shy. One of the boys in my class asked if he should divorce his wife if he***

finds out that she is circumcised. This really shows that boys are changing their opinions about circumcision, and know it is bad and affects everyone'.

While similar findings were echoed in the FGDs, some of the FGDs participants warned that there are still negative perceptions against uncircumcised girls. For example, some midwives shared their knowledge about some young men who still demand to have a circumcised wife. While school pupils were dismayed by peer pressure in the school as one of the pupils puts it ***'If a girl is not circumcised, people call her horrible names. At school, girls who are not circumcised are still being called names 'galfa' and stuff like that'.***

As some mothers do not want to get their girls circumcised, and at the same time they do not wish them to get ostracised by the community, they pretend that they have circumcised their daughters. For example, they make the girls wear *henna* and then they organize a party, while the actual FGM surgery is not performed.

However, in some cases and despite their knowledge on the risks of FGM, some girls and their families had to submit to these societal pressures as the following case study reveals.

> '***My neighbour was called horrible names in the neighbourhood as she was not circumcised. Both boys and girls called her names. She was upset so she went to her mum and asked her to get circumcised. Her mum agreed and took her to get circumcised. Seems the person who did it did not do the procedure right, so when she came home she was bleeding a lot, and despite this they did not take her to a doctor. She continued to bleed, so eventually the mum and the neighbour took her in a rickshaw, which she also covered completely in blood, and was taken to a hospital. There, the mum and neighbour were reported to the police and they got prosecuted to 6 and 3 months respectively, they did not tell on the person who did the circumcision. The girl is still in hospital' -*** A School pupil participating in one of the FGDs.

Similar to the neighbour of the school pupil whose story was cited in the above, some families have to perform circumcision on their daughters so early that the girl cannot even protest. 'Some of these girls can be as young as 4 years old and some are only a few months old' – this is according to the accounts provided by the school pupils. In one of the SSIs interviews, a teacher explained that ***'women tell me that even though FGM causes health problems, they cannot stop it as otherwise, their daughters will not get married'.***

Interestingly, some of the FGDs participants indicated that there is a growing stigma against uncircumcised girls as others call them 'you *mooshawahat'* meaning distorted (Pl.).

4.2. Prevalence, types and performers of FGM

A reduction in FGM/HTP's is observed in the target area (Mayo Farm)

Many IDPs who have responded to the survey (60) indicated that FGM is no longer taking place among Mayo Camp's IDPs communities. Likewise, 76 respondents reported that people are less inclined nowadays to perform FGM on their daughters and that the practice is on the decline. The

majority of the respondents (59) have further indicated that they have not heard of a girl who has been circumcised in the recent years.

Q/A	Yes	No	Other	I do not know
Responses to whether FGM is still practiced in the community	30	60	6	4
Responses to whether the number of girls circumcised is decreasing	76	8	3	12
Responses to whether respondents have heard of a girl who has been recently circumcised	30	59	4	7

Table (20): perception on whether FGM is still practiced in the community

Similar to that, during the discussions which took place in the FGDs, many participants across the five categories indicated that FGM is declining in the community. For example, in the community and religious leaders' FG, everyone in the group has agreed that there has been a reduction in the number of girls circumcised in Mayo and that FGM has reduced significantly from earlier days. One of the leaders elaborated that the efforts of the community and religious leaders have contributed to this reduction in the FGM incidence rates. He commented that '***We have no more circumcision being practiced in Mayo, as community leaders we have told them [the community] about the problems which it causes and that they should not do it anymore'.***

Moreover, the views which were expressed by the evaluation participants during SSIs have largely suggested that there are positive changes towards the eradication of FGM especially in areas targeted by activities and campaigners. For example, the SNCTP Program Officer noted that ***'when SNCTP initiated it program in Mayo camp there used to be many parties celebrating circumcision of girls. Now, this is much less'.*** Further, the SNCTP Executive Director remarked that ***'there has been a reduction in the rates of FGM, but mainly in areas with CBOs and NGOs work'.***

The debate on whether FGM is still prevalent in the community has drawn a considerable amount of discussion in the FGs. While many voices agreed that FGM has been reducing among Mayo's IDPs, others opposed this idea and asserted that the prevalence of FGM in Mayo is still high and confirmed that they still hear about cases of circumcision regularly

In General, most of the evaluation participants observe that there is still support for FGM at least amongst some groups of IDPs, but the practice is certainly starting to fade away. That is due to the continuous efforts of awareness raising that have been taken place through SNCTP and others. They also concluded that because of all the campaigns those who are still in support for FGM practice have to perform it in clandestine or in other areas outside Mayo and that is why it is not clear who exactly carries out FGM.

It was considerably significant to ask the females who participated in the survey whether they were circumcised. As illustrated in figure (21) and table (11) cited below, the quantitative data came out to indicate that almost 70% (42 out of total 60 female participants) of the female respondents are circumcised.

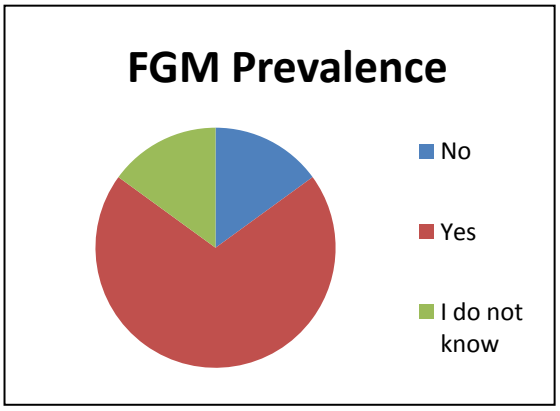


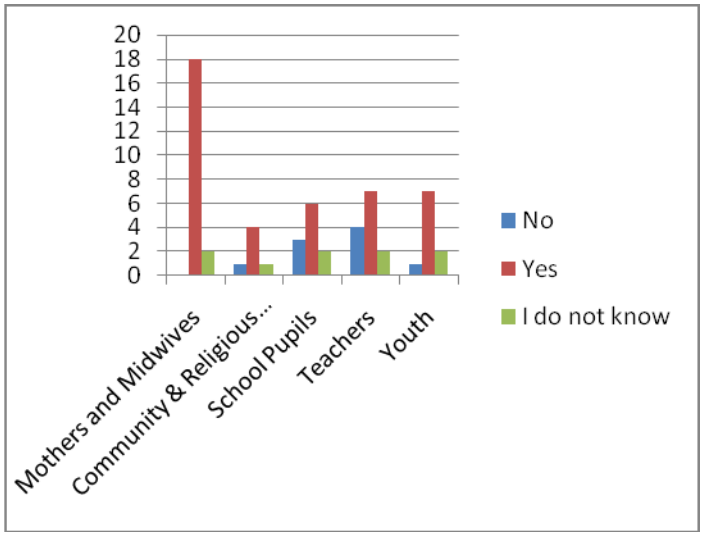
Figure (11): Total number of female circumcision

Yes	**42**
No	**9**
I do not know	**9**
Total	**60**

Table (21): Total number of female circumcision

Young girls are less likely to be circumcised

This finding suggests that FGM is still carried out with high prevalence rates across age groups though slightly decreasing among the younger generation as it is the case in the category of school pupils (6 out of 11) as opposed to the category of the older generations of the mothers and midwives (18 out of 20). The following illustrations present the number of female circumcision among IDPs differentiated by category.



Category	yes	no	I do not know
Mothers & Midwives (20)	18	0	2
Community & Religious Leaders (6)	4	1	1
School Pupils (11)	6	3	2
Teachers (13)	7	4	2
Youth (10)	7	1	2
Total (60)	42	9	9

Figure (12): The prevalence of female circumcisions differentiated by category

Though the rate is descending among younger generation, a fact remains which is the performance of FGM is still a common HTPs practice among IDPs. The number of the female school female pupils who are circumcised is still high. The percentage (70%) is close to the national prevalence rate cited in the national surveys and organizational reports. This finding contradicts the indicated earlier responses which suggest that the number of female circumcisions is dramatically decreasing. However, it has also be taken into account that the demographic composition of IDPs is shifting to the favour of to displaced people coming from western Sudan where FGM is practiced in aggravated rates. The sample of the evaluation survey is merely a reflection to these changes – as explained earlier.

Sunna type of circumcision is more common among younger generations.

One way to measure the decline of female circumcision in Sudan is to note the type of circumcision which is commonly practiced. In general, stakeholders suggest that the transition from the severe form of *Faruni* to *Sunna* is regarded as a positive step on the road of FGM eradication. The data presented in table (23) demonstrates that *sunna* type is more common among younger generation of circumcised girls. For example, out of the 6 female school pupils who were circumcised, five respondents stated that the type of the circumcision they have undergone was *sunna* while one of them had been under the *Faruni* type. On the other hand, the common type of circumcision among the mothers and midwives category was *Faruni* (13), followed by *sunna* (3) while two of the respondents were either not aware of the type of their circumcision or had been through another form of FGM which was not clearly identified.

Category	Faruni	Sunna	Other
Mothers & Midwives (18)	13	3	2
Community & Religious Leaders (4)	3	1	
School Pupils (6)	1	5	
Teachers (7)	4	2	1
Youth (7)	5	1	1
Total (42)	26	12	4

Table (23): *Types of circumcisions differentiated by categories*

This finding has been further emphasized in the qualitative data. Thus, the evaluation participants across the various categories have largely agreed that though FGM is still being practiced, however it is now done in a much less severe form (i.e. *Sunna*).

This shift from the most severe of FGM which is type III (known in Sudan as *farouni)* to the milder form of type I (know in Sudan as *Sunna*) is a positive change but on the other hand it can also present an alarming trend. During some of the FGDs, there was as sense of acceptance for *sunna* circumcision among some groups describing the girls who have gone through it as ***'they ONLY had sunna circumcision'***, implying that the circumcised girls would be playing a few days after the operation.

It was of a high relevance at this point to learn on the most common performers of female circumcision known to the IDPs community? In order to gain some insights on who performs female circumcision at present, we asked the respondents the following question: If you heard of a girl who has been recently circumcised who did the circumcision? Responses to this question revealed performers can be either the relatives of the girl (grandmothers or other relative/acquaintance old women). Some health workers including doctors, nurses and midwives were also reported to be performers of FGM. Further, during the FGDs it was noted that some untrained midwives still continue to practice female circumcision. Female circumcisers along with the families of the young girls tend to conceal avoiding legal persecution or any pressure or confrontations with campaigners.

Even though national laws are ambiguous in the area of female circumcision, midwives are sworn not do carry out any form of circumcision (please see figure 13 a & b). In 2001/2002, the Ministry of Health had issued a directive that midwives do not perform FGM, so all midwives were sworn not to practice it otherwise they would risk losing their licenses and equipment; this provided the way for SNCPT, who find the conditions suitable.

Figure (13) a: Midwives' code of honor against the practice of FGM

Midwives' Oath

I swear to God Almighty to perform my duties faithfully and diligently, that I practice my profession as I learned, not to hesitate if I was called to any place under all circumstances regardless of colour, race or creed, to preserve the secrets of homes; not to practice female circumcision and to be honest and truthful in all my words and my actions.

Midwives Code of Honour to abstain from practicing female circumcision

I swear to God Almighty that:

- I do not perform female circumcision of any kind or any surgical operation of the genital organs for any child, even at the insistence of her parents.
- I do not perform female circumcision of any kind or any surgical operation on any adult woman but only at the reversal of circumcision, as necessary.
- I do not cause any change to the external genitalia of any adult woman during or after childbirth (so-called Adal), or to participate or contribute in any ceremony or ritual celebrating female circumcision.

Figure (13) b: Midwives' code of honor against the practice of FGM (unofficial English translation).

Therefore, many of the evaluation participants indicated that the midwives, after being sworn by Ministry of Health, are extremely cautious for not to lose their jobs. They also abandoned practicing FGM because if any medical complications happened to the girl, they are aware that they will be held accountable.

Likewise, the majority of the midwives stressed that they have been resisting many pressures in order to fulfil their roles as DBs in combating the practice of FGM. For example, one of the midwives illustrated that '***there are many families who want to circumcise their girls, but they cannot find any midwives in Mayo who will do it for them, so they have to try to find someone from another area to do it, or when they go on holiday to their home areas. This shows that now everyone knows that the midwives will not do it, and we do have a good reason'.***

Another midwife articulated that ***'my family knows my position regarding FGM, so they do not tell me when a neighbor or a relative is planning to circumcise their girls. Just recently I found***

out that my sister-in-law circumcised her daughters, my nieces. She did it in al-Obaid, even though she lives in Mayo, so I do not know about it. The whole family had been hiding it from me for months. I was so upset when I found out, but it was too late'.

The midwives did not only give up practicing FGM but they have also intervened to stop or punish other colleagues who might get lured to do the operations. They proudly cited they imposed both social and legal sanctions when possible against midwives who have taken the oath but were found to continue practicing FGM. This was confirmed by the SNCTP Program officer who shared the following two accounts: ***'There has been a case of one midwife who had carried out a circumcision, the case was reported and her equipment was confiscated by the head midwife for the area. This was a very good and shows that there is control'.*** Another narrative came up to suggest that in 2007 two midwives who carried out a circumcision were beaten by the Popular Committee and were sent to jail. They were also kicked out of the area.

Despite that, some accounts have repeatedly emerged to suggest that at least a few numbers of midwives still operate FGM in the community but behind closed doors. Wondering on how some midwives can not be controlled and they do the operation in secrecy, one of the midwives accounted that ***'who knows when and where they do it. I guess they just need to have a different colour of toub (the uniform one is white) then the equipment is easy to hide, you just carry it in a small bag. They can just go very early in the morning, or later at night, and no one will notice what she (the midwife) did'.***

During the interviews, one of the midwives admitted that she circumcised her niece. She justified her decision by saying that her sister in law was going to get it done anyway, and she would have done it in a type I or II, rather than type III. The midwife explained the incident saying that ***'...my brother's daughter was circumcised. I had heard that her mother had insisted that she gets circumcised, and I tried to persuade her not to do it. Then I ended up doing it as I did not want someone else to come and gets it done badly. You know some circumcisers have no knowledge about the body and health of girls.*** **Maybe the girl is diabetic? You are always worried about the problems, until the girl has healed properly.** ***So I decided that I will do it myself so I can guarantee that at least it is done right. I only took a very small bit, and she has healed OK ...'***

Finally, it has been confirmed by many participants in this evaluation research that some midwives will continue to carry out circumcision in secret as the practice of FGM remains a lucrative business with a scarcity of other alternative financial means. They suggested that midwives should be given a steady salary so they do not get tempted to carry out circumcision.

4.3. SNCTP program relevance and effectiveness

This section aims to highlight the relevance and effectiveness of the SNCTP program in Mayo. It specifically reflects the views of RHs and DBs who participated in the evaluation specifically with regard to the relevance of the approaches and pedagogical methods used by the SNCTP during its camping against FGM in Mayo area. It also aims to highlight to what degree the program has tackled the agendas of participation, equity and protection set out by NCA GSP. In other words, it aims to explore to what extent RHs, DBs and other stakeholders have participated in the planning and implementation of the program and how this might have contributed to create changing attitudes in relation to FGM in the area.

4.3.1. The relevance of the approaches and pedagogical methods used by the SNCTP

SNCTP developed a wide range of strategies and techniques during the campaign against FGM in Mayo and this enhanced its ability to reach out to various groups of the IDPs communities and establish a position in the area. As Mayo represents a diversity of cultures and ethnicities; SNCTP was able to diversify its intervention techniques and hence reach to larger sectors in the community. The role of SNCTP in raising awareness around the negative consequences of FGM, HIV/AIDS and other HTPs has been widely acknowledged by most of the evaluation participants; who became acquainted with the SNCTP program through the various activities which were implemented in the area; the various channels and avenues in which these activities took place; and through the various stakeholders who have taken part in the campaign. As one of the participants in the community and religious leaders FGDs put it ***'many of us know about SNCTP through its campaigns. We welcome the efforts to raise awareness on the dangers of HIV/AIDS and FGM, and will endeavour to share this message with others in the community'***.

<u>The link between FGM and HIV/AIDS</u>

It is important to mentions that the link between FGM and HIV/AIDS was discussions substantially during the FGs and SSIs. As it has been mentioned in chapter two in this report, SNCTP has adopted an integrated approach in which it aimed to combat FGM/HTPs through education and advocacy and at the same time create awareness on the modes of transmission and protection of HIV/AIDS and as such HIV/AIDS became a cross-cutting issue when discussing FGM. It should be noted however that although SNCTP was pioneered the campaign against FGM in Mayo, the Sudan Council of Churches (SCC) worked on HIV/AIDS in the area with the midwives before SNCTP started their activities '***SCC had actually worked closely and introduced SNCTP to the camp, hence why HIV/AIDS was included to the FGM programme'*** according to the SNCTP Program Officer.

In reaction to this integrated approach, many evaluation participants stated that there is in fact an evident link between HIV and FGM and hence it was appropriate to send a message on HIV/AIDS

during the FGM campaign. That is because HIV transmission is likely to occur in circumcised girls for example due to the use of unsterilized sharp instrument such as razors and shaving blades. One of the school pupils supports SNCTP's work on HIV/AIDS by saying '***Yes, I think it is good to discuss circumcision and HIV/AIDS at the same time. When a midwife is circumcising a girl with polluted equipment, she can transmit the virus to her, or if she's circumcising several girls with the same equipment, then they can also get infected if one of them has the virus'.***

In addition, HIV/AIDS is a deadly disease and many people in the area are 'fearful' of the infection and of the health as well as the social consequences that it might cause. Therefore, it was believed that addressing the two issues simultaneously was a successful strategy adopted by SNCTP program as it brought a considerable attention to the campaign.

Nevertheless, the integration of HIV/AIDS and FGM in one campaign was disapproved by some FDGs participants across the groups – who believed that FGM is one of the prevailing HTPs in the Sudanese society but it has been addressed sufficiently since very long. While HIV/AIDS is a 'new' disease and people still need to learn about it. For example one of the teachers explained that '***financially, it is more expensive to divide the work FGM and HIV/AIDS, but the two issues are indeed different. There is a lot of accurate and comprehensive information that needs to be communicated. I think they should be dealt with them separately'.*** Another opponent from the youth FG expressed his opinion as follows ***'I think HIV/AIDS and FGM campaigns should be addressed separately. This is because they both have a lot of information, and it will be difficult to talk about the two topics at the same time…people will be more interested in listening about HIV/AIDS as they're more scared of that'.*** Others indicated that addressing HIV/AIDS in one campaign with FGM might distract the target groups and divert their attention from the latter and hence jeopardize the purpose of the campaign. This was expressed by one of the midwives as follows: '***HIV is a 'hot' topic, and if discussed at the same time as FGM, people will ignore it'.***

On the other hand, beside HIV/AIDS and FGM there are other HTPs which require additional attention by campaigners. For example, several teachers mentioned that even though FGM is a human rights violation and a HTP, there are more dangerous HTP which 'can lead to death' such as early marriage, *gatta alrisha* (throat cutting) and tooth removal. Also child labour which prevails in the community- as school pupils get removed from classes by their parents who send them to the market to work and earn money. One of the teachers pointed out that ***'In my class, I use child rights as an entry point to raise awareness about FGM. There are many child rights problems, for example, child labour is a big problem in my school. Some of my students disappear all of a sudden from classes, and when I go and inquire, I am told they work in the central market, or other places, so they can earn money and support their families'.***

Methods of education and advocacy:

SNCTP program has developed pedagogical and advocacy methods based on its experience to carry out the campaign against FGM in Mayo. This was translated into a wide array of awareness raising

activities which was in general described to be effective and relevant, according to the reports delivered by the evaluation participants. In order to learn about what methods were more relevant during the campaign, the evaluation survey respondents were asked to identify the program activities which they were perceived to be effective. The reports came out from the evaluation to suggest that the methods used by SNCTP were appropriate to raise awareness amongst the population in the area and to enable broad accessibility for stakeholders particularly amongst the hard-to-reach groups such as religious leaders and policy makers. In general, workshops, school debates, midwives training, ToTs, FGM international day and posters produced and distributed by SNCTP were described as the most effective tools in the campaign. One participant in the community and religious leaders accounts ***'the best methods used were seminars, workshops for volunteer, activities in community and medical centers that mothers can access, plays, female community leaders (hakamat), video/film shows and festive occasions'.***

Likewise, the survey data indicated in table (26) and figure (20) below suggest that the most effective and popular methods that SNCTP has followed in its campaign were the various workshops organized (60%), School activities (55%), activities targeting midwives (50%), posters (49%), FGM International day (33%), various types of meetings (27%), football competition (17%), distribution of T-Shirts (16%). Only 17% had a previous knowledge on all the activities listed in the table and 3% did not posses any previous information on these activities.

Workshops	62
Meetings	27
Work in Mayo Schools	55
Work with mothers and midwives	50
FGM International Day	33
Posters	49
Football	17
T-Shirts	16
All	17
None	3

Table (24): Responses to the relevance of the methods used in the campaign

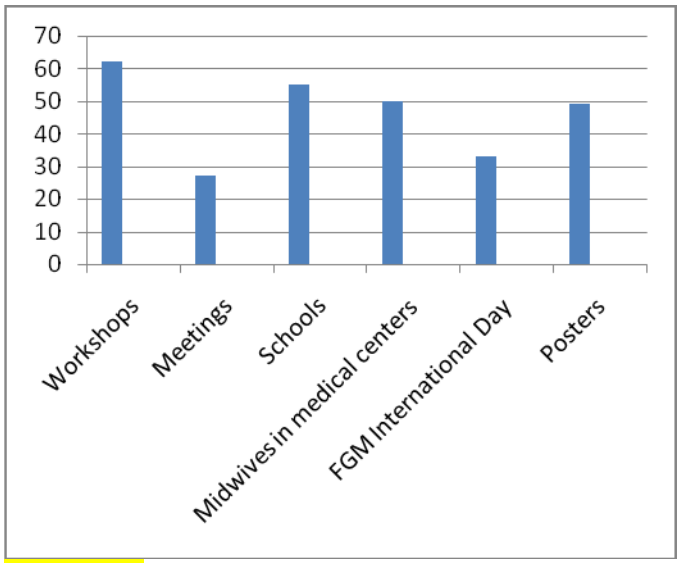


Figure (14): Responses to the relevance of the methods used in the campaign

These findings were confirmed by the qualitative data; as most of the FGDs the participants felt that the strategies employed by SNCTP were suitable for the conditions in Mayo, for the indented beneficiaries, and for the locations targeted by the campaign such as schools, mosques and medical

centres. These included various lectures, seminars and workshops and distribution of leaflets and posters. Advocacy through audio visual materials specially showing films was highlighted as a particularly useful and effective tool. For example, it was referred to a film that displayed an operation of circumcision and fistula, and it was highlighted in numerous occasions as one of the better and effective methods. One of the school pupils said '***I saw the video which showed a girl was being circumcised, it was horrible. This video really scared me and showed me how bad circumcision is, I do not want this to happen to my sisters'.***

Also effective was the distribution of leaflets and poster to the medical centres which graphically illustrate the problems associated with FGM such as problems child birth complications, complication in monthly cycles, etc. These graphic objects are seemingly replacing the place of TV and radio which are becoming not very useful methods in an environment like Mayo camp as 'hardly anyone is at home as they're all busy working and also some families do not have such devices' - according to the SNCTP Executive Director. In one of the groups, the use of plays was suggested as an alternative and a powerful tool to raise awareness regarding the dangers associated with FGM, especially when targeting mothers and grandmother

Further, the FGM international day has been a memorable event and was repeatedly cited as one of the prominent achievements of the SNCTP program. The international day was described as follows: '***the most effective campaign was FGM international day event. It was such an organized masira (march) from Bashaer Hospital to the Medical Services Centre; religious leaders came and interpreted the sura which prohibits FGM'.***

Having said so, there were also some views which suggest that SNCTP needed to revisit its methods and introduce more suitable and creative ones. One of the youth commented that '***the programmes and methods used to fight circumcision are not suitable or encouraging, the methods used at the moment by SNCTP need to be reviewed. This is the main reason why that circumcision is still being used in parts of the area***'.

4.3.2. Community participation: SNCTP and target groups as sources of message

SNCTP has identified and approached groups of IDPs to be at the core of its focus. In 2005, SNCTP started working with the midwives and at schools with teachers and pupils, and then in a later stage community and religious leaders were included until all the target groups were covered. These groups were selected based on the substantial roles they play in the community and in relation to female circumcision; whether they are DBs or RHs. Therefore, medical centres, schools, mosques and churches constituted important locations where SNCTP was able to reach out to the community and spread messages against FGM – as will be discussed later in this section.

In order to assess to what extent the strategies implied by the program allowed the various groups of IDPs to become engaged in the planning and implementation of the program's activities, it was important to ponder on the two following and intersected points and relate them to the different categories of RHs and BDs:

1) Were the target groups given the opportunity to participate in the planning and implementation of activities?
2) Were the target groups able to play a rather proactive role and become agents of change on their own right?

In this regard, it was appropriate to ask the evaluation participants to state the most popular sources of message against FGM in the community and the channels in which these messages are conveyed. According to the survey respondents; the sources of message are respectively SNCTP (50), teachers (33), midwives (33), religious leaders (30), workshops (30) posters (28), TV (23), health workers (22), radios (19), community leaders (7), all (7), parents (5), non (2), relatives (1), and friends (1).

In terms of planning and implementation of SNCTP activities, the evaluation participants have generally agreed that they have been engaged in the implementation of the program activities in their capacities either as targets of these activities or as implementers. The following are some examples of the individual testimonies cited in response to the survey's open ended questions:

- I participated in and helped in organizing awareness raising activities against FGM and advocated through lectures and other methods for abandoning FGM because of its severe consequences on women
- As a midwife I gave orientation sessions for mothers
- As a midwife I gave lectures for other midwives in health centres on the hazards of FGM and its consequences on women's health
- As a man of religion, I participated in many activities and I preach against FGM in the mosque in Friday Prayers and in the religion oratories and occasions
- I always preach that FGM is forbidden both legally and in the religion
- As a teacher I participated in almost all activities which were organized in my school
- I participated in the activities which were organized by SNCTP in my school
- I participating in workshops in the schools, awareness raising for mothers, meeting with religious leaders to explain the risks associated to FGM
- Helped to organize and participated in a workshop with mothers and pupils in the school and gave lectures on the risks associated with FGM
- I gave awareness during the school's morning assembly and gave lectures inside the school and for mother and midwives
- I participated in the FGM International day and I distributed anti-FGM posters and materials
- I distributed anti-FGM posters for people in markets and streets
- I met with Prof. Amna Abderahman (SNCTP executive director) and went to workshops in SNCTP
- I participated in creating awareness around the risks of FGM among friends and in the neighbourhood where I live

- Participated in a workshop which was entitled 'the risks of FGM on women at present and in the future'
- I participated in a first aid course and in women and child health courses
- I have never participated in their activities

In addition, the qualitative data gained during FGDs and SSIs provided a platform for the evaluation participants to reflect on their relationship with SNCTP and on the specific roles played by each category in delivering message against the practice of FGM. This will be explained in details in the following section.

Midwives

As it has been frequently repeated, the midwives who are living and practicing in the area of Mayo were central actors in the SNCTP campaign against FGM. In order to access, train, and work closely with the midwives, SNCTP expanded the locations of its activities to encompass the medical centres serving the area. The activities carried out by SNCTP in the health centres have been seminars to raise awareness amongst the midwives. During the trainings, midwives were given incentives (in the range of 15-20 Sudanese Pounds) to come 'or otherwise it is not worthwhile to lose out of possible birth jobs in the area on the day' according to the Director of Omer Ibn Alkatab Medical Centre in Mayo. Health centres were a good entry point for SNCTP where access for a large number of women in the community was made possible. In a manner of a snow ball, SNCTP works closely with the midwives affiliated to the specific health centres who in their turn offer orientation and advice for women who visit the centre seeking medical services. The midwives receive women in the centre, but they also carry out house visits – three times a week. This of course offers an opportune time to convey message and influence the women.

In total, SNCTP collaborates with eight health centres in Mayo, out of 22 centres covered by the Jabal Awlia locality. Every two years, SNCTP works with a specific health centre. It also implements a follow up program with the previous centres in order to identify challenges and the way to address them and most importantly to enable the sustainability of the campaign and ensure that the midwives were not reverting to practice FGM. Therefore, the midwives are expected to provide monthly reports to their supervisors in the medical centres on the number of women they have reached out with regards to FGM. SNCTP monitors the implementations by holding a focus group to gather qualitative information. A midwife who has been interviewed during the course of the evaluation describe the relationship between her, SNCTP and the medical centre as follows: ***'We submit monthly reports with details of all cases and follow-ups (births), which include notes on complications, etc. The reports are submitted to the manager of the health unit. Women who have just given births receive four visits, at least. At the centre, we speak to women about health issues, but also about FGM. To protect the women and babies during birth, we wear gloves during delivery so to avoid HIV/AIDS transmission. But we have to pay for the gloves from our pockets. There is now a new directive from the office to carry out HIV testing on women who come to the centre, as part of the general follow up testing they get when they are pregnant'.***

Providing training and working with midwives has been proven to be a successful strategy in the SNCTP campaign. Not only because midwives were the traditional performs of FGM but also because they are commonly regarded as wisely respected and knowledgeable women in the Sudanese society; and whom their advice and service are sought after and valued by the community members. In addition, due to the nature of their job, midwives acquire firsthand information on what risks FGM and HTPs can pose on the wellbeing of women. Midwives are very close to the local community and share social gatherings such as *wanassa* sessions (general chit-chat), and general community gatherings (weddings parties, death or occasion of celebrating births private homes; so many of them take this opportunity to spread the message regarding the risks of FGM and other social and health issues as demonstrated in this narrative: '***I usually have chats with the women casually about circumcision and how it is bad for the health, for example when there is a community occasion such as celebrating a birth or even weddings'.***

Most of the midwives who participated in the FGDs reported that they were consulted during the planning and implantation stages of the events organized within the SNCTP campaigns against FGM. One of the midwives indicated that she was given the responsibility to organise an event (open day) for awareness raising campaign in Mayo.

Some of the constraints that the midwives had to encounter during their advocacy work against FGM were summarized as follows:

1. The midwives cited that they are not able to fully stop the FGM practice in Mayo, as now some mothers get their daughters circumcised in other areas, or even other towns outside Khartoum.
2. The midwives think they have lost a source of income especially that they do not have a regular income; and also women now started to go to hospitals to give birth. A midwife articulates '***Our salaries are low, and for some of us we do not get a regular salary. This is why some of the midwives go out in secret and carry out circumcision to get some money'.*** The cost of carrying out circumcision was cited to average 25 Sudanese Pound, to as high as 50-70 Sudanese Pounds. For births, the midwives sometimes do not get any money, and if they do, they're given around 30-50 Sudanese Pounds. In some cases, the people in the household are so poor they cannot afford to pay the delivery fees.
3. Some midwives mentioned that the Popular Committees have been ordering some of the midwives to carry out circumcisions, even though the Ministry of Health had sworn the midwives not to carry out any form of circumcision, otherwise they risk losing their license and equipment.
4. The midwives stated that it is hard to convince people who relate their decision to circumcise their daughter on religion. They attack us by saying that we have no religious authority or knowledge and that we should not tell people what is *haram* and what is *halal*.

<u>Community and religious leaders</u>

Community and religious leaders play an instrumental role in the raising the level of awareness on HTPs – in particular because misconceptions on FGM are still dominant. Hence, they were identified

as a key target by SNCTP. Workshops and lectures were organised on regular basis, and they were engaged in major events, such as the International Day against FGM. Some religious leaders were also sent on trainings to Islamic countries such as Saudi Arabia, Iran, Jordan, and Qatar. This was done with the purpose of having them to come back to Sudan and issue a fatwa stating that female circumcision is not a religious duty. However, that was not possible as *fatwa* can be recognised only if it is approved by the officially recognised body existing in the country, not from individuals or other Muslim authorities abroad.

Nevertheless, religious leaders who participated in the FGDs have all confirmed that they are aware of the risks caused by FGM and that they are committed to preach at any accession and invite people to abandon such perilous practice. One religious leader highlighted the role of the mosques and the Imam as key and holy powers in the community as follows: ***'the Imam can hold a sermon for the community about the dangers of FGM. We can even reach out to those who are not in the mosque such as the mothers, girls and youth, are close to the mosque so they can hear the sermons very easily and clearly'.***

Similarly, the community leaders remarked that they are committed to play their role as duty bearers and protect their communities from dangerous practices such as FGM. For example, one of the leaders was persuaded that young people should be in the centre of any social initiatives; hence he used his influence to ensure greater participation for youth in any social projects that might emerge. He remarks that '***As a Sultan, I always make sure that I have some youth working with me in the office, so if we need to get the youth involved in the event, we can do that very quickly. The youth are organised and are happy to engage in the matters that affect the community'.***

Both the community and religious leaders expressed ambivalent views with regard to the way SCTP plans and carries out its campaign activities. While some of them reported that they have been engaged during the planning and implementation of several activities pertinent to the campaign such as SNCTP's workshops, meetings with youth and midwives, and international FGM day; others were not properly involved in the campaign. They only received patchy or no information about the updates in the SNCTP program and were partially invited to some of the program's events.

<u>Youth, teachers, school pupils and volunteers</u>

Emphasis on youth leadership development in the community has been a major objective for SNCTP, because they are the future parents. Thus the strategy employed by SNCTP is to reach out to young people, so that the FGM will not affect the next generation. As the SNCTP Executive Director put it '***we work with youth- students who are members of student union as we believe that working with youth ensures continuity'.*** Training programmes for youth and school pupils were designed to help them understand the danger of FGM and HIV/AIDS. But it also encouraged young people to be agents of change through education, information, workshops and informal networks to educate others as well. During the evaluation, we asked the youth and volunteers on what are the

key lessons they have learned from the SCTP program. Some powerful response emerged as follows:

- I learned that we are leaders and we are able to convey a message
- I learned to confront the society without fear or hesitation in order to fight against HTPs
- I learned to ask questions and receive the right answers
- I became aware of the danger of FGM - To promote awareness on the risks of FGM within my family including uncles and aunts
- I learned that we should not repeat the mistakes of our parents with our children and to create awareness among our families, relatives and neighbours and to warn them by reminding them that they are practicing something which is illegal. Contributing with the society in combating HTPs and AIDS
- I received through information on the risks of FGM and I understood that as a woman I have rights and duties towards the society and my duty is to contribute to create change and abolish HTPs

The methods employed by SNCTP include seminars in schools under the banner of 'a whole girl should not be circumcised'. Teachers who teach both minors and/or adult students were recognized as duty bearers and as such they have been involved in the campaign. In their capacities, they work to pass the message and raise the awareness of the school pupils on the negative consequences of the FGM practice. One of the teachers interviewed during the evaluation explains how SNCTP is intervenes in Schools:

> ***'The campaign to end of FGM started in 2004 in the school (mixed school). The first round of training was targeting young girls at the school. The school pupils start participating in seminars from year 4, but the focus is on year 6-8. In our school we developed a slightly different program as we target year pupils in years 1-3 and give them basic information and we increase the level of information when we target those in years 4-8. We have one class each week where we discuss the problems with FGM, and I am the only teacher in school who raises this issue. Usually in the second round of training the girls become more confident about their knowledge, and are at a stage to speak to their families about the dangers of FGM. Some of the girls even understand the different types of circumcision. I also had some of the boys in the class telling me they do not want to marry circumcised girls. In the past couple of months, we have not been able to work because of the referendum, and then the separation. We had many students from the South, and now all of them have left. I also taught adult education classes, and I raised the topic of FGM indirectly during discussions etc'.***

In addition to school teachers and pupils, volunteers mainly youth were also involved in order to ensure community ownership and sustainability for the gains of the campaign and after the SNCTP organization pulls out. For example, one of the SCTP's board members and who also an activist and a volunteer in the program explains her involvement in the FGM campaign as follows:

> 'A***s part of my volunteer activities for the organisation, I hold lectures in different locations about FGM and other HTP. So far, I held 189 lectures, with a minimum attendance of 45 people, and sometimes the numbers reaches more than 100 people, especially when the venue is an***

IDP camp. There is also engagement with the schools on issues of nutrition. We target mothers through adult education, training is provided on practical skills, such as sewing, and then we use these links as an entry point to discuss FGM. We have also targeted men in lectures to raise their awareness of the dangers linked to FGM. All the board members contribute to the work of SNCTP by participating in lectures'.

Like the leaders and midwives, some of the youth and volunteers pointed out that they were involved in the planning and implementation of the activities organized by the SNCTP program while others were not. One participant in the youth groups contends that 'how people were selected was not very clear to us and I do not know when we can be involved in the planning when we are not even invited'. He further elaborated that members of the community were not fully engaged or consulted in activities set-up by SNCTP and that was a mistake as people know what information they exactly need, and how it should be delivered to them. Others voiced critical views stating that there is a need by SNCTP to design more effective policies for engaging volunteers and that at present the programmes for volunteers are inconsistent and not very organised. For example, one of the volunteers commented by saying ***'I am very active at the medical centre; however, no work would have been done if I was not committed, and after all this it is not appreciated. Efforts made by volunteers need to be recognised which is very disappointed. It is as if we do not matter'.***

Young school pupils had to deal with another type of constraints while they are fighting FGM. They indicated that when they try to share a message of FGM, some of the people (their families) listened to us, but some did not, mainly mothers and grandmothers. This was articulated by some of the pupils as follows '***our families do not take us seriously as we are so young, especially our grandmother. My grandmother herself does circumcisions, so how can I persuade her or other family members otherwise?'. 'Because we are young, our mother and grandmothers tell us to shut-up or go away as soon as we start talking about how bad is FGM, they say to me "what do you know, you were just born yesterday", and "this is our culture and traditions, do you think school is going to change that?'.***

Despite that, and asserting their roles that they can both RHs and DBs, school pupils expressed very strong opinions emerged: some of the girls supported fully the arrest and prosecution of those who carry out the circumcision. '***We have to continue to pass the message regardless of what our families say. Yes, I know we are young, but what else can we do except try?'*** as one of the young girls put it.

5. Lessons Learned and best practices

Most of the evaluation participants pointed out that the SNCTP program in Mayo has been a successful project with a remarkable and diverse influence in raising awareness on FGM/HTPs and HIV/AIDS and their associated hazards and consequences on individuals and society. This section of the report aims to capture and bring together the lessons learned and best practices that can be usefully applied to future projects on the FGM/HTPs campaigns. These are the best practices of the SNCTP program:

1. The SNCTP program against FGM in Mayo was a pioneering project which responded to unfulfilled social and development needs in the community. Through intensive and continuous efforts of advocacy and education, the program had achieved substantial gains in terms of scaling up the level of awareness on the risks associated with FGM and HTPs and on the modes of transition and protection from HIV/AIDS among various categories in the IDP community.

2. The program's emphasis on categories such as midwives, opinion leaders, and teachers - has been one of the most successful strategies. These categories of beneficiaries have influence and play important role in the society. Given this role, they have offered the opportunity to SNCTP to access and collaborate with key social institutions such as the household, churches, mosques, schools, medical centres and enabled the program to reach to a wide mass of the community's members.

3. SNCTP has a huge advantage on the advocacy front on the national, regional and international levels. This outreach capacity has significantly influenced the campaign and ensured its success. For example, the organization is a member of the Inter- African Committee against Traditional Harmful Practices.

4. SNCTP has been strategic in starting a dialogue with religious groups. The Executive Director has the skills and ability to work with religious leaders, which is a unique skill for those working on FGM. She is able to relate to religious leaders and is highly respected in these circles. The outreach and involvement of religious powers has given credibility to the campaign. This had a great impact on the program as the practice of FGM has been mistakenly justified and interpreted on religious basis.

5. Shifting from a purely health approach to a rather inclusive human rights approach which addressing FGM as a rights issue and as a violation for the rights of women and children is appropriate and is consistent with the intentional and regional conventions – as in Maputo Protocol.

6. Engaging and empowering both RHs and DBs in the planning and implementation of the program created the chance for IDPs to learn about the risks of FGM/HTPs and triggered

them to shift their attitude against the practice. It also enabled the beneficiaries to be sources of message against FGM and to be agents of change – regardless of their position in the society.

7. Working with young people and volunteers as holders for the future was another successful strategy in order to ensure community ownership and sustainability for the future.

8. Developing innovative methods of diversifying educational and advocacy program and materials such as debates, audio visual materials and festivals enabled a greater visibility and influence for the campaign.

9. Lessons learned in Mayo were shared with other SNCTP-projects operating at other states. The lessons learned and the experiences gained from the work in Mayo were also shared with Inter-African Committee Harmful Traditional Practices.

10.

6. Concluding remarks

1. The SNCTP program in Mayo has made considerable progress vis-à-vis the set out objectives and continued to be relevant to the target beneficiaries, despite the challenges- numerous interviewees spoke highly of the work carried out in the FGM campaign.
2. The repatriation of Southern Sudanese – who were initially the target of the program - to their newly established country hindered the possibility of the evaluators to access them and hence gain a tangible and comprehensive insights on the development, gains, and constraints of the program.
3. The campaign against FGM in Mayo yielded remarkable results in terms of an evident shift in attitudes against FGM, a considerable knowledge on the risks of FGM and HTPs, and in enabling the beneficiaries to be sources of message and hence agents of change.
4. Despite the success of the campaign in lifting the level of awareness on HTPs, FGM is still practiced in the community. The persistence of the practice is most attributed to reasons of poverty, tradition and distorted religious beliefs. Mothers and midwives are still the main decision makers and midwives are still the most common performs.
5. The SNCTP program in Mayo was designed with some weaknesses in terms of translating the focal target groups and strategies for different phases of the project and different targets. Some important weakness observed; the program management tends to initiate activities but was less concerned about engaging beneficiaries and partners in the process of policy/strategy change and about follow up.

6.

7. Recommendations

Based on the data that has been gathered and analyzed during the NCA-SNCTP program evaluation, this section presents the key recommendations which address the main aspects of the program in Mayo in relation to its moving forward. It aims to provide insights for future implementation or redesigning of future FGM/HTPs campaigns in Sudan.

For SNCTP

1. **Approaches:** continue using a comprehensive approach which addresses FGM/HTPs not merely as health issues but also as violations for the rights of women and children and this should be the platform for advocacy. The psychological impact of FGM should be also adequately emphasized.
2. **Outreach outside Khartoum:** FGM is still being practiced widely in areas such as in Blue Nile and Nuba Mountains. In order to avoid recurrence of the practice, both SNCTP and its partner organizations need to expand activities in the other regions beyond Khartoum State. This can be done whether through direct interventions by the organization or through establishing networks and collaborations with other individuals and organizations working the field of reproductive health and HTPs/FGM.

3. **Funding**: Diversify funding sources so the program is not completely relied upon funding from NCA. One of the strategies to reduce cost is to encourage and attract volunteers and interns to engage in the program and contribute to its implementation. Non-finical incentives can be designed and offered in return.
4. **Planning**: Design a clear long term strategy (2-5 years) with the aim to clear focus on key areas of change, i.e. changing laws at state level, and then progress to federal level, identifying and addressing stoppages etc. Establish an exit plan from the onset of the project to ensure consistency of the program then smooth transition and sustaining the gains. Coordinate with similar initiatives in order to avoid duplication.
5. **Monitoring and Evaluation:** Improvements to current program monitoring tools and practices and in particular impact measurement. Clear Monitoring and Evaluation (M&E) framework should be established and put in place. There needs to be periodical and annual assessment of the work, this is particularly needed because people change in the organizations. Every 5 years, SNCTP can conduct a study on prevalence rates among young girls, which can inform next steps and encourage donors etc.

6. **Family approach:** Reach out to mothers, grandmothers and fathers as a priority in future project and design a family approach. Create engaging materials targeting them and which would also allow them to share it with other relatives, etc. Some of the strategies that can be adopted should include encouraging dialogue in the family and discuss issues of sexual health etc. They can be encouraged to spend half an hour or an hour each week to discuss issues such as marriage, sexuality and cleanliness.

7. **All should get the message:** Empower young girls (school pupils), and ensure that all get trained on FGM and its dangers. For example, consider having volunteer doctors visit their families to tell them about the health complications associated with FGM. SNCTP should engage the medical officers by giving them adequate training, as they also go into the community when they're in vaccination campaigns. There is about 30 of them.
8. **Promote local ownership and local leadership:** SNCTP as an organization needs to have better engagement with the community to give them ownership. To ensure sustainability, there should be ownership for the local population. Design training workshops within the community, by the people in the community, rather than outsiders. Build strategies in order to volunteers to carry out the activities. Design an innovative and efficient mechanism in order to track volunteers and beneficiaries and enable a better communication, flow of information, and networking and collaborations.
9. **Capacity building:** build capacities and leadership inside the organization and enable the staff to be proactive in order to ensure continuity and sustainability. There needs to be capacity building training for SNCTP staff on human rights and gender. Enhance the engagement of the border members.
10. **Resource centre:** Establish leadership resource center in order to enable an increasing knowledge sharing among the stakeholders. The documentation of the stories of success and the entire process and implementation of the program among IDPs should be given more attention.
11. **Learning and knowledge sharing:** there is a need to learn from experiences in other countries, for example, in Eritrea and Ethiopia where FGM is now banned and is substantially decreasing.

For NCA

1. **Approaches**: continue using a rights-based approach; but this approach should be implemented through fostering leadership and building a dialogue among the stakeholders. The division between RHs and DBs which NCA follows might need to be revisited. Placing the two parties in confrontation against each other might bring tension and dependency – at least by RHs whom role in the process of change would be limited to receivers of aid instead of agents of change.

2. **Fund**: Ensure faster transfer of funds to SNCTP to avoid delay in the implementation of the programme. If necessary, the programme start dates should be changed in anticipation of delays or through advancing grants bi annually instead of every year.

3. **Monitoring**: Set-up regular monitoring visits to the field and design regular and periodical monitoring activities for the program.

4. **Capacity building:** carry out capacity building trainings for all SNCTP staff, and not just those working on the project; this will ensure continuity and institutionalization of the programme and activities.

Annexes

I. Work plan

Updated: 29 October 2011

Dates	Task	Lead
25- 29 October	***Preparations (5 working days):***	
	▪ Collection and review of documents and relevant materials (list of documents – see TOR page 6) ▪ Search and collection of contextual documents (FGM, Sudan, FGM in Sudan)	**Amira and Bashair**
	Tentative report outline (background, objectives, research questions, literature review, etc)	**Amira- feedback from Bashair**
	List of interviewees (share with NCA in advance to prepare schedule) + no of interviewees	**NCA**
	Conference call with NCA	**Amira and Bashair**
30 October- 6 November	***Methodology (6 working days):***	
	▪ Outline achievement indicators – research Matrix (TOR page 4) - research questions - methodology and data collection tools: ▪ Preparations of guide questions for semi-structured interviews (target group, midwives, community leaders, NCA, policy makers in Sudan, Norwegian Embassy, NGOs other stakeholders – KIIs) ▪ Focus group (questions and methodology) ▪ Survey (knowledge and practice survey) - to assess the prevalence rates in 2003-2010 – Baseline survey *Note: Guide questions (for team) have to be adjusted according to interviewees:*	**Amira and feedback from the team**

	1. *Beneficiaries* 2. *Community leaders* 3. *Officials (government, funders)* 4. *NGOs* 5. *health workers (midwives)*	
13- 15 Nov	***Travel to Khartoum to finalise methodology, conduct interviews and assessment (3 working days):***	**Team**
	Meeting and presentation to NCA Khartoum on methodology + collecting more relevant materials	
	Identify and schedule meetings with target groups and relevant stakeholders	**Amira , Bashair with NCA**
	Collection of quantitative data	**Bashair**
15 -23 Nov.	**Field work: interviews with relevant stakeholders (6 working days)**	**Bashair**
	Midterm Review and further steps	Amira + Bashair
	Type notes and summaries from field work	Bashair
23 Nov - 4 December	**Work on the first draft of the report *(5 working days)***	**Amira with input from Bashair**
	Draft structure of the report	
	Put together analysis , strategies and recommendations	
	Put together appendices, detailed notes etc	
	Submit draft report to NCA	
4-7 December	**Discuss draft report with NCA Khartoum (2 working day)**	**Amira, with support from Bashair**
8-12 Dec	**final report, incorporating all comments *(4 working days*)**	**Amira and Bashair**
14 Dec	**Presentation of final report *(1 working day*)**	**Amira with support from Bashair**
16-17 Dec	**Tweaking and finalisation of report *(2 working days)***	**Amira and Bashair**
20 Dec	**Final submission**	**Amira**

II. Khartoum meeting Agenda – 14 November 2011

	ITEM	PAGE
	List of Acronyms **List of Tables** **List of Figures & Illustrations** **Excusive Summary**	

1	**Executive Summary**	
2	**Introduction and Background to the Evaluation:** Evaluation Objectives Structure of the Report	
3	**FGM context in Sudan:** Socio-economic and Political Context and their impact on reproductive health situation (Mayo) The context of female circumcision in Sudan SNCTP FGM program goals, objectives and initiatives in Mayo and its contribution on the national level	
4	**Methodology:** Documents Review FGDs SSIs Survey	
5	**Evaluation Findings:** **Section A: Prevalence, Knowledge and attitude towards FGM** **Section B: SNCTP Program Relevance and Effectiveness:** Approaches – Rights based approach Awareness raising methods and tools Outreach Networks and Partnerships: locals + other stakeholders **Section C: Program Implementation** Lessons learned Sustainability and the way forward	
6	**Conclusion** **Recommendations**	
	List of Annexes **List of References**	

III. FGDs Design

FGD - Evaluation for SNCTP FGM Activities in Mayo (Draft) **Date:** **TIME**	**ACTIVITY**	**METHODOLOGY**	**Logistics/Setting**
08:30-09:00	Registration and coffee		Attendance sheet Notebook & pens
Session 1: INTRODUCTIONS/ HOPES AND FEARS			
09:00- 09:10	**Opening:** **1. Welcome and Introduction** **2. Introducing participants**	**Welcoming remark (10 min)** - Samuel and Tarig welcome participants and give a background of the evaluation and rationale for this focus group. - Participants introduce themselves briefly - Samuel introduces the Evaluation Consultant/Facilitator(s). Afterwards, s/he hands over the "process" to the evaluators/facilitator(s) and leaves meeting room.	Three tables will be placed at the corners of the room for later use.
09:10- 09:30	**3. Hopes and Fears regarding the Evaluation**	**Exercise- Hope and fear exercise (20min)** **In Plenary:** the Facilitator(s) will ask the participants to reflect and comment on the following questions: **Q. What are your hopes and your fears about this SNCTP activities evaluation process?** Facilitator comments on the reason for discussing these hopes and fears: understanding ourselves requires us knowing what we want to achieve and what concerns we have. We all hold concerns about ourselves and our abilities but we don't always acknowledge them so we can recognize our fears when they emerge and can possibly address them. A reporter should collect the information gained during the discussion and then hand them in to the consultant	

Session 2: WORLD CAFE			
09:30- 10:30 including tea break (if possible)	**World Cafe**	**Group work 1 – SNCTP FGM activities in Mayo – World Café (1hr 30min – 2hr)** Facilitator(s) explains the process that we will use in this exercise. She notes that there are three different topics we will be considering and during the next 90 minutes or so, we will get a chance to visit each table. It doesn't matter where you start, you will move to another table after the first discussion. At each table there are a set of questions. The questions will guide your discussion but you can consider other questions that may come up. We ask one of you to volunteer to "anchor "the table. That means you will not move but will be responsible for sharing what people talked about during the previous round so that the discussion can build on what has already taken place. The anchor will also report out the key points of the discussion at the end of the process. The purpose of this methodology is to help cultivate the collective wisdom of the group and to build on each other's observations and ideas. Facilitator tells everyone they will have approx 25 minutes for discussion. She will ring a bell or make a sound when it's time to move. When it's time to move, please move to a different table with different people. Mix up as much as possible. Try not to stay as one group moving around. Participants rotate to different tables after about 20 minutes. An anchor remains on each table to ensure that the discussion from the previous table is summarised for the new table participants. In total 3 rounds are conducted ensuring that all participants, except for anchors have visited all the tables. - **Round One**: (20 minutes) - **Round Two**: (20 minutes) - **Round Three**: (20 minutes) *They will cover the following themes (TRANSLATED):* **1) "Relevance of methods used by SNCTP in their awareness raising activities against FGM in Mayo"** **2) "community participation in design and implementation of SNCTP activities"** **3) "prevalence of FGM"**	**<u>Preparations:</u>** Room Set up: Three tables for the three groups Questions, themes, etc
10:30: 10:45 COFFEE/TEA BREAK TO BE SERVED DURING WORLD CAFÉ EXCERCISE			
10:45- 11:30		**Report out (15 minutes)** Each anchor is invited to briefly share the main themes of discussion emerging from their table. Each person will have about 5 minutes. **Plenary reflection (30 min)** The facilitator asks the participants the following question for reflection **Given the discussions from the World Café, how would you assess SNCTP intervention for TP/FGM?**	

		How effective are these awareness raising activities in a country like Sudan?	
Plenary			
11:30- 12:00	**Lessons learned and best practices** **Sustainability and way forward**	**Open Discussion** **In** Plenary – participants will discuss the following questions: 1. What might be replicable for future FGM Campaigns? 2. What was the least effective part of SNCTP activities against FGM in terms of implementation and contribution to the awareness raising around FGM in the community? 3. How do stakeholders and other key actors apply, expand or sustain the gains from SNCTP activities against FGM and from the FGM campaign in Sudan in general?	**Preparations:** Questions, themes, etc
		Closing Circle. Facilitator will ask all participants to express one thought, learning, or experience from the day this FG to close.	

- Energizers will be used when needed and participants will also to be invited to bring own

IV. Surveys

QUESTIONNAIRE- MOTHERS AND MIDWIVES

All questions contained in this questionnaire are strictly confidential.

Demographic and socio-economic background			
Name (optional)		2. Sex:	☐ Male ☐ Female
3. Age group:	☐ Under 20 ☐ 21-30 ☐ 31-40 ☐ 41-50 ☐ 51-60 ☐ over 60 ☐ I do not know ☐ no response		
4. Level of Education	☐ Never been to school	☐ Still in school	
	☐ Primary (complete or incomplete)	☐ Secondary (complete or incomplete)	
	☐ High school (complete or incomplete)	☐ University (complete or incomplete)	
	☐ Other (please specify)		
5. Current Employment	☐ Housewife	☐ Nurse or Midwife	
	☐ Domestic worker	☐ Teacher	
	☐ Student	☐ Construction Worker	
	☐ Street Vendor	☐ Officer Worker	
	☐ Tea seller	☐ Other (please specify)	
6. Current marital status:	☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Not specified		
7. Religion:	☐ Christian ☐ Muslim ☐ No answer ☐ Not specified		
8. Geographical Origin:	☐ South[24] ☐ North ☐ East ☐ West ☐ Central ☐ Other (please specify):		
9. How many years have you been living in Mayo Farm (Mandela)?			
☐ 0-5 ☐ 6-10 ☐ 11-20 ☐ 21-30 ☐ more (please specify)			
10. Are you planning to go back to your home area?			
☐ Yes ☐ No ☐ Maybe ☐ I do not know ☐ No answer			

Knowledge, Attitude and Practice of FGM[25]
11. During the past 10 years, do you think that circumcision is still being practiced in your community?
☐ Yes ☐ No ☐ To some extent ☐ I do not know ☐ Other (please specify):
12. Have you heard of a girl who has been recently circumcised?
☐ Yes ☐ No ☐ No answer ☐ Other (please specify):
13. If yes, who did the circumcision?
☐ Midwife ☐ Nurse ☐ Doctor ☐ I do not know ☐ Other (please specify):
14. Are you circumcised?

[24] Former South Sudan, currently Republic of South Sudan

[25] For sections B & C – respondents may choose more than one answer

☐ Yes ☐ No ☐ No answer ☐ Other (please specify):			
15. If yes, what is the type of circumcision?			
☐ Faruni (Infibulations) ☐ Sunna (type I & II) ☐ I do not know ☐ No answer ☐ Other (please specify):			
16. If you have female children under your care, are they circumcised?			
☐ Not relevant ☐ Yes ☐ No ☐ Not yet ☐ I do not know ☐ No answer ☐ Other (please specify):			
17. If you have female children under your care, would you circumcise them in the future?			
☐ Not relevant ☐ Yes ☐ No ☐ Not yet ☐ I do not ☐ No answer ☐ Other (please specify):			
18. If yes, what would be the type of circumcision?			
☐ Faruni (Infibulations) ☐ Sunna (type I & II) ☐ I do not know ☐ No answer ☐ Other (please specify):			
19. Whom are you going to seek to carry out the circumcision?			
☐ Midwife ☐ Nurse ☐ Doctor ☐ I do not know ☐ No answer ☐ Other (please specify):			
20. Is there a difference between circumcised and uncircumcised girls?			
☐ Yes ☐ No ☐ Maybe ☐ I do not know ☐ No answer ☐ Other (please specify):			
21. Is circumcision legal under Sudanese law?			
☐ Yes ☐ No ☐ Maybe ☐ I do not know ☐ No answer ☐ Other (please specify):			
22. What are the reasons for girl's circumcision?			
☐ Religion	☐ Good tradition	☐ Better hygiene	☐ Protects girl's honor
☐ Marriage	☐ All	☐ No response	☐ Other (please specify):
23. Do you think circumcision is a good practice?			
☐ Yes ☐ No ☐ Maybe ☐ I do not know ☐ No answer ☐ Other (please specify):			
24. If yes, why?			
☐ Religion	☐ Good tradition	☐ Better hygiene	☐ Protects girl's honor
☐ Marriage	☐ All	☐ No response	☐ Other (please specify):
25. If no, why?			
☐ It is not important now		☐ no difference between circumcised and uncircumcised girls	
☐ not good for women's health		☐ Not good for girl's education	
☐ it is illegal		☐ against religion	
☐ heard message[26]		☐ all	
☐ I do not know		☐ no answer	
☐ Other (please specify)			
26. Do you think the practice of circumcision should continue?			

[26] Information regarding the risks associated with FGM

☐ Yes ☐ No ☐ Maybe ☐ I do not know ☐ No answer ☐ Other (please specify):
27. If you decided to go back to your region, would you support the performance of girl's circumcision?
☐ Yes ☐ No ☐ Maybe ☐ I do not know ☐ No answer ☐ Other (please specify):

SNCTP COMMUNITY-BASED ACTIVITIES

28. Do you think that the number of girls who get circumcised is less than before?	
☐ Yes ☐ No ☐ Maybe ☐ I do not know ☐ No answer ☐ Other (please specify):	
29. Who are the sources of messages against FGM in your community?	
☐ Parents	☐ relatives
☐ friends	☐ religious leaders
☐ community leaders	☐ teachers
☐ health workers	☐ midwives
☐ radio	☐ TV
☐ posters	☐ workshops
☐ SNCTP	☐ none
☐ All	☐ Others (please specify)
30. Have you ever heard about SNCTP?	
☐ Yes ☐ No ☐ Maybe ☐ I do not know ☐ No answer ☐ Other (please specify):	
31. If the answer is yes, have you been aware of any of their activities? Such as:	
☐ Workshops	☐ meetings
☐ work in Mayo schools	☐ work with mothers and midwives
☐ FGM international day	☐ Football competition
☐ Posters	☐ T-Shirts
☐ All	☐ None
☐ Other (please specify):	
32. If you have ever participated in one of these activities, what was it/they?	
33. What are the key lessons you have learned from you participation in it/them?	

QUESTIONNAIRE- religious and community leaders

All questions contained in this questionnaire are strictly confidential.

Demographic and socio-economic background			
Name (optional)		**2. Sex:**	☐ Male ☐ Female
3. Age group:	☐ Under 20 ☐ 21-30 ☐ 31-40 ☐ 41-50 ☐ 51-60 ☐ over 60 ☐ I do not know ☐ no response		
4. Level of Education	☐ Never been to school	☐ Still in school	
	☐ Primary (complete or incomplete)	☐ Secondary (complete or incomplete)	
	☐ High school (complete or incomplete)	☐ University (complete or incomplete)	
	☐ Other (please specify)		
5. Current Social Status	☐ Religious leader	☐ tribal leader	
	☐ public figure	☐ Grandmother/relative	
	☐ Other (please specify)		
6. Current marital status:	☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Not specified		
7. Religion:	☐ Christian ☐ Muslim ☐ No answer ☐ Not specified		
8. Geographical Origin:	☐ South[27] ☐ North ☐ East ☐ West ☐ Central ☐ Other (please specify):		
9. How many years have you been living in Mayo Farm (Mandela)?			
☐ 0-5 ☐ 6-10 ☐ 11-20 ☐ 21-30 ☐ more (please specify)			
10. Are you planning to go back to your home area?			
☐ Yes ☐ No ☐ Maybe ☐ I do not know ☐ No answer			

Knowledge, Attitude and Practice of FGM[28]

11. During the past 10 years, do you think that circumcision is still being practiced in your community?
☐ Yes ☐ No ☐ To some extent ☐ I do not know ☐ Other (please specify):
12. Have you heard of a girl who has been recently circumcised?
☐ Yes ☐ No ☐ No answer ☐ Other (please specify):

[27] Former South Sudan, currently Republic of South Sudan

[28] For sections B & C – respondents may choose more than one answer

13. If yes, who did the circumcision?				
☐ Midwife	☐ Nurse	☐ Doctor	☐ I do not know	☐ Other (please specify):
14. For female leaders, are you circumcised?				
☐ Yes	☐ No	☐ No answer	☐ Other (please specify):	
15. For female leaders, if yes, what is the type of circumcision?				
☐ Faruni (Infibulations)	☐ Sunna (type I & II)	☐ I do not know	☐ No answer	☐ Other (please specify):
16. If you have female children under your care, are they circumcised?				
☐ Not relevant	☐ Yes	☐ No	☐ Not yet	☐ I do not know ☐ No answer ☐ Other (please specify):
17. If you have female children under your care, would you circumcise them in the future?				
☐ Not relevant	☐ Yes	☐ No	☐ Not yet	☐ I do not ☐ No answer ☐ Other (please specify):
18. If yes, what would be the type of circumcision?				
☐ Faruni (Infibulations)	☐ Sunna (type I & II)	☐ I do not know	☐ No answer	☐ Other (please specify):
19. Whom are you going to seek to carry out the circumcision?				
☐ Midwife	☐ Nurse	☐ Doctor	☐ I do not know	☐ No answer ☐ Other (please specify):
20. Is there a difference between circumcised and uncircumcised girls?				
☐ Yes	☐ No	☐ Maybe	☐ I do not know	☐ No answer ☐ Other (please specify):
21. Is circumcision legal under Sudanese law?				
☐ Yes	☐ No	☐ Maybe	☐ I do not know	☐ No answer ☐ Other (please specify):
22. What are the reasons for girl's circumcision?				
☐ Religion	☐ Good tradition	☐ Better hygiene	☐ Protects girl's honor	
☐ Marriage	☐ All	☐ No response	☐ Other (please specify):	
23. Do you think circumcision is a good practice?				
☐ Yes	☐ No	☐ Maybe	☐ I do not know	☐ No answer ☐ Other (please specify):
24. If yes, why?				
☐ Religion	☐ Good tradition	☐ Better hygiene	☐ Protects girl's honor	
☐ Marriage	☐ All	☐ No response	☐ Other (please specify):	
25. If no, why?				
☐ It is not important now		☐ no difference between circumcised and uncircumcised girls		
☐ not good for women's health		☐ Not good for girl's education		
☐ it is illegal		☐ against religion		

☐ heard message[29]	☐ all
☐ I do not know	☐ no answer
☐ Other (please specify)	
26. Do you think the practice of circumcision should continue?	
☐ Yes ☐ No ☐ Maybe ☐ I do not know ☐ No answer ☐ Other (please specify):	
27. If you decided to go back to your region, would you support the performance of girl's circumcision?	
☐ Yes ☐ No ☐ Maybe ☐ I do not know ☐ No answer ☐ Other (please specify):	

SNCTP COMMUNITY-BASED ACTIVITIES

28. Do you think that the number of girls who get circumcised is less than before?	
☐ Yes ☐ No ☐ Maybe ☐ I do not know ☐ No answer ☐ Other (please specify):	
29. Who are the sources of messages against FGM in your community?	
☐ Parents	☐ relatives
☐ friends	☐ religious leaders
☐ community leaders	☐ teachers
☐ health workers	☐ midwives
☐ radio	☐ TV
☐ posters	☐ workshops
☐ SNCTP	☐ none
☐ All	☐ Others (please specify)
30. Have you ever heard about SNCTP?	
☐ Yes ☐ No ☐ Maybe ☐ I do not know ☐ No answer ☐ Other (please specify):	
31. If the answer is yes, have you been aware of any of their activities? Such as:	
☐ Workshops	☐ meetings
☐ work in Mayo schools	☐ work with mothers and midwives
☐ FGM international day	☐ Football competition
☐ Posters	☐ T-Shirts
☐ All	☐ None
☐ Other (please specify):	
32. If you have ever participated in one of these activities, what was it/they?	

[29] Information regarding the risks associated with FGM

33. What are the key lessons you have learned from you participation in it/them?

QUESTIONNAIRE- SCHOOL PUPILS

All questions contained in this questionnaire are strictly confidential.

Demographic and socio-economic background			
Name (optional)		**2. Sex:**	☐ Male ☐ Female
3. Age group:	☐ Under 10 ☐ 11-15 ☐ 16-20 ☐ above 21 ☐ I do not know ☐ no response		
4. Religion:	☐ Christian ☐ Muslim ☐ No answer ☐ Not specified		
5. Geographical Origin:	☐ South[30] ☐ North ☐ East ☐ West ☐ Central ☐ Other (please specify):		

Knowledge, Attitude and Practice of FGM[31]

6. Do you think that circumcision is being practiced in your community?
☐ Yes ☐ No ☐ To some extent ☐ I do not know ☐ Other (please specify):
7. Have you heard of a girl who has been recently circumcised?
☐ Yes ☐ No ☐ No answer ☐ Other (please specify):
8. If yes, who did the circumcision?
☐ Midwife ☐ Nurse ☐ Doctor ☐ I do not know ☐ Other (please specify):
9. For female pupil, are you circumcised?
☐ Yes ☐ No ☐ No answer ☐ Other (please specify):
10. For female pupil, if yes, what is the type of circumcision?
☐ Faruni (Infibulations) ☐ Sunna (type I & II) ☐ I do not know ☐ No answer ☐ Other (please specify):
11. Is there a difference between circumcised and uncircumcised girls?

[30] Former South Sudan, currently Republic of South Sudan
[31] For sections B & C – respondents may choose more than one answer

☐ Yes ☐ No ☐ Maybe ☐ I do not know ☐ No answer ☐ Other (please specify):			
12. What are the reasons for girl's circumcision?			
☐ Religion	☐ Good tradition	☐ Better hygiene	☐ Protects girl's honor
☐ Marriage	☐ All	☐ No response	☐ Other (please specify):
13. Do you think circumcision is a good practice?			
☐ Yes ☐ No ☐ Maybe ☐ I do not know ☐ No answer ☐ Other (please specify):			
14. If yes, why?			
☐ Religion	☐ Good tradition	☐ Better hygiene	☐ Protects girl's honor
☐ Marriage	☐ All	☐ No response	☐ Other (please specify):
15. If no, why?			
☐ It is not important now		☐ no difference between circumcised and uncircumcised girls	
☐ not good for women's health		☐ Not good for girl's education	
☐ it is illegal		☐ against religion	
☐ heard message[32]		☐ all	
☐ I do not know		☐ no answer	
☐ Other (please specify)			
16. Do you think the practice of circumcision should continue?			
☐ Yes ☐ No ☐ Maybe ☐ I do not know ☐ No answer ☐ Other (please specify):			

SNCTP COMMUNITY-BASED ACTIVITIES

17. Do you think that the number of girls who get circumcised is less than before?	
☐ Yes ☐ No ☐ Maybe ☐ I do not know ☐ No answer ☐ Other (please specify):	
18. Who are the sources of messages against FGM in your community?	
☐ Parents	☐ relatives
☐ friends	☐ religious leaders
☐ community leaders	☐ teachers
☐ health workers	☐ midwives
☐ radio	☐ TV
☐ posters	☐ workshops
☐ SNCTP	☐ none
☐ All	☐ Others (please specify)
19. Have you ever heard about SNCTP?	
☐ Yes ☐ No ☐ Maybe ☐ I do not know ☐ No answer ☐ Other (please specify):	

[32] Information regarding the risks associated with FGM

20. If the answer is yes, have you been aware of any of their activities? Such as:	
☐ Workshops	☐ meetings
☐ work in Mayo schools	☐ work with mothers and midwives
☐ FGM international day	☐ Football competition
☐ Posters	☐ T-Shirts
☐ All	☐ None
☐ Other (please specify):	
21. If you have ever participated in one of these activities, what was it/they?	
22. What are the key lessons you have learned from you participation in it/them?	

QUESTIONNAIRE- TEACHERS

All questions contained in this questionnaire are strictly confidential.

Demographic and socio-economic background			
Name (optional)		**2. Sex:**	☐ Male ☐ Female
3. Age group:	☐ Under 20 ☐ 21-30 ☐ 31-40 ☐ 41-50 ☐ 51-60 ☐ over 60 ☐ I do not know ☐ no response		
4. Level of Education	☐ Primary (complete or incomplete)	☐ Secondary (complete or incomplete)	
	☐ High school (complete or incomplete)	☐ University (complete or incomplete)	
	☐ Other (please specify)		
6. Current marital status:	☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Not specified		
7. Religion:	☐ Christian ☐ Muslim ☐ No answer ☐ Not specified		
8. Geographical Origin:	☐ South[33] ☐ North ☐ East ☐ West ☐ Central ☐ Other (please specify):		
9. How many years have you been living in Mayo Farm (Mandela)?			

[33] Former South Sudan, currently Republic of South Sudan

☐ 0-5	☐ 6-10	☐ 11-20	☐ 21-30	☐ more (please specify)
10. Are you planning to go back to your home area?				
☐ Yes	☐ No	☐ Maybe	☐ I do not know	☐ No answer

Knowledge, Attitude and Practice of FGM[34]

11. During the past 10 years, do you think that circumcision is still being practiced in your community?				
☐ Yes	☐ No	☐ To some extent	☐ I do not know	☐ Other (please specify):
12. Have you heard of a girl who has been recently circumcised?				
☐ Yes	☐ No	☐ No answer	☐ Other (please specify):	
13. If yes, who did the circumcision?				
☐ Midwife	☐ Nurse	☐ Doctor	☐ I do not know	☐ Other (please specify):
14. If you are female, are you circumcised?				
☐ Yes	☐ No	☐ No answer	☐ Other (please specify):	
15. If you are female, if yes, what is the type of circumcision?				
☐ Faruni (Infibulations)	☐ Sunna (type I & II)	☐ I do not know	☐ No answer	☐ Other (please specify):
16. If you have female children under your care, are they circumcised?				
☐ Not relevant	☐ Yes	☐ No	☐ Not yet	☐ I do not know ☐ No answer ☐ Other (please specify):
17. If you have female children under your care, would you circumcise them in the future?				
☐ Not relevant	☐ Yes	☐ No	☐ Not yet	☐ I do not ☐ No answer ☐ Other (please specify):
18. If yes, what would be the type of circumcision?				
☐ Faruni (Infibulations)	☐ Sunna (type I & II)	☐ I do not know	☐ No answer	☐ Other (please specify):
19. Whom are you going to seek to carry out the circumcision?				
☐ Midwife	☐ Nurse	☐ Doctor	☐ I do not know	☐ No answer ☐ Other (please specify):
20. Is there a difference between circumcised and uncircumcised girls?				
☐ Yes	☐ No	☐ Maybe	☐ I do not know	☐ No answer ☐ Other (please specify):
21. Is circumcision legal under Sudanese law?				
☐ Yes	☐ No	☐ Maybe	☐ I do not know	☐ No answer ☐ Other (please specify):
22. What are the reasons for girl's circumcision?				
☐ Religion	☐ Good tradition	☐ Better hygiene	☐ Protects girl's honor	
☐ Marriage	☐ All	☐ No response	☐ Other (please specify):	

[34] For sections B & C – respondents may choose more than one answer

23. Do you think circumcision is a good practice?			
☐ Yes ☐ No ☐ Maybe ☐ I do not know ☐ No answer ☐ Other (please specify):			
24. If yes, why?			
☐ Religion	☐ Good tradition	☐ Better hygiene	☐ Protects girl's honor
☐ Marriage	☐ All	☐ No response	☐ Other (please specify):

25. If no, why?	
☐ It is not important now	☐ no difference between circumcised and uncircumcised girls
☐ not good for women's health	☐ Not good for girl's education
☐ it is illegal	☐ against religion
☐ heard message[35]	☐ all
☐ I do not know	☐ no answer
☐ Other (please specify)	

26. Do you think the practice of circumcision should continue?
☐ Yes ☐ No ☐ Maybe ☐ I do not know ☐ No answer ☐ Other (please specify):
27. If you decided to go back to your region, would you support the performance of girl's circumcision?
☐ Yes ☐ No ☐ Maybe ☐ I do not know ☐ No answer ☐ Other (please specify):

SNCTP COMMUNITY-BASED ACTIVITIES

28. Do you think that the number of girls who get circumcised is less than before?	
☐ Yes ☐ No ☐ Maybe ☐ I do not know ☐ No answer ☐ Other (please specify):	
29. Who are the sources of messages against FGM in your community?	
☐ Parents	☐ relatives
☐ friends	☐ religious leaders
☐ community leaders	☐ teachers
☐ health workers	☐ midwives
☐ radio	☐ TV
☐ posters	☐ workshops
☐ SNCTP	☐ none
☐ All	☐ Others (please specify)

30. Have you ever heard about SNCTP?
☐ Yes ☐ No ☐ Maybe ☐ I do not know ☐ No answer ☐ Other (please specify):
31. If the answer is yes, have you been aware of any of their activities? Such as:

[35] Information regarding the risks associated with FGM

☐ Workshops	☐ meetings
☐ work in Mayo schools	☐ work with mothers and midwives
☐ FGM international day	☐ Football competition
☐ Posters	☐ T-Shirts
☐ All	☐ None
☐ Other (please specify):	
32. If you have ever participated in one of these activities, what was it/they?	
33. What are the key lessons you have learned from you participation in it/them?	

QUESTIONNAIRE- YOUTH

All questions contained in this questionnaire are strictly confidential.

Demographic and socio-economic background			
Name (optional)		**2. Sex:**	☐ Male ☐ Female
3. Age group:	☐ Under 15 ☐ 15-20 ☐ 21-25 ☐ 25-30 ☐ over 30 ☐ I do not know ☐ no response		
4. Level of Education	☐ Never been to school	☐ Still in school	
	☐ Primary (complete or incomplete)	☐ Secondary (complete or incomplete)	
	☐ High school (complete or incomplete)	☐ University (complete or incomplete)	
	☐ Other (please specify)		
5. Current Employment	☐ Housewife	☐ Nurse or Midwife	
	☐ Domestic worker	☐ Teacher	
	☐ Student	☐ Construction Worker	
	☐ Street Vendor	☐ Officer Worker	
	☐ Tea seller	☐ Other (please specify)	
6. Current marital status:	☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Not specified		

7. Religion:	☐ Christian ☐ Muslim ☐ No answer ☐ Not specified
8. Geographical Origin:	☐ South[36] ☐ North ☐ East ☐ West ☐ Central ☐ Other (please specify):
9. How many years have you been living in Mayo Farm (Mandela)?	
☐ 0-5 ☐ 6-10 ☐ 11-20 ☐ 21-30 ☐ more (please specify)	
10. Are you planning to go back to your home area?	
☐ Yes ☐ No ☐ Maybe ☐ I do not know ☐ No answer	

Knowledge, Attitude and Practice of FGM[37]

11. During the past 10 years, do you think that circumcision is still being practiced in your community?
☐ Yes ☐ No ☐ To some extent ☐ I do not know ☐ Other (please specify):
12. Have you heard of a girl who has been recently circumcised?
☐ Yes ☐ No ☐ No answer ☐ Other (please specify):
13. If yes, who did the circumcision?
☐ Midwife ☐ Nurse ☐ Doctor ☐ I do not know ☐ Other (please specify):
14. For females, are you circumcised?
☐ Yes ☐ No ☐ No answer ☐ Other (please specify):
15. For females, if yes, what is the type of circumcision?
☐ Faruni (Infibulations) ☐ Sunna (type I & II) ☐ I do not know ☐ No answer ☐ Other (please specify):
16. If you have female children under your care, are they circumcised?
☐ Not relevant ☐ Yes ☐ No ☐ Not yet ☐ I do not know ☐ No answer ☐ Other (please specify):
17. If you have female children under your care, would you circumcise them in the future?
☐ Not relevant ☐ Yes ☐ No ☐ Not yet ☐ I do not ☐ No answer ☐ Other (please specify):
18. If yes, what would be the type of circumcision?
☐ Faruni (Infibulations) ☐ Sunna (type I & II) ☐ I do not know ☐ No answer ☐ Other (please specify):
19. Whom are you going to seek to carry out the circumcision?
☐ Midwife ☐ Nurse ☐ Doctor ☐ I do not know ☐ No answer ☐ Other (please specify):
20. Is there a difference between circumcised and uncircumcised girls?
☐ Yes ☐ No ☐ Maybe ☐ I do not know ☐ No answer ☐ Other (please specify):

[36] Former South Sudan, currently Republic of South Sudan
[37] For sections B & C – respondents may choose more than one answer

21. For males, would you marry uncircumcised girl?			
☐ Not relevant ☐ Yes ☐ No ☐ Not yet ☐ I do not know ☐ No answer ☐ Other (please specify):			
22. Is circumcision legal under Sudanese law?			
☐ Yes ☐ No ☐ Maybe ☐ I do not know ☐ No answer ☐ Other (please specify):			
23. What are the reasons for girl's circumcision?			
☐ Religion	☐ Good tradition	☐ Better hygiene	☐ Protects girl's honor
☐ Marriage	☐ All	☐ No response	☐ Other (please specify):
24. Do you think circumcision is a good practice?			
☐ Yes ☐ No ☐ Maybe ☐ I do not know ☐ No answer ☐ Other (please specify):			
25. If yes, why?			
☐ Religion	☐ Good tradition	☐ Better hygiene	☐ Protects girl's honor
☐ Marriage	☐ All	☐ No response	☐ Other (please specify):
26. If no, why?			
☐ It is not important now		☐ no difference between circumcised and uncircumcised girls	
☐ not good for women's health		☐ Not good for girl's education	
☐ it is illegal		☐ against religion	
☐ heard message[38]		☐ all	
☐ I do not know		☐ no answer	
☐ Other (please specify)			
27. Do you think the practice of circumcision should continue?			
☐ Yes ☐ No ☐ Maybe ☐ I do not know ☐ No answer ☐ Other (please specify):			
28. If you decided to go back to your region, would you support the performance of girl's circumcision?			
☐ Yes ☐ No ☐ Maybe ☐ I do not know ☐ No answer ☐ Other (please specify):			

snctp cOMMUNITY-BASED ACTIVITIES

29. Do you think that the number of girls who get circumcised is less than before?	
☐ Yes ☐ No ☐ Maybe ☐ I do not know ☐ No answer ☐ Other (please specify):	
30. Who are the sources of messages against FGM in your community?	
☐ Parents	☐ relatives
☐ friends	☐ religious leaders

[38] Information regarding the risks associated with FGM

☐ community leaders	☐ teachers
☐ health workers	☐ midwives
☐ radio	☐ TV
☐ posters	☐ workshops
☐ SNCTP	☐ none
☐ All	☐ Others (please specify)
31. Have you ever heard about SNCTP?	
☐ Yes ☐ No ☐ Maybe ☐ I do not know ☐ No answer ☐ Other (please specify):	
32. If the answer is yes, have you been aware of any of their activities? Such as:	
☐ Workshops	☐ meetings
☐ work in Mayo schools	☐ work with mothers and midwives
☐ FGM international day	☐ Football competition
☐ Posters	☐ T-Shirts
☐ All	☐ None
☐ Other (please specify):	
33. If you have ever participated in one of these activities, what was it/they?	
34. What are the key lessons you have learned from you participation in it/them?	

V. Interview questions

Interviews' Questions for NCA-SNCTP Joint Activities Against FGM in Mayo

A. Interviewee's background information (for All if possible/relevant/proper to ask)

Date of interview:
Location:
Name:
Sex:
Age group:
Education:
Material Status:
Organization and position:

B. FGM Prevalence in Sudan/Khartoum/Mayo (for Duty Bearers *and Right Holders when applicable*)

1. From your own observations, do you think there has been a reduction in the FGM practice (in Mayo, and/or in Sudan overall?
2. Are you aware of any recent statistic which shows the prevalence rates of FGM in Sudan, Khartoum or in *Mayo*?
3. How would you describe the context of FGM/TP in 2004? And how would you describe it today?
4. Think back to 2004, were there any activities or initiatives that aimed to raise awareness against FGM?
5. Do you think that FGM is still practiced now? If so, at what level- amongst most of the population, or only some?
6. Do many people still support girls' circumcision, in your view?
7. Have there been any notable changes- in the practice or within the legal framework (jurisprudence- prosecutions of those who carried out type III, which is illegal under the Sudanese penal code)? In other words, does the law support FGM, or provide protection against it? How – and which article in specific?
8. What about those who have shifted to or still practice Types I & II?
9. Do you think that the awareness of people on the risks of FGM has increased?
10. Does this have to do anything with an increasing awareness around women rights in general and GBV in particular via campaigns?
11. Or – is it due legal obligations- i.e. does this have to do anything with the convention of child rights? And in particular protecting the rights of female children? Or both?
12. Sudan is a signatory to the child convention (1991), what implication did this have on the practice of FGM, if any?
13. So what are the efforts that have been made in order to eradicate FGM in Sudan, Khartoum and Mayo by the government and other stakeholders?
14. Are you aware of the activities that SNCTP have been implementing in its campaign against FGM – particularly in Mayo? If yes, how did you get to know about that?
15. Have you been engaged in any sort of collaborative activities with SNCTP in Mayo?

16. How do you evaluate the approaches and strategies used by SNCTP in the campaign to eradicate FGM in Mayo? Were they effective, were they responding to the context and to the needs of the target population?

C. SNCTP Programs (awareness raising methods) relevance and effectiveness: (for Right Holders)

17. Are you aware of the activities that SNCTP have been implementing in its campaign against FGM - particularly in Mayo?
18. Can you specifically give some examples of such activities? Which ones do you feel were the most successful?
19. Have you been part of these activities?
20. Were you involved in previous planning, evaluation or implementation of SNCTP activities in Mayo Farm? In other, do you think that SNCTP followed a right-based approach during the campaign against FGM in Mayo?
21. How relevant/effective was their approach and strategies? For example the approach of mixing the campaign against FGM and HIV/AIDS?
22. Overall, in your opinion: do you think these activities have responded to the needs of the community in order to address FGM and raise awareness around its associated risks?
23. In what ways, if any, do you feel that SCNTP contributed or influenced the changes which may have occurred during the past 10 years?

D. For NCA and SNCTP only

24. Would you tell us about this story of collaborations and partnerships with SNCTP with regard to their activities against FGM in Mayo?
25. Would you tell us about SNCTP Partnerships with IAC and other donors and how this is relevant to the organization's work in Mayo?
26. How relevant was the approach of mixing work against FGM/HTP with HIV/AIDS in Mayo? Would you advise that the two issues should be split in the future? - *consider recommendations as to split the two issues (ref. Sudan Country Case Study, 2010)*
27. What are the best practices that can be replicable in the future with regard to the methods used by SNCTP in the FGM/HTP awareness campaign in Mayo?
28. What would be the way to improve the current programs against FGM in Mayo in terms of monitoring tools and practices and in particular in impact measurement?
29. What were the constraints and challenges which have been encountered during the implementation of the FGM campaign in Mayo?

E. Recommendation: Sustainability and way forward (for Right Holders + NCA + SNCTP)

What are some concrete next steps which should be taken in order to sustain the gains which have been accomplished through the activities which SNCTP has implemented during the campaign against FGM in Mayo?

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