

Joint Evaluation of the UNFPA-UNICEF Joint Programme on the Abandonment of Female Genital Mutilation: Accelerating Change Phase I and II (2008-2017)



Volume 3: Country case study evidence tables

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Evaluation Management Group - Evaluation Offices of UNFPA and UNICEF

Alexandra Chambel	Chair of the Evaluation Management Group, Lead evaluation manager, Evaluation Adviser, UNFPA
Mathew Varghese	Co-evaluation manager, Senior Evaluation Specialist, UNICEF
Karen Cadondon	Evaluation Analyst, UNFPA
Laurence Reichel	Evaluation Specialist, UNICEF

Core Evaluation Team – ImpactReady consultants

Susanne Turrall	Lead evaluator for the synthesis
Rafael Eguiguren	Co-lead evaluator for in-country case study approach
Corinne Whitaker	Senior gender and harmful practices expert
Katherine Garven	Evaluation expert
Maria Borisova	Evaluation process and quality support

Evaluation Reference Group

Nafissatou Diop	Joint Programme Coordinator, Senior Advisor, UNFPA
Nankali Maksud	Senior Adviser, Harmful Practices, UNICEF
Berhanu Legesse	Technical Specialist, UNFPA
Thierno Diouf	Monitoring and Evaluation Programme Specialist, UNFPA
Harriet Akullu	Child Protection Specialist, UNICEF
Mar Jubero	Child Protection Specialist, UNICEF
Cornelius Williams	Associate Director, Child Protection Section, UNICEF
Charles Katende	Chief, Policy, Strategic Information and Planning Branch, UNFPA
Mauricio Saavedra	Programme Specialist, Policy, Strategic Information and Planning Branch, UNFPA
Enshrah Ahmed	Regional Adviser for Gender and Culture, UNFPA Arab States Regional Office
Idrissa Ouedraogo	Regional Gender Technical Adviser, West and Central Africa Regional Office, UNFPA
Sumaira Chowdhury	Senior Adviser Child Protection, Child Protection Section, UNICEF
Claudia Cappa	Statistics and Monitoring Specialist, Child Protection, UNICEF
Eri Dwivedi	Child Protection Specialist, Child Protection Section, UNICEF
Jonna Karlsson	Child Protection Specialist, Eastern and Southern Africa Regional Office, UNICEF
Ramatou Toure	Senior Child Protection Specialist, West and Central Africa Regional Office, UNICEF
Anthony Macdonald	Regional Senior Child Protection Specialist, Middle East and North Africa Regional Office, UNICEF
Charlotte Lapsansky	Communication for Development Specialist, UNICEF
Ingrid Hordvei Dana	Adviser, Norway, Ministry of Foreign Affairs
Anja Sletten	Senior Adviser, Norway, NORAD
Maxence Daublain	Policy Officer, European Commission, DEVCO, Human Rights Unit
Loredana Magni	Senior Development Cooperation Adviser, Italy, Ministry of Foreign Affairs
Beth Scott	Social Development and Health Adviser, UK, DFID
Thea Willis	Policy Adviser, UK, DFID

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Any enquiries about this evaluation should be addressed to evaluation.office@unfpa.org

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Copy editor: Ablative Absolute

Designer: Rec-Design

Acronyms

ASRO	Arab States Regional Office (UNFPA)
CSO	Civil society organization
C4D	Communication for Development
DFID	Department for International Development (UK)
DHS	Demographic Health Survey
ECA	United Nations Economic Commission for Africa
ECOWAS	Economic Community of West African States
ESARO	East and Southern African Regional Offices (UNICEF and UNFPA)
EU	European Union
FGM	Female genital mutilation
GBV	Gender-based violence
HRC	Human Rights Council
INGO	International non-governmental organization
M&E	Monitoring and evaluation
MICS	Multiple Indicator Cluster Surveys
MENARO	Middle East and North Africa Regional Office (UNICEF)
OECD-DAC	Organization for Economic Cooperation and Development, Development Assistance Committee
NGO	Non-governmental organization
QCA	Qualitative comparative analysis (methodology)
SDG	Sustainable Development Goal(s)
SNNPR	Southern Nations Nationalities and People (Ethiopia)
SP	Strategic plan
UN	United Nations
UNDAF	United Nations Development Assistance Framework
UNEG	United Nations Evaluation Group
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commission for Refugees
UNICEF	United Nations Children's Fund
UN Women	The United Nations Entity for Gender Equality and the Empowerment of Women
USD	United States Dollars
WCARO	West and Central Africa Regional Offices (UNICEF and UNFPA)
WHO	World Health Organization

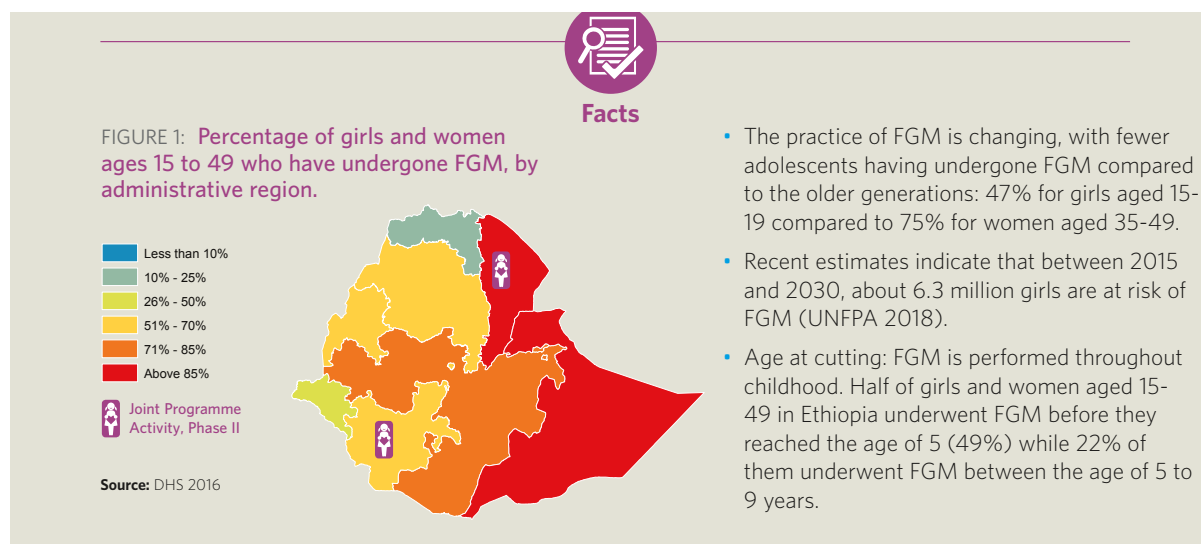
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Ethiopia

Figure 1: Extract from Joint Programme Phase II Performance Analysis, country overview (UNFPA-UNICEF, 2018)¹



Context

Interventions

The joint initiative is being implemented in two phases: The first phase started in 2008 and ended in 2013 with interventions in six woredas (districts) out of thirty-two woredas of the Afar Region. The second phase started in 2014 and ended in 2017 covering three additional woredas in Afar. Phase II further expanded to include SNNPR Region and have a strategic and policy engagement at the federal level, with regard to advocacy. The key interventions implemented in phase II includes community and youth dialogues and educational activities which reached individuals and families in the communities. Specifically, in 2017:

- national level coordination mechanism, best practice documentation, advocacy events,
- consensus building and establishment of partnership framework with religious leaders; community dialogue, religious leaders engagement, sensitization and advocacy events,
- database and capacity building;
- legal literacy to the community, build capacity of law enforcement bodies, establishment and strengthening of surveillance mechanisms, legal manual development;

¹ DHS survey data for 2019 was not available at the time of publication. DHS 2016 remains the most recent available data for Ethiopia. See https://dhsprogram.com/Where-We-Work/Country-Main.cfm?ctry_id=65&c=Ethiopia&Country=Ethiopia&cn=&r=1. Clarification of text: 20% of FGM in Ethiopia occurs in adolescence.

- technical capacity building of the programme staff including exchanges of experience and development of inter-faith teaching manual and monitoring and evaluation framework for FBOs; formalizing linkages between FBOs and line bureaus
- building capacity for integrating FGM in reproductive health services (including Health Extension and Women Extension Workers) delivering overall health education, ante natal post-natal check, referrals, supporting maternity hospitals to provide counselling and assist those affected by FGM, including opening of scars and treating urinary infections.
- community dialogue on gender norms and stereotypes that perpetuate FGM

Expenditure²

Name of Implementing Partner (IP)	Which Agency provided direct funding to the IP in 2017? Please also indicate expenditures by the IP in 2017 by Agencies	
	UNFPA	UNICEF
Ministry of Women and Children Affairs	35,000	159,170.17
Afar Bureau of Women and Children Affairs	72,000	293,481.03
SNNP Bureau of Women and Children Affairs	20,000	60,000
Afar Bureau of Justice		134,577.22
SNNP Bureau of Justice		40,000
Tigray Bureau of Women and Children	30,000	
Norwegian Church Aid (NCA)	79,284	19,999.31
Afar Pastoralist Development Association (APDA)	104,458	
KMG Ethiopia	109,918	
Total	450,660	707,227.73

Implementing partners delivering

- BOWA/BOWCYA (national and Afar and SNNPR)
- Rohi Weddu
- Bureau of Justice

² 2017 Annual Report, Joint Programme on FGM, Ethiopia

- Kembatti Mentti Gezzimi (KMG)
- APDA
- Norwegian Church Aid

Evaluation question 1

To what extent is the Joint Programme (design, strategies, implementation) relevant, responsive, and evidence based to contribute towards accelerating efforts to abandon FGM globally, regionally, nationally, and sub-nationally (including intranational and international cross-border regions)? **Criteria: *Relevance and effectiveness***

Assumption 1.1

Joint programme interventions at the global, regional, national and sub-national level are based on a comprehensive analysis of all available evidence (e.g. situation analysis, needs assessments, identification of drivers, stakeholder mapping) of the populations of interest in programme countries, and are flexible enough to adapt to changing realities and priorities.

The Joint Programme interventions within Ethiopia are informed by the available data on prevalence and practice, the overall situation analysis and programming insights of both agencies in their respective areas of expertise and regions and, on an ongoing basis, by feedback from implementing partners working at the level of the communities.

The programme has invested substantial effort in identifying the major stakeholders involved in work on FGM at the national level and played a leading role in assuring that the experiences of Ethiopia informed the first International Girls Summit in London and the follow on Ethiopian National Summit both of which launched Ethiopia to the forefront of the effort to link the work on Child Marriage and FGM. There has been less investment in mapping the diverse mix of stakeholders who could be involved at the subnational level, however new coordination structures will make that more possible going forward.

For guidance on needs and drivers, the program had been reliant on the limited population-based data of the DHS and other surveys which identified regions with high prevalence. Although not fully synchronized, the historical data from independent surveys as early as 1997³, the 2005 standard EDHS and the 2011 welfare monitoring survey combine to illuminate secular trends, provide some insight into more recent changes (the 2011 survey included questions of girls under 15), limited information on practices, and offer a region-level comparison of changes in cutting based on age cohorts. With the active involvement of the Joint Programme, the 2016 EDHS provided significantly more data on FGM which may help to inform programme planning—planning being key to evaluation⁴.

This data, however, has not been sufficiently disaggregated to capture program relevant differences. In a region as culturally diverse as SNNPR, the need for significantly more disaggregated data is critical⁵—age of cutting and “rites of cutting” can vary from one kebele to its neighbor. “If a man brings a wife from next village, we will watch (him) to be sure he does not cut her on the second day of marriage as is the custom in his community, not hers” (Gezzima Group, SNNPR). This is changing with the development of new tools and methods to analyze the data in a more disaggregated way⁶.

³National Committee for Traditional Practices in Ethiopia. 1998. Baseline Survey on Harmful Traditional Practices in Ethiopia. Referenced in EGLDAM, 2007, see above.

⁴ Interviews with agency staff, implementing partners, other UN agencies

⁵ Bekele Ababeye and Habtamu Disasa, 2015, Baseline/Endline Survey: Female Genital Mutilation (FGM) Situation in Six Regions of Ethiopia, Addis Ababa, Norwegian Church Aid, Save the Children International.

⁶ UNICEF. 2010. The Dynamics of Social Change towards the abandonment of female genital mutilation/cutting in five African countries.

Another major gap relates to refugee populations which are significant in particular states and bring their own cutting practices “across borders” but also remain settled for extended periods even when retaining their “refugee” status. This gap relates in part to the fact that the DHS relies on the sampling frame of the 2007 census which did not sample refugees in camps—the next census will include refugee populations in camps which have increased in size in the interim period⁷.

The Joint Programme supported a major effort to conduct a detailed baseline survey in Afar region which provided significantly more detailed data to inform an assessment of the Joint Programme investment from Phase I. However, even though the region is less ethnically diverse than SNNPR, the programming challenge derives from changes in the practice of FGM which should influence programming. With the overarching threat of the law and the tendency to hide the practice (in fact and in language), it becomes very difficult to adapt well. Debates about religious exception for Sunna cutting and inability of the supreme leader to influence imams who do not agree with his rejection of the practice make evident the need for more in-depth data to tailor responses. Accordingly, Save the Children has made understanding and unpacking “Sunna” a priority in Somaliland which shares the ethnic, religious and traditional practices as well as a border with much of Afar⁸. In a significant effort to understand the impact and cost of the predominant “community conversation approach”, UNICEF supported a mixed method study in selected woredas. Apart from the challenge of a baseline to measure changes in prevalence and thus a denominator to measure cost, the study provided very valuable insights and additional questions informing program. This included that adolescents were not involved in or aware of the community declarations and that girls reported a very small decline in cutting, and men and boys needed to be better engaged.⁹ Given the critical role of young people in fostering change, these are key findings.

Despite changes in context and practice, types and timing of FGM cutting remain popularly associated with ethnic groups—with insufficient attention to the economic drivers which are better articulated for Child Marriage. Ethiopia’s ongoing ethnic conflicts and experiments with “ethnic federalism” present challenges beyond the mandate of the JP. These may further complicate efforts to eliminate FGM as it becomes a “mark of identity” for groups under siege, a justification for what may be perceived as federal level “intrusion” to enforce the prohibition law, and a point of contention between the major ethnic foes in country.¹⁰

Much to its credit, the Joint Programme has leveraged these general insights on the prevalence of FGM among particular ethnic groups and particular religions to work within the structures that wield the most influence, but without defining the problem as one of particular groups. Its support for the work of the NCA with the faith-based communities of all traditions is evidence of this.

This “responsive” approach is also characteristic of the “community conversations” work of KMG which has defined the more recent support of the JP in SNNPR¹¹. This presents a significant challenge for evaluation, however, in that the unit of analysis “the community” is not well defined, nor are its characteristics. It also risks focusing so much on the micro differences in practice and justifications, that is

UNICEF. 2013. Female genital Mutilation/Cutting. A statistical overview and exploration of the dynamics of change

⁷ Interviews with UNFPA Statistical staff, Plan International, EGLDAM

⁸ Interviews with implementing partners at national and Afar region level

⁹ Alem, E., Hailu, E., Siyoum, H., Sesay, I., Mitik L., Suyama, M., et al, 2013, ‘Evaluation of progress with using community conversation as a strategy to encourage district level abandonment of female genital mutilation and/or cutting in 10 districts in Ethiopia’, African Evaluation Journal 1(1), Art. #11, 10 pages. <http://dx.doi.org/10.4102/aej.v1i1.11>

¹⁰ Country Profile: FGM in Ethiopia, 2013. 28 is Too Many, London, UK, P. 24

¹¹ DENDINAME, KMG Ethiopia 15 year journey: Change takes commitment to action, not a miracle, December, 2014, Addis Ababa

misses the undeniable common driver of gender-based discrimination and control of women's sexuality and reproduction. Here the Joint Programme has an opportunity in Phase III.

The Joint Programme has and continues to support the many Ethiopian coordinating mechanisms put in place before the program existed, as well as those put in place more recently by the GOE. In the first phase, the Joint Programme partnered with some of the leading groups (EGLDAM, KMZ, the NCA), however there are many more resourced international actors with experience and substantial data which could inform programming at a more micro level. These groups have produced valuable sub-national studies which could help tailor programming. This includes a mixed methods review of the knowledge, attitudes, practices and effectiveness of key interventions in six regions of Ethiopia including JP areas.¹² Although ESSWA is beginning an analysis of patterns of FGM, their 2017 research on prevalence, drivers, and protective factors around early marriage would also provide valuable insights on the drivers of FGM.¹³

This stocktaking and coordination is the intent behind the creation of the National Alliance, which is already showing fruit as it helps to facilitate exchanges on multiple analyses of the most recent DHS. This mechanism needs to be made more inclusive, particularly of local NGOs, and in so doing may help bridge some of the gaps created with the restrictions of the 2015 Charity Law¹⁴. The JP is also supporting a review of best practices in addressing FGM to inform the costed roadmap effort—this is a valuable contribution and can also build on other “inventories” of FGM work being supported by e.g. DFID.

The example could also inform the subnational level. As articulated by JP staff, the challenges faced in defining outcomes for measurement may contribute to a lack of rigorous assessment of whether the particular method is effective even when the approach has not changed much “...for 7 years”. For lack of such data, engaging with diverse actors at that implementation level could contribute to better reflection.

That said, the decision on where to work is ultimately that of the government. The mechanism for allocation of funds involves the Ministry of Finance and Economic Cooperation as the interlocutor for other ministries and there are clear guidelines on how much funding is spent at local level vs. woreda or zonal level.¹⁵ This is intended to assure that resources are used for the intended beneficiaries but may make a critical assessment more challenging. As articulated by government partners in Afar, decisions on where to work “...reflect where there are strong partners, where other agencies are already addressing FGM effectively and the GOE's own criteria of fairness, equity, internal capacity for implementation in a particular region”.¹⁶

This is a challenging balancing act as capacity and fairness may be inversely related. In SNNPR, Woreda level coordinating groups repeatedly articulated that the “remote kebeles” were still practicing and they were threatening the progress made in the reachable kebeles. Although the National Alliance has provided an operational and effective forum in which to consider the role and comparative advantages of other actors and helped in “reducing redundancy” at the national level, the issue of hard to reach kebeles remains. “Everyone is working in accessible ones”.¹⁷

¹² Bekele Ababeye and Habtamu Disasa, 2015, *Baseline/Endline Survey: Female Genital Mutilation (FGM) Situation in Six Regions of Ethiopia*, Addis Ababa, Norwegian Church Aid, Save the Children International.

¹³ ESSWA, 2017, *Prevalence, Drivers and Protective Factors of Early Marriage in Amhara, Oromia and SNNP Regions of Ethiopia*, Addis Ababa, Plan International.

¹⁴ Interviews with multiple INGO partners, national partners, donor agency, national and subnational programme staff

¹⁵ Interviews with development partners, subnational level staff of UNICEF and UNFPA

¹⁶ Interview with Afar IP X

¹⁷ Interviews with SNNPR implementing partners, development partners, INGOs

The restrictions on non-state actors does contribute as does the division of labor within the Joint Programme itself: working with NGOs (UNFPA comparative focus) and with government (now UNICEF primary entry point) means the most resourced partner must work within the limitations of the public sector. For example, after substantial training efforts on FGM in SNNPR, the regional UNICEF office lamented that “...more than 2000 government officials have been removed in SNNPR” in recent years impacting UNICEF outreach.¹⁸

“There is an inability of the government to reach TO borders (much less ACROSS them). NGOs and religious groups reach borders. But UNICEF has changed their partnership modalities, they are working with the government not with NGOs. the government is more empowered now, they didn’t have the capacity back then. BOWCA has a lot of experts- they can lead, it is also very important to work with NGOs. We have experience of working in the area. It should be a collaborative effort. They can focus on much bigger issues. There are few NGOs working but it’s not as strong as before.”¹⁹

Assumption 1.2

Joint Programme approach, strategies and interventions are appropriate and aligned with national and sub-national priorities to address barriers to and promote drivers of change to end FGM on multiple levels and contexts (e.g. (global, regional, national/subnational, cross border), taking into consideration the role and comparative advantages of other actors working in this field.

The Joint Programme is aligned with national priorities and supports national initiatives and structures which facilitate coordinated operationalization and enforcement of national normative frameworks, guidelines, laws and policies.

Addressing HTPs is a national government priority and FGM is specifically addressed in the Growth and Transformation Plan 2 (2015-2020), thereby framing it as a national development concern. FGM is also specifically addressed in the guiding documents of other key ministries including the coordinating ministry for development partners which places it within an “equity” framework.²⁰ The JP supports the three major tenants of the National HTP Policy: prevention, protection, provision—notably through its support for community dialogue, enforcement of the law, and clinical services for those at risk or suffering sequelae from FGM (the latter not always a component of response by other agencies)²¹. The JP both directly and through the coordinating agencies of UNFPA and UNICEF, support the National Alliance to Eliminate HTPs. The implementing partner at national level on FGM is the MOWCA, however the National Alliance is a platform to facilitate coordinated efforts on the part of government ministries, key CSOs and INGOs, development partners, and research entities. Although the staff are limited (only UNICEF was able to support their commitment) and play a facilitating role, there is potential for substantive guidance. By way of example, it is a forum through which the findings of in-depth-issue specific analyses of the DHS to document the linkages between FGM and other related priorities (e.g. fistula, child marriage) can be shared in process to explore additional linkages. Co-leadership with the MOWCA is rotated (formerly UNFPA, currently DFID) helping to engage key development partners.

¹⁸ Interviews with subnational level staff, development partners

¹⁹ Interview with Awash Fatale group

²⁰ Ministry of Finance and Economic Cooperation, The Federal Republic of Ethiopia and UNICEF, 2015, Updated national Equity Situation and Analysis on Children and Women in Ethiopia, Addis Ababa, MFEC, interviews with development partners, JP focal points

²¹ Federal Democratic Republic of Ethiopia, Ministry of Women, Children and Youth Affairs (MoWCYA), **National Strategy and Action Plan on Harmful Traditional Practices (HTPs) against Women and Children in Ethiopia**, Addis Ababa, 2013.

The Alliance was originally established in 2013 to address Child Marriage, but following the GOE's pledge to address both CM and FGM by 2025 (pledge taken following on the 2014 London Girl Summit and follow on 2015 Ethiopia-level Girl Summit), FGM was added to its title (in fact, the mandate also addresses several other less visible practices). The Alliance is currently understaffed (UNFPA was not able to support a position as planned) and significant investment is required to maintain the active engage of government ministries, however it is playing a critical role.

The linkage of the issues of child marriage and FGM reflects Ethiopia's own contributions to the global agenda of the Girl Summit. It also offers potential for more cost-efficient strategies, particularly when addressing the root causes of gender inequality. However, such programming needs to be informed by a concrete analysis of the common drivers and the differences in drivers and/or their manifestations between the two issues. The advocacy adage that *FGM is linked to child marriage and therefore a rite of passage* risks reliance on strategies which are not as well targeted in that FGM is a much more diverse phenomena than child marriage. The surge in resources for Child Marriage risks neglect of FGM or addressing it only in the context of marriage (potentially missing e.g. cutting in the first weeks of life—a frequent practice in many regions of Ethiopia-- which some respondents indicated may contribute to higher mortality rates for females and more severe sequelae which are more difficult to “link” to FGM). The research on linkages between FGM and e.g. child marriage or child marriage and fistula may help engage additional sources of support and could potentially inform more nuanced and practice-specific prevention strategies.²²

The JP has long supported subnational level work—prior to Phase II, all of the implementing partners were at regional level. Even at that level, the JP continues to support coordination mechanisms which allow a more holistic approach to addressing FGM and address the complex intersection of the roles of the state and traditional power structures. In Awash Fertale, Afar, the Justice Coalition was originally established in 2005 to address GBV and VAC. It is a government structure whose 7 members include representatives of BOWCA, the police, the Woreda administration, Justice office (prosecutor), the traditional court, and the Sharia court. The coalition is established at regional, Woreda and Kebele level. In seeking justice for survivors of GBV including FGM and early marriage the members work together to enhance speedy trial. “We work together in a coordinated manner as opposed to on individual basis, which was less effective”. The Coalition also does awareness work, and monitoring at the Kebele level (with monthly reports on number of FGM, CM and any other VAWG cases on women and children) which involves oversight by focal points within the government oversight mechanisms-- there is one focal point in school, health extension workers, community level representatives of women's affairs and youth affairs.

The Joint Programme has appropriately aligned itself with congruent but differently codified subnational priorities and supported the efforts of non-state actors to address FGM. Although resistance is often assumed to stem from Islamic religious leaders, a longstanding JP partner in Afar noted “the opposition was traditional (leaders) as opposed to legal and religious leaders”.

In Afar, the JP supported local organizations to enable key sources of influence and power brokers to engage in dialogue, find their common humanity, and act together leveraging both their cultural influence as well as their political power. Respondents for both local organizations working to end FGM as well as high level Islamic religious leaders and Islamic law scholars narrated the debates and developments through which FGM was pronounced delinked from Islam; pharaonic infibulation was condemned as a practice which “came from Egypt”, not Islam or Ethiopia; and the harsh reality of the harmful practice was condemned as “non-Islamic”. This shifted both authority and accountability to clan-based power structures

²² Interviews with Development Partners, research agencies, girls groups, implementing partners

and civil authorities and provided impetus for a legal, juridical response from traditional and local leaders and the promulgation of a law which reflected both the context and response mechanisms of Afar region. That law informed the national law. This model, however, may work in Afar because there is some consensus. “Afar is the only region where religious leaders have a common position on FGM (at regional and Woreda levels). This is not the same in Somali because of the religious leaders having different opinions.” Thus, as the JP expands to other areas, it will need to further adapt²³.

Based on support from UNFPA to address GBV, the Inter-religious Council has been very successful in bringing all religious groups together at the national level. The focus is religious institutions (not religious justifications—the group is working to demystify and delink harmful practices and religion). Involving 7 major religions, all active on development issues, the criteria for inclusion in the IRC included serving more than one region. It “must be more than an individual—it is a synergy of institutions that makes IRC work—when we stand together as institutions (rather than a few leaders) we are more powerful. Each of the members produces own material in keeping with their faith community. We work through dialogue forums to raise awareness and a committee of religious leaders”. However, this shared structure and effort is much more difficult at the woreda and kebele level precisely because not all faiths are represented at that level. There is more fragmentation among groups, however more cooperation within groups (such as in Afar)²⁴.

Assumption 1.3

Joint Programme interventions have been designed and implemented to address barriers to and promote drivers of change to end FGM.

The Joint Programme works with a diversity of stakeholders including local level representatives of national level actors (faith-based structures) and local coalitions providing the foundation for adapting to the many variations of barriers and drivers of change. However, because so much of what is learned about FGM is anecdotal—given the ethical limitations on e.g. observational data and the secrecy which comes with both a traditional practice and the threat of the law-- a clear entry point and pathway to change can be difficult to define. The Joint Programme has been innovative in adapting strategies to overcome some of the key barriers to change.

The differences in practice suggest different audiences for the message—parents, grandparents, traditional leaders, religious leaders, age groups; different timing for the message—before holidays, at marriage, at birth; different perpetrators-cutters, parents, elders, midwives; and differences over time.

“In Gewani they do it right before weeding. But in our area, its right after birth. If she is born in the morning, she could be circumcised in the evening. Circumcision is not done in groups here, it’s rather on an individual basis. “

“It differs from community to community. My sister came from rural area and I noticed she did Sunna but my sisters here in Chifera are not circumcised. We also see students from other region in our school that are not circumcised- we don’t see them suffering like we do.”

“There is lack of clarity of Sunna what it is and what is being done. Shifting implementation to Sunna and what does Sunna means for Muslim leaders? Are they doing Infibulation but saying Sunna??? We have

²³ Interviews with Afar implementing partners, religious leaders

²⁴ Interviews with implementing partner and religious leadership groups

conducted qualitative study on Sunna, and it is not clear. The study done in Somaliland helped illuminate some of this and... We need to learn.²⁵

The differences in justifications for the practice suggest different messaging²⁶—cleanliness, beauty, tradition, reducing hyperactivity, assuring marriage, etc.

The changes in practice suggest a need to drop some change strategies and try different ones²⁷.

“What is abandoned is doing FGM in public—bringing the eligible girls together along with ceremony of circumcision.... The declaration hasn’t stopped the practice- they were quick to announce a declaration. The Woreda administration has not received this awareness on FGM. “

“There are also ethical issues with some of the strategies and efforts to account for those issues creates other problem. The punishment for FGM is 5-10 years. Doing Excision- is 500 birr fine and 3-month imprisonment. This is not difficult to comply. They all know that the punishment is 500 birr and they don’t mind being fined of 500 birr. So, they are of the view we won’t stop this. Some religious leaders, from Djibouti and here, are preaching for Sunna and they do it.”

We work on both customary approach and statutory approach. we focus on awareness creation among traditional leaders. This is important because the "penalties" under the law are not sufficient deterrent. imprisonment or 500 birr. 500 birr is not much for a cutter who gets much more from each procedures. However, the law needs to offer both imprisonment and fine which helps when parents are at risk of punishment--loss of parents harms others in family so they pay rather than be imprisoned.

The problems arise for many reasons. The concern is that the intensity of investment for the early change in perspective cannot be sustained and that “change is not linear- change is always up and down. There are communities that regress”²⁸

From a very practical perspective, this means a need for flexibility. However, that flexibility means that there is not sufficient time, consistency of intervention, “level of exposure” to ascertain whether the intervention is effective. An added challenge is that the interventions are intended be a package and synergistic. This is challenging because few methods for disentangling combined effects exist.

The critical “constant” in all of this is gender inequality as a driver of practice and a barrier to change. The centrality of gender is evident in all JP and national level documents addressing FGM and is an important element in the interventions of key implementing partners. However, the messages on gender may be lost in too much flexibility of approach, or risk being “filtered” by, for example, public sector implementing partners with insufficient capacity, or the community mobilizers and outreach staff who are not selected on the basis of gender sensitivity.

Assumption 1.4

The Joint Programme has emphasized a holistic approach to cross-border work to improve the effectiveness of support.

²⁵ Interviews with ex-circumcisers, girl activists in Afar, and INGOs

²⁶ Iftu, TRC, 2017, Concerted Efforts of FBOs to Abandon FGM and CEFM in Ethiopia: a Consolidated Report. Addis Ababa, Norwegian Church Aid.

²⁷ Boyden J, Pankhurst, A and Tafere, Y, 2013, Harmful Traditional Practices and Child Protection: Contested Understandings and Practices of Female Child Marriage and Circumcision in Ethiopia. Oxford: Young Lives

²⁸ National level and subnational level government agencies (Afar and SNNPR); JP staff

The Joint Programme is struggling with how to address the issue of cross border influence and cross border enforcement and, in addition, has not sufficiently addressed the problem of influence across “internal borders”.

International borders present the most difficult problems in part because government is not able to intervene. One of the most elusive is communications. In Afar, the influence of media across the borders is a major issue. “In Djibouti, Eritrea, and Ethiopia. If something happens in Djibouti, with mobile phone it comes here. They saw a TV, a sheik in Djibouti said Sunna is halal. After the change in that community, Sheik Mohamed Amin. They heard to this Sheik and they changed their mind.”

The JP is supporting an “answer” to this problem with work with the media. The programme has used both the national broadcasting and regional media houses to disseminate information to the wider community. This includes National Radio, Radio Fana, and FM both at national level and in SNNP region, the Afar regional Radio, and Social media of the agencies. The JP reports that it has reached 1.2 million people with messages on the harms of the practice and the progress in changing attitudes and reducing prevalence. This tool has been explored in Kenya as a means to addressing cross border challenges including a vernacular radio station targeting the majority of a particular practicing group in a neighbouring country which has blocked efforts of their fellow clans to address FGM. Some of the radio work included sharing the stories of uncut girls which is a powerful tool provided protections for those girls are in place—similar to the ethical challenges faced with early work on HIV.

Movements of populations across porous borders is also a challenge. Ethiopia has a strong monitoring mechanism in place at the community level and it may be able to track when a girl is missing from school, but it cannot keep her parents from taking her across the border to have the procedure done when they themselves are travelling. The substantial population of refugees is also a factor as they bring the practice with them. Although the BOJ can “chase” cases of FGM across internal borders, cases involving refugees, which implicate international borders, must be resolved at federal level.

Clearly Ethiopia needs to cooperation of neighbouring countries and there is need of a regional strategy to address borders. This is increasingly the case as popularly illustrated by the “marathons” organized by Uganda. Three athletes from Ethiopia participated in a mini-marathon organized by the UNFPA Uganda Office and Church of Uganda in September 2017 to raise awareness with the slogan “Run to end FGM”. The event itself was large (1000 runners and 200 “elite athletes”) and highlighted one of the particular strengths of Ethiopia on the global stage as well as promoting cooperation. Although the border with Somalia is more challenging, the JP had previously helped support the joint learning efforts of NCA and Save the Children—work which has advanced significantly and is of interest to addressing the practices in Afar in particular²⁹.

With the significant progress made by Ethiopia compared to neighbouring countries, Ethiopia’s own services are overburdened. In Afar, it is not just a matter of behaviour, but also impact on services. “They come across the Eritrean border. When some people from Djibouti also come to see family and when they see service (of the Mille hospital) they use it”

Apart from international borders, there are concerns about influence across the regions of Ethiopia. “There is lack of consensus across internal regional borders. “The high officials/religious groups need to have consensus on FGM. Not only in Afar, but also in Amhara, Tigray, Oromia. Sometimes the community tell us, the Amhara and the other regions are doing it, so why are u telling us to stop “There is a lack of awareness in communities outside our border: there are people coming from different areas, as there are humanitarian interventions. This makes monitoring FGMC cases difficult. We don’t know about the other communities that comes here how they practice. It’s only the people that are aware that accepts the law,

²⁹ Norwegian Church Aid and Save the Children in Ethiopia and Somalia Programmes on Female Genital Mutilation/Cutting: Joint Programme Report 2011-2015, Addis Ababa.

not everyone”³⁰ This is illustration that, although community level monitoring mechanisms have been supported by the JP, the community borders are porous.

Aware that the proximity of practicing populations to areas in which the practice has been reduced risks a relapse the JP is adapting its strategies. This includes both reaching the “hard to reach” areas and adapting interventions to the unique challenges of the pastoralist groups which are regularly crossing “borders”.

“One of the key challenges faced was the limited scope of the geographic targets. The surrounding communities have strong social ties to the target areas of the Joint Programme and decisions are often made inter-dependently. In order to address this, UNICEF and UNFPA have mobilized additional financial resources based on the learnings gained from the Joint Programme and have expanded the programme to additional woredas within the targeted sub-national areas. The pastoralist life style, which is based on a high level of mobility, necessitates a different approach. This is specifically with regard to the need for continuous engagement of communities as per the implementation guidelines for community dialogues. To address this, season-sensitive planning was conducted, which takes into account the dates and time period of mobility. As such, messages were disseminated regularly through various targeted platforms like ‘Dagu’, Radio, and Friday prayer. This helps ensure continuity of efforts for pastoralists who are on the move and more difficult to reach”³¹

Evaluation question 2

To what extent has the joint programme integrated a human rights, gender equity and culturally sensitive approach in its programme design and implementation at all levels, over time? **Criteria: *Relevance***

Assumption 2.1

Joint Programme interventions are designed and implemented in alignment with international and regional human rights frameworks addressing FGM.

The JP has largely followed human rights principles in the design of the programmes. There is evidence of efforts to engage implementing partners in the early phases of planning—this was most evident during Phase I when partners were at regional level. With a shift to national level engagement, the responsibility to coordinate inputs falls to the ministry which may not be the more efficient or the best placed if federal-regional-woreda issues remain.

One of the key constraints on implementing in alignment with human rights frameworks is the UN principle of letting government partners take the leading role. Although UNFPA has the responsibility to “ensure (that planning of the intervention) is done in a participatory manner ...and then to (share that document with all implementors)”. Following the human rights principle of participation, the government implementing partner should take the lead in continuing to foster the involvement of the implementing partners in the process. However, as some program staff noted “the partners never came together after (the process was turned over to government level)”³²

The messaging around FGM is mixed—currently focusing significantly on health impacts and criminal behavior—violating the law. A key factor which has “muted” the rights focus of the current work is the 2015 Charity Law which restricted work on human rights to those agencies which are funded through

³⁰ Interviews with religious leaders, justice partners, medical staff in Afar and SNNPR regions

³¹ Joint Programme, Annual Report for Ethiopia, 2017.

³² JP National staff

Ethiopian derived funds at a level of at least 90%. This was in response to accusations that selected international and non-governmental agencies had helped to bring down the previous regime and, although this was never proven, the law had a significant impact on agencies working on gender-related issues including UN Women as a whole. Over 200 NGOs “closed their doors” and several INGOs left Ethiopia; the leading local NGO on FGM issues, now ODAWACE was forced to change its name more than one.

Many agencies continue their work but do not use the term rights - “the work stays the same, but the word “rights” is not used in reporting to government agencies”. In the case of FGM, the shift to a health argument is a logical resolution and provides opportunity to highlight the health sector guidance documents produced with WHO. Of note, WHO itself takes exception to the ban on rights language—currently undertaking a major campaign which includes FGM to train health personnel using the CEDAW framework which is the foundational document for the majority of women’s rights work. The Joint Programme, despite having collaborated with WHO on the development of manuals for the health sector addressing FGM, had not endeavored to join WHO in this approach—however UNFPA in particular is not particularly well positioned for such a threat to funding.³³

Within the faith-based community, the “rights” language is still in need of strengthening. The rights of women and girls have been lost in debates over the interpretations of religious dictates and specificities of practices such as Sunna. Even in an “inter-religious” dialogue, in SNNPR, two different traditions focused on how to interpret religious dictate, not universal human rights. The Orthodox Church, which has not engaged until recently, representative explained: “we have learned that it is optional--what is optional? based on text of conversation with Abraham. previously the practice was seen as obligatory, now we see not in the bible in genesis or new testament. Abraham previously said it was for children but didn’t specify female or male; after consideration of text, we realized practice was meant for men, not women. It is an Ethiopian traditional practice but that was also informed by Abraham”³⁴.

With the critical role of the NCA and building on UNFPA support for the launch of the Inter-religious Council, the JP has very strong partnerships with religious leaders at the national level including declarations by individual faiths and joint declarations. This was recently reinforced with UNICEF 2016 MOU with the same groups. This work has, in many ways, enabled the JP to continue the work on FGM despite the restrictions on “rights” work arising from the Charity Law. As the work with the religious community can help fill gaps, and as the work at national level is “cascaded to sub-national levels through issuing theological reflections and organizing consensus building sessions”³⁵, strengthening the focus on rights and gender—in addition to the “wellbeing of women and children” becomes very important.

The strongest “rights” language was documented in programming with girls. Nearly all of the uncut girls in a group supported by KMZ, spoke boldly in the presence of men to make a case for not only for the right to bodily integrity and freedom from the harm of FGM, but also for the “right to sexual pleasure for women”. They articulated their own wish to “enjoy sex with (their) husband”. The Joint Programme has only been involved in the SNNP region since 2016: although this group built on the longstanding community-based work of KMZ, it nonetheless represents a significant shift towards a more holistic “rights” approach and provides an excellent entry point for the Phase III work on gender transformative approaches.

It also presents a possible solution to some of the challenges of working with the “diversity” of FGM practice in Ethiopia. Although the SNNPR region faces the challenge of huge cultural diversity making adoption-diffusion challenging, these girls share with broader networks with whom they have many

³³ Local NGO staff, UN agency staff

³⁴ Interviews with multiple religious leaders

³⁵ Joint Programme Ethiopia Annual Report 2017.

interests in common—providing a strong basis for shifting thinking. They recounted sharing amongst peer groups working on HTPs; uncut girls engaged in the business development program of KMG (a 15K revolving fund for loans for business with support to develop a business plan); a church choir and school forum; in “peace youth sessions” every 15 days (facilitated by the Gezzima group of KMG as a dialogue within the high school). A secondary college student noted that they use the content in school and church including in worship team and prayer team. They can even make an announcement about it in the morning after the flag anthem³⁶.

The Joint Programme expanding investment in girls is promising. By 2017, 76 in-school and 40 out-of-school girls clubs (of approximately 30 girls each) were formed supported by mentors and networked within their respective woreda/district. In addition to education, the clubs provide a solidarity and support network to help girls cope with the pressures around marriage and FGM including “secret boxes” in the schools where anyone can leave notice of a girl at imminent risk such that school authorities can engage with parents and local officials to help intervene. Through the regional exchanges on programming for FGM, the Ethiopia office was also introduced to the alternative rites work in Kenya. The JP in Ethiopia launched its own ‘Uncut Girls Whole body, Healthy life’ celebration involving an estimated 10,000 including 1,200 uncut girls brought from various communities and international representatives—a step towards establishing in a new tradition during the cutting season. Tutorials to improve girls’ chances of advancing to the next level of their education are part of a strategy with very long-term benefits. In 2017, 375 uncut girls were trained on “coaching, mentoring and psychosocial counseling to survivors of FGM and other HTPs at kebele level in SNNPR” and shared that knowledge with others in their communities—an investment which, in other country contexts, has served to encourage girls to pursue work in this area in addition to expanding girls social networks.

There are more problematic “rights” debates which do need to be addressed explicitly. A new “rights” argument has recently arisen—that of a girl’s right to be cut should she “choose to be cut”. A member of the Justice Coalition noted “In our Woreda, we have consensus not to circumcise girls. I have 8 daughters but none of them are circumcised. One of my daughter, aged 16 says to me” it’s my right to get circumcised, I am going to ask for the court to get circumcised” I told her it’s her right. What can I do? ³⁷“Although this is a valid argument, it risks obscuring the reality that girls face a “forced choice”. Additional work with men and boys beyond religious leadership and in a dialogue, which is more in-depth than what may transpire in a Dagu may help to address this and thus the support for MOWCA to develop a dedicated manual for work with boys and men is a key step in this direction.

There are rights issues arising from the interventions themselves and these are ones which should also be a priority for the Joint Programme. Multiple respondents expressed concern about rights violations arising from a weakness in the judicial and security systems. The failure of due process and justice in pursuing those who violate the law is less a matter of ingrained discriminatory patterns (as is the gender bias described above) than a matter of insufficient training, lack of resources, and a shared lack of embrace of the law³⁸.

³⁶ Uncut girls group

³⁷ Afar Justice Coalition

³⁸ Interviews with development partners, government partners on legal work

Evaluation question 3

To what extent has the JP contributed to the mitigation and eradication of FGM and to better services for the already affected population? **Criteria: Effectiveness and Sustainability**

Assumption 3.1

Individuals, households and communities in programme areas were educated about the harms, rights violations, and alternatives to FGM and mobilized to change the practice and related social norm at the community, household and individual levels in a sustainable way.

Ethiopia's Demographic and Health Survey (EDHS) findings from 2016 (the previous survey was published in 2005) showed progress in the reduction of the prevalence of Female Genital Mutilation/Cutting (FGM). There is evidence of a generational decline in the practice: around half of girls aged 15-19 years have undergone FGM, compared to three quarters of women older than 30. The prevalence among girls age 0-14 years is 16 per cent. The EDHS findings also show that knowledge among communities on the harms of the practice has shown an increase across different educational backgrounds and wealth quintiles, and among rural and urban residents. In addition, Further analysis of the EDHS results is currently being undertaken to identify more specifically any changes in the 0-18 age group and across the different regions. While acknowledging that reductions are attributable to a range of developments, including ongoing social and economic change, the findings should indicate where and to what extent the investments are on track in bringing about an abandonment of FGM by 2025 as per the commitment of the Government of Ethiopia, and by 2030 according to the global target of the Sustainable Development Goals³⁹.

1. Awareness of FGM has increased at community level in JP areas. The consultations made with different kinds of stakeholders both in Afar and SNNPR⁴⁰ indicate strong and general awareness at community level in the JP areas about the harmful effects of FGM. This is a significant achievement given the very low baseline in many communities, where even traditional birth attendants (TBAs) in constant contact with the girls, would not make the causal connection between FGM and medical complications, not to speak about men, for whom in many cases FGM was just a name that they could not connect with a practice they would not be able to visualize in realistic terms even if it happens in their own communities for time immemorial. These low initial baselines and differences within communities have also implications in the effectiveness of the strategies to raise awareness.

In SNNPR, awareness of the practice is high, reflecting a long-standing effort on the part of many actors even prior to the involvement of the Joint Programme: some of those actors, such as KMZ, are currently partners of the Joint Programme and also visible on the global stage. Many respondents at village level reported publicly that FGM had been eliminated "except in the kebeles which are at the 'edge' of the woreda" however, in more private discussions, they indicated that FGM was still practiced. At the woreda level, of 4,209 kebeles, 1430 had made a public declaration abandonment. Once the kebele has declared, the follow up to enforce that promise is done by the community itself. The ministry visits "every 3 months for check-up" but the community does the required follow up. The rigorous mechanisms for follow up may

³⁹ Annual Report JP Ethiopia, 2017 & Ethiopia Demographic and Health Survey 2016.

⁴⁰ Finding supported with very high frequency by interviews and focus groups with community members –both girls and boys, married and unmarried- traditional leaders, religious leaders, ex-circumcisers and medical doctors. Both in Afar and SNNPR and, in addition, by CSOs working with FGM. This is also confirmed by the JP country reports.

help explain why public declarations were so often “FGM eliminated since the program began 2 years ago”. (see below)

The awareness achieved is more specifically referred to four critical aspects of awareness that are in turn related to behaviour change: **1.a)** Awareness of the causality link between the FGM practice and the frequent medical complications suffered by women in the community, including deaths; **1.b)** Awareness of the fact that religious texts do not approve FGM; **1.c)** Awareness about the fact that the community as a whole does not approve FGM; **1.d)** Awareness that the laws condemn and punish FGM.

However, the level of awareness and the weight of *each* of these factors in relation to behaviour change varies from community to community and also within communities (see consequences and analysis under 3.2). Finally, it is also important to clarify that the main consensus among religious leaders is on the fact that the religious texts do not support FGM, but the additional step of saying that the texts *condemn* FGM is shared by some religious leaders, but not by all of them⁴¹.

In the awareness effort with religious leaders, it has been an important factor to work at different hierarchical levels, so as to achieve consensus for example at regional level first, but also at kebele level, as each level requires specific discussions addressing their own concerns, so as to ensure the solid consensus that can reach the community level.

A widely recognized contribution of the JP has been its role on allowing the Ethiopian Government to **reach beyond regional level, into the more concrete sub-level of kebele**, a crucial addition given the grassroots nature of the practice and the need to address it on equally grassroots level.

In SNNPR, the relative effectiveness of the Joint Programme support to grassroots level community dialogue and monitoring is enabled in large part by building on highly structured and closely managed governance systems (the Women’s Development Army and the 1-and-5 system) and leveraging the very effective traditional structure of the Edir. The governance structure makes it possible to engage large numbers in a very short time to e.g. undertake community conversations e.g. within a year, 1120 community facilitators from 185 kebeles were trained and lead a series of 5 rounds of a community conversation for 32,858 individuals (19704 male, 13,154 female)⁴².

These groups are not established to address FGM specifically—it is one issue on their agenda. HTP committees have been established at the kebele level and all NGOs are necessarily members of that committee. However, it is their effectiveness as means to purvey information and monitor behavior that are so powerful. A 2017 national level assessment involving the Attorney General’s office demonstrated that the program worked best in communities with strong community engagement and structures. The Women’s Development Group in each kebele’s has a monitoring checklist and reporting structure. The 1 in 5 structure is a mechanism for monitoring community compliance with desired behaviors (e.g. growing vegetables, feeding children, not practicing FGM) and involves 1 leader and 5 agents each of whom is assigned households which they must visit regularly to report on progress. The leader also undertakes spot checks as quality control. There is an internal database for reporting. In addition, each community has a “Crimes committee” which involves the 1 to 5 leaders, the village leadership, the police and others and to which any violation (such as practicing FGM) can be reported and resolved.

Another key entry point is the Edir for educational programs and dialogues. The Edir is formal community structure with own bylaws: members make monthly contributions to a pooled fund. One of the most

⁴¹ Finding supported by religious leaders interviewed in afar region, triangulated with community members in different districts and communities.

⁴² Powerpoint, interview MOWCA, SNNPR

important services provided by the Edir is access to a large lump sum of money at the time of a funeral. This assures that the member's funeral (for themselves or a family member) is large enough to involve the entire community—one of many means of building social capital and support. The Edir is a voluntary group, but everyone is expected to be part of one. Each one has meeting schedules and attendance is monitored—if someone is missing, the group follows up. As traditional and religious leaders and other influential people from the community (teachers), they are a valuable entry point for fostering change⁴³.

The strategy to **scale up** to other kebeles remains unclear at the present moment, both for the JP and for the rest of actors in Ethiopia.

2. Change of behaviour and abandonment of FGM has increased at community level in JP areas. There is a very high consensus among the persons consulted in the different communities⁴⁴ stating that there is a strong behaviour change towards FGM. This change is characterized by two main elements: firstly, at community level, there is a positive change of social norm and secondly, at individual level, there is a large proportion of the community that fully abandon the practice or substitute it by less harmful types of FGM.

2.a) At community level, there is a positive change of social norm, which has shifted from “General appreciation of FGM” to “General condemnation of FGM”. The change of social norm at community level, be it through formal declarations or a general consensus about the main leaders of a community, constitutes a tangible and visible achievement in JP areas in a task that is extremely difficult, technical and time-consuming. However, FGM abandonment, as most processes related to social behaviour change, are rarely abrupt. They tend to happen in a gradual pattern (and not always linear) that contains different milestones until the total abandonment of a practice is fully achieved. In that gradual scale, a change of social norm at community level does not automatically imply a change of behaviour in each member of the community—the ultimate goal—, but it constitutes a very significant milestone. The adoption of a new social norm at community level is not only very difficult to achieve in its own sake, but it also has tangible consequences in the path of full abandonment (see below). As such, this milestone should not be underestimated.

Some of the tangible changes provoked by the change of social norm at community level are as follows:

- (i) **Weight of proxy for individual behaviour.** A vast majority of leaders and community members interviewed declare the abandonment and condemnation of FGM in the community. In more collective societies, such as Afar, where important decisions are taken at collective level and little space is left for individual deviations, this milestone of social norm change constitutes a very reliable proxy for individual behaviour change. Also, in the context of the study of a phenomenon that cannot be observed physically, the assumption that collective communities that declare abandonment of FGM have effectively abandoned the practice at individual level is highly plausible. In less collective communities, the proxy is less solid, but still important for other reasons (see below).
- (ii) **Taboo break.** The vast majority of girls and boys interviewed speak openly about FGM and their consequences, even in public settings. This is a very significant change when considering previous situations where just mentioning the word “FGM” or similar equivalents would be

⁴³ Interviews with Office of the Federal Attorney General, subnational JP staff, MOWCA, SNNPR, KMZ

⁴⁴ See list of interviewees in Afar and SNNPR. Finding strongly and generally supported by interviews and focus groups with community members—both girls and boys, married and unmarried—traditional leaders, religious leaders, ex-circumcisers and medical doctors, both in Afar and SNNPR. The public consensus is also supported by JP country reports and other stakeholders working on FGM, including Government and CSOs.

considered a strong taboo. This is important both as proxy of social norm change and as a factor to encourage further social change. As a proxy of change, it shows that members of the community no longer expect social punishment for talking about the issue or for talking against FGM. As a factor to encourage further social change, the discussions in public permit others to observe and learn from those who speak, something that was impossible previously. The fact that some share with pride that, for example, they are uncut, and that they do it without fear for punishment or less chances of marriageability constitutes a remarkable change, that also enables a better transmission of messages within the community against the practice. More importantly, not only the members of the community speak openly about FGM, but they do so in an unequivocal condemnatory way, a remarkable element given the hundreds of years that the FGM practice has been embedded in the collective psyche. This taboo break is a very solid indicator of social norm change, in line with the results framework of the JP and its theory of change.

- (iii) **Change of paradigm regarding effective strategies to eradicate FGM.** The change of the social norm from “General appreciation of FGM” to “General condemnation of FGM” has important implications at social and individual level. These changes require a change of paradigm in the strategies to address FGM towards full eradication, an aspect that is analysed in detail under Assumption 3.2.

2.b) At the level of individual practice, key stakeholders reported that some individuals have abandoned the practice while others have changed the practice notably by changing the type of cut from infibulation to cutting without stitching. The latter is sometimes referred to as “sunna” although there is not consensus on what procedures are included under “sunna”. The exact number of persons who abandon the FGM practice is not known, due to the limitations of the existing monitoring systems, quality of data and the invisibility of the phenomenon once it becomes illegal and/or condemned by a majority of the community. Having said this, a significant percentage of the interviews with a diverse groups of stakeholders in both in Afar and SNNPR⁴⁵ in the communities where the JP operates, show an important change at the individual level suggesting a possible shift in the the social norm as accepted by the majority. **(i) The reported abandonment of FGM by a majority of the community** in the JP areas would constitute an impressive success in what can be considered a relatively short period of time when we consider the difficulty of behaviour change in practices deeply enrooted in societies for hundreds of years. **(ii) The change in the type of cutting being done ie cutting without infibulation, is an important development however any cutting** remains a Human Rights violation regardless of its type. There is a difference in the level of physical harm at the moment of cutting and, to some degree, a reduction in the most extreme complications arising in childbirth. Infibulation implies risks for an infinite number of medical complications during a woman’s whole life, ranging from infections and sexual pain to death. Those types of cuts included under type I are less invasive from a physical and medical point of view. This does not eliminate potential negative impact during sex and childbirth as well as scarring and infertility (and does have negative impact on sexual sensations or pleasure which is a primary justification for practice. The elimination of the less invasive type of cutting (often called Type I) may require more sophisticated messaging and targeting: (1) The awareness tool for behaviour change based on the exposure of serious medical complications during childbirth is weakened, as these consequences are much less obvious. (2) The Hadith of the Prophet, which

⁴⁵ Finding supported by practically all consultations, both by interviews and focus groups with community members –both girls and boys, married and unmarried- traditional leaders, religious leaders, ex-circumcisers and medical doctors. Both in Afar and SNNPR and, in addition, by CSOs working with FGM. This is also confirmed by the JP country reports.

in Islam has an authority as a source for religious law and moral guidance that is second only to that of the Qur'an, are much easier to argue against infibulation than cutting without sewing⁴⁶. (3) The strength of the conviction against the less invasive practice is in many occasions less firm and clear-cut than against infibulation⁴⁷. **(iii) Relapse.** Most community members consulted consider that once full abandonment has been decided by a community and a majority of individuals, it is difficult to revert to adopting the practice again, as awareness of the harmful consequences, of the lack of support by religious precepts and of the legal consequences, constitute critical factors for said abandonment. This finding also matches the logic of the evaluators, but should be taken with caution, as it is not supported by facts (the timeframe under evaluation is too short to establish such comparisons), but by perceptions and projections about the future.

(iv) The most recent research effort to understand the drivers of FGM (funded by DFID) is focusing its attention on the Oromia and Somali regions precisely because, following a reported decline in practice in those regions, there was a seeming relapse and a resurgence of the practice. Others have described it as no change in actual practice but a change in the visibility of the practice ie that cutting continued but hidden. The concern is that a more micro level understanding of drivers is important, particularly as the practice changes in response to efforts to end it. "An overall assessment suggests it is declining as a practice, but we still have it in some spots. It came back in some spots. We need to use the structure to push it back again. There is "backward, resistance to accept change". We will keep to our strategy, but we have seen "adaptation"⁴⁸

Assumption 3.2

Joint Programme interventions identify and influence driving factors of social norm change in focus areas at country level, and in cross-border regions in a sustainable way.

1. The JP is a mature intervention that understands drivers of change for FGM at general level⁴⁹. The JP has been able to gradually integrate the learning from its previous 10 years of experience, from the focus in its different phases and from the experience of others. Presently, the JP shows significant success in contributing to change in social norms at community level and a partial success, but also important, in contributing to transforming FGM at individual level in a large proportion of the population of the targeted communities. The main strengths of the JP at community level are:

⁴⁶ The Golden Book, Al-Azhar University in Cairo, GGP-Media.2008. This publication has been issued under the patronage of the Egyptian Grand Mufti, Prof. Dr. Ali Gom'a, the most eminent scholar on theological law in the Egyptian Ministry of Justice, and is the result of an International Scholars Conference on Female Genital Mutilation on 22nd and 23rd November 2006 at the Al-Azhar University in Cairo to which the most prominent world representatives of Islam were invited. The finding is also supported by interviews with various religious leaders, both at national, regional and kebele levels in Ethiopia, including one who was part of said conference. Also direct perusal of the fatwa (religious ruling) against Female Genital Mutilation issued by Al-Azhar conference and of the most relevant Hadith in relation with FGM.

⁴⁷ Interviews both with Religious leaders, traditional leaders and community members show that whereas many of them hold a strong opinion against all forms of FGM some others still see with more benevolence Type I, or admit that others in the community see it with more benevolence even if not themselves personally.

⁴⁸ Interviews with local research groups and academics and subnational level government implementing partners

⁴⁹ There is a very high consensus on the right direction of the JP substantial approach in all actors interviewed, including community members and leaders, other actors working on FGM in Ethiopia and UNICEF and UNFPA staff.

- (i) The ability to find, in collaboration with local actors, the right **entry point** in communities where FGM is highly prevalent and promote **effective awareness strategies** that prove to be effective in a large proportion.
- (ii) The appropriate **focus on social norms** as the most effective strategy to obtain real change in an effective and sustainable manner. This decision is commendable, especially considering the technical challenges it presents, the requirements of patience, and the inherent complexities that make it difficult to explain to external actors and donors that hope for a rapid achievement of tangible results.
- (iii) The gradual comprehension that the characteristics of FGM do not demand an isolated approach in substitution of another, but a **holistic strategy** that includes simultaneously different elements in combinations, such as community conversation, work with religious leaders, with traditional leaders, with ex-circumcisers, on legal aspects, supporting law enforcement mechanisms, or government structures, etc, apart from the support to services.
- (iv) An appropriate identification of some strategic adaptations, such as the advantage of addressing contiguous districts in new interventions, so as to hinder underground FGM practice that is taken to the next village when the social norm shifts against FGM in their own community, or the recent emphasis put on support to law enforcement government services and local mechanisms for monitoring and enforcement.

2. Even if drivers of change are generally understood, they are still not comprehended with the level of detail that is needed to effectively achieve full eradication of FGM in the targeted communities. After awareness is achieved in a community and a social norm condemning FGM by the majority is accepted, there is a second phase that does not rely any more on awareness, but on more specific and nuanced strategies. At the present moment there is an absence of sufficiently detailed data and evidence so as to be able to work effectively in the last phases of FGM full eradication in each community.

A more detailed analysis of this scenario shows that after awareness on FGM negative implications is achieved in a community, there is a second phase characterized by **substantial changes both in empirical expectations and in normative expectations**. *Empirical* expectations can be defined as expectations on how other people will behave in a specific situation, whereas *normative* expectations are those related to what other people think one should do in a specific situation⁵⁰. Some of the main changes in said second phase after awareness success are:

- (i) **A minority continues FGM practice despite being aware** of the disadvantages of FGM, which makes an awareness focus no longer a priority or insufficient. Also, this minority can be presumed to be, by definition, different from the majority and with specific characteristics that need to be considered in any effective strategy. To effectively challenge behaviours that are against the new social norm of the community, two specific elements need to be understood: (a) the specific reasons that drive that behaviour in those specific individuals, who assess reality in ways that are different from the rest of the community, and (b) the social profile of that group as to understand the most effective way of exerting either influence or pressure given that specific profile.

⁵⁰ Bicchieri, Cristina. *Norms in the wild. How to Diagnose, Measure and Change Social Norms*. Oxford University Press. 2017.

- (ii) The practice of FGM **shifts from being visible and public to being underground and invisible**, which constitutes a radical change of paradigm both from a social point of view (a phenomenon that is not easily observable and is banned is socially transmitted in a different way) and from a strategic point of view. This characteristic has also implications in higher difficulties for monitoring.
- (iii) The **heterogeneity** of the profile to be addressed is extremely high. Again, whereas a level of heterogeneity of FGM is already widely known, distinguishing for example the diversity of practice in different countries and even in different regions within the same country, there is an additional level of heterogeneity that is still underestimated, with communities that are separated by only a few kilometres presenting different profiles and requiring differentiated strategies so as to achieve effective results.

In SNNPR, internal borders are a factor in overall strategy to effect norm change. SNNPR is 3rd biggest and most populous region in Ethiopia (15 zones, 45 woredas, 136 districts, 4000 kebeles, 20 million people). It is culturally and linguistically very diverse, with individual woredas just a few hours apart with different language, traditions, and even practice of FGM. Thus, the adoption-diffusion model which informs so much of the work on changing norms through community conversations and sharing, is not particularly effective—new thinking does not transmit well. “We have intentionally limited (the FGM) intervention in geography and scope and thus emphasize diversification of strategies. Unlike the model for community conversation, “diffusion” to other communities and woredas can be a problem because there is such diversity here in culture, language, practice. And even on HTPs as some groups do not have FGM”.⁵¹

The **significance and implications of the existing gap** between drivers of change being generally understood, but still not comprehended with the level of detail that is needed for full eradication of FGM, can be better explained with the use of a medical example. High blood pressure is one of the leading causes of heart attacks. It is presently known that for its treatment it is effective, in general, to use a drug combining four active ingredients: Angiotensin-converting enzyme inhibitors (**ACEIs**), Angiotensin receptor blockers (**ARBs**), Calcium channel blockers (**CCBs**) and Thiazide Diuretics (**TDs**). In order to simplify the example, we will call the four ingredients A, B, C, Ds, just taking the letter in bold in each ingredient. However, in order to help a patient, it is not enough to know that these four ingredients need to be present, but one needs to know **the exact dose** of each of them. Some patients need 20/40/5/10, others 25/30/10/10, others 15/20/15/5, etc. Failure to prescribe the right dose, results in an ineffective treatment, or even worse, in a counterproductive one. Thus, the general knowledge that leads to prescribing the same dose to all patients would result in most patients getting too much of one ingredient and too little of another, with a few patients, less sensitive to the exactitude of the dose or closer to the average provided, receiving an appropriate dosage by chance.

Similarly, at the present moment, the JP and its main partners working on FGM in Ethiopia understand the ingredients, but are unequipped to understand the exact dose combination needed in each community, something that depends in turn on a detailed understanding of the specific social profile of each community and the corresponding specific drivers of change –with their specific dose/weight- in each specific community. The drivers of change will very probably combine the already identified ingredients, i.e. community conversation, work with religious leaders, work with traditional leaders, work with excircumcisers, support on legal aspects, strengthening of law enforcement mechanisms, support to government structures, etc, but the amount of effort on each of them will be different depending on each

⁵¹ Interview SNNPR MOWCA

specific social profile. For example, even the simplest social elements will demand a different intervention, like the leadership profile of a community (e.g. it is different to work with a community with some girls with leadership that others follow that a more horizontal one); the degree of contact with urban areas (e.g. it is different to work with a community that has members who are often in contact with urban areas than more isolated communities); the degree of collective decision-making (e.g. it is different to work with communities in which decisions are strongly collective, than more individualistic ones), etc. Similarly, a community that belongs to a more collective decision-model pattern presents dense networks of relations, less dense in a less collective village culture and shows a completely different pattern in the much larger and anonymous environment of a city. If the size and density of the network matters, the social ecology does not matter less, i.e. who shares significant connections with whom, who are the most influential individuals in a community that the others observe before acting, who are more trusted, influential or feared than others. This complexity is compounded by the fact that these factors are also dynamic, as for example, communities' religious leaders used to be essential figures, may gradually shift into communities where social media begin to play a more important role for younger generations. In addition, it is different to work with a majority of the population in a community or with a minority, it is also different to address a visible phenomenon or an invisible one, and it is different to work in a community where boys prefer to marry girls that underwent FGM and one where boys gradually shift to prefer girls who did not undergo FGM. The degree and critical mass of these change matters in order to design the most effective strategy, etc.

All these elements cannot be identified in generic identification exercises, but need very concrete and in-depth ones. Measuring specific social expectations and their influence on behaviour allow the identification of different types of collective behaviours that may otherwise be confused and thus, addressed ineffectively. In this exercise it is important not only to determine what social expectations and punitive threats matter to that minority that still continues the FGM practice, but whether some specific expectations matter more than others and in what order. Only with that level of accuracy can a strategy contain the right dose of each element and the specific combination of ad hoc incentives and punitive measures, with the sufficient continuity so as to reach full eradication, hopefully with the sufficient duration so as to build an scenario in which the normality is not to have FGM nor have community members desiring it, be them women or men.

Finally, the change of social norm against FGM and the strengthening in the enforcement of the legal framework have caused other social changes such as:

- (i) **Change of age to undergo FGM.** It is very heterogeneous, but in general, the prosecution of FGM leads to incentives to carry it out at earlier ages e.g. immediately after birth or seven days after birth, which makes the practice more discreet and difficult to detect, given that older girls could protest, report the illegal practice or be missed during the period of recovery raising suspicion and unwanted questions. In other occasions (SSNPR) the FGM is performed two days after the wedding so that the husband can have direct control on the process.
- (ii) **Change of status in circumcisers.** In some communities, circumcisers did not receive direct payment at the time when the practice was common. With the change of social norm and prosecution, they get substantial payments, as the practice implies important punishments.
- (iii) **Change of protection needs for girls.** The creation of a law environment that encourages reporting of FGM cases is not accompanied by parallel protection measures for those girls who decide to report.

Addressing these behaviours requires disentangling the personal, social, economic, and cultural factors that support them and assessing their relative weights in sustaining these practices⁵².

3. Cross-border dynamics and IDPs/ refugees specificities remain unaddressed. In the case of Afar, with a close connection with Eritrea and Djibouti and sharing the same language than adjacent regions in those two countries, cross-border dynamics affect FGM interventions. For example, the effort to convince a number of communities in Afar that FGM is not prescribed by Islam, is severely distorted by the appearance of a religious leader in Djibouti TV stating the opposite idea. Similarly, the influence of IDPs coming to a new community in SNNPR can change the dynamics and social perception towards FGM in a given community. So far, there are no interventions by the JP addressing these specific situations.

Assumption 3.3

Joint Programme has contributed to availability of quality, appropriate, timely and sustainable services at service delivery points and to their knowledge and effective access by the affected population.

One of the strategic elements of the Joint Programme in Ethiopia is the support to the provision of services. The main focus of this component is on capacity building and technical assistance to different aspects related to health, law enforcement and education.

On the **medical services** component, the Joint Programme has provided capacity building to service delivery points throughout 2014-2017, focusing on health facilities that provide services for complications resulting from FGM. Since Afar and Somali regions widely practice infibulation, the health care facilities also provide de-infibulation services. The coverage expanded from 166 service delivery points in 2014 to 617 in 2017, a growth that surpasses 50%⁵³. In 2016 this component was expanded from Afar to also include the Somali Region. Key results under this component include the development and roll-out of three training manuals, on community dialogues, legal literacy and the clinical management of FGM complications in Afar and Somali regions⁵⁴. The quality of care services has also been strengthened through training, and the deployment of gynecologists to the two regions to provide services. Asayita and Mille Hospitals in Afar region and Karamara and Deghabur Hospitals in Somali region were supported with the necessary medical equipment to provide care services.

The strategy combining support to prevention and to provision of services constitutes a necessary strategy. All the stakeholders interviewed, from institutional instances to beneficiaries, emphasize the importance of maintaining both aspects. Not only the nature and timeframe of the phenomenon in Ethiopia demands attention to both the girls that have not yet suffered FGM and to those that have already suffered the practice, but the combination of both strategies is mutually beneficial for both components, as the awareness raising stimulates the use of formal health services, whereas the use of formal health services also encourages the elimination of the practice through exposure to the advice of doctors⁵⁵. A significant new investment to support this strategy was the training of over 500 health extension workers to both raise awareness on the need to end the practice, but also to connect those subjected to the practice to formal health facilities in Somali and Afar regions. This was the first time UNICEF has made a dedicated

⁵² Bicchieri, Cristina. *The grammar of society: the nature and dynamics of social norms*. Cambridge University Press. 2006.

⁵³ Annual Report JP, 2017.

⁵⁴ Ministry of Health, Federal Democratic Republic of Ethiopia, 2016, *Management of Health Complications and Prevention of Female Genital Mutilation/Cutting: Participants Manual*. Addis Ababa, MOH.

⁵⁵ Interviews with doctors, administrators and APDA NGO at Mille's hospital, Afar. Confirmed by community FDG in Mille and other Woredas in Afar.

investment on this issue in the health sector⁵⁶. Significantly, the emphasis on training female extension workers contributed to encouraging women in rural areas to seek care as they were reticent to visit the predominately male doctors for FGM related issues.

Support to Mille’s hospital in Afar remains highly effective and relevant in providing effective access. The demand for medical services is over the capacity of the services, attracting cases not only from Mille but from the 32 woredas in Afar, and even patients from the Eritrean border and from Djibouti (although those from Djibouti are more opportunistic patients that use the service when they come to see family, given that the services in Djibouti are generally better). In addition, the support given by the JP to APDA contributes to an access to community level that is so far inaccessible for government structures. It is worth emphasizing how a few years ago most communities were not aware of the hospital, but the “Dagu system” of mouth to ear communications in Afar, the campaigns through radio and the work of APDA’s health workers in the communities have gradually transformed the situation in combination with the breaking of the taboo regarding FGM. As a result, the hospital is now very popular and working at full capacity. For example, the administration registers 60 de-infibulation cases only in the quarter of April-June of 2018, with doctors recurring to teaching also nurses so as to help coping with the demand. Doctors declare that 80% of the cases they see are related to FGM⁵⁷. Having said this, continuation of awareness remains important, as women come almost exclusively when the complications appear, and the post-natal care check-ups are still exceptional.

One module on FGM was included in the national training manual of midwives and the training of midwives has strengthened both health services and community awareness. The support to the Ethiopian Midwives Association to integrate FGM in the training curricula has been complemented by training to 286 midwives using the e-learning training module produced by UNFPA Headquarters on the role of midwives on FGM prevention. The importance of this element given the key role of TBAs in providing both peri-natal services and trusted advice, is confirmed by FGDs and interviews⁵⁸, pointing at the benefit of having this component expanded in the Phase III of the JP.

The integration of FGM in the curriculum of faith-owned health facilities, in combination with the work done by health extension workers, has contributed to wider awareness coverage and referral to hospitals in some woredas of SNNPR⁵⁹.

An emerging issue with respect to building the capacity of the health community is medicalization of the practice i.e. health providers either making the original cut, or re-infibulating after birth (as distinguished from an episiotomy or resewing a tear). There is a demand side factor driving this change in practice—as people become more aware of the risks of cutting (infection, HIV, infertility) having the procedure done in a medical facility or by a medical practitioner is seen as a safer option. WHO has been the most active on this issue at national level in Ethiopia, bringing together stakeholders from the ministry, medical, academic, and faith-based communities to focus attention on the issue which lead to advocacy setting in place a strict ban on medical and health practitioners’ participation in any such cutting⁶⁰. This includes the private sector which risks legal action and suspension of license for participating. The FMOH, the national association for

⁵⁶ Annual Report, Joint Programme, Ethiopia, 2016.

⁵⁷ Interviews with doctors, administrators and APDA NGO at Mille’s hospital, Afar. Confirmed by community FDG in Mille and other Woredas in Afar.

⁵⁸ Interviews and FGDs with Beneficiaries in Afar, TBAs and local authorities.

⁵⁹ Annual Report JP 2017, and interviews with beneficiaries and midwives in SNNPR.

⁶⁰ FMOH issued a circular in 2016 which prohibits undertaking FGM in health facilities to reinforce the national law which criminalized the practice.

Obs/Gyn, and NCA (which supports private sector clinics through faith-based groups) are currently working at the level of individual health facilities to train on this issue. As concern has been expressed regarding the role of midwives as cutters apart from the moment of childbirth addressing medicalization provides an opportunity to engage explicitly on their complex relationship to the practice. This needs to be done in a manner which does not demonize midwives and holds accountable practitioners who are part of the “new wave” of medicalization⁶¹.

Much of the work on addressing FGM within the health sector has focused on Ob/Gyns and been tied to issues in childbirth and RTIs—a very narrow entry point which is akin to post-abortion care in that it addresses the problem “after the fact”. Significantly the FMOH in Ethiopia has addressed the broader health community including pediatrics in providing “clear strategic guidance on the health sector engagement in ending FGM” in the National Adolescent and Youth Health Strategy (2017). Much more can be done in this area and, as UNICEF made a first step in investing in the health sector work on FGM through training of the health extension workers, there is momentum.

The support to **Law enforcement** mechanisms has been gradually upgraded by the JP, leading to the inclusion of direct allocations of budget to the Regional Bureaus of Justice in Afar and SNNPR and to the Islamic Affairs Supreme Council in Afar (the Bureau of Women and Children Affairs already had Budget allocated). This step is **generally perceived as effective and highly complementary** to the work on change of social norms, in particular thanks to the strengthening of monitoring mechanisms for violations of FGM adopted norms⁶². The establishment of community surveillance mechanisms in 2015, with further efforts in 2016 to strengthen them is contributing in better tracking of cases and making justice services more accessible through information and referrals⁶³. In addition to legal education and guidelines for the police, SNNPR, has trained 505 “legal education groups” (of young people, women’s development groups, youth groups, local leaders and parents) in an approach focused on: 1) discussion of the problem and 2) action in practice (how to work with the law). This broad-based training effort will continue with teachers and health personnel. Presently the BOJ supports social workers who provide immediate support to survivors. The actual investigation is done by the police but transferred back to an MD to conduct the examination and provide the forensic report- a time consuming process. One of the most significant developments is that the BOJ recently developed special investigative units in all woredas (previously only national level offered such a unit). The special units are trained to manage the sensitive nature of FGM investigations and should help to speed the process⁶⁴.

There is also a deterrent effect on FGM that is impossible to calculate specifically, but that stems from the increased opportunities available for girls to denounce cases, which can be reasonably expected to contribute to the cancellation of an undetermined number of practices. In this regard, it should be noted that the highest measure of success is not given by the number of cases reported, but by the number of times that an intention to practice FGM on a girl was frustrated through dialogue and convincing without having to resort to punitive measures⁶⁵. SNNPR reported that of 50 FGM cases brought forward in 7 woredas, 30 were “attempted” cases and 18 were commuted. They noted that the attempted cases were illustration of the deterrent effect of the law.⁶⁶

⁶¹ Interviews with WHO,

⁶² Interviews with BoJ in Afar, local JP staff, traditional leaders in Afar.

⁶³ Annual Report JP 2016.

⁶⁴ BOJ SNNPR, 25/06/18 Hassawa

⁶⁵ Interviews with girls and with traditional leaders in Afar.

⁶⁶ BOJ SNNPR, 25/06/18 Hassawa

Finally, the **support to extracurricular activities** related to FGM and girl clubs in schools, has been of a lesser magnitude, but it is locally perceived as effective in contributing to reduced FGM and empowerment. Both aspects are actually interrelated, as Child Marriage and FGM complications are a direct cause of school drop-out whereas staying in school helps to avoid FGM with the community support and the encouragement from the other girls⁶⁷.

Assumption 3.4

Management information systems are in place to monitor and report FGM related data.

1. The Joint Programme has contributed significantly to strengthening population-based data sources which include information on FGM and thus can inform macro-level planning and reveal generational trends. There is expectation that the increased coordination enabled by the National Alliance will support much needed improvements in administrative data systems which are needed to inform overall program planning and budgeting and can help to develop context-specific strategies.

The Ethiopian community addressing FGM played a leading role in the earliest efforts to monitor and measure FGM at a subnational level even before it was included in the DHS and before the Joint Programme was established. The 2005 DHS provided a valuable baseline to track the impact of the Joint Programme contributions in Phase I. Unfortunately, the 2011 DHS, which would have provided both a key baseline measure for Phase II and potentially some indication of trends from Phase I did not have a module on FGM. The only resource from that year was the national survey done by ODAWACE (then EGLEDM) and welfare monitoring survey (which provided insight on under 15 girls but presented possible issues with allowing any adult respondent including those who may know less about the practice). The Joint Programme was very proactive in assuring that an FGM module was included in the DHS survey in 2016.

The critical gap demonstrated the need for overall capacity building but also coordination, communication, the involvement of government entities beyond the MoWCA, and the importance of cooperation among the various development partners working with these entities—a core principle behind a Joint Programme. FGM is a contentious issue and reportedly “some regional representatives” had refused to accept the results of the 2005 survey. When the Central Statistics Agency was informed that the MoWCA planned to carry out a national survey that included FGM, “it was decided” that two surveys on FGM at the same time would be both a waste of money and risked creating unnecessary debate and lack of confidence if the two surveys produced very different results due to differences in methodology⁶⁸. Thus, the DHS did not include FGM, but unfortunately the MoWCA study on GBV did not include FGM and thus no data was collected.

The inclusion of a full module (chapter 16) with 10 questions on FGM in the Ethiopia Demographic and Health Survey (EDHS) of 2016⁶⁹ was the result of successful advocacy by UNICEF and UNFPA in collaboration with other stakeholders including UN Women. More importantly, UNFPA and UNICEF provided financial support to the Central Statistical Agency and technical support for the development of the module on FGM, the analysis of the data, and the drafting of the final section of the EDHS 2016 report released in August 2017. The support for analysis in particular remains highly valued by FGM stakeholders and in particular by the government.

⁶⁷ FGDs in Mille’s school, BoWCA in Afar.

⁶⁸ ODAWACE, 2013, Prevalance of FGM in Ethiopia, Based on the Aligned Data of 2005 EDHS and 2007 EGLDAM National Follow up Survey on HTPs, Addis Ababa, Save the Children, NCA; interview with ODAWACE

⁶⁹ Demographic and Health Survey (DHS) of 2016

The Joint Programme continues to focus on ways to improve these population-based data sources. UNFPA, which provides support to the Ethiopian census has focused attention the fact that the census does not sample refugee populations living in camp settings (as opposed to those integrated with the community). This will change in the next census and these populations will be included. This is significant for the work on FGM as these populations remain in place for extended periods of time, come from areas with very high prevalence of FGM, and not only influence but may provide access to cutters away from the eye of Ethiopian law (UNHCR, which manages such camps, does not prioritize the issue of FGM when dealing with short term emergency needs).

The Joint Programme has also highlighted the need for a more disaggregated sample which goes below regional or even woreda level to the kebele level. This is important primarily for planning interventions which respond to the contextual specificities of the practice of FGM in Ethiopia—both the significant diversity in a context such as SNNPR and the change in practice in a region such as Afar. The detailed baseline done in Afar region illustrates the importance of such data, as does the six-region survey supported by Save the Children and NCA. However, these are expensive undertakings with limited scope and thus there is need to strengthen ongoing data collection by public sector entities.⁷⁰

There is not yet a national tracking system that effectively captures data on FGM. There is a tracking system for GBV with a dedicated form and two different institutions which provide training on forensic data collection. However, in an effort to avoid a proliferation of forms, FGM does not have a dedicated form: “it is expected” that the individual filling the form for GBV will specify the type of violence on the form and thus FGM can be recorded that way (as a form of violence). However, a limited number of discussions with health personnel at the field level made clear that FGM is not viewed as violence to be included on that form. That the NCA is funding capacity building for a small-scale program to track FGM by type in the maternity wards of Catholic clinics in SNNPR is indication that either a dedicated form and/or inclusion of specific training on FGM within the forensic data course are needed⁷¹.

However, such a dedicated effort and the sustained attention and support of the JP leveraging the unique data strengths of UNFPA and UNICEF with respect to administrative data (as well as population-based data) will only begin to address the needs beginning with the health sector. The dependence of the JP on data owned by a government system that faces important monitoring and technological limitations (many areas with high prevalence are difficult to access and many data are still on paper with limited digitalization) presents a situation that requires a long-term process with capacity building and investments that are beyond the scope of the JP. These limitations not only affect the JP, but all the stakeholders working on FGM in Ethiopia, and the magnitude of the challenge is not matched by the resources employed by government or international agencies. Once again, the coordination potential of the National Alliance is critical.

The challenges faced in tracking FGM and the response to FGM through MIS are not limited to the health sector. Even within the security and judicial sector, there is a need for a regional coordination mechanism so the information from a case handled in both sectors filters up to the national level. At the present time, the police and the judiciary each make their own reports and it makes it difficult to know which data to use. At the present time, one form is used for all child protection cases, however the Attorney General has

⁷⁰ Baseline Survey on Female Genital Mutilation/Cutting and Child Marriage in Adaar, Chifra and Mille Woredas of Zone one in the Afar Region Final Report January 2016, B & M Development Consultants PLC; Bekele Ababeye and Habtamu Disasa, 2015, Baseline/Endline Survey: Female Genital Mutilation (FGM) Situation in Six Regions of Ethiopia, Addis Ababa, Norwegian Church Aid, Save the Children International.

⁷¹ Interview with WHO, Medical Providers SNNPR

been in discussion with UNICEF on a format specific for FGM because of the many unique aspects of such cases⁷². In 2017 an additional 70 “justice professionals” were trained on monitoring and evaluation and tracking changes in social norms as a result of the programmes. **UN agencies working on FGM also present some limitations.** Whether the staff and management are well prepared to manage programmes of different types, it is also worth mentioning that the focus on social norms, their specific functioning and related indicators is highly technical and relatively new for UN agencies, especially when comparing it with more developed and better tested indicators such as those on nutrition or health. Social norms and their technical implications are still insufficiently understood by UN agencies themselves, and specific Capacity Building on their technical and methodological implications has not been observed by the evaluation. An additional obstacle stems from the pressure exerted by global indicators included in the results framework. The focus given to fulfill these overarching indicators detracts from a more flexible approach to match the different patterns of change observed in the different woredas and kebeles, which are driven by more specific and detailed indicators and monitoring needs. In addition, some global indicators would require such an expensive survey that are bound to remain unanswered⁷³.

As mentioned before, the **implications of these MIS limitations** affect the accuracy with which the FGM practice and changes is understood. Even if drivers of change are generally understood, they are still not comprehended with the level of detail that is needed to effectively achieve full eradication of FGM in the targeted communities and, in particular, after awareness is achieved in a community and a social norm condemning FGM by the majority is accepted, there is a second phase that does not rely any more on awareness, but on more specific and nuanced strategies. At the present moment there is an absence of sufficiently detailed data and evidence so as to be able to work effectively in the last phases of FGM full eradication in each community. (see 3.2 for a detailed analysis on implications).

A **solution to these limitations** will require both prioritization of which specific elements need to be understood more urgently and creative solutions within the limited resources. Some suggestions to be explored may be, for illustrative purposes: (a) an alliance between government, regional researchers and JP to focus on specific research aspects that need to be understood more urgently⁷⁴, study of local approaches such as the one attempted by health providers in woreda Doyagana (SNNPR) who are developing a Health MIS on FGM that gives more accurate information on FGM and complications than what is offered by national systems; it includes for example client information, type of FGM, case history for treatment, etc., for those clients seen in the clinic. (c) Study specific initiatives by NCA to monitor behavior and actions of religious leaders vis-à-vis FGM, etc.

Evaluation question 4

To what extent has the Joint Programme contributed to promoting national ownership and uptake by governments, in the commitment to end FGM? **Criteria: *Effectiveness and sustainability***

⁷² Interview with Federal Attorney General Office

⁷³ Interviews with JP staff and management at Country Office, and with monitoring officers at different levels in UNICEF and UNFPA.

⁷⁴ Suggested informally by BoWCA in Afar based on previous experiences with other similar challenges, and triangulated with MoWCA at Federal Level and key informants.

Assumption 4.1

Joint Programme has contributed to promoting national ownership and uptake by governments, including policy makers mainstreaming the commitment to end FGM throughout legal and policy frameworks as well as the national budget, and supported regional efforts (through training, producing and sharing data, supporting legal interventions, etc.) to implement the normative agenda to end FGM.

The Joint Programme has contributed significantly to supporting national ownership reflected in enforcement of the law, policies, budgets, implementation and coordination. This includes important global and national overall commitments, integration of FGM into the national development plan, and, in 2014, a commitment to increase by 10% the allocation to all relevant sectors and develop a costed roadmap to guide the plan to eliminate FGM by 2025. The Joint Programme is integrally involved in development of the costed roadmap which will put into practice the significant advances in policy.

Although Ethiopia's Penal Code criminalized 3 types of FGM in 2005 (followed by a few local level by laws) prior to the start of the Joint Programme in 2008, progress on capacity building and actual enforcement is more recent. In 2012, a national committee drafted an "integrated and multi-sector strategy and action plan" to address VAW and VAC including FGM with responsibility to implement given to a National Coordination Body located in the Ministry of Justice.

Addressing HTPs is a national government priority and FGM is one of those specifically addressed in the Growth and Transformation Plan 2 (2015-2020), thereby framing it as a national development concern (DFID). This is bolstered by a national HTP policy for which the JP supports the three major tenants: prevention, protection, provision—notably through its support for community dialogue, enforcement of the law, and clinical services for those at risk or suffering sequelae from FGM (the latter is a less common component of response by other agencies).

The commitment to end was made globally with Ethiopia's participation in the first Global Girl Summit. The JP supported the development of Ethiopia's country pledge and facilitated sharing of Ethiopia's experience within the First Global Girl Summit to address child marriage and FGM. The JP supported Ethiopia's own Girl Summit, one year later which affirmed the commitment to end both harmful practices by 2025.

Implementation of the HTP national policy is the responsibility of the MOWCA, however the National Alliance was established as a platform to facilitate coordinated efforts on the part of government ministries, key CSOs and INGOs, development partners, and research entities. The Alliance was originally established in 2013 to address Child Marriage, but following the GOK's pledge to address both CM and FGM by 2025, FGM was added to its title.

The JP both directly and through the coordinating agencies of UNFPA and UNICEF, supports the National Alliance to Eliminate HTPs. UNFPA was an original co-leader together with the MOWCA (it is now DFID). Accordingly, the National Alliance supported the development of a broad "road map" to end child marriage and FGM for which the BOWCA is responsible to implement at regional level. This complements a broad governmental commitment to increase the overall budget allocation to address these issues by 10%. The road map is drafted but is yet to be validated and finalized. The regions will then validate the core packages as well as set their budget (realistic budget). The alliance intends to revise its own strategy in accordance to the road map and global evidence. A new action plan should also be developed, once the road map is finalized.

Although the staff are limited (only UNICEF was able to fulfill their intent to fund a position) and its mandate is a facilitating role, the Alliance is able to make substantive contributions through information sharing and as a forum through which multi-stakeholder initiatives can be coordinated more intentionally. For example,

the planning, analysis and findings of in-depth, issue-specific analyses of the KDHS to document the linkages between FGM and other related priorities (e.g. fistula, child marriage) is shared among the several agencies each of whom has committed to supporting one particular “focus”—early sharing of the work can help to illuminate these complex linkages.

Efforts to strengthen local level leadership to implement these plans has been more limited and challenged by a series of wholesale changes and the common pattern of moving field personnel (see below on capacity building).

The majority of this work focused on Afar region and an understanding of the importance of “parallel systems” of influence and power lead the JP to invest in FBOs including strengthening of the interreligious council (seven major religious institutions) and individual religious entities for discussions against FGM and key declarations against FGM at regional level (Afar). This work has been a signature contribution by the JP to the work in Ethiopia and provided a base for not only advocacy and prevention efforts but also services for survivors.

Assumption 4.2

Joint Programme has contributed to the utilization of disaggregated data and best practices to enforce law and implement evidence-based programmes to progressively eliminate FGM.

The earliest work on FGM in Ethiopia was informed by demographic data. Rohi Wodu, established in 2004, was one of very few local NGOs working in the Afar region (apart from INGOs and UN agencies). Their review of DHS and census data revealed a “demographic anomaly” i.e. the male population was larger than the female (male 54%, female 44%). It was also clear that maternal mortality in Afar was the highest in the Ethiopia and infant mortality was for females was more than double males. That focused their work on women and children.

Although the DHS continues to serve as an indication of trends of FGM, the ability to monitor change resulting from ongoing interventions remains weak. There is no national database in Ethiopia which captures FGM. There is hope that the National Alliance, as platform to bring together bilateral, UN, international NGO and a few local agencies, could help a coordinated effort but there is no line ministry strong enough to manage such an effort currently and insufficient resources are available for the level of ongoing monitoring required. The MoWCA itself has limited resources from government--most of its funding and that of the national alliance is bilateral or multilateral and not designed for ongoing support of such a data effort.

There are individual agencies pursuing more rigorous data to track impact which could inform a national effort. Save the Children has its own monitoring and evaluation plan for work on FGM and broader child protection including standardized routine data collection tools. As they are working with the PC, they will inform and benefit from the new initiatives to monitor drivers of practice being undertaken by ESSAWA (with NORAD support). Their system has 10 outputs and each partner and field officers trace progress with an indicator performance tracking table to monitor (process, output, and outcome indicators). In addition, Save has its own quality benchmarks and standards for specific areas which also inform the monitoring efforts. They hope others can learn from this work e.g. as in a recent workshop on experience sharing with KMG.

Another key type of data which could potentially focus powerful interests on the need to end FGM would be costing of the impact of FGM and its health, fertility, production and longevity-related sequelae. There is potential within the private FBO-based services currently supported through JP IPs although it may not reflect public sector costs. More recently, the MOH developed e.g. online forms that require organizations

to document the types of information they share, the activities they are undertaking, the cost of their work. This reflects earlier efforts when the ministry was mapping activity in the sector but been done in 5 years⁷⁵.

Assumption 4.3

Joint Programme has contributed to the development of the capacity of programme managers to implement national and decentralized policies to end FGM in a coordinated way.

The Joint Programme has contributed to developing the capacity of implementing personnel in several sectors—justice, health and education—primarily in Afar region. Apart from investment on enforcement of the law—which expanded annually to include a wider circle of actors—the contributions have been discrete investments at small-scale. The global and perennial problem of loss of trained personnel to other regions, ministries or projects remains a challenge however, based on the experience to date, the JP is supporting multiple efforts to “institutionalize” such efforts.

Ethiopia’s penal code outlawing HTPs including FGM was passed in 2005: immediately following the launch of the Joint Programme in 2008, a broad-based training program on implementation was done for law enforcement agencies and continued over 3 years. The limitations of such an approach were addressed with subsequent training of key government and ministry officials, community leaders, and the operational arms of the system—police, prosecutors and judges, including dedicated desks within police stations. It was not until 2012 that national government developed a strategy to implement the law for which the MOJ was given responsibility and the Joint Programme again responded by training 150 law enforcement staff as a means of strengthening the judicial sector.

While these investments are important, they cannot compensate for the overall weaknesses within the security and justice sectors—and this is work requiring engagement beyond the Joint Programme. Research by the Federal Attorney General’s office showed that, although the police are the “first responders” it is hard for policemen to negotiate with the community on customary practice as they are part of the community. Even if cases are discovered, they may not make it into a court and when they do, they do not move “up the system”—the federal level courts were not seeing any FGM cases leading to the mistaken impression that FGM was not a major concern. A factor was lack of coordination between the police and judicial system i.e. “the judicial system is only engaged once the case has gone to the police. Although in many cases, the police and judiciary are in the same office at the kebele and woreda levels, at the region level there is a disconnect between the 2 parts of the system: the case will be referred to the public prosecutor⁷⁶. Strengthening of the justice sector and improved coordination of structures below national level (e.g. woreda and kebele level) is a priority of the Flagship Joint Gender Programme involving 6 UN agencies including UN Women with a focus on justice and the law and UNDP with a focus on strengthening coordination and functioning below national level⁷⁷

Subsequent investments focused on awareness raising with educators, community level monitors and faith-based actors who helped to monitor practice at the micro level. Most recently the National Alliance, proclaiming that “What happened after the public declaration is what we don’t know”, has developed a verification tool, a “social change measurement”, so as to identify which kebeles are successful in achieving a total eradication of FGM. The tool was still being field tested during the evaluation mission.

⁷⁵ Interviews with Save the Children, ODAWACE, Rohi Weddu

⁷⁶ Interview with Federal Attorney General

⁷⁷ Interview with UNDP

Effort was also made to build capacity within the health sector focused on services rather than prevention: training health providers based on modules developed with a local NGO and the JP and based on the UNFPA/WHO guidance on how to manage complications. Although the MOH would only allow UNICEF to add their logo to the document, Ethiopian NGO ODAWACE was also supported to translate the manual into Somali and to do a TOT with health professionals in Afar and Somali region. The JP also supported a training for midwives and community health workers on “awareness and early treatment”: Longstanding FGM advocate ODAWACE worked to build the capacity of HEWs and health workers on management of FGM complications and care of survivors in the Somali region. together with support for service provision for complications to private health services under the auspices of private NGO and FBO.

In an effort to put in place a more sustainable system FGM content was integrated into the overall curriculum for midwives—a critical audience in that midwives are not only most likely to see sequelae but are sometimes perpetrators of the practice. More recently, UNFPA as one of the two coordinating agencies worked with ODAWACE on a 2015 publication on complications from FGM-- the first study of its kind in that it was hospital based looking at complications including of Sunna (assumed to be less damaging and increasingly reported to replace infibulation in e.g. Afar region). This effort informed the "red hand" campaign which was also supported by NCA.⁷⁸

These efforts were not able to overcome two fundamental challenges: bridging the “gap” in effective coordination within the security sector (between police and judiciary) and between the health a security sector and the turnover of staff which is an issue for all ministries and all programmes. In a contribution to institutionalizing and making more sustainable such capacity building efforts, several manuals are under development. MOWCA has been working with an adaptation of the social norms change manual and with checklists to identify when communities are ready to undertake a declaration; an interfaith tool for FBOs involved in delivering services was developed by NCA and there are plans developing with the Federal Attorney General and regional justice bureaus to “standardize the training and working manuals used by justice professionals, and link them with the Justice Professionals Training Centers in Phase III of the Joint Programme” and, more broadly, in supporting better monitoring efforts of implementing partners. These offer much promise for scaling efforts to address FGM, although they need to be reinforced with other means of encouraging “rethinking”.

The need for intersectoral coordination is well understood even by the Supreme Sharia court in Afar “We need to have a critical mass (multi-sectoral bodies): we need to include gov’t, legal, health, religious, clan leaders etc. to prevent FGM... we need intersectoral coordination and work collaboratively. There should be revolution with all the actors involved”.

One of the challenges is with such coordination is the regular shifting of responsible ministries in response to political concerns. The ministries with FGM mandate are MOH, MoWCA and ministry of tourism and culture. However, following the new (Charity) law, proposals related to FGM must go through several levels of signature approval i.e. financial and economic commission, MOH, MWCA, and, depending on content, other ministries (e.g. MOE).

⁷⁸ Interviews with ODAWACE, WHO

Evaluation question 5

To what extent the programme has developed strategic partnerships and collaborations to accelerate and sustain global efforts to end FGM and transform social and gender norms, over time? **Criteria: Effectiveness and Sustainability**

Assumption 5.1

Joint Programme has effectively developed and leveraged partnerships and collaborations with other development actors to amplify efforts, particularly with regards to more in-depth research on social norms change and its linkages to changes in individual and collective behaviours.

The Joint Programme has cultivated a versatile mix of different types of partnerships through formal agreements, working groups, convening including jointly for events such as the Girl Summit, and support for the National Alliance. Although the National Alliance make up does not reflect the range of national level CSOs within the JP relationships, new leadership within the MOWCA provides an opportunity to revitalize that effort with new actors. At the grassroots level, government structures predominate built on the Women's Development Army and, in SNNPR, the 5 in 1 system—a structure which does not provide the same terms for partnership. However, the JP is able to support well established national NGOs such as KMZ able to serve as a bridge.

Engagement with research partnerships and academia has not been possible given resources, but through the National Alliance, the JP is closely involved in an effort to undertake in-depth analysis of DHS data to explore linkages between FGM and related issues including fistula, maternal health, and child marriage. As UNFPA is actively involved in development and implementation of the DHS surveys, and UNICEF at headquarters level continues to lead on trend analysis and cohort tracking of DHS and MICS surveys for FGM and child marriage, this “research” partnership is a strong opportunity.

What respondents described as the “signature contribution” of the JP is support for the work of NCA and other well established FBOs and regionally-based groups to engage the leadership of key religious groups including a wide range as well as the two key religious groups-Islam and the Ethiopian Orthodox Church. These FBOs serve as strong normative influences both by example but also through the educational mechanisms of the church hierarchy. They also provide services⁷⁹.

The three major FBOs developed theological reflection on FGM and declared zero tolerance and this is reflected in the National HTP strategy: the Ethiopian Orthodox Church (2011), Catholic Church (2013) and the evangelicals (2010). The Muslim community has not been as responsive although this relates in part to the structure of the Sunni tradition which is more decentralized. More than 30 high level inter faith dialogue forums and consensus building at national, regional and lower level were organized. Theology and bible colleges incorporated FGM in their curriculums. FGM become a topic in ongoing FBOs activities: Sunday school youth, women of faith, clergy centers, Quranic schools FBO owned health facilitates and schools. In the case of the Ethiopian Orthodox Church, this includes leveraging a unique tradition of the church: e.g. 8 days after a birth, a priest visits the woman having given birth to bring “cleaning water”—every member must go through the holy sacrament which gives the priest an opportunity to follow up on anything noticed in the home.

⁷⁹ Norwegian Church Act Alliance, 2015, Faith Based Organizations' Response for the Abandonment of Female Genital Mutilation (FGM) an other Harmful Practices in Ethiopia, Addis Ababa, NCA.

The Ethiopian Catholic church's declaration against FGM was the first in the world. It was also shared in the world (through church networks and at the London Girl Summit). In Ethiopia, the catholic church serves only 0.3 % of the population but they have many facilities including clinical services. Indeed, the clinical services in SNNPR are also tracking cases of FGM seen to strengthen data. These fill a significant gap in the MOH services. Using catholic church General Assembly, the cardinal gave directions that FGM response should be integrated in all health facilities. The church developed an integration manual on how to integrate FGM in the church's structures. The Ministry of health's FGM management protocols/guidelines were duplicated and distributed for reference purpose. Because FGM is not included in the national MIS and hence not captured in health facilities, following the training of the church providers, a format was developed for registration and reporting of FGM related complications. Health facilities started to give health promotion education on FGM in their compound

The Ethiopian Orthodox Church provides access to a critical percentage of the population. The EOC accounts for 43.5% of the 63% of Ethiopians declared as Christian adherents in Ethiopia. Yet over 50% of the self-declared EOC members surveyed in the 2016 EDHS reported practicing FGM.

The EOC program on FGM and GBV has been staffed since 2008. The church works through its religious leadership/priests, its religious schooling, its traditional (full curriculum) schools at primary through tertiary, its women's groups and other social networks including the established local networks of Edir (a variation on a ROSCA), a busy calendar of feast days, celebrations and rallies, and radio programs in local languages. It is in every region of the country; in the east the church works within established structures which have been operational for centuries. Little has changed in the structures (30 training centers, Sunday schools reaching 12 million young people, 38 campus programs reaching 2 million students, 2000 traditional schools (mostly for males, some females) as training for priests as well (the latter taking up to 37 years).)

The EOC has developed a standard guide for all work in this area--the Development Bible and accompanying texts--as well as specialized materials for different audiences and venues based on this same content. Messaging and explanations are very consistent--these materials also help priests in isolated areas work with radio programmes or other sources from other agencies. The messaging has been developed in close collaboration with the NCA and the Joint Programme. It also works with community conversations "using the person already in the (church) structure". That person is also an advisor to the district government structure and the BoWCA committees. The church produced a 6-point declaration which has been distributed through the structure. Every clergy member will answer that FGM is forbidden.

Assumption 5.2

Joint Programme acted as a catalyst for established and emerging actors to strengthen the response to end FGM, at national, regional and global levels, including e.g. other UN agencies, other programmes, new donors and funders, national governments, regional bodies, civil society, faith-based organisations/leaders, and implementing partners.

The JP has supported the leading actors on the FGM issue in both Afar and in SNNPR. Their contributions include some of the very early work done on FGM before it was even tracked by the DHS (ODWACE) and before the "Tostan" model for community dialogue was promulgated so widely (the work of KMZ). Through the support for these agencies, Ethiopia has contributed to the global agenda on FGM beginning with early identification of patterns and relationship to female survival rates (and gender based discrimination), early and now in-depth work on understanding changing practice (notably Sunna), and added momentum to the issue by linking it with child marriage on the global stage. The JP has also

leveraged the influence, resources and structure of the Christian churches to address FGM including services provision and the first ever declaration on the issue by the global Catholic Church.

These efforts focused primarily on some of the most challenging contexts in which to address FGM (Afar and Somali regions) and the most diverse contexts (SNNPR). These agencies helped support both public sector response and local community based organizational structures including those integrally linked to government structures.

Unfortunately, in 2015, the GOE took action which threatened the substantial base of emerging actors addressing FGM particularly as a rights or gender issue. Ostensibly a reaction to the contribution of selected INGOs in bringing down a previous regime, “rights” related work was severely curtailed and could only be undertaken by truly Ethiopian NGOs who received no more than 10% of their funding from sources outside the country.

This demand was quite different from the existing “test” which related to national level control of regional level operations—reflecting tensions between national level and regional alliances. This “test” still allowed a diversity of emerging actors and remains in practice. I.e. NGOs agreements are done at federal level and to show that an agency “works in Ethiopia” it must work in at least 5 regions. Even as NGOs had to negotiate with line ministries, the formal agreements and financial support are channeled through the Financial and Economic Development Commission at the federal level and its structures at regional level or directly through the Charity Board. Where an agency “enters” the system depends on the level of funding at which they are working (e.g. under 15 million birr can go directly to region level; under 2000 birr goes directly to the kebele level).

The new “rights-based” restrictions had huge impact particularly on the gender sector. Approximately 200 local NGOs closed up business. Some programs and UN agencies whose work was ongoing with government were “grandfathered” in and allowed to continue.

“Ethiopian sources” of funding are limited. Government funding for NGOs is inadequate and there is little evidence of efforts to expand that funding. Ethiopian sources of private funding are mostly at federal level and citizen funding is “in infancy”. In short, the law forced agencies to work with and through government. Although effective advocacy with government should be informed by field experience it is this “link” that may have been what the law was intended to restrict (on other rights issues not necessarily on the issue of FGM).

Its impact on work on FGM was made evident in the fact that ODAWACE was the only NGO on the National Alliance until a newly formed NGO, Young Lives, began its work more recently. The potential “Ethiopian sources of funding” which would benefit from the grassroots work on FGM and might therefore fund it are the extreme poor. The most likely sources of funding outside of government are not likely to be interested in funding FGM work. There is hope that this may change/revert under current government. There is a lot of international and local pressure to change. A 2016 assessment of the FGM program involving the Federal Attorney General’s office noted that the programme did best in well-organized communities but also areas in which donors or NGOs are present because they provide more support than government (and serve as an accountability force). The concern is that “Ethiopian funds” are hardest to come by in these communities which are also underfunded by government. *“We have been working on this issue for a long time. Government alone cannot do it, change at the level of community needs to presence of NGOs. Within the regions, government has put in place many structures even at kebele level, but there is no budget line to support them. If you don't work at grassroots, people will just shift back to practice.”*⁸⁰

⁸⁰ Interviews with National Alliance, ODAWACE, development partners, KMZ

Evaluation question 6

To what extent does the Joint Programme draw on the relative strengths of each organisation so as to promote efficient programme implementation to amplify the Programme contribution? **Criteria: Coordination/Efficiency**

Assumption 6.1

Joint programme financial systems and structures enable the efficient and timely flow of resources to support implementation and achieve planned results.

- 1. The management** of the JP is found to be generally appropriate and conducive to a responsible implementation of the JP actions in the country according to the agreed AWP and making use of the accumulated knowledge gained by the focal points and management.
- 2. The funds at the disposal of the JP** could be considered adequate in the framework of a catalytic approach, but are far from being sufficient when compared with the expectations and magnitude of the needs in relation to FGM eradication in Ethiopia.
- 3. Annual funding cycles and quarterly report systems entail significant administrative burdens and strategic limitations** both for JP managers and for Implementing Partners (IPs). Even if both JP and IPs try to adapt to the situation, the distribution of funds on an annual basis creates a tendency to support short-term activities and makes longer term planning difficult, something that is detrimental in a field such as FGM, especially in long-term approaches related to influencing social norms. In addition, the actions become sensitive to delays in approval of annual plans, which may force partners to borrow from other sources of funding to maintain continuity, something that is not always possible⁸¹.

NB. Finding 3 needs a bigger sample of interviews with IPs to be nuanced and confirmed as significant.

Assumption 6.2

Management arrangements and coordination between UNFPA, UNICEF, national authorities and programme partners are optimal to create strong synergies, address gaps and harness the relative strengths of all implementing agencies.

- 1. The consensus among high-level management** of UNICEF and UNFPA on a common goal with the JP mitigates to a large extent the natural differences in internal processes, such as partnership modalities, processes and preferences, or corporate tools and approaches. The management structure based on assigned focal points both by UNFPA and UNICEF has been crucial to institutionalize and maintain the engagement of both agencies. In addition, the good understanding at high level is reinforced by a very good professional relation and personal chemistry between said focal points, an element that cannot be underestimated for an efficient management on a day-to/day basis.
- 2. UNICEF and UNFPA capitalized on synergies and on their relative strengths.** The JP paid attention to use its human and material resources in a cost-efficient and strategic manner. For example, both agencies benefited on their combined territorial presence, which allows a deeper intervention and closer follow up than two isolated programs. The annual meetings for annual review and workplan discussions establish an important common basis of work that is followed up by ad hoc interagency meetings, for example to

⁸¹ Interviews with Implementing Partners in Ethiopia.

discuss common monitoring arrangements that can take the form of joint monitoring, or coordinated split monitoring, being both more beneficial than independent monitoring patterns. The good progress on joint work is also positively perceived by the majority of stakeholders interviewed, which either value the initiative of joint work as necessary for the country, or just do not distinguish who is doing what between UNICEF and UNFPA, an indicator of consolidated common work⁸².

Evaluation question 7

To what extent has the governance structure of the Joint Programme facilitated an efficient and/or effective programme implementation, including the coordination and labour division between UNFPA and UNICEF? **Criteria: Coordination**

Assumption 7.2

Management arrangements and coordination between UNFPA, UNICEF, national authorities and programme partners have facilitated both agencies to leverage their relative strengths and capacities for more effective programme implementation.

1. Strong coordination of JP on FGMC at national level

Based on their comparative advantage and relative strength, UNICEF and UNFPA roles and responsibilities along with potential areas of overlap were identified right from the design of the program intervention. While sexual and reproductive health (SRH) and adolescent and youth engagement is central to UNFPA work, UNICEF is better positioned to dealing with social norms and mobilization, religious leaders engagement and law enforcement, as indicated by the evaluation interviews. *"The roles are divided on the basis of our organization experience, mandate and comparative advantage,"* noted a key informant. The clarity on the roles and responsibilities of each partner on the basis of their relative strength has contributed to building on complementarity and brings together the added value of each partner in addressing FGMC in the targeted areas.

Cognizant to the above clear roles and complementarities, a strong level of coordination and interaction has been observed by the technical focal points of JP in management and implementation of the program. *The complexities of the program intervention areas demanded close interaction of the two Agencies on a regular basis.*⁸³ Coordination also takes place at various levels, notably, at planning, monitoring and reporting. Joint planning has been one of the key strategies used by the JP to avoid overlaps and create synergies, among the various program interventions. *"We coordinate not to overlap"* and areas of overlaps are identified and addressed during planning, as indicated in the interviews.⁸⁴

Planning is done on a yearly basis, through a bottom up approach and engagement of field offices and IPs, sub-national government and NGO partners. The product of this joint effort is annual joint work plan with clear delineation of roles and timeframes.

Apart from planning, there is also a certain degree of coordination in monitoring the program implementation. Coordinated approach in the form of joint monitoring is key to ensuring if the program implementation is on track, identify the challenges, and take corrective measures, whenever needed. A

⁸² Interviews with implementing partners and with government partners.

⁸³ UNFPA

⁸⁴ Ibid.

good example to site is the measure taken⁸⁵ on a former IP after identifying a lag on the major component of the program implementation, community conversation. *“Had it not been for joint monitoring, we wouldn’t have identified the problem which could have brought a bigger damage,”* noted a key informant. While joint monitoring is ideally carried out quarterly, by field focal points of the two agencies, it has not been consistently carried out owing to competing priorities of the Agencies. At least two joint review/monitoring missions should also be done by the technical focal points of the country offices, in accordance to the plan. Given its significance for effective program implementation, joint monitoring should be periodically conducted both by the technical and field focal points of JP.

In regard to reporting, as a lead Agency, UNFPA coordinates the result framework reporting of the JP on the basis of the input provided by UNICEF. A vetting process is also done by the senior management team both agencies as well as headquarters.

Among the potential contributing factors for effective coordination and program implementation is a review meeting that convenes both Agencies and all implementing partners and stakeholders together. The review meeting that took place in Afar, mostly during phase I of the program implementation period and recently in 2017 was a key platform for the program assessment, reflection and learning for effective program implementation and delivery. This platform was also instrumental to share the results of implementations, draw lessons and create inter IP coordination and overall synergies of the program.⁸⁶ As a lead coordinating body, BOWCA is primarily responsible to call for review meetings with the support of UNICEF and UNFPA, though it has not been materialized as planned. The lack of prioritization of the review meeting compounded with BOWCA’s limited capacity is among the reasons cited for slow progress in conducting and capitalizing the program review platform.⁸⁷

2. Management arrangement and partnership between UNFPA and UNICEF has been formalized through a signing of a MoU for more effective program implementation

The joint program has witnessed good leadership and oversight by the senior managements and technical focal points of both Agencies. This was also evident by the various achievements obtained by the program, which in part correspond to the leadership and oversight of the program. *“We wouldn’t have seen this level of progress had it not been for the political will, leadership and support provided to the program,”*⁸⁸ noted a senior management team of the program.

The leadership and management arrangement for implementation of Joint Programs⁸⁹ was also demonstrated by the signing of a Memorandum of Understanding (MoU) between the two Agencies. The MoU, which was signed in January 2016, intends to enhance coordination and collaborative actions between the UNICEF and UNFPA. At the heart of the coordination is the recognition of the respective mandates and responsibilities of each organization and the understanding that each agency shall act within its mandate and the available funding.⁹⁰

The signing of the MoU was materialized at the end of a review workshop organized to assess the level of partnership of the two agencies, strength and weakness, inter alia. While the MoU calls for thematic review and coordination meeting to be conducted by the two Agency, every two month, it has not however been

⁸⁵ A removal from an IP list, having been given a one-year grace period.

⁸⁶ Interview with Agencies and review meeting note 2017

⁸⁷ See log book Interview with UNICEF and UNFPA

⁸⁸ Participant in debriefing workshop

⁸⁹ This is not solely for FGMC

⁹⁰ Memorandum of understanding (MoU) for enhanced collaboration in Ethiopia between UNFPA and UNICEF

strictly adhered. It also calls, among many others, for a conduct of a review meeting, with all IPs, at least once a year.

Whereas the informal regular interaction and coordination channels have been working thus far, putting a formalized and institutionalized coordination mechanisms in place, as called for by the MoU, would enhance coordination of the program at all levels and accelerate efficient program implementation. Therefore, while the signing of the MOU is a positive way forward in identifications of roles based on comparative advantage of both agencies, and avoidance of overlap, a concerted effort should be made by both Agencies for adherence.

3) The degree of coordination of the JP at sub-national level is generally low but stronger in Afar than SNNPR Region

In terms of the program coordination at sub-national level, while the degree of coordination is low in general, a better coordination was observed in Afar than in SNNPR. This is mainly attributed to the fact that the program has long been implemented in Afar, since 2008 than in SNNPR 2013. The program intervention Woredas of the two Agencies are also similar in Afar, which necessitated regular interaction between the JP field focal points.⁹¹

The JP intervention Woredas of UNCIEF and UNFPA, on the other hand, are different in SNNPR so are the IPs. While UNCIEF works with a government partner, Bureaus of Justice (BOJ), UNFPA IPs are NGOs (KMG, NCA). The joint effort comes at BOWCA level, where both agencies provide support, in areas of joint planning, reporting, coordination and organization of review meetings.

The evaluation findings indicate that there is limited platform that brings JP implementing partners together in SNNPR, for exchange of experience and coordination, among others. Apart from the inception meeting conducted with the program partners at the launch of the intervention, there has not been any coordination or review meeting carried out.⁹² The gap in coordination has also been witnessed in poor coordination and collaboration between the various implementing partners,⁹³ a missed opportunity for cross referral of FGMC cases, draw lessons and experience sharing, among others. *“Had there been strong coordination, we would have accelerated change,”* lamented a respondent. Among the suggested way forward is for UNICEF and UNFPA to provide technical support to BoWCA in both regions, along with allocation of sufficient resources, for coordination.

4. Strong coordination between the JP and national authority and coordination body has enabled both agencies to leverage their comparative advantage and strengths

In 2014 the JP made partnership with Ministry of Women and Children Affairs (MOWCA), a national coordinating body for the women’s machinery in the country, with a view to increasing its sphere of influence at national level. Some of the areas of interventions at MOWCA level include supporting the coordination mechanism, monitoring and data, and supporting international activities.⁹⁴

Both UNCIEF and UNFPA are not only members of the National Alliance⁹⁵ to end Child Marriage and FGMC but also part of the steering committee. UNFPA has also served as a co-lead of the Alliance prior to rotating it to DFID, the current co-chair with MOWCA. Relevant sectoral ministries, UN Agencies, NGOs and bi-

⁹¹ Interview with UNICEF and UNFPA

⁹² UNFPA staff member

⁹³ Interview with Agencies and Review meeting report (2017)

⁹⁴ AWP and interview with

⁹⁵ The National Alliance is a national coordination mechanism for ending Child Marriage and FGMC

lateral organizations are members of the national alliance that was established in 2013 to end child marriage and FGMC.

The JP has both finically and technically supported the Alliance and has contributed to influencing the strategic positioning of FGMC at a national level. The JP has supported the Alliance in its preparation to the Girl's Summit in 2014, including in development of its country position, where Ethiopia made a commitment to end FGMC and CM by 2025. The Agencies used the opportunity to popularize the JP both during the London and post-London summit organized at a national level, through development of the program brochure and presentation.

A key national level partner expressed hope that given the JP support of the unifying platform of the National Alliance, the JP itself would begin to “reflect the same jointness and foster an evolution from work with one agency to planning jointly with the IP and relevant agencies. The structure of the program operations (UNFPA hosted, funding through one or the other agency for particular projects, different systems) does not support this, but perhaps it could be addressed upfront with new IPs including how IPs themselves can foster jointness in their approach” (Office of Attorney General, 5-2-18)

The JP played a key role in development of the coasted road map to end FGMC and CM in 2025 as well as provided technical support to the development of verification tool for monitoring FGMC in the regions. The coordination platform provided the opportunity for both Agencies to leverage their comparative advantage. This has been evident by successful advocacy and support provided by the JP, through the national Alliance, to include FGMC module in EDHS 2016. UNICEF has also undertaken further EDHS analysis on FGMC and Child Marriage.

Illustrative Key Testimonies

“Men don't know what FGM entails, so when they saw the video, everyone was emotional. I remember once we had a regional conference, 600 people attended the meeting: 29 Woredas—government (and community leaders), representative of the circumcisers. The regional government was chairing the meeting. We ...show them a video on FGM- we showed them a Harari case and they said no, it doesn't represent us. We then showed them the Afar one, they couldn't continue watching it. The president stopped us and told the religious leaders to tell them what the religious obligations are in Quran re FGM. ...The religious leaders met for two days and they came up with an agreement/decision... and on the basis of this argument, a decision was made to come with an anti-FGM legislation.

That was the first declaration signed by the regional government, 2009. We then set up an anti-HTP committees (BOWCA, BoH, Muslim supreme council, elders). The first activity was preparation of the anti FGM legislation. (After 2 years of advocacy) The regional council approves the anti-FGM legislation and it becomes the first legislation. Afar is the only region with anti FGM legislation. It demonstrates the commitment of the government. It's (now) in the penal code at federal level.” 1.2

[RE] Head of Bureau of Women and Children Affairs in Afar Region, female. “Even I could not say menstruation at the doctor before, I had to say headache or stomach ache. Now we can talk about deinfibulation!”

[RE] Three Traditional Birth Attendants and ex-circumcisers in their 60s, Afar Region, females “We had a problem because most daughters in the village were dying due to delivery and bleeding, and we did not know this was related to FGM. When the white peoples (adae maras) came to teach us the consequences of FGM, we were shocked, and we decided to stop. See, we are not at the age of lying, it was like this.”

The Criminal Code 2005

The Criminal Code was passed in 2005. Article 568 and 569 contain provisions on ‘circumcision’ (meaning, in this context, Types I and II FGM) and Type III infibulation respectively. In Article 568, the penalty for Type I or II FGM is from 3 months to 3 years’ imprisonment and a fine of no less than Birr 500 – 10,000 (approximately US\$ 27 – 528) or both imprisonment and fine. Article 569 focuses on Type III infibulation and provides that, ‘Anyone if engaged in stitching the genital part of a woman shall be punished by rigorous prison term of 3 to 5 years. If the practice causes physical or health injury notwithstanding the severe punishment provided in the Penal Code, the penalty will be rigorous prison term of 5 to 10 years.’ (UN/IAC, 2009) (Country Profile, FGM in Ethiopia, 28 Is Too Many, 2013 p. 58)

Considerations for the overarching global thematic level

Consideration 1. Joint Programme management

The management of the JP is found to be generally appropriate and conducive to a responsible implementation of the JP actions in the country according to the agreed AWP and making use of the accumulated knowledge gained by the focal points and management. Management arrangement and partnership between UNFPA and UNICEF has been formalized through a signing of a MoU for more effective program implementation. Strong coordination between the JP and national authority and coordination body has enabled both agencies to leverage their comparative advantage and strengths

Consideration 2. Funding

The funds at the disposal of the JP could be considered adequate in the framework of a catalytic approach, but are far from being sufficient when compared with the expectations and magnitude of the needs in relation to FGM eradication in Ethiopia. Annual funding cycles and quarterly report systems entail significant administrative burdens and strategic limitations both for JP managers and for Implementing Partners (IPs).

Consideration 3. Extreme heterogeneity of the FGM phenomenon and implications: distinguishing general and specific identification processes

The extreme heterogeneity of FGM-C, with a different profile in each community, makes the general understanding of drivers for FGM-C abandonment insufficient: it could be said that the JP knows the *ingredients of the medicine* or, in other words, the generic toolbox to be potentially used, but not the specific dose that is effective for each *patient* (i.e. community). This characteristic entails a number of considerations:

Some aspects of intervention at national level can remain generic, like need of improved DHS, need of curricula in medical schools including FGM/essential sexual health education, curricula in schools, etc. **However, the effective landing of all these strategies at community level needs to be specific for each community** and requires **specific in-depth identification processes** including essential aspects such as: decision maker within the family, mapping of persons perceived as influential in each specific community (will differ), critical mass status in the community (hidden or public practice, percentage in each camp, understanding of paradigm change in social norms), drivers in community, leadership profile.

Consideration 4. Extreme heterogeneity of the FGM phenomenon and implications: understanding change of paradigm after public declarations

In particular, there is insufficient understanding of the change of paradigm in the social norm caused by public declarations (changing public manifestations towards the practice and also bringing the practice

underground), which would also entail a different type of intervention from the first stages that focus on trust building and awareness. Research and/or thematic evaluation on this specific issue is necessary,

Consideration 5. Extreme heterogeneity of the FGM phenomenon and implications: results-oriented follow up vs. activity based

Results-oriented follow up based on indicators of effective change vs. activity-based follow up to understand what works, what does not work and why. It is also worth mentioning that the focus on social norms, their specific functioning and related indicators is highly technical and relatively new for UN agencies, especially when comparing it with more developed and better tested indicators such as those on nutrition or health. Social norms and their technical implications are still insufficiently understood by UN agencies themselves. The contextualization of the global programme to the different country contexts is important to ensure that the programme is relevant and appropriate. A global menu of indicators for the Joint Programme is identified at the outcome and output levels for planning processes and the results framework. Whilst the global alignment of indicators is recognised as important for aggregation across the programme, it is felt that the indicators are too numerous and in cases inappropriate to national contexts. Furthermore, the pressure exerted by the need to respond to global indicators, which may or may not be relevant to the specific country, brings the JP further apart from a focus on understanding the factors for real change in the ground.

Consideration 6. Extreme heterogeneity of the FGM phenomenon and implications: connecting community learning with policy and research

The knowledge acquired through interventions at community level needs to be connected to policy level and to research institutions in an effective and timely manner. The convening role of the JP can be particularly beneficial in this dimension, linking knowledge in the field with the needed understanding at programmatic or policy levels. In this context, the knowledge generated by the JP at grassroots levels needs to be strategically collected and systematized so as to be actionable at higher levels of intervention and programming.

Consideration 7. Cross border and migration movements

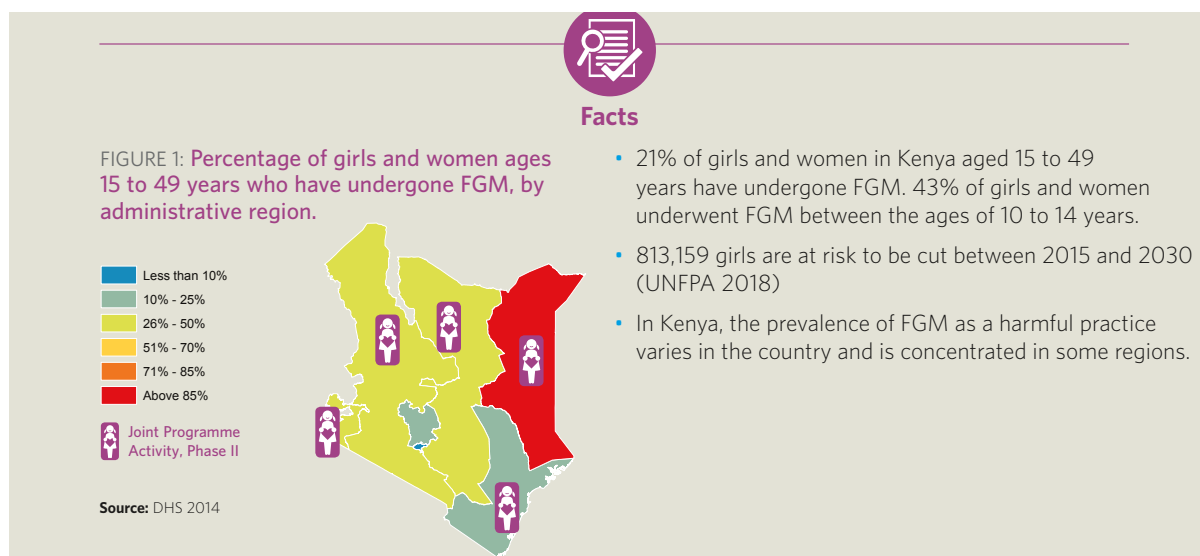
The Joint Programme does not have a clear strategy on how to address the issue of cross border influence and cross border enforcement and, in addition, has not sufficiently addressed the problem of crossing “internal” borders, such as the influence of a refugee camp full of Somali’s who practice infibulation or even of IDPs. As a result. cross-border dynamics and IDPs/ refugees specificities remain unaddressed.

Consideration 8. Sustainability and scale

The Joint Programme **has contributed significantly**, within its limited resources, to supporting national ownership, something that is reflected in enforcement of the law, policies, budgets, implementation and coordination. A widely recognized contribution of the JP has been its role in allowing the Ethiopian Government to reach beyond regional level, into the more concrete sub-level of kebele. The Joint Programme has contributed to developing the capacity of implementing personnel in several sectors— justice, health and education—primarily in Afar region. Apart from investment on enforcement of the law—which expanded annually to include a wider circle of actors--the contributions have been discrete investments at small-scale. Scale up thorough clear advocacy paths so as to have a more central convening and catalytic role remain challenges to be addressed.

Kenya

Figure 2: Extract from Joint Programme Phase II Performance Analysis, country overview (UNFPA-UNICEF, 2018)⁹⁶



Context

Interventions

- Advocating the endorsement and approval of Eradication of FGM Policy in Kenya by the Cabinet in Kenya.
- Advocating the approval and endorsement of national guidelines for FGM in Kenya including the alternative rites of passage for girls and community dialogue.
- Strengthening coordination including multi-disciplinary interventions including education, psychosocial support, health, legal and safety and security sectors.
- National and county engagement with elected leaders for policy improvement, part of movement and leveraging resources.
- Working with Area of Advisory Council for Children Services to support in identification and referral of vulnerable cases.
- Community led dialogue forums with men, women, youth, council of elders, religious leaders, political leaders, reformed circumcisers, girls and boys.
- Alternative rite of passage for girls.
- Capacity build key stakeholders on child protection and gender issues. This also include in and out of school girls and boys with in schools and at community level.
- Specific engagement with a focus to boys and men networks to accept and protect uncut girls.
- Partnership with traditional council of elders and religious leaders (use of positive cultural approaches to accelerate abandonment of FGM for those who perpetuate it).

⁹⁶ DHS 2014 remains the most recent available data for Kenya at the time of publication. See: https://dhsprogram.com/Where-We-Work/Country-Main.cfm?ctry_id=20&c=Kenya&r=1. Clarification of text: 21% of girls and women in Kenya aged 15 to 49 years have undergone FGM. 43% of the girls who underwent FGM did so between the ages of 10-14 years

- Media engagement: Communication for development including key messaging around FGM and public education through radio including talk shows and forums.
- Partnerships with traditional dance groups to pass anti FGM message at the markets, weddings, public gatherings, funerals etc. as part of abandonment process.
- Raising the visibility (text and videography as part of human-interest stories) and using the anti-FGM role models and champions during community dialogues or other public forums

Expenditure

Total Fund Available for Programme Implementation in 2016	\$1,937,438
Provisional Expenditure as captured in the financial system, as of 13 January 2017	\$1,632,922
Commitment as captured in the financial system, as of 13 January 2017	\$219,944
Total provisional expenditure and commitment as captured in the financial system, as of 13 January 2017	\$1,852,866
Fund Utilization Rate, as of 13 January 2017	96%

Implementing partners delivering

Kenya Women Parliamentary Association (KEWOPA), Kenya National Assembly, Kenya Women Judges Association (KWJA), Federation of Women Lawyers Kenya (FIDA), National Gender Commission, Ministry of Gender, Children and Social Development, MOSOCHO, Coalition of Violence Against Women (COVAW), Catholic Diocese of Nakuru (CGN), Kenya National Assembly, Kenya Women Judges Association (KWJA), Federation of Women Lawyers Kenya (FIDA), Ministry of Gender, Children and Social Development, Kenya Women Judges Association, Ministry of Public Health and Sanitation (MOPHS), Ministry of Medical Services (MOMS), Anti-FGM Board, State Department of Gender Affairs, Africa Coordinating Centre for the Abandonment of FGM (ACCAF). Ministry of Health, KCIU, NCA, Women Empowerment Link (WEL), Ministry of Gender, Children and Social Development, Ministry of Youth and Sports (MOYA), Young Women Christian Association (YWCA). Maemdeleo Ya Wanawake Organization (MYWO), APHIA Plus, World Vision Kenya, State Department of Gender Affairs, Office of the Director of Public Prosecution (ODPP), SDGA, AFGMB, ODPP, Ministry of Gender, Children and Social Development, Womankind Kenya (WOKIKE), Maemdeleo Ya Wanawake Organization (MYWO), World Vision Kenya, Pastoralist Child Foundation (PCF), ADRA Kenya. Catholic Diocese of Nakuru (CDN), Tasaru Nonok, World Vision, ADRA -Kenya, Pastoralists Child Foundation MOGCSD, ADRA, KEMEP, CIPK, CDN MYWO, CDN, Pokot Outreach Ministries; Anti-FGM Board, ADRA Kenya, KCIU, MYWO, WVI, FIDA Kenya Womankind WEL, WEL, MOGCSD, MOYAS, MYO, RWRF, APHIA PLUS, YCA, NCA, ICC, Gender Directorate, Gender Commission, MOMS, MCRH, ROAD Research institute, MD, ACCAF, NGEC, KIE, MOE Min of Health, Min of Gender, NGEC, UNHCR, UNFPA, National Police AMWIK, BBC, Star FM CDN, CIPK, MYWO, Pop Council, CCM, MOYS NCA CDN, CIPK, Catholic Secretariat, SUPKEM, Christian/Muslim network SDGA with AFGMB and other partners, CLAN

Evaluation question 1

To what extent is the programme (approach, design, strategies) relevant, responsive, and evidence based to contribute towards accelerating efforts to abandon FGM globally, nationally, and sub-nationally (including in cross-border regions)? **Criteria: *Relevance***

Assumption 1.1

The Joint Programme design (including approach, strategies and interventions) is aligned with global, national and sub-national priorities and is flexible enough to be responsive to different local contexts and to changing realities and priorities.

The JP reflects the principles of the major global and regional agreements and conventions on FGM, VAW/G and VAC, human rights, women’s rights, and children’s rights⁹⁷ as well as the commitments outlined in the 2014 Girl Summit Charter on Ending FGM and Child, Early and Forced Marriage. Kenya is signatory to all of these documents. The multi-sectoral approach and multi-stakeholder strategies of the JP reflect the holistic and development focus of the foundational agreements under CEDAW, the CSW and ICPD. This perspective has been enabled at a national level by positioning FGM within and building on the ministerial and agency alliances supporting the joint programming on ending GBV.

The multiple strategies supported by the JP in Kenya program are aligned with the key articles of the Maputo Protocol (to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa). This includes, among others, Article 4 (life, integrity and security of the person) and particularly article 5 (elimination of harmful practices) which addresses public education and awareness; support to victims, protection for those at risk and the “...prohibition, through legislative measures backed by sanctions, of all forms of female genital mutilation, scarification, medicalisation and para-medicalisation of female genital mutilation and all other practices in order to eradicate them”.

The Joint Program supported efforts to advance and now implement the current Kenyan law. The East African Community (Kenya, Tanzania, South Sudan, Uganda, Rwanda, Burundi) Act on FGM was informed by the Kenya 2011 law, and includes many of the same provisions as well as requiring other states to adopt similar laws and indicating that the act “shall take precedence over other Partner State laws to which its provisions relate” (of relevance for Tanzania who has no law and shares a border with Kenya).

For some allies, the inclusion of FGM within the GBV agenda was beneficial particularly in light of both the substantive linkages among FGM, EFCM, GBV and teen pregnancy, as well as the anticipated reorganization of the GOK’s “new national agenda” around 4 “core” issues one of which may serve as a link for GBV work (thereby putting FGM on the agenda). Similarly, the JP supported schools to participate in the Kenya National Music Festival to raise awareness about broader violence against children directly reaching about 1.5 million children and youth, and approximately nine million indirectly. The topic “No violence against children is justified – all violence against children can be prevented” was selected as one of the festival’s themes. A strong emphasis was placed on FGM.

For others, the need for a dedicated focus on FGM—at policy, at data monitoring, at implementation level—illustrated concern about losing sight of FGM among the more generic understanding or “GBV”⁹⁸ as

⁹⁷ The 1979 Convention on the Elimination of Discrimination Against Women (CEDAW); Convention on the Rights of the Child (CRC) 1989; International Covenant

on Economic, Social and Cultural Rights (ICESR); African Charter on the Rights and Welfare of the Child; Maputo Protocol to the African Charter on Human and Peoples’ Rights on the Rights of the Women in Africa; African Charter on Human and People’s Rights (the ‘Banjul Charter’);

⁹⁸ As an example, although the current Gender Policy for the educational sector includes FGM in its “List of Abbreviations and Acronyms”, the document itself addresses GBV and does not specifically reference FGM or harmful practices. It does focus on creating a safe environment and does specifically reference girls returning to school from rescue shelters for GBV, post pregnancy, and post delivery. In light of the very significant impact of FGM on schooling of girls and the enormous importance of education as the primary “alternative pathway” for girls refusing the cut, a specific reference may be merited. Ministry of Education, Science and Technology (MoEST)

well as competition from “emerging” issues such as child marriage. This is part of the interest in assuring that at subnational level, there are dedicated budget lines to support the uniquely complex work on FGM. This is also relevant to the challenges faced in national level tracking with administrative data (see below).

At operational level, this multi-sectoral approach is sustained through the Anti-FGM Board which also intends to create linked coordination entities at county level—a much needed addition in the still evolving and somewhat disjointed implementation universe emerging from the devolution process. The board will be officially in place when the bill passes end of year. In addition, the majority of the JP NGO implementing partners have portfolios reaching beyond FGM to broader development goals and well-established relationships with the local communities including through provision of direct services—e.g. World Vision (Narok), ADRA (Migori), Womenkind (Garissa). The value of this holistic approach was made clear with dismissive references by both implementing partners and beneficiaries to “briefcase NGOs” who appeared in communities a few times a year (primarily with an advocacy focus) and were “hard to find” when needed.

The periodic national level monitoring of population-based data on FGM through the DHS informs the targets and indicators of SDG 5.3 within the Global 2030 agenda. A new initiative reflects multiple calls for a linked national level tracking mechanism to monitor both prevalence and response

The work of the JP is aligned with the child protection and growing gender emphasis of UNICEF as well as with the gender and growing services focus of UNFPA. The more recent support for a mix of programming focused on girls reflects this effort to hold both truths i.e. support for rescue centres for girls at risk, a call for integrating content on FGM into the national primary level curriculum informed by a statistically rigorous sampling of populations in selected sub-counties of the major regions in which the Joint Programme is operating⁹⁹. The next generation of this work could include support for the Ministry of Education to mainstream a gender perspective into all programming including schools as safe spaces, support for life skills and girls’ empowerment programming including solidarity building through use of social media, and nascent efforts to address the issue of FGM within the national MOH Adolescent and Youth Policy¹⁰⁰.

The Kenyan programme has hosted multiple learning visits from other country programs to learn from supported diverse work on ARP, addressing cross border issues, and with the religious communities. It has hosted the JP Steering Committee more than once. It was described by a key regional stakeholder as “one of the best examples” of joint and complementary agency planning and programming. “lenses”: visibility of “protection” reflects UNICEF comparative strengths in the field-focused post-policy phase and girl programming.

Kenyan law, policy, advocacy and, increasingly, practice have been supported and now reflect within the JP support on FGM.

The JP was integrally involved with the development of and continues to support the FGM Prohibition Act (2011); the national policy on FGM (2012-revision awaiting cabinet approval); and the formulation and staffing of the Anti-FGM Board (2013). The JP has helped convene stakeholders to support the First Lady’s Beyond Zero campaign; and provided fora for the President’s own advocacy efforts. Although the official

Education and Training Sector Gender Policy, 2015 (Second Edition), Addis Ababa.

⁹⁹ Balambala sub-county in Garissa County; Habaswein sub-county in Wajir County; Sook division in West Pokot sub-county in West Pokot County; Wamba division in Samburu East in Samburu County; Laisamis sub-county in Marsabit County; and Kajiado Central sub-county in Kajiado County.

¹⁰⁰ Interview with key government stakeholders and UNICEF staff.

policy which supports and guides the Anti-FGM board is still awaiting cabinet approval, the government has already funded a modest budget line, doubling their contributions last year.

FGM is formally addressed in the Kenyan 2030 Vision. The current UNDAF includes dedicated indicators (prevalence and prosecution) and targets (prevalence) on FGM: the UNDAF positions FGM within the broader frameworks of addressing GBV and VAC, linking it as well with child marriage as a harmful practice. The JP emphasis on both reduction in prevalence of FGM and pursuit and prosecution of cases of FGM reflects and goes beyond the targets and indicator set forth in the UNDAF.

At County level, FGM policy is beginning to be integrated into county level plans such as the Garissa County Integrated Development Plan (CIDP) 2018-2020; multi-sectoral structures (active participation of the implementing partner in Garissa in the Area Advisory Councils at the County and sub-County Levels; in Narok, participation in the Gender Technical Working Group (GTWG) a new entity, which intentionally links county level government agencies with the local CSO network (NASCNET), to facilitate better coordination among county level actors working in not just FGM, but broader areas of gender related work, e.g. GBV, CP; and thematic coordinating mechanisms (in Migori the working groups on child protection and on gender). To date, two counties have established budget lines for the work on FGM.

The JP consults annually with leadership of implementing partners to review progress and outline overall strategies to inform planning for the coming year—these provide a platform for sharing important contextual factors as each of the implementing agencies is firmly grounded in local context.

In an effort to foster greater ownership, the JP has tried to encourage government implementing partners to take on that role of coordination and consultation but has found that difficult. It is expected that the Anti-FGM board, once its mandate is formally approved by the Cabinet, will greatly facilitate such consultations at the national and county levels, as it is currently operating with the excellent but limited human resources of staff funded by UNFPA.

At the sub-national level, the JP planning is significantly informed by its partners to contextualize strategies and interventions although their work is not always based on a formal assessment process and does not reflect the constructs of the global framework of the JP. Womankind in Garissa is a grassroots organization well-grounded in the communities in which it operates. The major INGOs supporting work in other regions have country offices and a strong local presence—powerfully demonstrated by the degree of “name recognition” accorded the ADRA regional coordinator in every office visited in Migori region¹⁰¹.

These empirical assessments have been complemented by in-depth cross-sectional surveys of practice, drivers, and attitudes in key counties and ethnic communities (some overlapping). These in-depth assessments have informed overall strategies and also informed a best practice example of inter-agency coordination in Samburu region with both agencies and the implementing partner planning jointly guided by the research results and resulting in adaptations of key strategies based on the insights from the research (e.g. need to work with grandmothers, not mothers; religious leaders, not elders).

At the county level, the individual IPs are also often the source for a mapping of key actors. Because the IPs are involved in multiple sector initiatives, they have a good sense of the major players. Of note, as an additional step key to effective advocacy, UNICEF support for ADRA in Migori to undertake “power mapping” at field level to prepare for a campaign to stop FGM during the 2016 cutting season. The need for such an

¹⁰¹ There has been some criticism of the degree to which the IPs are able to mirror the community sufficiently to inform interventions. “The partnerships of the JP are not with CBOs, the groups with whom they are working are not grassroots nor are they not resourced”. Of note, this critique comes from a group which does not work through local structures and relies on more of a social media strategy.

investment was highlighted by many implementing partners at county level who expressed frustration with “briefcase NGOs” which appear only at key campaign moments and are focused on discrete advocacy efforts and not sustained services.

Efforts to coordinate at national level have encountered limits of capacity as well as some lack of clarity regarding which government entity is responsible for implementation i.e. the Ministries of Women’s Affairs, of Health, of Youth, the Anti-FGM Board which remains in administrative limbo until approved by the Cabinet even as it continues with significant and excellent work, etc. The Anti-FGM board had benefitted from the seconding of several government staff, inter-sectoral competition which has not facilitated this solution. Multiple stakeholders reported that the government’s Joint Sector Working group meeting in May of 2018 was the first in many years. The JP has found it difficult to foster coordination when government is not playing its own convening role.

In the process of programme design, the JP has supported critical inputs from experts who are also implementors. ACCAF’s efforts to design and integrate content on FGM into the medical school curriculum received 2017 UNFPA support to conduct a survey and stakeholder consultations on how best to integrate the content and a follow up pre- and post-test of the piloting of the material

At the county level, consultations are currently complicated by the relatively recent development of new administrative structures notably the devolution of some but not all of the key government ministries and responsibilities and the associated arrival of new staff. In Migori county where a limited number of externally financed actors are engaged in this work, the gaps in public sector coordination are bridged in part by the longstanding presence, regular visits, relationships and accessibility of the leadership of the primary implementing NGO—a mutual trust and forbearance were still evident. In Narok county, where more numerous resourced actors are engaged on this issue—including the “briefcase” (non-operational) NGOs noted above—government IPs raised concern about “information sharing” and periodic reports; the lack of consultation with the CC for inputs; and the need for the CC to “...know what the (international IP) and the JP are doing” and to be able to “direct funds/resources to (the) correct areas”.

One of the most influential communities with which the Joint Programme has consulted regularly is the universe of Islamic leadership and scholars—both within Kenya and through regional efforts to bring scholars together. This has been critically important for gaining access and disseminating messages in particular communities, such as those in the northeast. The Joint Programme in Kenya has not been as effective in engaging the non-Islamic communities perhaps because those communities are more fragmented in Kenya than in the neighboring countries of Ethiopia and Uganda. Among the Christian denominations, the SDA, Presbyterian, Catholic and others took different positions and often “no position” on ending the practice. Even today, those who practice within the SDA communities are denied the right to do certain things within the church, but not excommunicated for cutting.

Unfortunately, this understandable imbalance may reinforce tensions between religious and/or ethnic groups—such tensions fanning the kinds of conflicts which have undermined recent political progress in Kenya. This focus on religious and/or ethnic groups may also obscure the root causes of FGM which are common across many groups, require different types of interventions from those being pursued, and may result in more sustained change. This risk is not unique to the Kenya programme, however the degree to which ethnicity and religion guide the overall strategies in Kenya is “different” i.e. until very recently community declarations of intent to abandon were measured based on the “community” of an entire ethnic group. As a result, the process of community dialogue could not possibly have included even a significant percentage of the 2.5 million members of an ethnic group; the leadership which represented the community decision did not consult and would be unable to monitor and hold accountable the entire group even using group accountability mechanisms; and the diversity of a community-including examples

of positive deviance—would be lost in the generalization regarding a particular group. A key document defining this perspective was produced just prior to the start of the Joint Programme in Kenya by the Kenya office of the Population Council Frontiers Project supported by USAID. The paper, focusing on Garissa region, argued that it was critical to “delink” Islam and FGM¹⁰². This was important to demonstrate that it was not a religious requirement but also to magnify the impact of appeals from religious leaders to their adherents to stop the practice.

SUPKIM, one of the leading Islamic organization in Kenya, supported delinking religion and FGM to “demonstrate that the reasons for practicing FGM are...mostly cultural. One of them being to curb the sexual desires and chastity of the girls... but Islam focuses on the family upbringing and teachings of religious obligations to promote chastity and not such acts as FGM. The reasons given for FGM are all traditional practices and in many Muslim nations FGM is not practiced.” Characterizing FGM as a cultural practice and not a religious practice is a key first step to focusing attention on the root cause of gender-based discrimination and patriarchy—a “vice” shared across groups. Kenya provides an excellent example to make this argument, in that high prevalence areas include those dominated by various religious traditions.

As a key reformed circumcisor in Garissa explained, “They have known that which “firooni” (infibulation) was wrong but the sunnah cut was requirement, but “having listened to religious leaders we are now aware the practice of cutting girls is not a religious requirement but was a traditional practice”. That is the reason they stopped cutting girls and they are currently educating those who still believe that it is a religious duty.

ADRA provided some examples of involving the beneficiaries themselves in program planning and to inform the development of a proposal.

Based on discussions with beneficiaries themselves regarding the key components of the program which needed to be strengthened, in a 2016 dialogue at community level, “The men and women proposed action areas including; need for increased grass root interventions including address to root causes, enforcement of the law to be enhanced, supporting girls from poor families to continue with education and formation of community support groups for parents who have not cut their daughters. There is also need to enhance counselling to individuals affected.” Accordingly, ADRA itself sought support for this work and launch multiple innovative initiatives over the course of the next year.

Similarly, ADRA trained 63 community-based monitors in the two counties including role models, opinion leaders and change agents. These individuals are in charge of “identifying & supporting the girls at risk from abuse, educating the community and organizing their respective villages towards the community declarations against FGM and child marriages”. As part of the review of the work during the previous year, 12 of those monitors were brought together to assess which communities were progressing most rapidly and which needed additional investment to move them forward.

The Joint Programme continues to struggle with the lack of rigorous, microlevel data to document change in prevalence and change in practice—i.e. to assess which interventions or combinations of interventions are most effective and to adapt programming to new patterns of practice. The cost of repeated in-depth surveys is prohibitive and thus the programs fall back on the Kenyan DHS.

Significantly, the KDHS has collected data on FGM consistently since 1998. This data has been used to track important longer-term trends in prevalence at a zonal level: these comparisons have helped to highlight

¹⁰² De-linking Female Genital Mutilation/Cutting from Islam Ibrahim Lethome Asmani and Maryam Sheikh Abdi 2008, Frontiers Program, Washington DC

important positive change in regions such as West Pokot and demonstrate the stubbornly high prevalence levels in Somali communities.

The Joint Programme has not yet been able to use the KDHS data to undertake analysis at the more micro administrative county level. The lack of such analysis significantly impacts programming in multiple ways. Disaggregated and diverse measurements could help “delink” FGM from relatively simplistic associations with ethnic identity and/or religious adherence and help to focus on root causes, including control over women’s sexual activities and reproduction, and shift the emphasis to alternative intervention pathways such as women’s economic empowerment which can be pursued no matter the ethnic group and which avoids fueling inter-ethnic or inter-religious violence. In addition, such data would help to measure change at the administrative level at which the various interventions are delivered making it possible to determine what works.

The challenge of using population-based data to measure micro contexts and change is, again, not unique to the Kenya programme. Indeed, significant progress in testing new analytical methods allowing for more refined insights from DHS data has advanced in Kenya (the Evidence to End FGM programme of the Population Council funded by DFID¹⁰³) in part because data collection has been so reliable. A similar effort is being undertaken through the Population and Development branch of UNFPA in close cooperation with the Joint Programme which addresses, for example, the limitations of the data itself—both quality and lack of data for under 14, and enables even more refined analysis by year of age—a critical measure in light of the gradual shift to cutting at younger ages in response to the laws banning FGM. These developments are very recent, although they reflect a shift in 2015 within UNFPA on strengthening the demography expertise within the agency.

Within the limitations of the available data, the JP programming has been very responsive to changes in both the national and subnational communities of interest. The program has evolved in a logical fashion building on the previous success. It has explored alternative strategies to cope with new challenges such as “hidden practice” including supporting a diverse mix of community level “observers” and reporters to identify girls at risk and actual practice.

In a significant move for the future, it has leveraged the comparative strength of UNICEF in working with younger age groups to engage with girls and boys on changing norms and refusing practice. The challenge of any such strategy is that it is heavily reliant on access through the schools. The reliance on schools is even more important in more marginalized areas where other media and communications tools are less accessible to the program. However, these tend to be both the areas with higher prevalence and with low enrollment rates and high attrition of girls.

Of note, the 2015 UNICEF report on educational enrollment highlighted that “According to 2015 UNICEF report on education and resilience in Kenya’s arid lands, the enrolment levels are low, ranging from net enrolment of 27.2 percent of children of primary age in Wajir to 58.8 percent in Turkana and 65.7 percent in Marsabit. At a secondary level, net enrolment is almost the lowest in Kenya: 8.7 percent of secondary age children in Turkana, 9.3 percent in Wajir and 12.9 percent in Marsabit. Performance in these counties is consistently below the national average. ...religious practices were found to affect parents’ choices in what kind of education to enroll their children in. According to the study, Muslim parents are increasingly

¹⁰³ Ngianga-Bakwin Kandala, Damaris Kinyoki, Ahmed Sarki, David Gathara, Paul Komba, and Bettina Shell-Duncan. “Modeling and Mapping of Girls’ Female Genital Mutilation/Cutting (FGM) in the context of economic, social, and regional disparities: Kenya Demographic and Health Surveys 1998-2014”, May 2017,” Evidence to End FGM: Research to Help Women Thrive. New York: Population Council, http://www.popcouncil.org/uploads/pdfs/2017RH_FGMC-ModelingMappingKenyaDHS.pdf.

choosing to send children to Islamic madrasa instead of secular schools, as they trust these institutions to provide a good education; while traditional pastoralist education, and its urban equivalent where children learn a business or artisanal trade from family, is showing consistency in providing a relevant, but limited, education to the majority of children.”¹⁰⁴

From a more macro perspective, the overall programme approach of the JP in Kenya has followed a well sequenced and strategic mix of interventions building on progress, the Phase I evaluation findings, the data-based and anecdotal evidence on success and changes in practice shared by key partners, and opportunities presented by new stakeholders. At the same time, it has necessarily had to adapt to the significant political and administrative structural changes—particularly at the sub-national level—of the last five years.

The sequence could be seen as a series of stages which align with the early phases of the JP, described below with the last phase being areas where action needs to be taken:

Stage 1: Frame the issue and entry points: National coordinated multi-stakeholder advocacy results in Prohibition Act; community awareness raising provides an entry point for dialogue

Stage 2 Foundation for implementation: law actualized through policy, guidelines, a national coordinating entity to facilitate multi-stakeholder and multi-sectoral response; moving from awareness to action through a focus on strategic stakeholder groups in community in a clear plan;

Stage 3: Testing mechanisms for operationalization: state security and judiciary enforcement of the law, parallel “watchdog” mechanisms (champions, FBOs, councils of elders) building on county structures and leveraging devolution; intensive work with community stakeholders

Stage 4: Corrections, capacity for evidence-based approaches, change in agents and drivers: Adapting to limitations of sub-national structures-expedited identification and prosecution, CHWs to bring to health services; development of administrative data systems to inform implementation of e.g. a child protection agenda; focus on youth, girls, and re-embracing gender and rights

Stage 5: Revisions to relaunch: Clarification, domestication, capacity, protections, and cross-border applications of the law; alternative but non-traditional accountability mechanisms at community level; systems and human capacity to apply data and new learning from research; expansion of “alternatives” not just “protections” for girls in health, education, employment; shifting discourse to gender and rights including with religious leaders.

Assumption 1.2

The Joint Programme approach is based on its comparative advantages, taking into consideration the roles and comparative advantages of other actors working in this field.

The JP explicitly considers the comparative strengths of the two agencies based on geography, influence and access, and technical capacity. The Kenya program was described as exceptional in coordination between the two agencies.

With respect to geography, the broad regions of intervention are chosen based on prevalence. Within the individual counties, each agency covers different counties and intentionally work together when there is

¹⁰⁴ National Council for Population and Development, 2016, SECONDARY DATA ANALYSIS AND LITERATURE REVIEW OF KNOWLEDGE, ATTITUDE, BELIEFS AND PRACTICES (KABP) STUDY OF THE 10 KEY CHILD SURVIVAL, DEVELOPMENT AND PROTECTIVE BEHAVIOURS IN KENYA, Addis Ababa

need for full participation (as in a major campaign) or the synergies of programming. This is to avoid too much overlap in activities and overburdening of IPs. With respect to influence and access, UNFPA is viewed as the lead in policy and legislation and national level coordination and remains in that role with its support to staffing for the Anti-FGM board at national level. UNICEF extensive field presence and relationships with multiple ministries based on the child protection agenda supports the services elements and the effort to engaging in more holistic, multisectoral programming. With respect to technical capacity, UNICEF has enabled expansion of work with schools, youth, and girls in particular whereas UNFPA has deepened the work with the FBOs. These relative strengths are not mutually-exclusive: the head of the Anti-FGM board brings her experience at field level with World Vision and UNICEF and UNICEF original office having been in Garissa, it provides additional networks to address Islamic communities.

The programming is also based on an assessment of the gaps in programming, notably that of government. Filling in a gap in government capacity, the JP (via World Vision) plays a significant role in efforts to rescue girls by acting as a trusted community partner to respond rescue claims, providing transport and other services to girls to access rescue centers, and offering other support once girls are in the rescue homes (education support).

There is concern that the resources available to the IPs are insufficient to fully meet the needs. And that, in addition, it is counter to child protection principles to take children from parents and keep them in isolation. A role model who lived for some time at a rescue center shared: *“At the rescue center, the girls are their own support system – they pray with each other, help each other, share clothes, become a second family. The challenge is lack of parental love – the workers were not kind or didn’t care about the reason why girls leave rescue center or end up reconciling”*. She thought of going back to her family as well. *“Rescue centers are not a lasting or an effective solution”*; rather the focus needs to be on changing the mindset of parents”¹⁰⁵

One proposed solution to this cost is temporary rescue shelters during “cutting season” (to protect girls from being coerced while still keeping girls in the community). This would make it possible to leverage the services and supports already in that community—whether government or other family. Such an effort would require good coordination as the Narok leadership noted that the lack of government support for key services meant that many actors try to fill in services and end up overlapping. There is need not only for coordination among the IPs but for the government itself to help coordinate inputs. In Narok this may be addressed through the mechanism of the Gender Technical Working Group.

The Joint Programme is represented in the larger interagency groups addressing gender and children. In each setting, however, FGM is linked to a broader agenda (child protection; GBV) and therefore there is risk that coordination of FGM specifically may be missing. Within the Gender Technical Working Group and government gender coordination groups, FGM was addressed as a GBV issue. There is limited work with UN Women in part because UN Women is not addressing harmful practices as Kenya is not a Spotlight country. The work with WHO is also strained largely because, despite its central role in building the capacity of the health sector, it is the gender program which addresses FGM and was engaged primarily around law and policy. The emerging issue of medicalization has provided an opportunity to re-engage with WHO and the health sector and there are plans to do so before the end of the year.

Although coordination with other relevant agencies such as UNAIDS or UNESCO are not evident, within each of the agencies, there is significant awareness of the relevance of FGM and need to engage on that issue in other portfolios. This was particularly true for SRH services within UNFPA which viewed FGM as an

¹⁰⁵ Interview with rescued girl role model

opportunity engage on rights issues and for HIV/AIDS work within UNICEF which spoke to the overlap in populations addressed and the challenges in addressing male circumcision as a solution but female “circumcision” as a problem.

To this point, there has been significantly less coordinated planning with other non-UN and non-IPs working on this issue. This may reflect the complexity of the holistic programming undertaken by the JP IPs. However, there is need for an honest comparative assessment of similar methodologies used by different agencies. The complexity of the problem and the diversity of contexts in Kenya create challenges around solutions i.e. “it is not one solution fit all.”¹⁰⁶

Two of the key partner INGOs highlighted as an illustration the approach to use of the Alternative Rites of Passage (ARP). It is important to appreciate that it cannot be used in all communities. The assumptions and underlying principles of the ARP are not appropriate in communities in which FGM is “done to infants”, even if there is a link to marriage more broadly in those communities. This was also a conclusion of the 2016 five county study supported by the Joint Programme.

“FGM practice is mostly justified with cultural reasons such as a rite of passage, a cultural identifier and for marriage purposes. The study however found out new trends that FGM plays no role as a rite of passage since the age at circumcision has reduced over the years and a 10-year-old cannot be transiting to another stage of life i.e. womanhood. The other reason why it cannot be a rite of passage is that since the communities are aware that the practice is outlawed, the practice is carried out to girls individually and in hiding, with no preparations or teachings given to them. Married women are also going for the cut which defeats logic of the FGM practice being a rite of passage¹⁰⁷.”

As the JP is the major supporter, beyond government, of the Anti-FGM board, it has begun a process of documenting “best practices” to inform the board’s work. It is also currently developing guidelines to standardize several of the key methodologies used in this work including community conversations and ARPs. Although the Anti-FGM board will serve as a coordinating mechanism, the development of standards for practice necessitates in-depth partnerships with others with similar experiences with various strategies.

UNICEF and UNFPA have established processes for inclusive joint planning at national level; division of territory and labor based on the comparative geographic (field presence) and technical strengths to avoid duplication; and coordinated joint initiatives for key campaigns at field implementation level

The new challenges arise due to the county system’s own lack of coordination. According to one governmental partner at the county level: “With devolution things have changed – not all actors go through CC office. This makes coordination very difficult. People work in isolation, independently of each other. Other actors addressing FGM include USAID/FBOs/CBOS. The Gender Technical Working Group was created to bring all these actors together. But we are still working on a ToR. The JP (via World Vision – the JP IP) is part of this working group.”

The two agencies have piloted an approach to microlevel joint planning with key implementing partners to achieve cost effectiveness and greater synergy and avoid gaps in support to core program elements. This experiment was informed by in-depth baseline surveys in high prevalence, key intervention counties. Both agencies worked closely with the IP to identify what changes in program and method were suggested by

¹⁰⁶ Interview with key INGO

¹⁰⁷ Christine Sekadde-Kigonde, PhD Jane Wambui, PhD Charles Owuor Olungah, PhD Guyo Waqo Jaldesa, MMED, MSC Josphine Wanjiru Kagucia, MAA” Female Genital Mutilation/Cutting Practice in Five Selected Counties of Kenya: A baseline survey report on FGM in Baringo, Narok, Samburu, West Pokot and Elgeyo Marakwet Counties. AFRICA COORDINATING CENTRE FOR ABANDONMENT OF FGM (ACCAF), UNIVERSITY OF NAIROBI, 2016.

the data and, how to assure that the programming needs were covered effectively without too much overlap or duplication—thereby using resources more effectively.

Assumption 1.3

Joint Programme interventions at the global, regional, national and sub-national levels are based on a comprehensive analysis of all available evidence (e.g. situation analysis, needs assessments, gender assessments, identification of drivers of change, stakeholder mapping) of the populations of interest in programme countries and of the factors that create barriers and promote drivers of change to end FGM.

Because DHS data do not include data from the most affected age groups, are based on self-reporting, and cannot be sufficiently disaggregated so as to be meaningful for tailoring interventions and messages at the county level, the two agencies of the Joint Programme have supported dedicated in-depth research on practice in the target communities. Nonetheless, both UNFPA and other DFID-funded actors in Kenya are heavily engaged in testing methods for analysing DHS data to better inform programme, as dedicated surveys are expensive and typically do not provide insight on change over time.

Both the UNFPA county-based survey and the UNICEF ethnic group-based survey were comprehensive covering knowledge, attitudes, practice, plans, experience with cutting and complications, long-term and non-clinical sequelae such as sexual desire and sexual pleasure, how the cut was done, who did the cut, what services were sought, and male involvement. The studies echo and have reinforced much of the reflection on need to adapt strategy based on changes in practice including age at cutting. They highlighted some important distinctions (high levels of awareness of FGM but low levels of awareness of sequelae) and noted multiple internal contradictions in responses around who decides to cut, what men do and do not know about FGM, and other indicators which reflect what two other IPs referred to as “the blame game” between men and women¹⁰⁸.

With support from DFID, the Population Council has tested new approaches to the analysis of existing DHS data on FGM dating from 1998 and including the “six waves” of data collected to the present. In an innovative approach, the research group undertook a second analysis of the data using survivor analysis to try and ascertain the relative influence of community level and individual level factors and specifically explore the generational factors as well. The results, presented at a county level which helps inform programming, unpack some of the broader trends which obscure programmatically relevant micro-differences. It identifies where the practice has decreased and where it has increased, ages of cutting and associated variables. It notes that, as the practice declines, understanding the specificities of each context will become more important. This analysis makes possible a more disaggregated review of progress.

“The observed changes observed over time provide an important opportunity for understanding how, where and in what sub-groups change is happening. These findings are useful for policy makers in steering discussions on policies, but also for guiding where to target interventions especially due to the large ethnic and religious diversity. It also highlights where there are large numbers of women living with FGM who may be in need of specialized health services”¹⁰⁹

¹⁰⁸ Christine Sekadde-Kigundu, PhD Jane Wambui, PhD Charles Owuor Olungah, PhD Guyo Waqo Jaldesa, MMED, MSC Josphine Wanjiru Kagucia, MAA” Female Genital Mutilation/Cutting Practice in Five Selected Counties of Kenya: A baseline survey report on FGM in Baringo, Narok, Samburu, West Pokot and Elgeyo Marakwet Counties. AFRICA COORDINATING CENTRE FOR ABANDONMENT OF FGM (ACCAF), UNIVERSITY OF NAIROBI, 2016.

¹⁰⁹ Ngianga-Bakwin Kandala, Damaris Kinyoki, Ahmed Sarki, David Gathara, Paul Komba, and Bettina Shell-Duncan. “Modeling and Mapping of Girls’ Female Genital Mutilation/Cutting (FGM) in the context of economic, social, and regional

Although not yet at country level, UNFPA at HQ level is continuing to refine this new approach using survivor analysis to make it possible to measure year by year changes in practice (important in areas where the impact of the law is pushing down the age at which cutting takes place) and other programmatically relevant insights. This work began in the end of Phase II and has been informed by the deep and enduring experience of the Joint Programme on the ground. It is not yet part of either programming or evaluation at country level but offers much promise.

The DFID-funded research using the Kenya DHS also offered several key recommendations for future study. These research questions should be informed by the Joint Programme evaluation questions however the level of cooperation between the Population Council and the Joint Programme is limited at country and global levels. This is a missed opportunity which should be revisited in light of the new work with the DHS from within UNFPA.

Among the Kenya specific topics for further research raised by the DFID-funded effort are:

- *further investigation should examine why there has been little change in the decline of FGM prevalence in Mandera, Wajir, and Garissa counties in northeastern Kenya.

- *detailed longitudinal studies of girls' FGM incidence, intentions, health risks and psychological consequences, and attitudes are essential at fixed sentinel sites in Kenya.

- *an in-depth study is needed to examine how the seasonality of FGM, and social and economic contexts may become a control option for Kenya.

- *a future study could explore daughters' cutting by whether her mother was cut, to provide an inter-generational measure of change.

- *when strong campaigns against FGM exist, a concern always exists that underreporting will increase. A future study could compare FGM prevalence for the same birth cohort in the four KDHS surveys; one example would be to compare women ages 30 to 34 in 1998 with women ages 40 to 44 in 2008, and to determine the extent to which the estimates would prove similar if reporting propensity remains constant¹¹⁰.

As one of the subnational government staff noted, "this development will allow us to analyze what is happening at the administrative county level, not the tribal level" as counties are more diverse than assumed by data based on ethnic group and, for example, "the Maasai live in every part of Kenya." The challenge remains that Kenya plans based on a 3-year cycle and the DHS is done on a 4-year cycle, but it may also provide impetus for other types of analysis to fill the gap.

Although the geographic focus of the JP programme reflects DHS data on the counties (formerly regions) of highest prevalence, and the broad strategies are informed by in-depth cross-sectional research into the practices and situation among key ethnic groups, such as that supported by UNICEF, the most significant source of evidence remains field-based implementing partners with deep roots and experience in these communities pre-dating the activities of the Joint Programme. These agencies adapt

disparities: Kenya Demographic and Health Surveys 1998-2014", May 2017," Evidence to End FGM: Research to Help Women Thrive. New York: Population Council, http://www.popcouncil.org/uploads/pdfs/2017RH_FGMC-ModelingMappingKenyaDHS.pdf.

¹¹⁰Shell-Duncan, B., Gathara, D. and Moore, Z. Female Genital Mutilation/Cutting in Kenya: Is Change Taking Place? Descriptive Statistics from Four Waves of Demographic and Health Surveys. February 2017, Evidence to End FGM: Research to Help Women Thrive. New York: Population Council.

the global theory of change to the local reality in innovative ways providing the foundation for working across internal and international borders based on an understanding of shared drivers¹¹¹. For example:

- (i) In Migori region, resources are focused on “hot spots” (the global terminology for areas with very high prevalence identified by the DHS or other sub-studies) which programme staff explained are communities with high prevalence and resistant to change. In alignment with the core precepts of social norm change theory, they invest in both the hot spots and selected bordering/neighboring communities in which there is lower or changing prevalence and support community exchanges and dialogue between the two types of communities to demonstrate to practicing communities that their neighbors have and are changing their practice and therefore so should they.
- (ii) In all of the regions visited, the program supports work with communities which extend across international borders across which national legal strictures do not apply. Recognizing that the practices of the populations on one side of the border influence the practice of people on the other side, implementing partners have tested diverse strategies.

With a small but concentrated pattern of prevalence in the Karamoja region, Uganda was able to support dedicated in-depth research on practices to inform tailoring of interventions to distinct ethnic groups. This complemented UNICEF-Kenya’s broader comparative research on multiple ethnic groups across Kenya. The combination informs focused programming on each side of the border and efforts to work across the border.

In Migori, concerted efforts to engage the communities on the Tanzanian border have focused on gaining the cooperation of the Council of Elders for those Kuria clans on the Kenyan side and working through the Kuria’s own meta-structures to reach clans on the Tanzanian side. This has proven very challenging as the majority of clans and the “leading” clans remain on the Tanzanian side. Tanzania does not have a law and there is a lack of strong political will to address the practice. Even with an understanding of locally specific drivers, long-established local political structures must be addressed. An UNICEF-supported study on norms and practices related to broader child protection issues provided valuable input to inform program, but did not provide the kind of information needed to address the political dynamics which sustain the practice¹¹². Accordingly, the Joint Programme has begun to support alternative means of crossing the border including Kuria language radio which reaches deep into the Tanzanian Kuria territory.

- (iii) The primary implementing partners in each of the three regions are primarily focused on addressing broader gender and development issues of which FGM is just one symptom. These partners select sub-counties based on broader needs assessments including overall poverty levels, lack of services and infrastructure, the low status of women or the poor nutritional status of children. These criteria are most often closely associated, if not caused, by women’s low status and thus associated with a higher prevalence of FGM. Accordingly, the responses

¹¹¹ Unicef, Baseline Study Report: Female Genital Mutilation/ Cutting and Child Marriage among the Rendille, Maasai, Pokot, Samburu and Somali Communities in Kenya ©United Nations Children’s Fund (UNICEF), Nairobi, 2017

¹¹² GOK, National Council for Population & Development, 2016, Secondary data analysis and literature review of Knowledge, Attitude, Beliefs and Practices (KABP) study of the 10 key child survival, development and protective behaviours in Kenya, Nairobi, GOK NCPD.

to these communities are holistic and address multiple problems—including the root causes and economic drivers of the practice.

In both Migori and Narok, interviews with key partners highlighted that, across different (ethnic or religious) groups there are practical economic factors which intersect with gender-based discrimination to drive the decision on pursuing FGM. Families cannot afford to send to school all children, they prioritize male children, and for lack of the sole “alternative” pathway for girls of education, they determine that they have “no other choice” but to marry and for that, they must be cut. The priority given to male children reflects overall gender-based discrimination including the patrilineal practice of females leaving their natal communities to serve their husband’s family which serves as a disincentive to invest in females as such investments will be lost and repaid only in bride-wealth. In Narok in group discussions with girls, as well as with women and with men—respondents explained that even as girls reject the social norm and refuse to be cut, they still face the challenge of financing their education as they have no other alternatives outside of marriage to garner income to support themselves or their families.

The JP in Kenya has not supported substantial dedicated research or analysis on gender norms for the purposes of informing program on FGM. The data source for the JP work has remained the DHS which has made anything more than broad generalizations about gender and FGM difficult to identify or prove.

The most important in-depth research supported has been on medical practices (by UNFPA) or on a broader child protection perspective (UNICEF in Samburu)¹¹³. The latter has contributed substantially to coordination and program facilitation, and it has informed a gender perspective (e.g. in the case of Samburu noting that age and gender intersect—it is grandmothers, not mothers, who wield the most influence), but it is neither a gender analysis or addressing gender norms.

This is not to say that FGM programming is not given a gender lens in the Kenyan JP. FGM is embedded within the larger GBV agenda and builds on the alliances and frameworks of that agenda, thus a gender norms perspective informs the FGM work more generally. The national level legal and policy work does reflect the language of girls and women’s rights, in keeping with the primary role of UNFPA in that phase of the overall development of the program.

The work at field level, however, has been enabled significantly by UNICEF based on its long-established presence, relationships with multiple implementing partners and ministries, and substantial resources. This work privileges a child protection approach and although it speaks clearly to the rights of the child, it is less likely to emphasize gender dimensions. This is shifting not only with the “girl” work related to alternative rites of passage and life skills education, but with a new initiative from UNICEF to support “youth and gender mainstreaming” within the educational sector.

At the level of IP programming, there is a clear awareness of the gender dimensions of FGM. The work with girls' education (rather than protection) is the most significant indication. This is not necessarily true of the ARP: “In many cultures FGM often marks the transition from girlhood to adulthood. As a way to encourage families and communities to move away from FGM, the Joint Programme continue to support communities in Kenya to undertake alternative rites of passage (ARP), in which the girl experiences all the elements of the ceremony but is not cut. As expressed by community members who participated in this component, while ARP is targeted for girls, benefits are extend beyond this à brings together community (community

¹¹³ UNICEF, *Female Genital Mutilation or Cutting and Child Marriage among the Rendille, Maasai, Pokot, Samburu and Somali communities in Kenya, May 2017, Nairobi, UNICEF.*

involved in preparations, community contributes) and engages men especially elders/pastors/community leaders to take part in blessing girls creates buy in; provides legitimacy to ceremony; changes perceptions on uncircumcised girls as cursed programming with girls which is focused on engaging, educating, and satisfying the needs of the larger community.

The importance of an explicit gender focus in addressing FGM is that it serves as an entry point for engaging key stakeholders whose embrace of “gender issues” is sometimes obscured by other types of concerns such as preserving cultural or ethnic identity. This is illustrated by a key programming text with a child protection focus which highlighted the “conflict” for parents who fear that education of their (girl) children will result in the elimination of key practices associated with their cultural identity. “

Gimbo et al., (2015) found that, one of the major cultural practices that Maasai of the older generation would not want to change is Female Genital Mutilation/Cutting (FGM). Traditional ear piercing and stretching is yet another cultural practice that some Maasai parents fear losing, if their children obtain an education. Key informants told researchers that a big ear shows that a person is a good listener. Respondents reported that schools teach against these practices and so education may affect the sustainability of such cultural customs among the Maasai.¹¹⁴

The Kenya programme joined the JP from its inception and has maintained a substantial presence in most of the communities within which it is now working. As the JP overarching assumptions about the drivers of FGM has evolved over time as more research and study and new constituencies engage with the work (e.g. religion gave way to ethnicity gave way to social norms) the Kenya programme, reflects the early emphasis on “ethnicity” which is a defining factor in much of the national strategy and also a very important political factor in the country as a whole. This is most apparent in the reliance on “ethnic group” as the definition of “community” in the work on declarations of intent to abandon. Indeed, the early measures of progress on such declarations were described as “Population of Communities Supporting the Council of Elders’ Public Declaration Abandoning FGM Implementation Strategies” that is, community was defined by ethnicity and leadership defined by the Council of Elders¹¹⁵.

The challenge of this construction is twofold: 1) it focuses attention on the variations and evolution in actual cutting practice as meaningful to the degree that they are associated with particular groups (somewhat like the current debates on Sunna) rather than the shared root causes and 2) it may foster a dynamic which sets ethnic groups against each other on the basis of their practice (a parallel to the suggestion that Islam is more extreme in practice than Christian groups). The challenge here is very much like the arguments made for “delinking” FGM from religion—the intent was not to shift the focus to ethnicity¹¹⁶. The important message is that gender, power and control are central.

As noted, much of the work on FGM in Kenya is closely linked with ethnicity including variations in practice linked to ethnic group. Unlike other country contexts in which the “community” which chooses to make a public statement of intent to abandon is defined based on a defined village, settlement, or even family, in

¹¹⁴ National Council for Population and Development, 2016, Secondary Data Analysis and Literature Review of Knowledge, Attitude, Beliefs and Practices (KABP) Study of the 10 Key Child Survival, Development and Protective Behaviours in Kenya, Addis Ababa

¹¹⁵ The complexity of the interplay between ethnicity and social norms was illustrated by some of the research challenges encountered during a statistically rigorous sampling exercise for the survey on FGM and girls education in 5 key counties. Because a subgroup of respondents of Masai origin living in Kajiado district explained that they could not share information on FGM with members of their clan “who know them”—a subgroup within the larger ethnic group—the survey team had to shift interviewers not from that region to do the interviews.

¹¹⁶ De-linking Female Genital Mutilation/Cutting from Islam Ibrahim Lethome Asmani and Maryam Sheikh Abdi 2008, Frontiers Program, Washington DC

Kenya the “community” is an ethnic group even if that ethnic group may be dispersed throughout the country or in both urban and rural areas. This presents a major challenge when trying to ascertain the meaning of such a statement vis-a-vis the readiness to change of the entire group and is challenging from an operational point of view in that ethnic elders do not wield sufficient influence. Of interest, the IP in Garissa reported that the unit being used for public declarations in that region, is family—whether small nuclear, or larger clan based.

It has proven very challenging to change the mindset of these ethnic groups—in the case of the Kuria, the “head” of the clans remains in Tanzania although wields much influence over Kenyan clans. Kenya has made important contributions to work on cross-border issues because it faces significant ones—FGM is particularly prevalent among the groups along Kenya’s borders with Tanzania, Uganda, Ethiopia, and Somalia. A focus on ethnicity and cultural practice, may obscure the shared roots in patriarchy of both FGM and child marriage. Although when a girl from an ethnic group escapes the cut and returns having “made good” and is now a role model, the focus on ethnic identity is reinforced.

Given the difficulty of influencing or even accessing the leadership of these ethnic groups, the Kenya JP has very effectively engaged with religious institutions. These cut across many ethnic groups, provide access to large numbers of people on a regular basis, offer channels for messaging including their own messages on “challenges to harmful practice”, are powerful influences even through one-time investments such as a fatwah, and are well resourced.

In some cases, however, they are associated with particular ethnic groups (e.g. the Somali, the Kuria), and in many cases, the “tribes” within the religion (the denominations) may take different positions on FGM. The current debates within the Muslim community regarding “Sunna” cuts is far more transparent than the actions of the Seventh Day Adventists, the Methodists, the Presbyterians, on “ignoring” the FGM problem.

There is also a problem with “linking” FGM with religion—as evidenced by the substantial effort needed to challenge FGM as a religious edict. The need to delink FGM from the Islamic religion (using the texts of that same religion) was a key message in important work done in Kenya by the Population Council funded by USAID before the start of the Joint Program. A few select respondents objected to delinking in that religion is a powerful tool for working with sources of influence and the Islamic communities are not ready for broader gender issues. There is a need to unpack these complexities.

The JP Kenya has contributed to addressing cross-border challenges through bilateral cooperation, contribution to multilateral strategies, and work at community level among those groups straddling the border. As noted by at least 3 IPs, the coordination and convening power of the regional offices is important, but the most challenging work is actually at the community level because it is the community power structures and not the state level power structures that wield so much influence.

Cross-border factors are critical to any work addressing FGM in Kenya which borders practicing groups on every side. The country provides illustration of the degree to which neighboring communities influence each other’s practices through multiple “channels” including moving into new areas, displacement, intermarriage, and proximity resulting in sharing knowledge and appreciating difference. Of note, the patterns and prevalence rates of practice in Kenya are closely aligned with the neighboring communities¹¹⁷.

¹¹⁷ It is instructive to note the effect of border countries with high FGM prevalence rates, mainly Somalia and Ethiopia, on Kenyan communities, especially those bordering these countries: the Rendille bordering Oromiya and Southern Nations, Nationalities and Peoples’ (SNNP) regions with FGM prevalence rates of 87% and 71% respectively; the Somali in Wajir and Garissa counties bordering Juba and Gedo

The most investment has been made in West Pokot where, despite conflicts and VERY difficult mountainous terrain, the joint programmes in both Kenya and Uganda as well as the regional office have made some progress in advancing the dialogue. Uganda's Joint Programme initiated a marathon run across the Kenya-Uganda border to focus attention on FGM which engaged more than 3,000 people including high level political and religious leadership from the two countries, prominent athletes from Uganda and Kenya, and runners from other border countries¹¹⁸. The principle behind the motto "Run from FGM" echoed historical patterns in which women ran across the border to flee the practice. The regional office of UNICEF in particular was also very supportive of this effort.

The Joint Programme supports substantial ongoing work for change at the community/micro level. The Kuria are a clan-based society and the Councils of Elders wield extreme power and are able to override religious leaders. The JP has funded ADRA in Kuria region to support a strategy in which the Council of Elders in the Kebele of Nyetegere is involved in both challenging the practice within their own immediate community and undertake informal and formal outreach to their clans people in Tanzania including inviting them to visit the Kenyan side. It is difficult: with only 4 of 21 clans in the Kuria group residing in Kenya, the "head of the clan is in Tanzania and the tail is in Kenya" based solely on sheer numbers. In addition, the "origins" and head of the clans is in Tanzania's Mara region. As Tanzania is not a "JP" country, has no national law, and lack of political leadership on FGM, it is difficult to engage on a bilateral basis.

There are strong community-based efforts in the Mara region, for example, funded by UNFPA and potentially a link for groups on the Kenyan side, however it is difficult for state level actors to foster linkages. One of the key coordinating actors in Migori noted that, as the communities in each country addressing FGM become more organized, it will be easier to work across the border. Thus, even national level investments can contribute as Kenya continues to strengthen its subnational structures. As this expert noted, *"It will help cross border issues if each country has a coordinating board, so all donors and funders work together including across borders. Ethiopia has one. Somalia is starting. If the most powerful Kenyan Muslim leaders and older women speak publicly re not needing cut, it can inspire others."*¹¹⁹

One important contribution which helps "lay the ground work" for a cross border initiative, is radio. In early 2018, a Kuria vernacular station began a broadcast which reaches across the Tanzanian border into most of Mara region. With support from UNICEF, ADRA has brought experts, community members and girls to address the issue of FGM on radio broadcasts. In Garissa, radio is a standard tool of the religious communities--religious leaders engage the public in question and answer sessions on radio and this now includes frequent programs on FGM. It has shown anecdotal evidence of effectiveness in reaching a wide spectrum of the community—through call-ins, men, women, boys and girls join in the discussions on FGM. The area covered by Star Radio FM reaches the particular project sites, the refugee camps in the region which are home to many from the region and where much cutting occurs, and parts of the neighbouring countries like Dhobley in Somalia.

In a significant regional contribution, the JP funded the Anti-FGM Board's engagement with MPs from the East African Community to advocate for adaptation of the 2011 Kenyan law at regional level. As a result, the content of the regional law is similar to the Kenya FGM Act of 2011. Characterizing FGM as a

regions in Somalia where FGM is universal (98%) (World Bank and UNFPA, 2004); the Maasai bordering Arusha and Kilimanjaro regions in Tanzania, with estimated FGM prevalence rates of 57% and 22% respectively; the Pokot bordering Karamoja region in Uganda with an FGM prevalence rate of 5%. Baseline Study Report: Female Genital Mutilation/ Cutting and Child Marriage among the Rendille, Maasai, Pokot, Samburu and Somali Communities in Kenya ©United Nations Children's Fund (UNICEF), Nairobi, 2017

¹¹⁸ Highlights Report 2016, UNFPA-UNICEF Joint Program, 2016, NY, NY

¹¹⁹ Subnational government implementing partner stakeholders in Migori region.

“transnational crime”, the act also references a database on cross-border FGM...supported by exchanges of criminal intelligence, training of key personnel and strengthening of cross-border security”.¹²⁰

Work is continuing on advancing the law and developing shared terms of engagement for addressing cross-border accountability with the Uganda programme supporting a former woman member of the East African Legislative Assembly who originally tabled the bill to continue advocacy work. Although both Kenya and Uganda are prepared for joint action, all members must be in agreement and Tanzania—currently the host country for the EALA—is not in agreement. There seem to be problems with the democratization of the law with respondents in three different “border regions”, reporting a lack of clarity on the status of the Act and how it can be used to stop the practice. At the national level, some respondents indicated that “our law allows us to ‘go across the border and get them’” (the law does criminalize taking a Kenyan across a border to cut) however in Migori, local actors with little confidence in the cross border strategy set up “border blocks” to try and stop crossings—an unsuccessful effort on the long and highly porous border. One respondent noted that girls in the program who were rescued, may “disappear” and may be sent across the border to be cut and then marry—never to return (and unlikely to be accounted for in Kenyan statistics).

One of the key findings from the evaluation of Phase I, was that the Joint Programme was not effectively reaching the most marginalized populations—often those with the highest prevalence of FGM. Some important sector-specific efforts—including new communications methods such as vernacular radio—were made to reach those most excluded under Phase II, however the complete response remained a problem.

In the second phase, the JP addressed specific identified gaps directly: without legal services, the intervention of the law was not meaningful in these areas; without health services, the care and evidence would not be provided. With support from the Joint Programme, the Federation of Women Lawyers and ODPP provided free legal aid, witness protection and services to help victims prepare legal briefs for courts, referrals for social services, and increased media coverage of FGM cases in court to push for action. In the hard to reach rural areas, where poor infrastructure often prevents witnesses from appearing in court, the Joint Programme supported the establishment of mobile courts in Kenya in all 47 counties¹²¹.

¹²⁰ The EAC Act addresses (a) prohibiting FGM as a ‘trans-national crime’ across member states, (b) setting minimum penalties for FGM, (c) establishing institutions to foster co-operation and (d) developing and harmonising policies, laws, strategies and programmes to prosecute offenders, prevent FGM and provide services to victims and girls at risk of FGM. According to the law, performance of FGM carries a punishment of a minimum of three years’ imprisonment; ‘aggravated’ FGM carries a punishment of imprisonment for life (if the procedure results in the death or disability of the victim, or if she is infected with HIV, or if the perpetrator is a parent, guardian or health worker); anyone using derogatory or abusive language or ridiculing a woman (or her male partner) for undergoing or not undergoing FGM will be imprisoned for a minimum of six months; imprisonment for a minimum of three years or a fine of not less than US\$1,000, or both, applies to anyone procuring, aiding or abetting the practice of FGM (under Article 5), participating in cross-border FGM (under Article 6), using premises for FGM (under Article 7), possessing cutting tools or equipment (under Article 8) or failing to report FGM that has taken place, is taking place or is planned (under Article 9). It includes protective measures ie. compensation may be sought from the perpetrator for the victim of FGM, and if EAC state members are satisfied that a girl or woman is at risk of undergoing FGM, they may issue protection orders. The Miscellaneous Provisions) of the EAC Act requires member states to adopt comprehensive FGM laws and include in their national budgets resources to protect women and girls from FGM, provide support services to victims, and undertake public-education and sensitisation programmes on the dangers of FGM. A regional database on cross-border FGM will be established, supported by exchanges of criminal intelligence, training of key personnel and strengthening of cross-border security.

¹²¹ Highlights Report 2016, UNFPA-UNICEF Joint Program, 2016, NY, NY

Although a mobile approach to health services provision was not possible, the programme supported the training and engagement of Community Health Workers whose responsibilities included identifying those in need of care or at risk and encouraging them to use or even bringing them to the available health services.

One of the constraints on reaching the more marginalized were overall resources. Staff of some of the private sector partners noted that part of the issue was understanding when the areas already served were ready for the program to shift resources to more marginal communities. This challenge may have been an artifact of the early focus on ethnic group as community in which the process of change was more difficult to discern. Thus, one of the ways in which the Joint Programme has responded to the challenge of addressing issues of marginalization and power imbalances within the community is an adaptation of learning based on the work of other key partners on how to conduct community conversations. The Anti-FGM board is now engaged in developing guidelines and quality assurance tool to support the same amongst others.

As an illustration, a key shift in the JP strategy between Phase 1 and 2 was a move from broad-based community awareness raising to a more focused discussion with strategic stakeholders. This is very similar to the methodology long used by AMREF. AMREF, for example, uses “Structured Dialogue” to engage with communities. The approach first targets key stakeholders who are influential (i.e. gatekeepers to community/custodians of culture – elders, morans, and spiritual leaders) and initiate dialogue with them then rest of a community in a sequenced manner. Community dialogues are used to understand needs of community, what interventions are appropriate, and to ensure that community members are equal in decision-making. They can then engage the community in a discussion on ARP (to create a community-led ARP that values the girl-child) or community declaration or both.

Discussions with the leadership and community mobilizers for several of the implementing partners made clear that reaching the most marginalized populations was not solely a matter of human rights and righting power imbalances, but was also key to maintaining the progress made in less marginalized areas.

Community-based respondents frequently referenced the populations “on the edges” who continued to practice (most of them of the same ethnic group as the respondents), the risk of girls being brought into the marginal areas to be cut (including the refugee settlements in the east), and the logistical hardships of pursuing a community-based approach in distant communities which were hard to reach on a regular basis. They cited as one piece of evidence of the risk the fact that each of the areas studied had faced armed resistance to security forces coming to enforce the law.

The leadership of Narok County acknowledged that the JP had supported work in the areas “worst hit...for FGM” i.e. Narok South and Narok West. However, a concern was also expressed that the populations in the far north were not supported, that the practice continued in those areas, and that this was a risk to the work already done. In a twist on the JP core precepts with regard to fostering social norm change, the concern was that the sub regions which had shown progress in ending the practice might be influenced by the northern groups to revert to practicing. This was of particular relevance in that region in which populations are highly mobile. Thus, addressing the marginalized groups was key to the overall strategy.

The greatest challenge to efforts to reach the marginalized within the Kenya Joint Programme remained assuring that the “package” of services is delivered in such a way that the intended synergies are achieved—a issue which is not unique to Kenya. Although NGO-based programs may be able to cover all bases at once for a small population, scale is not possible without engaging the public sector. The need for government to take responsibility for, at a minimum, specific pieces of the package (e.g. health services, security services) was a topic of significant discussion during the field visit.

Even the minimum services to be delivered i.e. legal services, psychosocial, educational, and health services, typically require sustained human resource investments and reliable and sustained operations. These are likely to be weak in geographic areas which are not prioritized by the national government and/or in which the delivery systems in those sectors are already compromised. This is also true in urban areas which provide public services but restrict access or fail to account for the challenges facing migrants in accessing those services. The challenges of addressing the needs of women and girls' empowerment adds to the complexity.

The coordinated delivery of services is the goal of the national devolvement strategy and the synergistic delivery of a package of services the intent of the Joint Programme efforts to create coordinating anti-FGM boards at both national and county levels. Kenya's administrative "devolution" plan involving shifting sector specific functions and budgets to the county level where they were more accessible and responsive—was described by several key government focal points at the subnational level as an effort to push "power" to the subnational level to assure that marginalized areas were reached with services and services were better coordinated at the micro level. Unfortunately, this was either not backed with the fiscal and human resources needed or was undermined by the "devolution of corruption"¹²². This was partly the reason for the strikes within the health sector in 2018 which left those with minimal access with even less access.

For lack of such structures, the Joint Programme and partners have had to leverage existing structures such as the gender and child protection working groups or create new coordinating structures such as in Narok. These existing structures have facilitated coordination and, in all cases, at least one key implementing partner from the private sector is a member of the committee.

Based on anecdotal evidence, the host ministry for the coordinating group seemed to be of significance. Gender working groups tied to the Ministry of Women' Affairs had fewer resources and seemed less able to engage the health sector than the groups with a child protection focus which were already engaged with multiple sectors. Although the national level gender ministry urged private NGOs to pursue the small funding sources available at the county level to support e.g. rescue centers, the ministry was not prepared to take on board the responsibility for inter-ministerial coordination required to sustain that intervention.

Ideally devolution and the development of dedicated FGM coordination mechanisms at county level will address this problem. Unfortunately, the degree of "devolution" varies across the key ministries and thus coordination may be even more complex i.e. gender and security are not devolved, education and health are partially devolved. This makes all the more urgent the establishment of dedicated mechanisms at county level but also highlights the importance of placement of that mechanism within the government infrastructure.

The JP in Kenya has very effectively leveraged its limited funding for the most significant change and the opportunity to test diverse strategies working with a broad mix of stakeholders at national and subnational level.

The diversity of interventions in different parts of the country provide many valuable opportunities for a comparative analysis or cross learning within Kenya itself. This has happened within annual planning processes, in hosting visiting delegations, and in regional meetings, however the level of exchange and documentation does not reflect the value of the experience within Kenya. Kenya's work on the legal change was highlighted in best practice documents, however the experience with regional law, the cross-border

¹²² County and subcounty level respondents, not necessarily IPs.

work, and earlier efforts to directly address the situation in refugee settlements would all be of great value to other regions within the programme.

The program is now beginning to focus on addressing the “biggest” issues e.g. the root cause of gender inequality and new audiences (youth) which offer the greatest potential for sustained change. Particularly in Narok and Migori regions, support for educational programs and girls' leadership offer much promise. These new endeavors may help lay the foundation for more gender-centered work under Phase III, however the phases of this work need to be carefully considered, including from the perspective of ethical practice. As noted above, even when girls refuse the cut, challenge the status quo, and leave their families to remain true to their principles, they must be given other alternatives to marriage and cutting, or they will fail with possibly even more dire consequences. A discussion with rescued girls in Migori region made excruciatingly evident the challenges faced and significant risks taken in refusing the cut—as well as some of the despair and concern about “what next” given that the previous program for girls’ scholarships had ended, and they had few alternatives remaining¹²³.

Evaluation question 2

To what extent has the programme contributed to supporting governments, communities, and the girls and women concerned towards the abandonment of Female Genital Mutilation/Cutting through the establishment of conducive legal and policy environments, support for the provision of FGM health services, and the shifting of social norms?" **Criteria: Effectiveness and Sustainability**

Assumption 2.1

Programme countries enact legal and policy frameworks for eliminating FGM which are appropriately resourced and implemented (in line with AU and UN Resolutions);

The JP was integrally involved in the development, multi-faceted advocacy campaign, and thus the success in the passage of the 2011 Act Prohibiting FGM which addressing a broad range of possible violations as well as outlining in detail the roles and responsibilities of the Anti-FGM Board. The law was a significant achievement both for Kenya and the global movement. The campaign for the Kenyan law has been cited as a best practice by multiple actors¹²⁴.

Although the campaign to get FGM included in the sexual crimes law was not successful, the dedicated law is extensive and the penalties it outlines were considered severe (three- to seven-year sentence or a fine of what was at the time nearly US \$6,000 for anyone practicing FGM; anyone convicted of bringing a girl into Kenya from abroad to be cut; or anyone carrying FGM out on a Kenyan in another country. Anyone who causes death by performing FGM faces life imprisonment¹²⁵. The prohibition act also addresses medicalization of FGM: it stipulates that it is a criminal offence for a medical officer or related person to

¹²³ Discussion with 3 groups of rescued girls in Migori and Narok.

¹²⁴ 17 Ways to End FGM: Lessons from the Field: Companion booklet to the 2016 Annual Report of the UNFPA-UNICEF Joint Programme to End Female Genital Mutilation/Cutting: Accelerating Change

¹²⁵ Evidence in Action: GOOD PRACTICES on Integration of Gender, Human Rights and Culture in UNFPA Programming: Kenya Supporting Legislation that Criminalizes the Practice of Female Genital Mutilation/Cutting, 2012, UNFPA Technical Division, Programme Division, the Africa Regional Office and the Kenya Country Office, NY NY

perform FGM. “Aiding and abetting female genital mutilation” could include use of derogatory language to mock girls and women in order to force them to be cut; and failing to report”¹²⁶

There are additional laws passed during the period under review of relevance. The Children’s Act, 2001, S (14) criminalizes subjecting a child to harmful cultural practices. This provision of statute gives parents the responsibility of ensuring the safety and security of the child. The Penal Code, Chapter 63, also provides offences under which the circumcisers can be charged. The Protection against Domestic Violence Act, 2015 classifies FGM as violence¹²⁷.

The JP was integrally involved in laying the groundwork and supporting multiple stakeholder structures to inform the development of a national policy and that policy was the basis for the development of the law. With new political developments in Kenya (the Constitution of 2012), the JP supported the revisions to the policy to be sure that it was consonant with the new legal frameworks.

In 2008, UNFPA provided technical and financial assistance to the Ministry of Gender, Children and Social Development to conduct a national study on FGM that led to the creation of an FGM National Secretariat (see above). The Secretariat played a pivotal role in coordinating the efforts of various stakeholders and in the formulation of a national policy on FGM that paved the way in the drafting of the Prohibition of FGM Bill 2010. The following year, on October 7, 2011, Kenya’s President signed the bill into law known as the Prohibition of FGM Act 2011, which for the first time unequivocally criminalized FGM in Kenya”.¹²⁸

The campaign itself is considered an example of best practice. It included: advocacy and mobilization of parliamentarians, as well as community and religious leaders, women lawyers, medical professional associations and youth; high visibility of and active support given by parliamentarian men; personal testimony by women parliamentarians from practicing ethnic groups; education workshops and dialogues between communities, civil society and Government entities; and widespread media campaigns that stressed the human rights aspects and adverse health consequences of FGM.¹²⁹

The JP has staffed (with staff seconded from UNFPA) the new national structure to facilitate coordination and advance implementation of the law but also standardization and professionalization of community level education, work with girls, and eventually work with other sectors. The revised policy is awaiting cabinet approval however the board is already planning for the development of technical coordination mechanisms at the county level which will operationalize these policies and guidelines at the level of the

¹²⁶National Council for Population and Development, 2016, SECONDARY DATA ANALYSIS AND LITERATURE REVIEW OF KNOWLEDGE, ATTITUDE, BELIEFS AND PRACTICES (KABP) STUDY OF THE 10 KEY CHILD SURVIVAL, DEVELOPMENT AND PROTECTIVE BEHAVIOURS IN KENYA, Addis Ababa

¹²⁷ Baseline Study Report: Female Genital Mutilation/ Cutting and Child Marriage among the Rendille, Maasai, Pokot, Samburu and Somali Communities in Kenya ©United Nations Children’s Fund (UNICEF), Nairobi, 2017

¹²⁸ Evidence in Action: GOOD PRACTICES on Integration of Gender, Human Rights and Culture in UNFPA Programming: Kenya Supporting Legislation that Criminalizes the Practice of Female Genital Mutilation/Cutting, 2012, UNFPA Technical Division, Programme Division, the Africa Regional Office and the Kenya Country Office, NY NY

¹²⁹ The following policies and action plans were also set up to address FGM: Sessional Paper No. 5 on the National Population Policy for Sustainable Development (1999); The National Reproductive Health Policy Enhancing Reproductive Health Status for all Kenyans (2007); The National Plan of Action for the Elimination of Female Genital Mutilation (FGM) in Kenya (2008-2012); The Adolescent and Reproductive Health Policy and Plan of Action (2005-2015); Vision 2030 and the draft Reproductive Health and Rights Bill; The National Plan of Action on the Abandonment of Female Genital Mutilation in Kenya”; GoK, “The National Policy for the Abandonment of Female Genital Mutilation” Ministry of Gender, Children and Social Development, Nairobi, Kenya, June 2010. (National Council for Population and Development, 2016, SECONDARY DATA ANALYSIS AND LITERATURE REVIEW OF KNOWLEDGE, ATTITUDE, BELIEFS AND PRACTICES (KABP) STUDY OF THE 10 KEY CHILD SURVIVAL, DEVELOPMENT AND PROTECTIVE BEHAVIOURS IN KENYA, Addis Ababa)

key implementing government partners. The current working groups are helping to lay that foundation within a broader agenda of GBV and VAC¹³⁰.

In 2014 through the National Policy on the Eradication of FGM for 2016-2020 a budget line was established at country level. In addition, 12 county level coordination structures were established through the Anti-FGM Board. The combined budgets of the national and county structures increased from \$ 42,000 in 2014-15 to \$92,000 in 2016-17. The staff of the Anti-FGM board were initially seconded to the board for support, however they were returned to their original posts (as all await the approval of the policy by the cabinet) and it is now staffed with support from the JP and UNFPA. The approval process for the 2014 policy was put on hold during a tumultuous election period.

There was a substantial investment in capacity building at the time the law passed. In 2011-2012, nearly 2,000 police and probation officers, over 1,700 community leaders and more than 23,000 community members were trained by UNFPA to implement the new legislation¹³¹. In the context of a country the size of Kenya, this was a beginning and also highlighted the emphasis which the Kenyan programme would place on the involvement of communities and key actors within communities to assure accountability and identify and report perpetrators. This “watchful presence” has been an important tool, although it has also contributed to new challenges i.e. a range of very rigorous efforts to hide the practice—by ending the public celebrations which were part of the process previously or “obscuring” the celebration by tying it to the circumcision of a male relative; by crossing the border or sending a girl to be married across the border; by doing the cutting at night, in the very rural areas, or even by oneself. Such efforts to hide only made community monitors more important and efforts to strengthen a cadre of more strategic community members continues and has expanded to involve not just the morans of the Maasai communities, but other leadership in the village, CHWs, and the structure of the newly established “nyumba kumi” system.

Unfortunately, the capacity of the security and judicial sectors required for enforcement of the law (not just its application) also requires continuous reinforcement and has proven to be one of the most significant limitations on leveraging the law for change. The relative emphasis on police and probation officers in the early phase, may have reflected assumptions about parallel investments in the judicial sector from the work on violence against children and on gender-based violence. This was a reasonable assumption in that FGM was technically “subsumed” under GBV in the monitoring systems of the health and justice sector.

However, it became clear very early that there was significant need to build capacity and thus the JP undertook a series of trainings beginning with the broader law enforcement teams and ending with “mobile justice” teams able to gather data more on the scene soon after the accusation. The ODPD also put in place an expedited process whereby FGM cases could be considered quickly as lengthy process resulted in witnesses and even original defendants being intimidated.

Although much progress has been made, a key element of the Phase I plan—the translation, domestication and dissemination of the law—was not “finished”. In the course of the discussions for this evaluation, multiple stakeholders from government, IPs, and allied agencies raised concerns that the law was actually not well understood and the interpretations of the various “levels of culpability” (hosting the cutting, paying for the cutting, doing the cutting, witnessing the cutting) was very unclear. There were calls for an

¹³⁰ Agency and Joint Programme staff.

¹³¹ Evidence in Action: GOOD PRACTICES on Integration of Gender, Human Rights and Culture in UNFPA Programming: Kenya Supporting Legislation that Criminalizes the Practice of Female Genital Mutilation/Cutting, 2012, UNFPA Technical Division, Programme Division, the Africa Regional Office and the Kenya Country Office, NY NY

effort to clarify the law anew. Many of the concerns focused on treatment of parents and the implications of arrest, as well as the treatment of girls of major age who “chose” to get cut or even cut themselves.

Ongoing substantial investments made by the Joint Programme have resulted in increased numbers of cases identified and processed. At the end of 2011, five individuals had been charged and were awaiting trial under the new law.

At the field level, however, the weakness of the law and justice structures is a considerable impediment. In Narok, many respondents commented on e.g. limited capacity in the interior regions, no gender desks, no female officers, no resources including vehicles to enable apprehending perpetrators or transport witnesses. These are a significant challenge to enforcing the law, whether it be apprehending/arresting perpetrators; rescuing girls; providing services to survivors; or escorting witnesses. As a result, local govt institutions (e.g. ODPP) rely on other actors who are on the ground (e.g. World Vision) to fill this capacity gap.

In 2016, the JP invested in “mobile” justice strategies to address those cases in the hardest to reach (and highest prevalence) areas and supported FIDA to work directly with plaintiffs to support the processing of cases. In 2016, 75 cases of FGM were reported to the Office of the Director of Public Prosecution (ODPP). Ten cases were prosecuted and convicted, 49 were still ongoing at the end of the year, seven were acquitted, and nine were withdrawn due to lack of evidence. The ability to reach the areas of highest prevalence made a significant difference. By the end of 2017, the total number of cases across the hotspot areas (Maua, Kapengria, Kilgoris, Kehancha, Narok, Transmara East, Migori, Nyamira) was 155 with the following status: Withdrawn -59 (38%) Pending -62 (40%) Concluded –28 (18%) Care and Protection cases (children without families in need of support)– 6 (4%).

There are many instructive challenges facing application of the law including a profound lack of understanding on the tenants of the law among the general population but also the security forces themselves. Some additional challenges facing the ODPP in successfully prosecuting cases are:

- Non-cooperation of the victims and at times change of heart due to community pressure
- Poor attendance at Court
- Challenges with witness facilitation and attendance (transport costs, threats, etc.)
- Community threats and the victim becomes afraid
- The victims are hidden by the community
- Quality of the investigations is comprised in most cases
- Alternative dispute Resolution mechanism (ADR) at the community level is settled in most of the Gender Based Violence cases
- Family members are perpetrators – often they have to release perp due to community/familial pressures on girl to release mother/father and seek informal justice (e.g. give cattle as fine/payment)
- Facilitation of witnesses is biggest challenge – many cases are adjourned due to lack of witnesses due to transport issues. There is a fund for witness facilitation but this is provided to witnesses after (reimbursed, often don’t have money to front)

- Low/no reporting – even in sub counties where it is common knowledge FGM occurs the reporting is low due to community stigma (e.g. girl who died in community because of FGM. People knew who conducted it, the parents, but no one came forward). Most often reporting is a “tip-off”, not necessarily people actively reporting (e.g., not the chiefs or administration officers of which it should be their responsibility). Rarely find circumcisers.
- Limited police capacity, competency – need to conduct good investigations in order to prosecute a case but there is lack of police structures in the interior; most often there is no gender desk; often in interior there is no female police officer so many girls do not want to report/fear report/note comfortable reporting; all men investigating cases who often are not trained to deal with these cases (e.g. they do not know what to look for, not sensitized to FGM); no vehicles to apprehend suspect/alleged perp; no vehicles to escort witnesses. Forces ODPP to work w other actors who are on the ground (e.g. World Vision, JP IP) to help monitor, transport girls, witnesses, provide support to rescued girls)
- Lack of sensitization and training on FGM in public institutions – includes law enforcement, prosecutors, magistrates. Health providers are important to sensitize à when assessing injuries, it must specifically state FGM. Failure to do so will result in no case so they need to be trained.
- No standard sentencing in law –law is not clear (no standard sentencing) l with girls who claim to have cut themselves. Some think probation is fine (because we know the girl did not do it), but this is also not a strong deterrent as fine or imprisonment.
- Case backlog – generally speaking getting a hearing date is difficult; however, FGM is priority as well as child marriage and sexual offence cases so these are fast tracked and moved as fast as possible à “because when the cases are hot, they are more successful [to move forward to prosecute/go to trial]” NAROK ODPP

Additional considerations in implementation challenges are:

- Need for translation and dissemination” of the law: strengthening due process; clarifying provisions on culpability (including of parents), “intent”, witness participation and protection, expedited procedures, do no harm
- Need for training communities, empowering agents of change, using role models and ARP graduates, particularly in regions where intervention by security forces can result in backlash and further harm
- The significant influence of FBOs in fighting the practice should also affirm core human rights principles
- Balancing messaging on criminal offense with need to respect, protect and promote the fundamental rights of girls and women. This focus on criminality also reflects the global discourse at the time the Kenyan law was formulated which emphasized the importance of treating FGM as a serious crime as well as the significant role of the legal community in work on the bill. It’s “best practice” contribution includes this focus: Supporting Legislation that Criminalizes the Practice of Female Genital Mutilation/Cutting.

A major challenge in Garissa is competition with traditional juridical process. The “Maslah” system is traditional systems of alternative dispute resolution where the crime is paid for in terms of animals’ camel,

cows, goats and sheep; moreover, the elders engaged in the process of the “maslah” system are compensated and paid as well. This is a system advocated by the elders who have direct gain from the process and always bring different clan together and have the powers to withdraw criminal cases so as to accept the verdict of the community elders. In the Somali setting considered the clan that does not accept the elders’ verdict will have a curse that could affect their family, thus in most cases the “Maslah” method is still prevalent. For FGM the victims’ family is willing and even pay for the services and the poor girls are compromised.

Currently, FGM is tracked as part of the national GBV tracking system and thus is not necessarily captured (if not considered GBV or not viewed as a contributing factor by the individual filling the forms) or properly recorded.

The police and the health sector are the frontline agents who are responsible for recording information about GBV cases both to guide the case through the “roadmap” for integrated services which are the response to GBV and for forensic/judicial review should the case go to court.

The police already struggle to identify and properly record GBV issues: although much work has been done to build capacity at the level of the police stations/services, multiple stakeholders noted that that capacity frequently goes unused (e.g. those staffing the gender and child protection desks are not the ones trained) or leaves (with very high turnover rates within the security forces). Identification and confirmation of a case of FGM is significantly more difficult for many reasons: 1) the secrecy surrounding the practice 2) the resistance of the community and community leadership to ending the practice (“police have trouble reporting on their community because they are part of that community too”) 3) the privacy issues arising in confirming outcomes among young girls; 4) lack of understanding that FGM should be included on the forms developed for GBV.

The health sector does not have a dedicated, standard system to track prevalence, case management or cost of treatment of complications from FGM. The DHS continues to serve as the overall source of data on prevalence, but cannot replace administrative data. Important investments have been made in training health sector providers at all levels—technical leadership, medical doctors, nurses, midwives, and community health workers—to recognize, assess, respond to and treat FGM cases as well as contribute forensic evidence and age estimations to inform the legal process, the administrative side of the health sector has not been significantly engaged on tracking FGM. Even at field level, nurse practitioners themselves observed that FGM “could be recorded and tracked using the GBV form” but that this had not been emphasized in the training on the form or forgotten over time in the use of the form.

Multiple respondents attributed this lack of engagement on the part of the health community largely to the fact that the work on FGM is viewed as being the responsibility of the Ministry of Gender, not the Ministry of Health. The early work on FGM was the focus of the Ministry of Gender in keeping with the emphasis on legal and policy change. The Ministry of Gender does not have the capacity to track at a national level either GBV or FGM. The implications of this division of labor are more serious at this point in time given that “gender” was not devolved to county level but health was “partially devolved to county level” although insufficiently resources. As a result, there is less infrastructure at the services level to track FGM.

Under the third phase, the JP, UNFPA and UNICEF have been very proactive in engaging the MOH on the need for more effective monitoring. The current dialogue with the MOH and MOE focuses on the basics: the need for maternal health clinical services, and school-based services to screen for and identify cases of FGM. This data could inform individualized, “risk reduction” prevention strategies for the individuals screened and could be used as the forensic evidence for any legal action. More importantly, the health sector would be given the task of recording and tracking the actual status of these clients.

The Joint Programme itself has supported the development of data systems to track inputs and outputs linked to JP funding but this does not inform broader programming (the DFA system). It has also supported the development of smaller scale tracking tools for e.g. the Justice sector. As an illustration of the disconnect not only among government agencies but among their partners, a key tool within the child protection system which also addressed FGM was the child helpline system—anyone could dial 116 to report a child injured or at risk. Different agencies used the program but there was not 1 single agency collecting and integrating all of this data which represented very important administrative data. This was in part due to issues of confidentiality—the information was passed anonymously to child services. However, it also meant it was possible that the same case had been reported by different agencies with whom the child came in contact. Individual IPs and health services supported by IPs have developed their own tracking systems in part to measure progress and in part to identify and manage cases. This data can be particularly valuable as an illustration of the cost of FGM to the health system, families, production, the education sector, etc. On that basis, national level efforts to track costs and the differences by region and type of cutting of those costs could be very powerful and also inform the current challenges in assuring sufficient funding from the national level to the devolved county level services in e.g. health and education. This data is not a sufficiently representative sample (reflecting the selection factors influencing placement of the programs and the decision to use private services) to inform planning and budgeting in the public sector.

In addition, data collection across multiple sectors is prohibitive for smaller groups. This challenge undermines the efforts to approach cases of FGM in the holistic manner intended. If multiple sectors will be responsible for data collection, they must be linked. As the IP in Migori noted: of “A total of 148 cases were reported between Q1 to Q6 on FGM and other gender related issues in this case this early marriage cases. The information was only tracked from the case lots within the children and because standard reporting tool does not exist nor sharing of the data across the departments, we were challenged to get other information from all the information sources”.

There are multiple sources of data addressing the broader set of concerns within Child Protection and, on this basis, UNICEF has been very proactive in bringing together the various stakeholders who are part of that effort to develop a coherent or coordinated approach for an integrated dataset. This work will require significant capacity building at all levels.

The most important capacity to develop is the application or use of the data for programming. This will necessarily take place at both national and county levels given that national holds some of the sector ministries and the budgets for most while, e.g. health is partially devolved. The challenge of data collection and application within this system is illustrated by the description of the new gender working group in Narok county (see above).

Another key gap in capacity of relevance to programme planning data, is the lack of a clear “roadmap” for addressing FGM (as opposed to GBV). The GBV roadmap is associated with assuring the right services are accessed in the right sequence and also that data is recorded and shared among different types of providers. Technically, as FGM is subsumed under GBV, the same map might apply. But the ages of those involved in FGM cases are such that the GBV approach is insufficient. UNICEF has produced a clear map for child protection cases; however, this is more complex than might be needed for FGM. In addition, there are long term consequences with FGM, and the mixed role of parents is quite different from most CP cases.

The need for such guidance becomes more important with the proliferation of actors and services and with the addition of administrative structures at the county level. As UNFPA noted, “previously 1 IP would handle a case of FGM and follow up. Now when groups report cases, one addresses judicial, another health,

etc. We need coordinating a network of prosecutors, police health, gender. We need to be able to refer cases without losing them. In difficult areas, NGOs are like government, providing all services”.

Regional offices have supported exchanges of religious leaders and visits to share best practices. Work on data systems is beginning. The JP plays a central role in development, enactment and enforcement of the national Prohibition Act: this best practice has informed regional (East Africa) efforts.

- As platform for organizing/enabling collaborative advocacy strategies e.g. with male parliamentarians, women lawyers, and local and INGOs which has informed regional efforts
- Ongoing “inside” advocacy for cabinet approval of policy to guide eradication efforts coordinated across public and private entities
- Dedicated technical support to national coordinating Anti-FGM board (e.g. standards for best practice interventions, guidelines for county level branches, national-county linked advocacy for dedicated county budget lines)
- Support to govt partners (ODPP, police, judicial) for monitoring/surveillance, reporting, rescue, and fast tracking of FGM cases in legal arena
- Reports of lack of understanding/awareness of primary provisions of and interpretation of the act e.g. what constitutes criminal conduct/perpetration particularly vis-a-vis parents or majority age girls who choose to cut (including “vaginal surgery”); inability to prosecute “intent to cut”; definition of FGM vis-a-vis changes in practice; responsibility of “hidden” decision makers (Council of Elders); and linkages with male circumcision

Assumption 2.2

Service providers provide timely, appropriate and quality services to girls and women at risk or having experienced FGM in select districts in programme countries;

The JP in Kenya has prioritized prevention-related services such as engaging teachers in monitoring and reporting cases, strengthening the reach and speed of the judicial representatives, and even training of CHWs to serve as advocates to bring women and girls to health services for FGM or other needs. The JP has not prioritized core health sector or clinical services although it has invested in a survey of practice, the test of a curriculum module for midwives, and the integration of content on FGM into the medical school curriculum at the university of Nairobi Medical School.

Accordingly, the evaluation found that the health sector was a key missing element in the response to FGM in Kenya. The health sector plays multiple critical roles which impact many dimensions of the response: services for those affected; prevention information for those at risk; forensic evidence and age estimation for cases to be prosecuted; administrative data to demonstrate the need and impact of FGM, cost data to make a compelling argument for ending the practice; and potentially data to inform prevalence estimations.

The interagency structure was one contributing factor to this problem—UNFPA is the least visible of the “field actors” and health services are its priority; UNICEF is the most visible actor but its “medical audience” is paediatrics and to some degree maternal health—neither of them a current focus of joint program work—and it engaged in training of health providers (CHWs) on FGM only last year for the first time. In addition, the WHO office is split between the elements who coordinate with the gender ministry and those who deal with the health ministry. In a meeting with key staff, they that the MOH itself was not addressing FGM because the problem was situated in the “gender” ministry. This split continues at county level.

During Phase II, 5,074 girls and women received services related to FGM. This includes psychosocial, legal aid, education, health, family reunification, temporary shelters and critical child protection and reproductive health information.

The total number of girls and women reach by JP services in Kenya's (641 for 2016) is significantly lower than any other country except the Gambia, and it particularly low given the size of the population and the relative prevalence of FGM. This may be attributable to the fact that the NE region is not a focus of work with girls and women (as opposed to male opinion leaders) and does not have a services program, and this is where prevalence is highest.

During Phase II, 6,504 girls were rescued from undergoing FGM. In keeping with the JP emphasis on prevention, one of the most important services offered in Migori region, was counselling.

Over the course of 1 year, counselling was provided for 1089 clients (both male and female). The focus of the counselling was to "address trauma, positive living with the cut and also without the cut as both categories are affected in one way or the other and assurance of safety and security for those abandoned because of refusing to be cut" the latter including encouraging parents to accept their girl who chose not to be cut. This range of topics moves beyond "psychosocial" counselling to conflict resolution¹³².

As the primary mechanism for conflict resolution in the community settings remains the traditional mechanisms and traditional courts which typically do not support the outcomes for girls or women, there is a great need for "services" which move beyond education and clinical care, to supporting the process of social and generational change. This is made more urgent by the expanding strategy of encouraging girls to resist the cut even at a young age which implicates the program in serving as support and backup protection as they make this risky transition.

JP has contributed to development of pre-conditions for the provision of accessible, high quality health and clinical services for those at risk or already cut.

In Phase I the program supported a dedicated training of health providers which was informed by basic research on how FGM was treated and managed in the existing health services to better inform guidance/instruction on how to improve the management of complications as well as prevent complications and the practice. This was done as a baseline 5 counties (including Narok, Sambura, and W. Pokot).

This informed not only those tools but the strategy for incorporating FGM content within the curriculum of the University of Nairobi Medical School. A survey of stakeholders regarding how best to integrate the content indicated both the ACPD system and the formal medical curriculum. That "pilot" is being closely monitored to ascertain how best to adapt it to the mix of heterogeneous health and medical training institutes across Kenya.

On the basis of a core capacity building training for healthcare providers at all levels (200 providers from "hotspot" counties), ACCAF has developed and is piloting an eLearning module for midwives on FGM. It is expected that this product will be replicated by UNFPA in NY. The training ascertains and builds on the level of knowledge of those in the training. It is then a short, 3-day comprehensive overview of "where are the hotspots, who they cut, what complications are seen (psychological, sexual, physical), and how health care providers can be "champions" for change of practice.

¹³² ADRA, Accelerating the Abandonment of Female Genital Mutilation/Cutting (FGM) in Migori and Kisii County, 2016-2017 Programme Report, ADRA, Nairobi

Assumption 2.3

A majority of individuals, families and communities in programme areas accept the norm of keeping girls intact

During Phase II, the programme supported partners to conduct 350 community dialogue sessions with 77,777 people (46,626M and 19,151F). This solidified the national effort leading to claim that “the country has champions of change for every Joint programme focus communities (sic) and community-based surveillance systems for detecting, reporting, referring and following up FGM cases”¹³³.

It is very difficult to estimate the ‘proportion’ of the population who participate regularly in educational dialogues for a variety of reasons: 1) there is no denominator to assess relative importance of a particular number—in part because the “units” of analysis are ethnic groups which may number in the millions but for whom only a small part participate in dialogue and in the declarations. There is no question that “breaking the silence”, de-mystification, use of scientifically correct and concrete vocabulary, demonstration of clear links to sequelae have acquired a level of momentum such that they cannot “turn back” the clock. Even the strong resistance with which security forces met in early efforts to enforce the law (in Narok and Garissa) has not reoccurred as the JP has supported alternative sources of influenced and monitoring (teacher, health workers).

In some communities FGM is a ritual that serves as a girl’s rite of passage into adulthood. Thus, the Joint Programme has worked with 500 clan or councils of elder to support Alternative Rites of Passage and public declarations of FGM abandonment. In Phase II, 22,347 girls have undergone alternative Rites of Passage. This ceremony is intended to educate the larger community as much as the girls¹³⁴.

Please see above and below on the JP Kenya “definition of community”.

515 teachers (290 male and 225 female) supervising 80 Child Protection Clubs were trained by the Joint Programme on the psychological and health consequences of FGM and how it violates the rights of girls and women. Applying the cascade approach to training, trained teachers provided training to 6,200 in-school and out-of-school children (3,800 boys and 2,400 girls) who in turn trained 12,400 children (approximately 6,200 boys and 6,200 girls) about reporting FGM and referrals for SRH and child protection services.¹³⁵

The JP strengthened 208 multi-sectoral services including Schools (140 Protection Clubs), Health facilities (47 County level hospitals), Legal Aid Clinics and FGM Unit/Prosecution offices (21 Prosecution counsel) and Temporary Rescue Centres Services.

The number and types of community groups working to raise awareness vary significantly by community and intervention site as do the strategies—Kenya has more diversity in strategies tested than many other countries including community conversations, structured conversations, ARPs, radio call-backs, meetings of Council of Elders, etc. A very significant development in Phase II of the program was a shift from a reliance on the state security mechanisms to monitor and enforce compliance with the law, to supporting a proliferation of “watchdogs” to monitor, report, intervene, or even advocate against.

Multiple community level monitoring actors (champions, support groups, change agents) also offer the potential to overcome secrecy and obfuscation surrounding practice in face of enforcement of the law. As

¹³³ UNFPA-UNICEF JP Kenya Country Profile, UNFPA, Nairobi, 2017.

¹³⁴ Ibid.

¹³⁵ Ibid.

a child protection officer as county level described “Community champions work because they are part of community so will be alerted if FGM occurs; also, they are trained on procedures for preventing and reporting practice (vis a vis FGM, Children’s Act, Sexual Offences Act)”. Officially, the newly established “Nyumba Kumi” approach will support the same. The Nyumba Kumi is a local committee that bridges the relationship of community members with the police and Government agencies, this committee is part of the National Government initiative to restore peace and ensure compliance with the laws to ensure security of the residents at the village level.

In 2016, this approach was tested with different “community members” i.e. training of Community Health Workers not simply for services or accompaniment but also for monitoring. It was taken to scale with a focus on teachers-the Joint Programme trained 315 teachers (160 male and 155 female) on the psychological and health consequences, and rights violations related to FGM so that they in turn could support 60 school-based child protection clubs. Significantly, in 2016, 10 incidents of FGM were reported by teachers who referred cases to relevant authorities for action. These teachers were critical in training approximately 3,900 students on FGM issues, including reporting and referral links for girls at risk or affected by FGM, who were in turn tasked with at least 2 peer-to-peer discussions on FGM, including out-of-school children, reaching approximately 7,800 peers¹³⁶.

The involvement of these actors provides opportunities for alternative sources of support for girls, although the complexities of the relationships between teachers and parents, the potential impact on educational opportunities for the girls (and the remainder of the community should there be conflicts), and the need for Community Health Workers to retain the trust of their clients, requires careful ethical considerations. This is particularly true in a setting in which the primary messaging focuses on the criminality of the act, rather than the rights of women and girls.

The JP has invested in training of journalists to address FGM in their coverage since 2009. Much of that investment came to fruition in 2016 in which there was the largest amount of coverage yet of the issue in print and television documentaries. At the same time, the program invests in radio which is particularly important to reach marginalized and non-literate populations.

Radios includes vernacular stations, which are proving very promising in reaching across national borders to engage parts of ethnic groups or those groups sharing a language which cannot be effectively reached by other means. Radio has also been used to share about the efforts of diverse communities to address FGM and promote abandonment. These stories support both learning and accountability.

Kenya has been very active in testing alternative media tools. It has been testing approaches which address the importance of support and solidarity for those who choose to challenge the dominant culture vis-a-vis FGM. This has included use of WhatsApp, a less exclusive tool than other types of social media, to allow health care service providers to discuss issues related to FGM, and support each other

In their experiences as key expert witnesses on FGM court cases. It encouraged youth and women networks to use WhatsApp at social gatherings such as weddings or water points as a platform form for sharing and disseminating key messages on FGM. Broader social media including WhatsApp is currently the focus of a major component of the DFID funded project of which the JP is one partner. That programme illustrates a similar principle which is importance of solidarity building for girls who choose not to cut i.e. social media builds solidarity quickly through group communications. As the JP expands its work with girls, this element may prove a valuable point at which linkages with the DFID program can be leveraged.

¹³⁶ Highlights Report 2016, UNFPA-UNICEF Joint Program, 2016, NY, NY

During Phase II of the program, 31 communities made public declarations of FGM abandonment involving more than 8.3 million individuals.

The number of community declarations in Kenya remains very low, in large part because the “community” represents an entire ethnic group. This means that a single declaration may apply to a community of over 5 million people¹³⁷

Thus in 2016 there were 5 communities declared and in 2015 15 communities. Accordingly, the number of people participating in these declarations are 3,218,234 in 2016 and 2,340,505 in 2015—an indication that the communities declaring in 2016 were more populous as this represents a 27% increase even with a drop in the number of communities. Although the Kenya JP emphasizes that the declaration is the “start” of the abandonment process, there not much evidence of follow up subsequent to the declaration to either track compliance or foster ongoing progress towards abandoning.¹³⁸

The JP Kenya has only recently begun focusing on programming intended to empower girls and women—moving beyond a protection approach which provides a “safe space” primarily to avoid forced cutting or retaliation (including kidnapping), rather than an educational space to help them grow in independence.

The JP has not sufficiently engaged with other actors in Kenya addressing FGM with a dedicated focus on gender and empowerment in order to inform their own nascent efforts with girls. For example, Plan International is tackling the economic issues directly. It has also invested in three residential training for young girls in hairdressing, catering, chefs and hospitality. They need to ensure their young girls have skills to be engage in meaningful economic activities, and so far, all those who attended the short courses have been absorbed or began their own small business. “This is one way to engage young girls to be productive and also help them to be decision makers”.

The change is slow but gaining momentum. In Kajiado those trained in short courses have had an impact and the main reason for the project extension was their success stories of how their families changed their lives and supported the anti-FGM campaigns after the skills of the girls resulted in paid income which was shared with the household.¹³⁹

Beyond the national population-based data sources which suggest long duration secular declining trends in the prevalence of FGM, there have been dedicated representative surveys which suggest more dramatic changes in areas in which the JP is working¹⁴⁰. A reduction in reported practice may be attributed to fear to report, however there are still important percentages of each group which report planning to cut their

¹³⁷ Population of Communities Supporting the Council of Elders’ Public Declaration Abandoning FGM Implementation Strategies Progress and Results

2012 Kisii 2,400,000; 2009 Meru 1,600,000; 2011 Pokot 516,000.

¹³⁸ Highlights Report 2016, UNFPA-UNICEF Joint Program, 2016, NY, NY

¹³⁹ The approach of assuring that girls are able to demonstrate their economic potential early to reduce child marriage has been informed by decades of rigorous research (See Population Council). Although FGM is “more complicated” in those instances in which it is clearly linked to marriage, it could be valuable to test some of the same learning in addressing FGM. As the Anti-FGM board fosters collaboration and coordination among FGM partners, it will be important to draw from the lessons within the child marriage community.

¹⁴⁰ “A sharp decline in prevalence rates over the last 20 years as observed among communities in Kajiado Central and Wamba; and a steady, near linear decline in prevalence rates over the last 30 years as observed among communities in Sook. This is mainly attributed to intensified anti-FGM campaigns by state and non-state actors in the two study locations of Wamba division and Kajiado Central” Baseline Study Report: Female Genital Mutilation/ Cutting and Child Marriage among the Rendille, Maasai, Pokot, Samburu and Somali Communities in Kenya ©United Nations Children’s Fund (UNICEF), Nairobi, 2017

daughters¹⁴¹. This change is not necessarily an indication of the empowerment of girls and women, but it provides the basis for more in-depth analysis.

Of particular significance, are that the steep declines which took place in communities which traditionally cut at an older age (e.g. over 10 years) as compared to communities which traditionally cut at a very young age. It would be very valuable to examine the “drivers” associated with these differences e.g. the value of educating a girl is more apparent¹⁴², older girls have more agency, or programs targeting the girls who may be cut are more effective than those targeting their mothers.

The limitations of the protection approach are made evident by concerns about rights violations of girls who are held in cells or settings away from parents with inadequate support and supplies. Thus, a girl role model returned to her community described the fact that “girls had to be each other’s families and support” in those settings.

Based on field experience, the most progress has been made among girls who are still in school, still at home (with access to a temporary shelter during the “cutting season”), and supported by the teachers, administration and male colleagues in their choice. These younger girls contrast significantly with the older girls who shared the heart wrenching stories of retaliation, punishment (including withdrawal of school fees) and isolation as a result of their choices. Many of these girls engaged on this issue during a short period in which Sweden funded educational scholarships for girls who were not cut. As that program no longer continues, these girls are at the mercy of their detractors.

With respect to women, there has been some innovative work in the Southwest on income generation opportunities and even rotating credit approaches which support parents who choose to send their girl to school and not to cut her while also supporting a scholarship for her schooling. What is not evident is the degree to which the women in these situations maintain control of those resources.

No religious fatwa’s have been declared within Kenya, however Islamic leaders have benefitted from opportunities for discussion and debate among themselves as well as in exchanges with leaders from neighbouring countries including Somalia. A fatwa was previously passed in Somalia and, given the shared religious and ethnic base of the largest of the Islamic communities in Kenya (Somali), it is an important point of reference. The Islamic community in North Eastern Kenya is primarily Sunni and thus the current approach is better adapted.

¹⁴¹ Approximately 32% of surveyed mothers/caregivers in Balambala, 47% in Kajiado Central, 19% in Habaswein, 38% in Laisamis, 46% in Sook and 51% in Wamba have daughters who are uncut since they are still considered not ready for the cut in addition to refusing to undergo circumcision. Of the surveyed mothers with uncut daughters, approximately 63% in Balambala, 25% in Kajiado Central, 84% in Habaswein, 27% in Laisamis, 38% in Sook and 43% in Wamba intend to circumcise their uncut daughters. Intent to have FGM performed on uncut daughters decreases with increasing level of education: significantly more mothers with no education (48%, $p < 0.05$) as compared to 29% with primary education and 7% with secondary education intend to have FGM performed on their uncut daughters in future. A universal reason offered by surveyed mothers for intending to perform FGM on their uncut daughters is to preserve their long held traditions .

¹⁴² Approximately 73% of circumcised girls and women with no education as compared to 54% with primary education, 24% with secondary education and 20% with college or higher education were married before reaching the age of 18. This most likely reflects the influence of mothers education. Intent to have FGM performed on uncut daughters decreases with increasing level of education: significantly more mothers with no education (48%, $p < 0.05$) as compared to 29% with primary education and 7% with secondary education intend to have FGM performed on their uncut daughters in future. A universal reason offered by surveyed mothers for intending to perform FGM on their uncut daughters is to preserve their long held traditions . Ibid.

Evaluation question 3

To what extent do the JP country, regional, and global initiatives and holistic approach create synergies that accelerate efforts to end FGM? **Criteria: Effectiveness, Co-ordination and Sustainability**

Assumption 3.1

Management arrangements and coordination between UNFPA, UNICEF, national authorities and programme partners have facilitated both agencies to leverage their relative strengths and capacities for more effective programme implementation.

UNFPA and UNICEF in Kenya have collaborated well in the joint programme. Geographically, they work in the same regions, but focus on different sub regions or counties. Coordinated programming is outlined intentionally at the start of the year, however joint efforts around particular campaigns are still possible. The two organizations do programmatic collaboration by aligning the indicators and reporting systems and also on operational coordination by jointly planning and monitoring the projects and sharing the different inputs into the same activity to ensure efficient and effective use of resources.

At a national level, the two agencies are very clear on their comparative strengths—e.g. UNFPA in legislation and policy with strong relationships with the health sector and UNICEF in implementation and technical capacity building with a focus on the intersectoral approaches which characterize child protection work. With the advent of the new county system in Kenya, this clear division of labor is being challenged.

As individual county structures must develop their own coordination mechanisms and budget lines, UNFPA has again been called on to support advocacy for policy and budget lines at the subnational level—including with MPs at national level to effect change in their districts as well as the “first ladies” of the county leadership. UNICEF, which has engaged primarily through the educational system and with younger groups, has, for the first time, trained and deployed a large number of community health workers whose responsibilities include identifying those in need of health services as a result of FGM and directing to those services. As much of the work with the health sector on FGM has focused on the maternal health and ObsGyn community, this is an important advancement both in terms of reaching marginalized populations, as well as in potentially engaging the pediatric community and addressing early sequelae of FGM.

The challenge remains where FGM is positioned—in gender, health or broader child protection. Because cutting occurs at different ages, prevention and addressing sequelae need to be tailored and given the “natural” target populations of the two agencies, it will be important to align who takes the primary role with the age of the target population. JP focal points with an understanding of different country contexts provided examples: in Somaliland, FGM is a child protection issue based on the age group i.e. cutting is age 4-11 so that is a UNICEF issue. In Kenya, within the Somali community, cutting is ages 16-19 so that is a UNFPA issue. In Narok, the children’s Officer takes on FGM cases that are under 18 years of age and covers all areas of child protection vis a vis the Children’s Protection act (as lead). The gender officer at county level takes on older cases. And the county government (gender/children officer) covers issues related to street children.

In the joint programme, UNICEF is more focused on child protection and strongly on the ground while UNFPA is mainly at the advocacy and national level; but the joint programme is coordinating the programme very well and the stakeholders will actually not know what part is financed by UNFPA or/and UNICEF since they are closely knit and present their actions as one unit.

There are no concerns about duplication as they two organizations have distinct advantages and seamlessly managed the technical aspects of the programming together. Joint programme has been flexible at the national level as they invite partners to take what they can support at such days of zero tolerance, the day of the African child since most of the programs of the organizations are strictly on what it can support, in most cases the JP provided support after all other partners were comfortable to the items they supported that brings in the flexibility of the programme especially on how it directly supports the anti-FGM board.

Assumption 3.2

The global programme has effectively developed and leveraged partnerships and collaborations with other development actors to amplify efforts, particularly with regards to more in-depth research on social norms change and its linkages to changes in individual and collective behaviours.

The Joint Programme works closely with several of the strongest implementing field agencies addressing the broader concerns of women and overall poverty alleviation. As a result, their expertise has infused their work and informed the programme helping it to move in the direction of addressing some of the fundamental barriers to change in very poor communities as well innovative work focused on root causes or strategies for reaching particular populations.

The work of World Vision in Narok has illustrated the degree to which a lack of fundamental services and resources so constrains choice, that neither advocacy nor the threat of legal action is sufficient to end the practice. As recounted by the local government actors, community members, and the IP, World Vision directly supported the judicial process, transporting witnesses, providing protection for the plaintiffs, and even transporting the security officers and judicial agents to collect evidence. The Joint Programme is now integrating that additional level of support for the legal process through the participation of FIDA as well as its “mobile” judicial agents programme. A key local government entity in Narok noted that JP funded-activities go beyond planned interventions recorded on paper e.g. it necessarily supports rescue efforts of girls including funding basic commodities and services which government capacity/infrastructure fails to provide when parental support is withheld. Strategies for the rescue centres are currently being debated as government looks to the IP who rescues to support the costs of maintenance, while the IP objects that this is government’s responsibility.

In the case of ADRA, the insights on the economic drivers in decision regarding both FGM and child marriage¹⁴³ contributed to an innovative (now discontinued) programme to fund educational scholarships for girls who chose not to be cut—a critical contribution for girls whose choices in life are so limited as their families are not able or willing to continue to fund their education past primary age. Within the child protection agenda of UNICEF, ADRA has begun supporting small-scale economic programming including merry-go-rounds to encourage community champions or to support parents to pay for their daughters’ education when they choose not to cut.

The partnership with Womenkind in Garissa also provided a means of addressing one of the most marginalized groups the refugees living in camps near the Somali border¹⁴⁴. The concern was both the

¹⁴³ “In Maasai communities, girls—some as young as seven years of age, are considered mature after FGM has been performed and are quickly married in order to obtain a dowry (World Vision, *Before She’s Ready: 15 Places Girls Marry Before 15*, London: World Vision, 2008).

¹⁴⁴ . Womenkind used to work in camps and had a women's center which was a safe haven. They worked with IRC on GBV 2012-2014. UNHCR would refer to IRC who would refer to the hospital and services. Unfortunately the funding was cut.

negative effects of FGM on residents of the camps, but also the impact of the camps on the efforts to end the practice in the surrounding populations. The camps provided easy access to cutters who were not subject to the same laws being inside a UNHCR camp and FGM not a priority issue for UNHCR's refugee response. Womenkind worked in the camps directly and also addressed the linkages with the surrounding populations. This work was done in coordination with the Garissa chapter of the Refugee Council of Kenya (RCK) and thus offers the potential to inform work with other refugee groups and with the challenges of crossing other "borders".

The JP cross border collaboration with the Ugandan JP was a significant experience which has demonstrated the power of cross border strategies. These can also inform other cross border efforts.

The JP has not been able to collaborate effectively with the more in-depth gender responsive research being undertaken by the Population Council within the DFID Evidence to End FGM despite its base being in Nairobi.

This relates in part to the limitations on the JP ability and capacity to "apply" such research, as well as the timelines and rigor which characterise such a research project. Another issue may be the poor design and management of the "alliance" under the larger programme, which did not clearly assess the capacity and interests of the parties, put in charge the "new comer" to the group, and has not invested efforts in trying to make this more effective. Because the DFID funded program is managed from HQ level in the UK, this discussion must include the UN agencies HQ as well. Differences in methodological approaches among the various researchers in this new alliance are still being discussed.

The most important partnerships leveraged by the JP at this level are those with the multiple public sector entities who are still struggling to define the structure which will enable the continuation of the intersectoral work needed to address FGM. The JP actively supports and encourages the participation of IP representatives in the various new administrative structures and technical coordinating teams at county level.

Through the JP support to World Vision for meeting costs, the Gender Technical Working Group (GTWG) was very recently established in Narok and is intended to bring in NGOs, government, and potentially private sector actors who work in relevant areas including FGM. It mirrors the coordination mechanism of the Anti-FGM board at the national level but is very operational in its orientation and engages representatives of the key "entities" from both county and national level—overcoming some of the disconnections arising from the devolvement of some agencies and not others.

It will serve as a platform to facilitate coordination, reporting and sharing of data (currently not a practice) on FGM efforts in county. Prior to GTWG, the only coordination mechanism for FGM efforts (in the county) was the Area Advisory Council (AAC) which has a very broad mandate and works only at the local level. The working group involves the gender officer and 20 partners and is chaired by the county commissioner (while the gender office is the secretariat). It's multilevel membership - includes national level (ODPP, Police, Dept of Children), County government (Gender officer); NGOs, CBOS, FBOs, and hopes to include private sector actors. Representative of all relevant thematic areas – e.g. education. GTWG serves to bring together key actors at different levels to facilitate linkages between actors and interests and harmonize efforts (e.g. linking FGM-GBV-SRH).

This kind of very grounded coordinating mechanism which also taps resources at national and local level may provide opportunities for the kind of "engagements beyond contractual formalities" among partners which help to foster synergies, help maintain momentum at national and community levels and, through the participation of non-state partners', help provide continuity of capacity and advocacy even as political change challenges government partners.

Assumption 3.3

Joint Programme acted as a catalyst for established and emerging actors to strengthen the response to end FGM, at national, regional and global levels, including e.g. other UN agencies, other programmes, new donors and funders, national governments, regional bodies, civil society and implementing partners.

The ability to use research and findings is of importance to not only the Kenya program. The Kenya JP offers potential for comparisons among different approaches in the same ethnocultural and economic context or comparison of the same approach across different contexts. The five-county study of UNFPA and five community/ethnic group study of UNICEF illustrate the value of such an approach and have informed programming and coordination efforts. Additional learning is emerging from the work of the Population Council and its local partners which may provide insights at a larger scale and link research to public sector services.

These research efforts, however, cannot provide the same insights into changes in practice as either intended or unintended outcomes of interventions. For a deeper understanding of which interventions or combinations are most effective and why, intervention-based research and/or the intentional integration of design elements or evaluation tools within programme planning and placement are needed. Such a grounded approach has not yet been prioritized—by the JP due to limited resources; by UNICEF or UNFPA each with different monitoring and evaluation standards; or even by the major development partners currently investing substantial resources in research to better understand how to address FGM.

The Joint Programme is supporting efforts to standardize the core interventions e.g. community dialogue and ARP. This work is generally thought to be good programming practice for any future effort to use a comparative approach which can identify which interventions work best in particular situations. However, the lack of capacity combined with the constantly evolving “nature of the practice of FGM” (W Ngau 2015) and the urgency of a response, has led to a reliance on a “community driven approach” to assessment which does provide insight into the particularities of context but is challenging for broader program planning.

The Kenya programme has been successful in raising additional funds to support the work from in country sources. For example, in the first phase: UNICEF Kenya from SIDA (Sweden) for Calendar year 2012 \$50000; from Swiss Committee for UNICEF for 2014 \$413822 UNFPA Kenya from Maternal Health Trust Funds, 2011 \$66000.

Kenya also hosting the full JP Steering Committee for a week’s visit to the innovative programming in West Pokot which also showcased Kenya’s achievements vis-a-vis addressing cross-border issues—a key component of an enhanced regional strategy for the JP which is a top priority for the donors on the SC.

Assumption 3.4

The JP has raised the profile of FGM and contributed to the acceleration of its end through establishing global normative standards among governments.

Evaluation question 4

To what extent does the Joint Programme draw on the relative strengths of each organisation, promote efficient programme implementation to amplify the Programme contribution? **Criteria: Efficiency/ Co-ordination**

Assumption 4.1

Joint programme financial systems and structures enable the efficient and timely flow of resources to support implementation and achieve planned results.

The JP in Kenya faces some of the same challenges as other country programs in addressing a complex and deep-rooted issue working primarily with partners, but on a one-year funding and reporting cycle. This makes planning difficult for the IPs but also increases the burden on staff which impacts the quality of feedback and support. As noted by a key IP:

“JP funding needs to be consistent– it is not now. It comes every quarter and is often delayed which means you have to implement in 3 months. We use our own resource to undertake activities even when don’t have funding – we have to do so, or we will lose the investment made and the goodwill of the volunteers who continue to sustain the programme. The work of the volunteers undertaking education in the community needs to be consistent in order to change perception and it cannot be consistent with unreliable and short-term funding. It also reduces the effectiveness. When the work plan is just for quarter, it cannot be fully contextualized and there is only room for short term activities. And there is no room for innovation because we can only implement what is in work plan.”

Assumption 4.3

Monitoring, reporting and evidence-gathering systems are in place and are compatible across both agencies, and are adequate to measure progress towards expected results and promote learning at all levels.

The monitoring and evaluation approach and system is tied primarily to UNFPA (linked to UNFPA Strategic Plan) and the JP dedicated monitoring/DFA system common to all JP country programs. The DFA is currently focused on activities and outputs only thus outcomes are not tracked. Linking the resources and skills of the two agencies in M and E has yet to be the focus of key development partners now defining new work on FGM

To this point the reliance on the DHS to monitor trends has limited the ability to establish an association between interventions and change however recent statistical advancements may support county level analysis which will greatly facilitate programme development. The emphasis on social norm change which remains the focus of numerous research efforts to define appropriate indicators and measurements makes outcome level monitoring difficult.

The current JP approach to M&E is compromised by lack of rigorous follow up and monitoring of activities by the IP, incomplete baseline data, lack of administrative data from government services which support the interventions, and reliance on implementation by IPs without dedicated M and E specialists or sufficient technical capacity.

The focus on outputs, administrative data, and demographic trends has left a significant gap in understanding which drivers of FGM and change should be the focus of programming. This is normally addressed through intervention or operations research. Strengthening government and partners’ capacities for management, analysis and application of diverse data to guide adaptation to rapidly evolving contexts and new patterns of FGM practice (e.g. medicalization) and scale effectively

The comparative strengths of the two agencies in M and E—e.g. cost-linked data from UNFPA and descriptive data and social norms expertise from UNICEF, have not been sufficiently leveraged to inform

the development/improvement of the current system; use of existing data in innovative ways; means of applying the lessons learned from separate research efforts on drivers and change; or future improvements.

Evaluation question 5

To what extent does Joint Programme programming lead to sustainable change for the eradication of FGM?

Criteria: Sustainability

Assumption 5.1

The Joint Programme supports national ownership of efforts to eradicate FGM by building institutional capacity and by integrating programming into established national systems and processes.

The history of initiatives behind the law and the national policy are clear evidence of the government ownership of the interventions addressing FGM. The development of the anti-FGM board at national and subnational level provides a structure to fully embed the programmes and strategies. That the board itself is involved in developing standards for the most common interventions in FGM is further evidence—i.e. how such approaches are best used in Kenyan context. Finally, Kenya has “put itself on the map” with contributions to the East African law.

The Joint Programme has invested significantly in dissemination and development of tools and guidelines to support ongoing training of key cadre on FGM. This includes supporting the use of the manual on clinical management of complications produced with WHO, a dedicated manual for midwives and the development of SOPs for the prosecution of FGM cases.

It has supported the training of key actors in the judicial sector including 40 staff from the Office of the Director of Public Prosecution, security and probational officers, community health workers, midwives, teachers, and key leadership in the communities. Given the pace of change of FGM practice, it invested in a study of practice and complications in 5 counties in which it supports programming to understand implications for training of the health communities.

The JP has supported numerous capacity building initiatives to strengthen government-funded personnel in the health, security, and justice sectors—through training of leadership; and development of manuals and curricula. However, the JP has invested less in sustainable training strategies which are critical given the scale of the problem. In a first step, the development of tools provides a “handle” for applied training. The JP has also supported the integration of content on FGM into the medical curriculum within University of Nairobi—a careful process which reviewed both practice and the recommended “ways” of integrating and teaching the content.

As evidence of the JP contributions, UNICEF has launched a major new initiative to strengthen administrative data collection and foster coordinated analysis which can illuminate patterns and gaps in services. This effort requires additional capacity building of data agents both in terms of technical capacity and the ability to use strengthened data for support accountability for reporting (e.g. lessons from GBV joint programme)

See above on development of national and subnational budget lines.

Since the start of Phase II, the Joint Programme has necessarily had to focus on implementation at a subnational level. Thus, funding at this level becomes even more important. Although “addressing FGM” is itself “not a devolved function” (i.e. remains at the national level), many of the services which are central to the JP-supported response to FGM have been devolved to county level. There they face a

disconnect with budgets emanating from the national level—this was a contributing factor in the strike of medical personnel in 2018--or they remain at the national level leaving local level structures insufficiently resourced (e.g. the justice sector).

Medical service personnel in Migori’s Level 4 hospital appreciated the impact which FGM likely had on a limited county-level budget “every one of the C-section cases now on the maternity ward can be linked to FGM”. In Kenya, the First Lady has long been a champion on ending FGM and a leading figure in the annual 0 tolerance day contributing to support at national level. Notably, in 2016, the JP worked with leadership at the county level: 29 wives of State Governors lobbied for increased county government resources in support of anti-FGM and child protection initiatives. West Pokot County allocated funding in their 2016/2017 budget for work with the Council of Elders on ending FGM—a notable accomplishment given that FGM remains a “national level issue”.¹⁴⁵

Community contributions to events such as ARPs and community declarations are a sign of buy-in and sustainability; establishment of county-level budget lines despite confusion over positioning of work of FGM among various line ministries is indication of readiness to support. However, these are not necessarily gender-focused activities.

At national level, the GOK has taken an active role in development of national level law, policy, and coordination mechanisms which facilitate ownership. We need to engage political actors to be more informed and respectful in-home states: they will talk about it in Nairobi but not at home.

At County Level the evaluation found that:

- JP supports engagement of government leaders in Garissa e.g. the leadership of the JP has also been highlighted at the national celebration for the International Zero tolerance day 2017 was held in Sankuri, that was attended by Cabinet Secretaries, Government officials, UN, INGOs, CSOs, religious leaders amongst others
- The JP supports relevant Working Groups (Garissa, Kuria, Narok) ODPP and law enforcement (Narok); activating 2 AAC (Habaswein, Garsen; strengthened child protection referral pathways for service) (Garissa);
- In Narok, NASCNET (network of diff CSOs working in areas of gender and child protection - including FGM, child marriage, teenage pregnancy). was formed because there was lack of coordination. There was no way to know what each org is doing; communities didn’t understand why so many actors working on same thing à this led to formation of NASCNET. The join Programme IP (World Vision) is a part of this network. From this network, the GTWG was formed.
- given the need to understand issues at govt level and to strengthen coordination: “In coordinating issues of gender and CP only way to make more impact is partnering together”. It is a multi-sectoral group to include government, CSOs, and private sector. to coordinate efforts and effect long-term change. There are two significant risks facing the investments at this critical subnational level. One relates to the outcomes of the devolvement initiative which is still very much a work in progress, and which is closely linked to the current president.

¹⁴⁵ Highlights Report 2016, UNFPA-UNICEF Joint Program, 2016, NY, NY

“Devolution was a good move—power and resources closer to people; but corruption devolved and brought new centers of conflict particularly in communities where there are no boundaries (pastoralists) so a new fight over resources, extractives, land.”

In the next election in 2022 there will be a new president: how for new governors to take forward? If a system is not yet well developed, it is devolved services that will suffer including health. The programme will have a new crop of people needing capacity building, ownership and institutional memory will be weak. WHO has been working to develop the health sector personnel in 10 counties working through the national ministry. Although UNDP has a program with UN Women to support gender within the devolvement process, it does not include the health sector (just government, peace, security, environmental risk, and extractives). The election period itself has impact on health sector performance because of budget and payment problems.¹⁴⁶

The second relates to an ongoing problem shared with other countries. The repeated restructuring of key ministries (combined with transfer of staff at field level) and the embrace of the multi-sectoral CP entry point, risks FGM not being claimed or owned by any particular line ministry. In addition, subnational level staff are moved regularly and are currently very “new” in that to fill the structures and in keeping with “integration” across regions, many were brought from other regions to work in their current post.

Although there is much lamenting the loss of capacity which this represents, there may be solutions. Although not from the region, the majority of the government actors encountered in Kuria were well versed on FGM—including the sub commissioner who was newly arrived from another region. With sufficient administrative data strength, it should be possible to identify where the capacity goes and to leverage that expertise in another region.

Assumption 5.2

The Joint Programme promotes changes in social norms at the community level that are sustained over time and that lead to improvements in gender equality dynamics between men and women.

Leveraging the strengths and unique access of UNICEF, the Joint Programme in Kenya has invested significantly in engaging young children, not just youth.

In 2016-2017, ADRA supported the training of 884 young people (455 girls, 429 boys) to become “children change agents” to conduct dialogues among the peers. Although they were not able to sustain the participation of all those trained, they were able to document sharing with other children, parents and other duty bearers. Younger children can be reached with key messages before they are faced with the threat of cutting, and changes in the perspectives of younger boys, as well as girls, is much easier at younger ages. One of the challenges at this age, is a focus on protection—including boys protection of their sisters—rather than the empowerment of young girls to make their own choices. However, a sense of ownership of their own bodies is a first step in this direction.

Similarly, ADRA’s interclan dialogue engaged all ages from the communities and provided opportunities for them to ask questions of the elders. This method facilitated intergenerational discussion and the “opportunity to understand the view from elders”. It also demonstrated the range of positions within any one community which supported those in the process of reconsidering their own positions.

¹⁴⁶ Articulated by key UN entity representatives but echoed with less technical emphasis in dialogue with government actors at subnational level.

The Joint Programme partners have had dramatic success with targeted communities and groups as evidenced by reports of their activities in schools, churches, and public events such as alternative rites of passage and special national events in which thousands of young people participated. A recent dedicated survey illustrated that these investments have had impact on a much broader scale—i.e. both long trend and sharp declines in reported practice in high prevalence communities in which the JP has been supporting work for a long period. These are the seeds for social norm change.

The JP is supporting multiple new initiatives which have the potential to scale up outreach and overcome communication barriers (use of vernacular radio; experiments with social media for young people and dedicated community activists) as well as speed up the pace of social change (work with young adolescents/children and in schools on a sustained basis). These are the key elements for “acceleration” of efforts to end FGM, but not yet norm change.

Recent dedicated surveys demonstrate that there is a very high level of awareness of FGM in the key high prevalence communities in Kenya, but that despite awareness, knowledge of FGM and particularly knowledge about the negative effects of FGM remained low. As these effects are one of the major motivating arguments for stopping the practice, this suggests a need to reinforce that messaging—an important role for the health and education sectors (quite different from the security and justice sectors).

The stories of girls who have chosen not to be cut and the ethical dilemmas of those involved in rescues of girls at risk make evident that the norm of remaining intact is not yet accepted. The girls are taking huge risks. The stakes are clearly high for the parents who would not otherwise be trying to harm them. This suggests that there are more powerful drivers than social norms involved. It is not about just norms but about economics needs. The women’s groups in Narok linked FGM to marriage and early marriage “happens because of poverty, early pregnancy, and women are not recognized (men assume women are children, so they undermined them when they pursue education vs marriage). After girls finish 8th grade (13-14), the father sells them to be married. There are no jobs, options for girls – by that time they are already selected for marriage to highest bidder. There is no money for girl’s education, men give money to brewers (alcohol).” An added factor is who will benefit from the education investment in a patriarchal system.

Assumption 5.3

Interest around FGM generated by the Joint Programme at the global level leads to more sustainable donor funding and long-term efforts to eradicate it.

The Kenya JP has hosted numerous delegations of donors and the SC (donors) thus contributing directly to sustained donor funding and/or diversity of donors.

Important Issues not Included in the Assumptions

Manner in which the Programme engages boys and men

Engagement with male activists has been limited to religious and traditional leaders and then men in the key sectors. There are larger communities of men which can be engaged. Engaging boys provides many opportunities for substantive change. Due in part to the fact that work with this age group is under the auspices of UNICEF, there is more of a “protection” focus for the boys i.e. protecting their sisters. It will be important to integrate more of an agency perspective here.

Risk of human rights violations (rather than rights protections) when working from a rights perspective in a weak system

No rule of law; no gender language. As with other country programs, reliance on weak security and justice sectors especially in conflicted territories risks lack of due process, rights violations of perpetrators, and risks for girls (e.g. in adult holding cells due to inadequate safe spaces). Messaging on law focuses on criminality not rights violations and is poorly understood.

There are challenges managing the aftermath of girls who are encouraged and do reject the cut. If they stay home, they face discrimination (and pressure) within the family (and wider community) and may lose support for their education. If they leave, they face fewer options.

The importance of learning not only from best practice in addressing FGM, but also in addressing child marriage when the two are clearly linked. The JP has not explored the potential learning across the work on child marriage and FGM. Although FGM which takes place at birth is not tied to marriage explicitly, many of the root causes are shared.

Illustrative Key Testimonies

The Kenyan programme has hosted multiple learning visits from other country programs to learn from supported diverse work on ARP, addressing cross border issues, and with the religious communities. It has hosted the JP Steering Committee more than once. It was described by a key regional stakeholder as “one of the best examples” of joint and complementary agency planning and programming. “lenses”: visibility of “protection” reflects UNICEF comparative strengths in the field-focused post-policy phase and girl programming.

FROM TGG: Evolution of JP: 2008 building body of knowledge did well. Engage partners in every country. Could have done better in stepping up grassroots agencies. Can't be an implementer. Ask what you do and how we can help you do it better. Sharing knowledge on what works. We should be in a position to say if FGM due to religion-do this. If marriage, do this. They have been doing years of work so they should have something to tell us.

Considerations for the overarching global thematic level

Consideration 1.

In evaluating the JP efforts at fostering a “holistic” approach or pursuing “joint or integrated programming”, it will be important to distinguish between what is truly multi-sectoral and what is just a diverse group of stakeholders. Multi stakeholder approaches can work in any sector and both government and NGOs can do this work. Multi-disciplinary methods (e.g. qualitative and quantitative) may be best adapted for NGOs who can work with smaller datasets but review them in greater depth. Multisectoral approaches suggest a need to work with multiple government structures. A “transformative” approach may require all 3 which implies a partnership at all levels.

Consideration 2.

The regional strategy of the JP is one of the primary issues emerging from the evaluation of Phase I. The JP made significant progress in work with formal international, intra-regional entities such as the AU and ECA. These entities address primarily the normative and legal frameworks which were the major focus of Phase

I. Multiple respondents highlighted the importance of working at community level across borders, not trying to work through law. Thus, some of the most valuable work which could be supported by ESARO is capacity building which explores how this is possible.

Another important element to consider in work in East Africa, is how office structure impacts programming—i.e. when Somalia is situated within the MENA region, the key strategy will revolve around religion. When it is situated in the ESARO region, more work might be done addressing the cultural dimensions of practice. This observation was shared by the Somalia office in Nairobi” We need to do more with Somalia and Ethiopia and Kenya. Djibouti and Somalia are Arab states for UNFPA (and share a rep). For UNICEF, Djibouti is Arab states, but Somalia is ESARO. So, the work with Somalia crosses 2 offices. There is an advantage of engaging Somalia with Arab states and Islamic leaders. In meetings of religious leadership, they all speak Arabic, so language is not an issue. However, Somalia as a country shares a language, culture, religion and even type of FGM with Ethiopia and Kenya.

Consideration 3.

1a. Kenya’s struggle with fully engaging the health sector is illustrative the critical need for both UNFPA and UNICEF to reinforce health sector linkages. The health sector is “needed” for addressing the sequelae of FGM as well as for forensic evidence. The health sector can cut across age groups in a manner than the education sector cannot. The Health sector has access to data and a means for verification which is unique and may address some of the ethical challenges. The health sector is already the “center” of the GBV roadmap. The health sector is also the one to help untangle the confusion regarding “male circumcision” and to document and communicate the human cost (for community advocacy) and the health and productivity cost (for broader resource mobilization) of FGM.

Consideration 4

Many of the challenges with the data, service, and “reach” elements of the FGM work relates directly to its positioning within “gender”. In Kenya, multiple respondents indicated that there is not GBV money in health because it is "gender ministry" issue. As FGM is subsumed under GBV, it is subject to the same prejudice. However, the clinical manifestations and outcomes of FGM require much more engagement from the health sector. Thus, gender played a critical role in the “policy/advocacy” stage, but health needs to join in this new phase.

Consideration 5.

One of significant developments of during Phase II of Kenya program is substantial new investment in work with girls and young people. In the early stages of the JP, the differences in perspective on gender and girls of UNICEF and UNFPA would have presented a challenge. Although there are still significant challenges—UNICEF needing to embrace a rights perspective; UNFPA needing to strengthen technical capacity on gender programming, not just advocacy—there has been sufficient progress to leverage the contributions of both agencies. A key consideration, however, is HOW to do programming with girls, not just “involving” them. There are things that can be learned from the TGG program on one of the most important elements of working “with” girls i.e. building solidarity and support to make change. The TGG social media works is one way to make sure girl activists are not isolated when they leave the workshop or conference and go home.

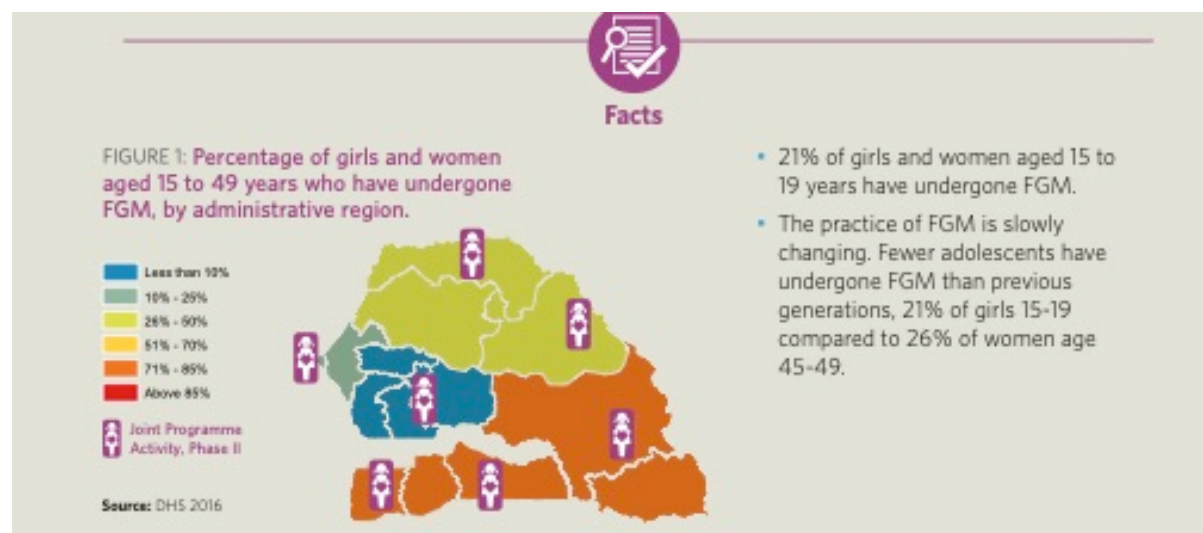
Youth use text, WhatsApp, etc. Safaricom knows the market. Community dialogue for adults (complex arguments) we also have old fashioned newsletter. We minimize telephone is expensive. Translate French Arabic or self-translate on website

Consideration 6

- The evaluation matrix structure can integrate “unintended consequences” across all criteria, as they go beyond lack of services or unsuccessful cases. This can be achieved during the final synthesis.
- The failure of the court system resulting in girls languishing in isolated rooms is an unintended consequence presenting a rights concern.
- Having to return a girl to an angry family because there is no option for her other than marriage is also unintended (i.e. no education option) but becomes a rights and safety concern.
- The “rescue” option can also have unintended consequences. There is literature and debate on this in the “trafficking” literature.
- It becomes important to establish rigorous standards and institutionalizing audits of “rescue” and “resistance” interventions to eliminate risk of greater harm arising from lack of sustainability, accountability, or protections as well as the failure to provide viable alternative choices for girls whose marriage and family support are withdrawn when they choose not to undergo FGM

Senegal

Figure 3: Extract from Joint Programme Phase II Performance Analysis, country overview (UNFPA-UNICEF, 2018)¹⁴⁷



Context

Interventions

The national strategy to end the practice of FGM in Senegal, supported by the UNFPA-UNICEF Joint Program to Accelerate the Abandonment of FGM in Senegal, is based on (i) a holistic and multisectoral approach based on the human rights approach, (ii) social mobilization and community capacity building, (iii) advocacy with central and decentralized authorities for the improvement and application of the legislative and regulatory framework at the national level (iv) youth involvement v) and cross-border cooperation.

- In addition, the Joint Program also focused in 2016 on:
- Capacity building and coordination of actors through regional FGM monitoring committees and the child protection committees set up as part of the implementation of the national childhood protection strategy
- The use of the medical evidence to sensitize the communities on the FGM consequences for the reproductive health of women and girls

¹⁴⁷ Clarification of text: analysis of several rounds of DHS indicates that most change is within confidence intervals and there has been little, if any, change in the prevalence in Senegal. The last available data for Senegal is DHS 2017, which indicates that 24% of women have undergone FGM. See: https://dhsprogram.com/Where-We-Work/Country-Main.cfm?ctry_id=36&c=Senegal&r=1.

- Cross-border meetings with administrative and local authorities, organizations, civil society, community-based organizations, development partners in different countries to promote a common and harmonized approach to FGM abandonment

Key results:

At the institutional level, strategic documents aiming to contribute to the abandonment of FGM have been developed;

- (i) The adoption of a National Action Plan for the eradication of GBV and the Promotion of Human Rights Senegal 2017-2021;
- (ii) The adoption of a new National Action Plan for the Protection of Children (PA / SNPE) (2016-2018);
- (iii) Development of the Gender Equity and Equality Strategy 2016-2026;

In terms of capacity building, several actors (technical relay teachers, young people, health providers, community health actors ...) have been trained / sensitized on human rights issues, prevention and management of cases of abuse and violence, including FGM. The holistic approach of TOSTAN has been revised to propose an approach integrating a package of services related to the protection of children and the abandonment of harmful practices: Gender Based Violence (GBV) and FGM.

In terms of innovations, the Joint Program has ensured better involvement of young people as agents of change through the establishment of a network of young people against harmful practices, and the reinforcement of their commitment through social networks and platforms such as: U Report, the Green Line Gindima, the "#No Step Up to My Sister" campaign, the SR Minute on Female Genital Mutilation, the Mannequin Challenge (1 minute video on FGMs), the participation from a representative from Senegal to the Forum for African and Arab Adolescent and Youth Driving Sustainable Development, the #KaayTwitte Digital Campaign on FGM, the Facebook page "Words to Youth".

Difficulties encountered during the implementation of phase II.

The major difficulties encountered during implementation of the Joint Programme:

- The weak application of the law: 8 known convictions since 1999; - the limited number of cross-border actions and strategies;
- The limited commitment of traditional / religious leaders (especially the major Muslim brotherhoods);
- Variable consideration of FGM in sectoral policies;
- The dispersion and small capitalization of community-based approaches;
- Low visibility of the issue of FGM in the media and public debates;
- The risks of rejection caused by the approaches implemented at Community level;
- limited and fragmented availability of data;
- lack of tools and devices to measure progress towards abandonment;

- Insufficient monitoring mechanisms for collective declarations of abandonment;

Expenditure

2008:	400,000 USD
2009:	400,000 USD
2010:	322,812 USD
2011:	820,000 USD
2012:	757,000 USD
2013:	820,000 USD
2014 and 2015 (combined):	3,000,000 USD
2016:	4,988,642 USD
2017:	1,112,150 USD

Implementing partners delivering

- Tostan
- Ceforep
- Grandmother Project
- GEEP
- RADDHO
- ASBEF
- PPJ
- FAFS

Evaluation question 1

To what extent is the programme (approach, design, strategies) relevant, responsive, and evidence based to contribute towards accelerating efforts to abandon FGM globally, nationally, and sub-nationally (including in cross-border regions)? **Criteria: *Relevance***

Assumption 1.1

The Joint Programme design (including approach, strategies and interventions) is aligned with global, national and sub-national priorities and is flexible enough to be responsive to different local contexts and to changing realities and priorities.

The Joint Programme is well aligned with the National Plan to Accelerate the Abandonment of Female Genital Mutilation as well as sectorial government documents that mention FGM.

FGM abandonment constitutes a priority for the Government of Senegal since the adoption of law N° 99-05, on 29 January 1999.¹⁴⁸ FGM is also mentioned within sectorial government documents, such as the National Strategy for Equity and Gender Equality, the National Child Protection Strategy, and the Political Norms and Standards for Reproductive Health.¹⁴⁹ The Joint Programme has assisted the national government in developing some of these documents (such as the National Child Protection Strategy) and

¹⁴⁸ (2016 Annual Report: p.6)

¹⁴⁹ Interviews with UNICEF and UNFPA Senegal staff

the JP approach reflects the holistic multi-sectorial approach to promote the abandonment of FGM that is promoted by the government.

The Joint Programme has increased its flexibility during Phase II of the programme by using a variety of approaches in different contexts to promote the abandonment of FGM.

The Phase I Evaluation of the Joint Programme found that Senegal was over reliant on the use of one model (the Tostan approach)¹⁵⁰ and recommended that the JP draw on a wider variety of approaches to address FGM.¹⁵¹ The Senegal Office acted upon this recommendation and has expanded its selection of approaches to include a more diverse set of actors and strategies. This diversification has provided the JP with more flexibility to choose from approaches that are tailored to specific circumstances, resulting in a greater ability to adapt to shifting contexts.

As part of this diversification process in Phase II, the JP in Senegal engaged in political advocacy with politicians; worked with Islamic religious leaders to document and spread the message that FGM is not a religious requirement; supported the empowerment of youth and girls through initiatives such as youth peer mentorship and the UNFPA Youth Caravan; and supported government capacity development initiatives with the Ministries of Gender, Justice, Health, and Education¹⁵². Specifically, the JP provided support to the Ministry of Gender to help coordinate the National FGM Coordination Committee; training and capacity development support to judiciary personnel around the application of the anti-FGM law; support to the Ministry of Health around national FGM data collection; and support to the Ministry of Education to integrate FGM into the national school curriculum.

The JP also started supporting a wider range of community actors and began experimenting with alternative community-level approaches in Senegal. New approaches include promoting change through inter-generational dialogue and advocacy targeted towards FGM decision-makers such as Grandmothers as reflected through *The Grandmother Project*, and by building male-sensitivity towards gender equality and the abandonment of FGM as reflected through the *School for Husbands*¹⁵³. Additionally, the JP is supporting the NGO *GEEP* to integrate FGM services into schools and to link them with communities.¹⁵⁴ The NGO *Sephora* has also been supported by the JP to provide pre-natal training to medical personnel and midwives and to provide special healthcare services to women who have experienced FGM.

During Phase II, the JP also increased its use of traditional and social media and supported a variety of communications initiatives that encouraged more open discussion around FGM and its consequences. Such communications initiatives include discussions through community radio and debates between Islamic leaders on television¹⁵⁵. The JP also conducted awareness-raising campaigns on FGM through social media (e.g. ‘#TouchePasAmaSœur’ campaign, ‘#KaayTwitte’ campaign, etc.). Young musicians and artists were also engaged by the JP to encourage advocacy among youth. During this period as part of the JP communications outreach, 50 journalists and radio animators received capacity building on FGM and child marriage¹⁵⁶.

¹⁵⁰ Tostan uses a holistic community-based educational approach to reinforce skills based on a human rights framework.

¹⁵¹ Phase I Evaluation, page 9.

¹⁵² Interviews with UNICEF and UNFPA Senegal staff

¹⁵³ Interviews with community-level IPs and community-based rights holders.

¹⁵⁴ Interviews with JP implementing partners.

¹⁵⁵ Interviews with JP media partners.

¹⁵⁶ 2016 Annual Report: p.6

Assumption 1.2

The Joint Programme approach is based on its comparative advantages, taking into consideration the roles and comparative advantages of other actors working in this field.

The Joint Programme draws on its comparative advantage of convening stakeholders by bringing its partners together at the national level and by supporting the National FGM Coordination Committee. While FGM actors are brought together regularly at the national level, they are not brought together to exchange information at the sub-national level.

The Joint Programme is effectively playing its convening role in Senegal by supporting the National FGM Coordination Committee, led by the Ministry of Gender. In fact, the JP supported the creation of the national committee to implement the Action Plan for FGM abandonment¹⁵⁷. Most of the stakeholders who make up the Coordination Committee are JP partners, reflecting the Programme convening power. Additionally, the JP provides valuable technical and financial support to the Committee¹⁵⁸. FGM activities executed by the Coordination Committee are usually financed by the JP (there is no government budget line to cover FGM activities), and the annual planning and implementation of committee meetings is done largely in collaboration with the JP¹⁵⁹. Even though there is a need to improve the functionality of the Coordination Committee (meetings occur at irregular intervals and not all government ministries are consistently present), the JP has made a valuable contribution to bringing relevant stakeholders together and to empowering a national coordination process¹⁶⁰.

Outside of the National FGM Coordination Committee, the JP regularly brings its partners together in Dakar to discuss issues relevant to FGM and to conduct annual planning. In fact, all of the JP key partners were brought together at the national level to plan out the JP Phase III using participatory methods¹⁶¹.

Even though national meetings are indeed very useful, the JP does not organise meetings to bring together partners at the sub-national level. The JP helped to establish and provides support for local child protection committees (CDPEs) primarily through JP and UNICEF funding, which serve as mechanisms to coordinate FGM efforts at the sub-national level¹⁶². However, the JP does not bring its own partners together at the sub-national level to share information and experiences¹⁶³. National level meetings in Dakar often include the same representatives from partner organisations, which limits how much information is shared among and between actors working at the community level. JP partners working at the community level expressed the need to be involved in sharing ideas and experiences around social norms change work with other community-level stakeholders within the region¹⁶⁴.

The Joint Programme at the global level has increased its commitment to providing regional support but there remain large gaps in terms of sharing information and bringing actors together at the West Africa regional level.

¹⁵⁷ 2013 Evaluation page 26.

¹⁵⁸ Interviews with government stakeholders

¹⁵⁹ Interviews with government stakeholders

¹⁶⁰ Interviews with JP staff, government partners and implementing partners

¹⁶¹ Interviews with JP implementing partners

¹⁶² 2013 Evaluation, page 27.

¹⁶³ Interviews with JP staff and implementing partners.

¹⁶⁴ Interviews with community-level implementing partners.

The Global Joint Programme has been responsive to a recommendation outlined in the 2013 Joint Programme Evaluation to provide programming support at the regional level by investing in new regional staff positions (i.e. the UNICEF RO in Dakar now has an FGM focal point)¹⁶⁵. The UNFPA and UNICEF Senegal country offices have appreciated this new investment and the FGM technical support provided by the RO focal points¹⁶⁶. Additionally, the JP has supported some south-south exchanges, for instance, through the visit of a Delegation from Gambia to Senegal (composed of UNFPA/UNICEF Gambia Staff, as well as staff from the Health Ministry, the Vice-President office, the Ministry of Women, etc.).¹⁶⁷

Even so, there remain important needs that have not yet been filled at the regional level. The JP does not have a regional strategy for West Africa to address cross-border issues and to address regional aspects of FGM. The 2016 JP Senegal Annual Report identified a need to further strengthen collaboration between decision-makers from governments in the region.¹⁶⁸ There are currently no established platforms to share documented information (including good practices and lessons learned) across countries within the same region, and events to bring actors together (including JP staff, partners, and government actors) are not organized regularly at the regional level.¹⁶⁹ While some progress has been made to establish a regional presence within the joint programme, some of the roles and responsibilities between the JP HQ and regional staff are at times unclear.

The JP has successfully mobilized additional international resources for FGM work in Senegal. Embedding FGM into other related themes has been a useful approach to generating additional funding.

The Joint Programme has demonstrated its capacity to leverage resources in Senegal by securing FGM funding from the Canadian Government and the Government of Luxemburg to complement JP funds. Recently, JP staff from Senegal met with EU funders to request financial support to help the JP build more high-level political commitment to abandon FGM in Senegal. The funding request was framed within a context of GBV, which helped the JP request for funds¹⁷⁰. Additional opportunities may exist to further frame FGM within a Gender Equality context by documenting transformational changes in gender relations that are taking place at the community level.

Assumption 1.3

Joint Programme interventions at the global, regional, national and sub-national levels are based on a comprehensive analysis of all available evidence (e.g. situation analysis, needs assessments, gender assessments, identification of drivers of change, stakeholder mapping) of the populations of interest in programme countries and of the factors that create barriers and promote drivers of change to end FGM.

JP programming in Senegal is based on available research but the JP does not have strong collaboration with research groups nationally or regionally.

The Joint Programme in Senegal has used whatever data, research and evaluation work that is available to inform its programming. For instance, the JP in Senegal used recommendations from the 2013 JP Evaluation to diversify its approach. This being said, the JP in Senegal does not have strong relationships with research institutions to explore issues related to FGM. Currently the Population Fund provides funding for FGM

¹⁶⁵ Interviews with UNICEF RO and CO staff in Senegal

¹⁶⁶ Interviews with Senegal JP personnel

¹⁶⁷ 2016 Annual Report Page 29

¹⁶⁸ 2016 Annual Report Page 29

¹⁶⁹ Interviews with JP staff and implementing partners.

¹⁷⁰ Interviews with JP staff

research through the research group “GRAG”. However, there is little to no collaboration between the JP and GRAG and information produced by GRAG is not readily or easily shared with the JP.¹⁷¹

The JP has provided support for research and evaluation but there are opportunities for the JP to increase its support for research, data collection, and the development of M&E tools in Senegal, particularly at the community level.

The JP has financed and supported a variety of research and evaluation initiatives in Senegal (ex: DHS, research into the application of the anti-FGM law, evaluation on the mechanisms to follow-up on community FGM declarations, the evaluation of the FGM National Action Plan, etc.). A review of key documents shows that the JP has contributed to approximately a dozen studies/publications, including studies quantifying FGM incidences in Senegal, analyses of key social and economic factors contributing to FGM, curriculum and training manuals on FGM, exploratory studies on how to integrate FGM in educational curricula, etc.

Even though the JP has supported research and data collection initiatives, it has not provided direct support for community organisations to conduct research on social norms and community behaviour to inform their approach prior to beginning programming within the community or to exchange information on what works well in terms of changing social norms¹⁷². For instance, community tailored initiatives like The Grandmother Project could benefit from JP support to understand the social and cultural dynamics of communities before expanding their programming into any new regions within the country since understanding the dynamics of each community is essential for delivering effect programming¹⁷³. There are also limited mechanisms in place for lessons learned on what works well around changing social norms at the community level to be brought back up to the JP in Dakar.

Evaluation question 2

To what extent has the programme contributed to supporting governments, communities, and the girls and women concerned towards the abandonment of Female Genital Mutilation/Cutting through the establishment of conducive legal and policy environments, support for the provision of FGM health services, and the shifting of social norms?" **Criteria: Effectiveness and Sustainability**

Assumption 2.1

Programme countries enact legal and policy frameworks for eliminating FGM which are appropriately resourced and implemented (in line with AU and UN Resolutions);

Senegal has a national law prohibiting FGM that is well known and understood by actors at all levels, but it is missing consensus as to how to implement it.

While a law prohibiting FGM has been in place since 1999, there remains disagreement around whether or not it should be implemented and if so, in what way. There is disagreement among key actors as to whether community denunciations should be supported or not. Some say that denunciations break the community fabric and criminalize an entire group of people for their cultural actions (i.e. this is the stance of many

¹⁷¹ Interviews with JP staff and the Population Council

¹⁷² Interviews with JP staff and implementing partners.

¹⁷³ Interviews with JP implementing partners.

community-based NGOs including Tostan and the Grandmother Project) while others (such as some youth groups) are calling for a more effective implementation of the law as a form of dissuasion¹⁷⁴.

In order to address the fact that law no. 99-05 on FGM abandonment was not being implemented and that the number of denunciation of FGM cases was low, the JP provided assistance in 2012 to vulgarize and further disseminate this law¹⁷⁵. A study was done in 2014 by the Ministry Justice and the JP to identify the extent to which the law is being applied, the barriers to the application of the law, and recommendations on how to improve the application of the law. The recommendations haven't been implemented in part because there is little political will to do so and in part because there is significant resistance from communities¹⁷⁶.

The law against FGM was established before significant social norms change took place. While the law can be a useful tool in supporting the abandonment of FGM, there is a risk that communities may feel persecuted or marginalized if they are not ready to accept the law.

The law against FGM can be a useful tool as it reinforces the message that the practice is unacceptable and may serve to dissuade people from practicing it. Focus group discussions with women from communities that have given up the practice have revealed that they feel protected by the law¹⁷⁷. However, the usefulness of the tool may depend on who transmits its message and how it is transmitted. For instance, the message seems to be most effective when transmitted by the local authorities (i.e. Prefect) in combination with another message (i.e. a religious message or some other issue deemed important by the community)¹⁷⁸.

Contrary to this, the application of the law also has the ability to make practicing communities feel attacked and marginalized and, in many cases, can drive the practice underground. When done in secrecy, it is more difficult for groups to monitor whether or not the practice is taking place. Even though the law is poorly implemented in Senegal, the fear of persecution has driven the practice into hiding and has led to people engaging when the girl is a baby¹⁷⁹.

There are problems in implementing the anti-FGM law, which revolve primarily around a lack of political will to do so and strong resistance from community members to denounce each other.

Denouncing one's family and neighbours is not culturally acceptable in Senegal, which leads to significant resistance on the part of community members to denounce each other when FGM has been committed. Resistance from community members to applying the law can be so intense that judicial personnel have at times been afraid for their physical safety. The implementation of the law risks creating social and cultural divisions; which can be unpopular among politicians (especially leading up to an election). The current legal system does not have enough resources dedicated to overcoming these challenges (especially in isolated and hard-to-reach communities). The 2016 JP Annual Report states that there is a need to not only disseminate the law further (including into local languages) but also to do a communications campaign to encourage anonymous denunciations of FGM cases¹⁸⁰.

¹⁷⁴ Interviews with community-based implementing partners and youth

¹⁷⁵ 2013 Evaluation: p. 28

¹⁷⁶ Interviews with JP partners

¹⁷⁷ Interviews with women rights holders from communities that have declared the abandonment of FGM.

¹⁷⁸ Interviews with JP partners and rights holders.

¹⁷⁹ Interviews with JP staff, implementing partners and rights holders.

¹⁸⁰ 2016 Annual Report: p. 28

Assumption 2.2

Service providers provide timely, appropriate and quality services to girls and women at risk or having experienced FGM in select districts in programme countries;

Implementation structures are in place to prevent FGM and to serve FGM victims, but they lack appropriate financing.

The Joint Programme has been instrumental in setting up the National Coordination Committee to coordinate anti-FGM efforts at the national level and in setting up child protection committees (CDPEs - comités départemental de protection de l'enfant) at the sub-national level. Both mechanisms bring together actors working on FGM to implement a coordinated approach. CDPEs are operational in 16 departments and are composed of multi-sectorial professional service providers (i.e. social action, justice, security, health, education, communication), CSOs, as well as traditional and religious leaders. CPDEs are key in the prevention and identification of FGM cases, as well as provision of services to those affected by FGM. In 2016, 222 FGM cases were identified and addressed by the CDPEs. Additionally, 180 members of the CDPEs received capacity building on the integration of gender in child protection (including on FGM).¹⁸¹

Even though both mechanisms are set up, they lack appropriate government financing. Only staff positions are covered by government budget lines, leaving the Joint Programme with the responsibility to finance FGM activities¹⁸².

The Joint Programme is starting to support the integration of FGM into pre-natal and post-natal health services. The NGO "CEFOREP" supported by the JP uses an interesting train-the-trainer approach to diffuse training on FGM among health workers but there is a lack of coordination between CEFOREP and the Ministry of Health.

The NGO CEFOREP has piloted a training module to strengthen the capacities of community health workers to address FGM and its related complications. The training provides health workers with skills to sensitize patients during pre-natal care around the consequences of FGM. CEFOREP also supports health workers to collect data relating to FGM and to refer women who have experienced trauma due to FGM to appropriate resources¹⁸³. As a result of this training, the capacities of 232 community health workers have been strengthened in three regions: Matam, Kolda and Tambacounda¹⁸⁴. While the scope of the training remains limited, CEFOREP uses an interesting train the trainer model to reach the widest audience possible with current resource constraints. This model has the potential to be scaled-up with support from the Ministry of Health. More active communication and collaboration between CEFOREP and the Ministry of Health would be required to scale-up these services¹⁸⁵.

Assumption 2.3

A majority of individuals, families and communities in programme areas accept the norm of keeping girls intact

¹⁸¹ 2016 Annual Report: p. 16-18

¹⁸² Interviews with government stakeholders.

¹⁸³ Interviews with JP partners.

¹⁸⁴ 2016 JP Senegal Annual Report

¹⁸⁵ Interviews with JP partners.

Using a health-based argument in Senegal has been an effective entry point to raise awareness around the negative effects associated with FGM. JP partners in Senegal tend to not use photos or visual aids when raising awareness on FGM, which may be a missed opportunity if done in a sensitive manner.

Community members who participated in FGDs and who have abandoned FGM could easily identify the health risks and consequences associated with the practice¹⁸⁶. They explained that they first learned about the health risks through NGO community engagement and then expanded their knowledge on FGM to include women's rights and gender relations. Most community actors supported by the JP in Senegal do not use photos or visual aids when discussing FGM. However, FGM actors outside of the JP in Senegal claim that, if done in a sensitive way (i.e. dividing participants by sex, asking first if they are ready and willing to see photos, etc.), the use of photos can be a powerful tool to raise awareness and lead to sustainable and impactful changes in people's perspectives and attitudes towards FGM¹⁸⁷. This perspective aligns with experiences of JP partners in other countries in the region who use visual aids to reinforce messages around FGM¹⁸⁸.

It is very difficult to raise awareness about FGM within communities who follow religious leaders who advocate for the continuation of the practice.

The Joint Programme has made some progress in supporting Islamic leaders in Senegal to develop a religious argument explaining how FGM is not an Islamic requirement. There are now some important influential Islamic leaders (known as "Grands Maribous") who advocate for the abandonment of FGM. However, there remain some highly influential Grands Maribous who actively call for the continuation of FGM. This active support of FGM from influential Islamic leaders creates an insurmountable barrier to changing behaviour among communities who are followers of these religious leaders.

During a field visit to one of the communities in the south of Senegal where FGM is still practiced, community members explained that they were open to learning from Tostan and discussing FGM until they were advised by their Islamic religious leader that Islam requires them to continue the practice¹⁸⁹. Community members were so upset about being placed in such a situation that they vandalized the Tostan building and never let the NGO return to the community¹⁹⁰.

Community declarations are most useful once the community has held inclusive dialogues and has undergone some change in social and cultural attitudes towards the practice of FGM. Correct timing for declarations is very important to ensure sustainable behaviour change.

Community declarations are important tools to unite communities around a common principle and to hold community members accountable for collective decisions. However, if declarations are made prematurely before community members have had sufficient opportunity to discuss, debate, and come to a meaningful conclusion, community declarations risk becoming misleading and ineffective¹⁹¹.

Since the 2013 JP evaluation, Tostan has modified its approach towards community declarations and now provides more time for communities to engage in discussion and organises inclusive public declarations that bring together community members and that document the declaration in writing to be used as a

¹⁸⁶ Interviews with female and male community-based rights holders

¹⁸⁷ Interviews with non-JP FGM actors in Senegal.

¹⁸⁸ Interviews with JP staff in neighbouring countries in West Africa.

¹⁸⁹ Interviews with rights holders at the community level.

¹⁹⁰ Interviews with JP implementing partners.

¹⁹¹ Interviews with JP staff and implementing partners.

follow-up tool¹⁹². Additionally, some communities (i.e. the community of Bakel) have taken the initiative to set up surveillance and follow-up committees to ensure that FGM practices don't continue post-declaration¹⁹³.

It is becoming apparent that some degree of socio-cultural transformations around attitudes towards FGM must take place prior to conducting a community declaration and that the declaration is neither the initiation nor termination of a process but is rather a mid-way milestone. The Joint Programme in Senegal provides very limited support and initiatives to communities once they have reached the milestone of a community declaration.

There is some evidence that interventions that are focused on community dialogue but that are also directly targeted towards FGM decision-makers can lead to meaningful change.

The Grandmother Project has demonstrated some interesting success by using a model that encourages inter-generational dialogue but that also supports targeted advocacy towards grandmothers, who are the FGM decision-makers in those communities where the Grandmother Project operates.¹⁹⁴ In other communities, decision-makers vary and can include mothers and/or fathers. However, the approach of specifically targeting decision-makers while engaging the wider community in inter-generational dialogue appears to be a successful strategy to change social norms at the community level¹⁹⁵.

Evaluation question 3

To what extent do the JP country, regional, and global initiatives and holistic approach create synergies that accelerate efforts to end FGM? **Criteria: Effectiveness, Co-ordination and Sustainability**

Assumption 3.1

Management arrangements and coordination between UNFPA, UNICEF, national authorities and programme partners have facilitated both agencies to leverage their relative strengths and capacities for more effective programme implementation.

Coordination between UNICEF and UNFPA has considerably improved since the end of Phase I in terms of design and implementation at both the national and community levels. While there is currently an excellent working dynamic between both agencies, roles and responsibilities are not clearly and formally defined.

The working dynamic between UNICEF and UNFPA has significantly improved since the end of Phase I¹⁹⁶. Both agencies are now represented with one unified voice, they share implementing partners and host regular meetings with all of the partners, and require implementing partners to report only to the Joint Programme rather than each agency separately¹⁹⁷. The positive working dynamic is largely a result of concerted efforts to improve the "jointness" of the two agencies while also the non-planned result of individual personalities working well together from each agency. The roles and responsibilities of staff from

¹⁹² Interviews with JP implementing partners.

¹⁹³ Interviews with rights holders at the community level.

¹⁹⁴ Interviews with JP implementing partners.

¹⁹⁵ Interviews with rights holders at the community level.

¹⁹⁶ Interviews with JP staff in Senegal

¹⁹⁷ Interviews with JP staff in Senegal

each agency towards the joint programme are not clearly documented¹⁹⁸. It is a risky practice to place institutional cooperation at the subjectivity of individual personalities rather than institutionalizing effective cooperation. The most opportune moment to define roles and responsibilities is likely when the relationship between both agencies is working well.

Assumption 3.2

The global programme has effectively developed and leveraged partnerships and collaborations with other development actors to amplify efforts, particularly with regards to more in-depth research on social norms change and its linkages to changes in individual and collective behaviours.

There is limited collaboration between the JP and its partners around research on social norms change. Some of the JP implementing partners are conducting community-based research to a limited extent (i.e. Grandmother Project and Tostan) but it is unclear to what point this information is shared with UNICEF, UNFPA, and other partners within the JP.

The Joint Programme does not provide any specific support to its implementing partners to generate and share information on best practices in changing social norms at the community level¹⁹⁹. Even so, some of the JP partners use funding from other donors to generate information on best practices at the community level²⁰⁰. It is unclear to what extent this information is shared with the Joint Programme since JP meetings occur only at the national level and systemic processes to feed information upwards from the community level to the JP are not formally established outside the parameters of implementation reports.

Assumption 3.3

Joint Programme acted as a catalyst for established and emerging actors to strengthen the response to end FGM, at national, regional and global levels, including e.g. other UN agencies, other programmes, new donors and funders, national governments, regional bodies, civil society and implementing partners.

The JP does not have a formal and documented partnership strategy that identifies opportunities to establish new partnerships and that outlines opportunities for synergies between current partners.

The JP in Senegal has identified FGM actors and potential partners through stakeholder mapping exercises²⁰¹. However, the JP does not have a formal partnership strategy that serves to identify opportunities to establish new partners (especially strategic partners) and that outlines opportunities for synergies between current partners²⁰². Some national FGM actors are not part of the JP (i.e. Population Council, Save the Children, Girl Generation, UN Women) and the reasons for not including these partners are not well documented as a result of a missing partnership strategy.

¹⁹⁸ Interviews with JP staff in Senegal

¹⁹⁹ Interviews with JP staff and implementing partners in Senegal

²⁰⁰ Interviews with JP implementing partners

²⁰¹ Interviews with JP staff in Senegal

²⁰² Interviews with JP staff in Senegal

Evaluation question 4

To what extent does the Joint Programme draw on the relative strengths of each organisation, promote efficient programme implementation to amplify the Programme contribution? **Criteria: Efficiency/ Coordination**

Assumption 4.1

Joint programme financial systems and structures enable the efficient and timely flow of resources to support implementation and achieve planned results.

Funds from the JP HQ consistently arrive late (at least by one trimester) and the COs struggle to distribute funds quickly once arrived. This has a direct negative effect on the implementation of activities.

Funding is consistently late from HQ (at least by one trimester) and is unpredictable at the global level²⁰³. There are also regular delays in releasing funding at the CO level²⁰⁴. The COs typically wait for enough funds to be received before making a “meaningful” payment to the implementing partners. This combination of late funding from HQ and delays in releasing funds at the CO level has resulted in significantly diminished implementation periods for JP partners. The delay in funding significantly affects the ability of implementing partners to achieve results due to a shortened implementation period²⁰⁵. In fact, in 2018, an implementing partner working with school children received the funds after the school year had already ended²⁰⁶.

The JP is based on a yearly planning cycle when social norms change requires a longer planning and financial cycle.

JP work plans are prepared on an annual basis and funding is unpredictable from year to year²⁰⁷. However, implementing partners require more stable funding in order to hire regular staff members²⁰⁸. In some cases, implementing partners went forward with activities under the assumption that JP funds were simply late only to discover at the end of the year that they would not be paid at all²⁰⁹. This kind of uncertainty puts implementing partners in a very difficult position. In order to plan meaningful change initiatives around social norms, a longer planning cycle (at least 2 years) is necessary. Donors appear to have unrealistic expectations of what can be accomplished within a one-year funding cycle. There may be a need for UNICEF and UNFPA to engage in further discussions with donors to explain why funding and planning needs to take place over a longer time period.

Assumption 4.3

Monitoring, reporting and evidence-gathering systems are in place and are compatible across both agencies, and are adequate to measure progress towards expected results and promote learning at all levels.

²⁰³ Interviews with JP staff in Senegal

²⁰⁴ Interviews with JP staff in Senegal

²⁰⁵ Interviews with JP implementing partners

²⁰⁶ Interviews with JP implementing partners

²⁰⁷ Interviews with JP staff in Senegal

²⁰⁸ Interviews with JP implementing partners

²⁰⁹ Interviews with JP implementing partners

In response to recommendations from the Phase I Evaluation, the JP invested in improving its monitoring systems by moving to the Di-Monitoring System and then to the Data for All system. The new Data for All platform is not yet functional in Senegal.

Since 2008, the Joint Programme has evolved to improve its monitoring and reporting systems so that they are more harmonized between UNICEF and UNFPA. The Phase I evaluation of the Joint Programme found that both agencies were using independent monitoring and reporting systems that were not harmonized, therefore making it difficult to capture information as one cohesive programme²¹⁰. The lack of harmonization also made it difficult for implementing partners, as they were required to report separately to both agencies on activities that were conducted through the Joint Programme, resulting in duplicated reporting²¹¹.

In response to the Phase I evaluation recommendation to improve joint monitoring and reporting, the Joint Programme implemented the Di-Monitoring System, which is a monitoring platform that can be used across both UNFPA and UNICEF to capture joint results²¹². This was implemented in all JP countries, including Senegal. In addition, the Senegal CO changed its reporting requirements so that implementing partners only have to report once to the JP for activities funded by it, thus reducing inefficiencies and increasing harmonized reporting. This shift towards increased harmonization has made it easier for the Joint Programme to operate as one cohesive unit; has fostered greater collaboration between UNFPA and UNICEF; and has made it easier for partners to report on results and for the JP to capture and use those results to inform future planning.

Near the end of Phase II, the Joint Programme decided to switch over to a new monitoring system called the Data for All system. The new system is designed to help country offices better capture progress towards outcomes and to present the data in a more user-friendly manner²¹³. The JP at HQ has provided some online training and coaching to the CO M&E staff to help them with this switch. However, the Senegal CO is currently in the process of making the switch and has not yet adopted the new system²¹⁴. The evaluators were unable to access the new Data for All system to provide an assessment around its structure and potential. It is expected that the new system will be up and running before the end of 2018.

Evaluation question 5

To what extent does Joint Programme programming lead to sustainable change for the eradication of FGM?

Criteria: Sustainability

Assumption 5.1

The Joint Programme supports national ownership of efforts to eradicate FGM by building institutional capacity and by integrating programming into established national systems and processes.

There have been some important advancements since the end of Phase I around supporting government capacities and better integrating JP activities into government systems to ensure greater sustainability.

²¹⁰ Phase I Evaluation of the Joint Programme

²¹¹ Phase I Evaluation of the Joint Programme

²¹² Interviews with JP staff in Senegal

²¹³ Interviews with JP staff in Senegal

²¹⁴ Interviews with JP staff in Senegal

The JP is currently working on integrating FGM data indicators into the Ministry of Health's database, which is an important contribution towards supporting sustainable nationally owned systems²¹⁵. Additionally, the JP has supported the Ministry of Gender to take greater ownership for national FGM coordination and is supporting the Ministry of Education to integrate FGM information into the national school curriculum²¹⁶. The JP has also provided capacity development support to justice personnel, healthcare workers, and education specialists²¹⁷.

Stakeholders agree that there is a need for higher-level political engagement around FGM (like the kind of support that was demonstrated when fighting AIDS). There is currently weak inter-ministry coordination and limited provision of government resources. The JP currently has no advocacy strategy to engage higher-level political actors in the abandonment of FGM.

Not all relevant government ministries are regularly present at the national FGM coordination meetings and the national government does not provide financial support for FGM activities²¹⁸. There was a plan to establish an FGM oversight committee that reports directly to the president (like was the case with the HIV/AIDS campaign) but it was suddenly dissolved due to a lack of political will²¹⁹. The JP has approached the EU for funds to help it better engage high-level political entities in FGM initiatives. However, there is currently no documented or formalized plan as to how the JP plans to engage high-level political actors around the abandonment of FGM²²⁰.

Assumption 5.2

The Joint Programme promotes changes in social norms at the community level that are sustained over time and that lead to improvements in gender equality between men and women.

When community members witness for themselves the benefits of abandoning FGM, they more deeply accept the norm of abandonment.

Focus Group Discussions with communities that have decided to abandon FGM indicate that people are most adamant about the benefits of FGM once they have witnessed them for themselves first hand. These benefits include improved health and better communication and understanding between women and men (which has reportedly led to improved sexual relations even among circumcised women, and self-reported decreases in violence against women).²²¹ More deeply embedded acceptance of FGM abandonment ultimately leads to more sustainable behaviour change but requires adequate time and investment to achieve.

The JP focus on youth engagement and inter-generational dialogue reflects a sustainable vision focused on preparing social norms change among generations to come.

The Joint Programme in Senegal promotes youth engagement and inter-generational dialogue as mechanisms to encourage social norms change. For instance, The Grandmother Project promotes inter-generational dialogue and the UNFPA Youth Caravan empowers youth to engage in peer education and to speak out about FGM. The JP also supports the integration of FGM into school activities and school

²¹⁵ Interviews with JP staff in Senegal

²¹⁶ Interviews with JP staff, government partners, and implementing partners in Senegal

²¹⁷ 2017 JP Annual Workplan

²¹⁸ Interviews with JP staff and government partners.

²¹⁹ Interviews with JP staff

²²⁰ Interviews with JP staff

²²¹ Interviews with rights holders and the community level.

curriculum. These initiatives focused on youth engagement and education encourage sustainable social norms change by investing in positive attitudes among today's youth that will become tomorrow's decision-makers.

In many communities that have abandoned FGM, there is strong engagement from community follow-up committees to ensure that this behaviour change continues and to encourage neighbouring communities to also abandon the practice.

Some communities that have passed community declarations against FGM have committees that do their own fundraising to continue promoting the abandonment of FGM even if NGO actors are no longer present within the community²²². An example of this is the “caisses villageoises de solidarité” that promote the abandonment of FGM within communities that have passed declarations and that visit neighbouring communities to engage in dialogue around FGM to encourage them to also abandon the practice²²³. These committees essentially serve as community watchdogs and promoters of FGM abandonment. This community-owned surveillance system promotes the sustainability of behaviour change.

Focus Group Discussions with community members suggest that community initiatives focused on education and community dialogue have led to improvements in gender relations.

Women and men participating in FGDs at the community level within those communities that have passed community declarations against FGM have universally attested to an improved gender dynamic where women are now better engaged in decision-making and are consulted with and listen to by male partners²²⁴. Community members largely cite increased community dialogue (between sexes and generations) as the key factor in improving gender dynamics within the community²²⁵. Men explain that they are now more engaged in “women's issues” and are able to better understand issues from a woman's perspective. Both women and men have self-reported decreases in VAW and child marriage as a result of increased communication between sexes²²⁶.

Illustrative Key Testimonies

“We need to understand who the FGM decision makers are and what kinds of community dynamics are present before we can expand our programming into new communities” Quote from a JP community-based implementing partner.

“We need to strengthen the implementation of the law so that people know that FGM is an unacceptable practice and that if you do it, you will be punished. We need some cases to be prosecuted to set an example to encourage people to come forward and report cases of FGM” Quote from an FGM youth peer.

“Both agencies are working really well together. We talk to each other every day and hold meetings regularly with all of the JP partners”. Quote from Joint Programme staff.

“Sometimes JP funding arrives so late that we hardly have any time to implement our annual activities” Quote from a JP implementing partner.

²²² Interviews with rights holders and the community level.

²²³ Interviews with rights holders and the community level.

²²⁴ Interviews with rights holders and the community level.

²²⁵ Interviews with rights holders and the community level.

²²⁶ Interviews with rights holders and the community level.

Example of gender change: An FGD participant from the “School for Husbands”: “I don’t have to beat my wife as much now because we are able to talk to each other and now she listens better to me. Sometimes she even changes my mind”.

“You can tell that husbands and wives are happier now in the community ever since Tostan arrived and we started engaging in community dialogue. Now husbands and wives spend the nights together rather than sleeping in separate rooms. I’m not married myself, but I notice the difference in the people around me”.
Quote from a young woman in a community FGD.

Considerations for the overarching global thematic level

Consideration 1. The influence of Islamic religious leaders among communities constitutes a key factor in the abandonment of FGM.

The JP has supported some important initiatives to engage Islamic religious leaders around the abandonment of FGM. Specifically, it has supported Islamic leaders to develop and document how FGM is not an Islamic requirement. As a result, there are many influential key Islamic leaders that have taken the position that FGM is not required under Islam. Even so, there are other key Islamic leaders that believe that FGM is an Islamic requirement and actually call for the continuation of the practice among their followers. This support for FGM from key Islamic figures constitutes a major barrier to changing social norms and practices among those communities to follow them. Consequentially, the JP should consider developing a strategy to convince those leaders that are in favour of FGM to change their position. It may be beneficial for this strategy to include opportunities for influential Islamic leaders to discuss and debate the issues together as peers. The JP strategy should also consider including practical ways to better distribute the established message that the abandonment of FGM is not contrary to Islamic practice.

Consideration 2. The context, timing, and the sequencing of events are crucial for the effective and sustainable abandonment of FGM.

The law against FGM was passed long before significant work around shifting social norms was done. This risks marginalizing communities that practice FGM and pushing the practice underground where it can be more difficult to address. Pressure (often imposed by donors) to reach a certain number of community declarations against FGM can be counter-productive if the community has not yet reached a consensus around abandoning the practice. Community declarations are most useful once the community has held inclusive dialogues and has undergone some change in social and cultural attitudes towards the practice of FGM. Correct timing for declarations is very important to ensure sustainable behaviour change. Community declarations are not the end of a process but are merely important milestones. The JP should continue to place its emphasis on changing social norms and facilitating community dialogue and on supporting social norms change even after community declarations have been passed.

Consideration 3. The selection of methods used to change behaviour at the community level are crucial in determining the initiative’s success.

The most effective approaches at the community level are those that are based on respect for community values, inclusivity that promotes community dialogue, an analysis of the particular barriers facing that specific community, and an analysis of key decision makers concerning FGM.

Consideration 4. The JP may be able to mobilize additional resources in the area of gender equality by clearly documenting changes in gender dynamics that are occurring at the community level.

The Senegal case study has revealed anecdotal evidence that changes in power dynamics within relationships between men and women is taking place at the community level through JP-supported initiatives. By more systematically documenting these changes, the JP could potentially use this evidence to mobilize resources dedicated to promoting gender equality at the global level.

Consideration 5. Planning and financing for JP initiatives must be done on a multi-annual basis.

Social norms change takes time and requires multi-annual engagement and financial commitments from donors in order to make sustainable changes. The JP should continue to engage in dialogue with programme donors to explain how social norms change takes time and to identify more meaningful progress markers that are based on changes in process rather than end-results since end-results will likely not be visible within the short term.

Consideration 6. The JP could potentially benefit from a formal partnerships strategy and regional strategy.

The regional strategy could:

- a. Create opportunities for COs, implementing partners, and government officials to learn from each other;
- b. Establish formal mechanisms and platforms to share print documentation;
- c. Set up forums to discuss policies and laws and the implementation of laws amongst government actors;
- d. Facilitate discussions around ways to tackle cross-boarded FGM practices; and
- e. Clarify the roles and responsibilities of the HQ vs. RO and identify specifically how the RO work feeds into the HQ work and supports country level initiatives.

The partnership strategy could:

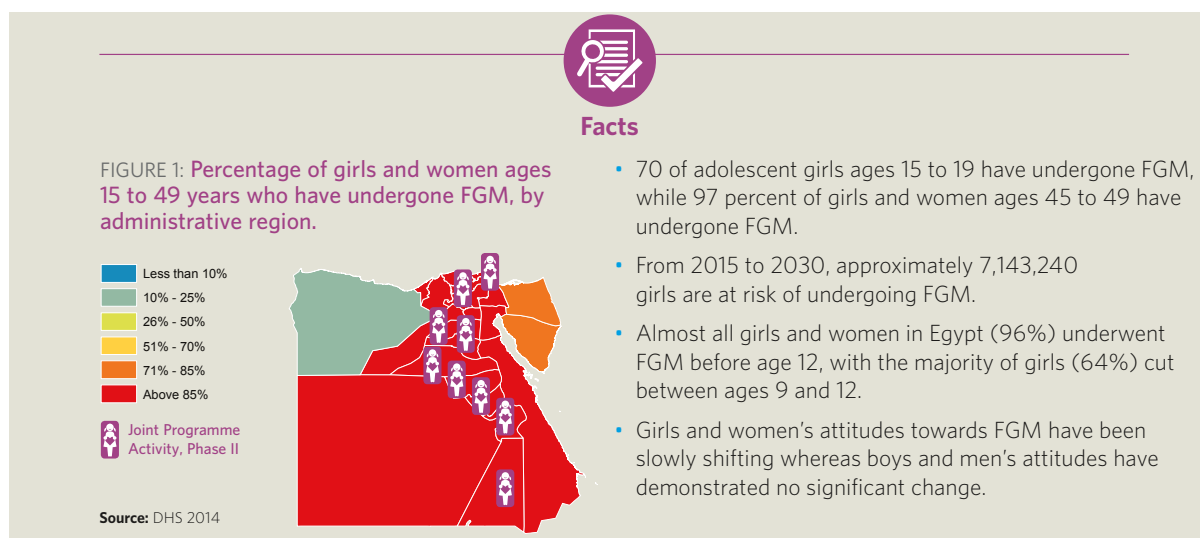
- a. Identify strategic partnership opportunities and
- b. Strategically build synergies between JP partners

Consideration 7. The clear definition of roles and responsibilities between joint programme agencies facilitates a good working relationship between actors.

The JP in Senegal may wish to consider defining roles and responsibilities now since the working dynamics are currently so positive.

Egypt

Figure 4: Extract from Joint Programme Phase II Performance Analysis, country overview (UNFPA-UNICEF, 2018)²²⁷



Context

Interventions

The UNFPA–UNICEF Joint programme to accelerate the abandonment of FGM has since 2008-09 been engaged in a broad range of areas such as law reform, research and data analysis, capacity building of medical personnel and field workers, as well as direct engagement with local communities and religious leaders.

In 2014, the UNFPA-UNICEF Joint Programme launched a second phase and has been working closely with the Ministry of Health (MoH) to address the growing challenge of medicalization, reinforcement of the FGM ban law, and mobilizing social change at the community levels.

Furthermore, the Joint Programme has addressed the following:

- Knowledge dissemination of socio-cultural dynamics of FGM practice.
- Expanding networks of religious leaders advocating abandonment of FGM.
- Collaboration with key global development partners on a common framework for the abandonment of FGM.
- Evidence-based data for programming and policies.
- Consolidation of existing partnerships and forging new partnerships.
- Media campaigns emphasizing FGM abandonment.

²²⁷ Clarifications since publication: Source DHS Special Survey 2015. Both girls and women's attitudes and boys and men's attitudes towards FGM are slowly shifting against FGM, but the rate of change is still very slow. Latest available data on women who have undergone FGM remains DHS 2014. See: https://dhsprogram.com/Where-We-Work/Country-Main.cfm?ctry_id=10&c=Egypt&r=2

- Better integration of the implications of FGM practice into reproductive health strategies.
- Building donor support to pool resources for a global movement towards the abandonment of FGM.

This joint programme also supports the National Programme against FGM, and Family Empowerment led by the National Population Council and most recently, supporting the National Population Council in the implementation of the National Strategy (2014-2018).

Egypt's current FGM status:

Female genital mutilation (FGM) is still widespread – but increasingly condemned – throughout much of the country. However, the recent history of the practice in Egypt presents special challenges for those trying to end it. According to the national 2015 Demographic and Health Survey (DHS), 87 per cent of all women between the ages of 15 and 49 have undergone FGM, 42 per cent of them by doctors. A closer look at the age ranges of the 2015 data shows that the practice may be declining amongst younger women; for example 97 per cent of 45-49 year old women have undergone FGM whilst amongst the younger age groups, 82 per cent of 20-25 year old women and 70 per cent of 15-19 year old girls and women have been subject to FGM.

Although a positive change in women's attitudes about circumcision has occurred, there is still a large part of the population that support for the continuation of FGM in Egypt, with men slightly more likely than women to have beliefs supportive of the practice . The 2015 DHS showed that 59 per cent of men agree with the continuation of the practice compared to 54 per cent of women. FGM is part of the social fabric of the Egyptian community and is in some cases upheld by beliefs associated with religion. Husbands' preferences for circumcised women and the prevention of adultery were among the most cited reasons by women aged 15-49 for supporting the practice in the different DHS implemented so far.

Expenditure

The total budget for the Egypt Country Offices was \$5,868,368.00 from 2009-17, and expenditure was \$4,798,124.

Egypt	Total Expenditure (UNFPA)	Total Expenditure (UNICEF)	Total Expenditure (UNFPA + UNICEF)
2008-2013			\$1,785,070
2014	409,665	158,353	\$568,018
2015	508,802	636,724	\$1,145,526
2016	436,395	204,181	\$640,576
2017	453,848	483,339	\$937,186

Implementing partners delivering

The Joint Programme work areas and corresponding partners within Phase I and Phase II

Programme Area	Partners
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Phase I	
Community Awareness and Mobilisation	NGOs - ACDA, Y-PEER
Legislation	Member of a Taskforce with other relevant stakeholders - Ministry of Health and Population, the Ministry of Education, the Ministry of Social Solidarity, and the Ministry of Endowment, media, UNDP, UNICEF and UNFPA Taskforce with other relevant stakeholders (government, UN, CSOs)
Awareness raising amongst health workers	Ministry of Health, targeting Public Health Facilities
Phase II	
Community Awareness and Mobilisation	ACDA, YPEER, Plan, Caritas
Legislation – strengthening the penal code	Member of a Taskforce with other relevant stakeholders - Ministry of Health and Population, the Ministry of Education, the Ministry of Social Solidarity, and the Ministry of Endowment, media, UNDP, UNICEF and UNFPA
Capacity building of law enforcement agencies	Prosecution Office, Ministry of Interior, Ministry of Health and Population, Ministry of Justice
Integration of FGM in curricula for judges and prosecutors	Egyptian National Centre for Judicial Studies
Lobbying on FGM National Strategy	Member of a Taskforce with other relevant stakeholders - Ministry of Health and Population, the Ministry of Education, the Ministry of Social Solidarity, and the Ministry of Endowment, media, UNDP, UNICEF and UNFPA)
Lobbying for Integration of FGM within Other Strategies e.g. Gender Based Violence	Respective Ministries/ Government Departments e.g. National Council for Childhood and Motherhood, National Council for Women
Training of medical practitioners	Ministry of Health, Public hospitals
Medical curriculum changes to include FGM/ harmful practices	Supreme Council of Universities, individual universities (including Assiut, Ain Shams, Zagzig and Sohag)
Doctors Against FGM	Coalition of doctors experts, academics and other national stakeholders
Development of Awareness-raising dramas and slots for TV and radio, social media campaign	Media – TV and radio Communication for Development forum– media and social development specialists
Interactive street theatre	NGO- Noon Creative Enterprise
Training of religious leaders and publications	Christian - Coptic, Evangelical and Catholic Churches Islamic - Al Azhar, International Islamic Centre for Population Studies

Journalists missions/ exposure visits	Journalists
Institutionalisation of youth peer work	University of Assuit (Y-PEER Centre)

Evaluation question 1

To what extent is the programme (approach, design, strategies) relevant, responsive, and evidence based to contribute towards accelerating efforts to abandon FGM globally, nationally, and sub-nationally (including in cross-border regions)? **Criteria: *Relevance***

Assumption 1.1

The Joint Programme design (including approach, strategies and interventions) is aligned with global, national and sub-national priorities and is flexible enough to be responsive to different local contexts and to changing realities and priorities.

The Joint Programme has been aligned with national priorities, supports national initiatives and structures and has been instrumental in its contribution to FGM national policy.

The JP has been aligned with national priorities since its inception, gradually adapting the weight of its intervention from community level awareness during Phase I of the JP to more holistic approaches during Phase II and III, including more weight on key elements such as religious leaders, anti-medicalization, law enforcement and young girls. This is coherent and complementary to “**The National FGM Abandonment Strategy 2016-2020**” for Egypt. This national strategic framework focuses on enhancing cultural and social strategies after the acknowledgement that “The issue of FGM is a cultural and social one, not a religious or health issue solely”²²⁸. In conjunction with this strategy, a national taskforce was assembled to coordinate its implementation, including members from line-ministries and key stakeholders. It should also be noted that UNFPA and UNICEF are among the six international partners of the Egyptian Government explicitly mentioned in said strategy.

In particular, the National Strategy focuses on three key strategies:

1. Enforce the FGM Criminalization Law and the relevant ministerial decrees related.
2. Continue strengthening and enhancing socio-cultural environment that supports the rights of children, women and hesitant families.
3. Develop information systems that monitor and evaluate family empowerment and FGM abandonment programmes.

In the framework of this National Strategy, the JP has as the objective in Egypt of the creation of sustainable political, legal and social change to empower families and communities to abandon FGM practices along with other forms of family/domestic violence. The aim of the programme is to strengthen, enhance and consolidate the achievements that have already taken place in abolishing FGM and to further mainstream the fight against FGM through scaling-up activities, enhancing partnerships and coordination

²²⁸ The National FGM Abandonment Strategy 2016-2020. Egypt. 2015. Published by Ministry of State for Population and Ministry of Health with support of United Nations and European Union.

mechanisms, strengthening, monitoring and evaluation activities and expanding current advocacy and communication strategies.

The different phases of the JP, respectively Phase I (2008-2013), Phase II (2013-2018) and the current Phase III (2018-2023), are **aligned to Government priorities** and are in general terms **responsive to the profile of the FGM situation in the country**.

During Phase I (2008-2013) the main focus of the JP has been on²²⁹:

- (I) **Increased community-led engagement** through education, dialogue and consensus building, including educating the public and raising awareness about FGM through messages in the media and community-based initiatives. The JP has worked with local partners to strengthen the capacity of religious leaders to change attitudes towards FGM in their communities. Several publications and manuals have also been written with partners, explaining that FGM is not a requirement of any religion. The JP has also contributed to public Mobilization in villages in Upper and Lower Egypt with the assistance of partner NGOs and young volunteers to form pressure groups that oppose FGM.
- (II) **Supporting the FGM-free Village Model** implemented by the National Council for Childhood and Motherhood (NCCM) and other partners which encourages collective abandonment of FGM. Entire communities signed village declarations saying No to FGM. In 2008, the project evolved into a joint initiative under the Ministry of Health and Population for family empowerment, taking a more holistic approach to the issue of the rights of the child.
- (III) **Developing an integrated communications campaign** with unified messages disseminated through the media, including television, radio, billboard advertising and theater. **Developing schoolgirl profile sheets** with partner NGOs with the aim of monitoring girls' socio-economic, health and education statuses on a yearly basis, and detect any potential threats such as FGM, child marriage and school dropout.
- (IV) **Partnerships with NGOs in events such as** the "Kamla Awareness Campaign" (Kamla = "complete") in eleven governorates by the Coalition against FGM, supported by the JP. Community celebrations were held commemorating the International Day of Zero Tolerance for FGM and the National Day of Zero Tolerance for FGM in 17 governorates. The events were held in schools where the anti- FGM Coalition has interventions, in youth centers, NGO premises and other venues. The activities focused on community dialogue using theatrical plays to disseminate the messages. Community leaders participated but the events essentially targeted community members in a bid to raise awareness about FGM.
- (V) **Working with Health Practitioners:** In collaboration with the Ministry of Health, a number of workshops were held in 2013 to ensure the commitment of medical staff in primary health care units and public hospitals and clinics in the governorates with the highest FGM prevalence towards the abandonment of FGM. It also helped support the Ministry of Health's "Doctors Against FGM" initiative, which spreads awareness about the dangers and un-Islamic nature of FGM. Doctors were trained on advising families to refrain from FGM and to explain why the procedure is not a medical necessity for girls.
- (VI) **Legal and Policy Framework:** the JP worked on advocacy with its partners, in strategic environments, such as with the Ministry of Health in relation to the regulation regarding the performance of FGM by medical doctors or with Al Azhar University and the Coptic Church (see analysis under 2.3).
- (VII) **Government Ownership:** the JP supported Egypt's National Population Strategy 2013-2015 aiming to eliminate FGM by 2030. It also helped develop the National FGM Abandonment Strategy that was launched in June 2015.

²²⁹ Annual Work Plans 2008, 2009, 2010, 2011, 2012, 2013.

Phase II of the JP (2013-2018) recognised the importance of developing a wider multi-sector approach against FGM and a stronger emphasis in mainstreaming in any area of intervention. The main focus of the JP has been on²³⁰ a wide range of projects undertaken with partners at both the national and local levels including:

- (I) Supporting the National Population Council in developing the aforementioned **National Strategy** for the Abandonment of FGM launched in the summer of 2015.
- (II) **Mainstreaming of anti-FGM discourse in relevant ministries**, including actions such as training programmes targeting junior district attorneys from different Governorates on FGM legal implications (collaboration with UNDP).
- (III) **Combating medicalization** of FGM became also a priority, raising the capacity of health service providers (doctors and nurses) in primary health care units, training to forensic doctors (as part of law enforcement strengthening), developing an anti-FGM medical curriculum and anti-FGM manual for doctors which were mainstreamed by the Ministry of Health (see analytical details under 2.2. Anti-medicalization);
- (IV) **Strengthening and expanding the operational and regulatory environment to promote the abandonment of FGM.** The JP established a task force with experts from the Ministry of Education, National Population Council and curricula experts to revise entirely curriculums of primary, secondary and preparatory schools for Arabic and Social Studies, incorporating messages on gender rights, family rights and FGM abandonment. Anti-FGM and Empowerment Community Campaigns were coordinated, at village and governorate levels, through 20 national NGOs in 10 governorates. The NGOs are also responsible for creating civil society synergies with the community development associations that enable larger organizations to implement their programs at village level.
- (V) **Media work.** The JP launched the Family Rights Platform that brings in over 50 journalists and media professionals including artists, social media experts and TV personalities, with associated media events; or the development of a Family Rights Declaration in collaboration with civil society, the media and religious organizations, which was and was adopted by Al Azhar. The JP worked with the media and religious institutions to counter conservative messages promoting FGM and any attacks on the FGM law. This was done through a strong media campaign on all major talk shows and key newspapers. In addition, a media awareness campaign “Enough FGM” was launched in 2015 with testimonials from people who denounced the practice and a short theatrical play (with the theatre group Noon Creative Enterprise), showing the harmful effects of FGM and child marriage.
- (VI) **Work with youth/girls.** In coordination with Ministry of Health, the JP supported the youth peer YPEER Network in Egypt to develop a training manual on FGM Abandonment (published in 2015) for peer educators. It also supported ‘youth-friendly’ group activities to explore sensitive topics (see details under efficiency and effectiveness sections).

Phase III of the JP (2018-2021)²³¹. In 2018, the JP continues, building on the lessons learned from previous phases. The focus in Egypt in the coming period continues to be on shifting social norms in affected communities while working with governments to put in place viable national response systems. The main focus will be explicitly on: 1) Mainstreaming the issue of FGM within the Health, Education and Child protection systems 2) Strong linkages between the work on child protection systems in the country with FGM 3) Addressing medicalization and overall law enforcement and 4) Adolescent empowerment as a cross-cutting strategy.

²³⁰ Annual Work Plans 2014, 2015, 2016, 2017.

²³¹ Annual Work Plan 2018 and JP Theory of Change narrative for Egypt, Phase III.

A **Programme Management Unit (PMU)** to oversee the implementation of the National Strategy was established in 2013 by the Ministry of Health and the National Council for Childhood and Motherhood (NCCM), and it is currently embedded at the National Population Council (NPC). This PMU has been strongly supported by the EU through UNDP. The JP has been working through the PMU at the NPC and in cooperation with other line ministries to implement activities at the national and community level (work also implemented with the partnership of CSOs). **This approach has been highly effective in regard to the alignment with the government strategies and the efficient operationalization of work against FGM. However, it poses important question marks in a framework of the political instability in Egypt in the last decade, not only at macro level, but also at ministerial level, with four different leaders at the NPC and five different Ministers of Health in the past four years. Its main limitation is that it constitutes a parallel system with strong constraints as regards national ownership.** Presently, the work of the JP at national level has been stopped for more than a year due to lack of understanding between senior management within the related government institutions.

Assumption 1.2

The Joint Programme approach is based on its comparative advantages, taking into consideration the roles and comparative advantages of other actors working in this field.

The design and approach of the JP is based on its comparative strengths although there is scope for strengthening its convening role, taking advantage of its global/ regional/ national/subnational presence. The comparative strengths are categorised as: (i) the ability to work across sectors and engage high level stakeholders; (ii) support to national co-ordination; (iii) providing a convening role in FGM.

(i) The JP approach recognises the multivariate nature of FGM and the need to work across different sectors and engage with relevant actors. This is particularly apparent from Phase II. The JP approach is based upon its comparative advantages of being a (dual) UN programme and able to 'open doors' and reach appropriate stakeholders across different sectors, for example²³²:

- In recognition of religious misconceptions and their influence, the JP approach includes working with different faith-based organisations (advocacy of religious leaders' messages, production of books and manuals, training) and senior leaders have been engaged
- Given the significance of medicalization in Egypt, the approach includes medical actors and in particular the Supreme Council of Universities to advocate for changes in the national curriculum
- Given the need to work on strengthening of the legal framework and law enforcement, engaging the Ministry of Justice working within a multi-stakeholder Taskforce to support legal strengthening
- Recognising the importance of media (particularly TV), the JP design includes working with media actors
- Within community mobilisation work, partnerships are formed between the different stakeholders: peer educators, religious leaders and doctors to spread awareness about FGM.

(ii) The JP, within Phase I and II has also drawn upon its comparative advantage of being in a position to support national co-ordination and capacity development

²³² These work areas are included within the Annual Reports and were corroborated in discussions with UN staff and relevant stakeholders

- Within Phase I and II, the JP supported the Taskforce and involvement of key stakeholders in the development of Egypt's FGM Strategy
- The JP has also been reactive to government requirements and supported the PMU where there were gaps identified in the National Strategy
- Supported capacity building in areas identified by government, including support to judicial officers, prosecutors, forensic experts and judges to help the Ministry of Justice better implement the law.

(iii) The JP is uniquely placed in Egypt as a dual UN agency programme with global/regional/national/ sub-national reach. The limited funding of the JP and its comparative strength demands a higher focus on its convening roles. The JP was found to fulfil a convening role to different extents across the various levels and stakeholders of the programme:

- Relevant convening of high-level stakeholders at the regional level. Two examples are of interest (i) UNFPA Regional Office (ASRO) convened a meeting on medicalization in the region involving the African Union, Arab League and medical associations, highly significant to Egypt; (ii) ASRO convened a faith-based organisations at the regional level involving Muslim, Christian and other faiths to take a stand on why FGM should stop. This led to National Organisations which were also set up
- Bringing together regional level technical work with national level
- Some, but insufficient, regional meetings bringing JP country office together. This has been limited to training/ feedback on global initiatives to date, an example being the Data for All workshop organised by UNICEF regional office MENARO.
- No regional meetings bringing together IPs/ other CSOs
- No national meetings bringing IPs/ other CSOs together
- Limited sub-national meetings or information-sharing exercises bringing IPs together
- Limited (to no) formal mechanisms in place to share documented information across countries, beyond the Regional Office sending documents to Country Offices (email list)

Assumption 1.3

Joint Programme interventions at the global, regional, national and sub-national levels are based on a comprehensive analysis of all available evidence (e.g. situation analysis, needs assessments, gender assessments, identification of drivers of change, stakeholder mapping) of the populations of interest in programme countries and of the factors that create barriers and promote drivers of change to end FGM.

There is an undisputable need for the JP in Egypt based on the evidence of high FGM prevalence rates in the country

The FGM prevalence in Egypt is one of the highest in the world at 92% in 2014 (the last DHS implemented in the country).

Despite the presence of a law banning FGM, the practice continues to be widespread in Egypt. Type I (i.e. partial or total removal of the clitoris and/or the prepuce) and type II (i.e. partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora) are the most common types of

FGM in Egypt²³³. Reasons underlying the practice of FGM include believing it is a religious requirement; it protects a girl's chastity and prevents against adultery or husbands prefer women who are circumcised²³⁴.

The JP strategy is based on existing evidence and a robust understanding of FGM in general terms, but there is room for improvement

The stakeholders working on FGM have been acquiring a progressively improved understanding of the complex FGM phenomenon, especially since the efforts by WHO and UNICEF in the 80s. Today UNICEF and UNFPA are widely considered in Egypt among the best-informed international agencies working on FGM²³⁵, despite the important remaining gaps (see below).

One aspect of added value mentioned with emphasis by key informants is the capacity of the JP to act as a bridge between global research and local needs. For example, the explanation in a UNICEF conference in Rome (2013) of how to compare and read statistical data, so as to understand that the FGM prevalence change is not given by the total 92% figure but by the change in the 15-19 range, was mentioned as enlightening. Even if the mentions to this added value are anecdotal in terms of sample, the influence of the key informants, the need for this connection and the objective capacity of the JP in this respect show the potential of the JP in this dimension.

The JP strategy is based on evidence in general terms as it is shown for example by its gradual widening of approaches against FGM following the gradual understanding of FGM drivers, in particular with the incorporation of a focus on social norms, or the focus against medicalization after the results of the DHS and other research showed the high degree of medicalization in the country. This approach based on evidence also applies to the geographical choice based on prevalence rates, mainly focusing on Upper Egypt.

Having said this, the evaluation has observed specific actions of the Joint Programme, such as media campaigns, which are not clearly linked to evidence in terms of messaging or approach. This observation is important at least for two different reasons. Firstly, messages not based on evidence may be ineffective and –in cases when the campaign emphasizes messages that the population perceive as unrealistic or exaggerated- even counterproductive. Secondly, the perception by other stakeholders that the campaigns are not based on evidence, diminishes institutional credibility. It should be noted that in those cases where evidence has been actually gathered to base campaigns, this perception would indicate a communication gap.

Despite the advances in FGM understanding, there are still important evidence gaps, especially in terms of trends in social norms change

A different challenge is posed by situations in which the JP is not able to apply evidence-based approaches because the evidence does not exist. This is a problem that affects all the actors working on FGM, not just the JP, but there are areas where the JP could contribute to a better capitalization of evidence or to a better targeting of research (see considerations for action at the end of this table).

The gaps concerning lack of sufficient evidence have several dimensions:

²³³ Eliminating Female genital mutilation. An interagency statement. Geneva: WHO, OHCHR, UNAIDS, UNECA, UNDP. 2008

²³⁴ Prevalence of female genital cutting among Egyptian girls. Bulletin of the World Health Organization, 86(4):269-274. Tag-Eldin MA, Gadallah MA, Al-Tayeb MN, Abdel-Aty M, Mansour E, Sallem M. 2008.

²³⁵ Wide consensus among interviewees be them research institutions, government, civil society or other international agencies.

(1) The DHS for 2018 has not been published as expected and it is still uncertain when will the government allow the disclosure of the information. This means that the programmes working on FGM in Egypt, including the JP, are in the blind on important overall trends, and the last information with a country level scope is from 2014.

(2) The primary source of data and statistics on FGM are the national Demographic and Health Surveys. These have critical limitations to monitor social norms change and actual behaviour change, primarily because they are designed for the understanding of a wider spectrum of demographic and health elements at macro level; but cannot substitute for intervention research focused on a sample of the universe of beneficiaries of an intervention.

(3) There are essential specific elements about FGM that need to be understood and that cannot be expected to be covered by a DHS exercise, but by dedicated and extensive research. For illustrative purposes, some of them are:

- Medicalization: there are strong opinions in the literature, but it is still unclear from an evidence point of view whether medicalization constitutes one step forward or one step backwards towards abandonment of FGM.
- Increasing legal punishment against FGM: unclear from an evidence point of view whether increased punishment and criminalization has a positive or counterproductive effect in a context where the social norm is still generally in favour of FGM (e.g. on the positive side it deters and sends a social message, on the negative side, the harsher the law, the less likely it is to be applied by a judge who considers FGM as a decent practice)
- Level of heterogeneity of FGM (street by street, community by community is different) – It is still insufficiently understood what works, what does not and why in each specific situation.
- Insufficient evidence on which messages work and the appropriate segmentation in different locations
- Insufficient evidence on the interaction between Child Marriage and FGM
- Insufficient understanding of the important causal relationship between FGM, marriage problems and the possibility of confounding variables.
- We still do not understand the main factors for first movers (positive deviants) and for followers
- How to work in an underground scenario after village declarations with a change of paradigm in terms of social norms?
- Insufficient/anecdotal information on cross-border or internal displacement and effect on FGM. Also lack of evidence-based guidance on who convinces whom in scenario of different opinions on FGM (immigration/ cross-border) and how to strengthen the chances of these in favour of abandonment to convince the others.

(4) The environment for research in relation with FGM is considered sensitive in Egypt at the present moment.

(5) There is considerable knowledge from Implementing Partners within the Joint Programme that is not being harnessed and utilized around social norms processes, gender dynamics and drivers of change at the global level.

(6) The contact between Population Council and JP is insufficient during research processes that are long and that offer intermediate opportunities for more interaction and synergy.

In this context, there is ample space for a more effective and proactive approach to bridging or mitigating those gaps, either involving additional actors for targeted research, better capitalizing existing collaborations, such as the one with the Population Council (under the DFID Evidence to End FGM initiative), focusing on quasi-experiments focused on a sample directly affected by the intervention of the JP and capitalizing the potential of implementing partners in the field (see considerations for action at the end of this table “Considerations for the overarching global thematic level).

Evaluation question 2

To what extent has the programme contributed to supporting governments, communities, and the girls and women concerned towards the abandonment of Female Genital Mutilation/Cutting through the establishment of conducive legal and policy environments, support for the provision of FGM health services, and the shifting of social norms?” **Criteria:** *Effectiveness and Sustainability*

Assumption 2.1

Programme countries enact legal and policy frameworks for eliminating FGM which are appropriately resourced and implemented (in line with AU and UN Resolutions);

The JP has contributed to strengthening legal and policy frameworks, although effective enforcement continues to be a challenge in Egypt

The normative framework against FGM has been slowly evolving in Egypt in a general tendency to be more punitive against the FGM practice. The JP has been an important actor –together with other stakeholders– in the contribution to this pattern. In the Egyptian context during the last 10 years, it is also important to realize that the contribution of the JP should not only be assessed in terms of contribution to visible steps forward, but also in terms of contribution to avoid regression in laws, as legislative progress is not yet stable and is subject to drawbacks if not protected.

The historic evolution of the legal approach to FGM and medicalization in Egypt is summarised in this excerpt²³⁶:

Egypt appears to be unique in terms of being the only African country to have formulated official policy to regulate, rather than ban, the medicalization of FGM. In an effort to improve the safety of what was viewed as an “inevitable practice” (Anonymous, 1996), the Ministry of Health issued a 1994 decree that lifted a 35-year ban on performing FGM in public hospitals. The Ministry asked state hospitals to set aside one day a week for performing FGM “by trained physicians under hygienic conditions” (Refaat, 2009: 1385). This policy came under intense scrutiny that same year when the news network CNN aired a documentary showing the circumcision of a 9-year-old girl from Cairo (Refaat, 2009). The film spurred an outcry from activists that led to the reversal of this policy, and as a result the policy was reversed to banning FGM in both state and private hospitals. A “loophole”, however, allowed for “medically necessary circumcision” (Modreck and Liu, 2013: 922), and was not closed until 2007, in the wake of public outrage over the FGM-related death of an 11-year-old girl. An ensuing Ministerial Decree prohibits doctors, nursing staff or others from performing FGM, whether in governmental or nongovernmental hospitals (UNFPA, n.d.). This decree was bolstered by the adoption of a 2008 law making FGM a crime punishable by imprisonment or fine. A hospital-based study revealed that, despite the law, health care personnel have continued to perform FGM

²³⁶ The medicalization of female genital mutilation/cutting, What do the data reveal? Population Council. February 2017

(Rasheed et al., 2011). The first criminal case, brought against a doctor accused of being responsible for the FGM-related death of a 12-year-old girl, aimed to discourage Egyptian doctors from conducting “the endemic practice” (Kingsley, 2014). The trial ended in an acquittal of the accused doctor, and media reports speculated that the publicity surrounding the trial may have served to drive the medicalized practice underground (Kingsley, 2014). In January 2015, the first successful FGM-related prosecution took place, convicting a doctor of involuntary manslaughter for his role in the death of a 13-year-old girl and sentencing him to 2 years and 3 months in prison (Michaelson, 2016). In 2016 the law banning medical professionals from performing FGM in either state or privately-run clinics was amended to raise the maximum sentence from 3 to 15 years in prison (Sirgany, 2016).

Whereas it is difficult to isolate specific moments of JP contribution in what is mainly a continuous collective work, the following can be considered indicative milestones in the contribution to a stronger normative framework against FGM:

-UNICEF and UNFPA contributed to the passing of the law criminalizing FGM in June 2008, as a misdemeanour. Even if this is just before the start of the JP the experience acquired was incorporated in the JP, which also contributed to help break the silence and succeeded in mobilizing various segments of the society and in establishing a network of citizens who are willing to fight FGM. Moreover, it succeeded in developing the capacities of the media (TV, Radio, Press, Online) which played an important advocacy role in disseminating messages against FGM, successfully stimulating public debate on the issue, which also influences the normative framework. This work was done mainly in partnership with the Ministries of Health and Population, Education, Religious Endowments, Al Azhar, Dar El Iftaa, all of which made efforts towards integrating anti-FGM in their programs and curricula.

-In 2011, when the Muslim Brotherhood came into power, the 2008 law was put into question, mainly in reference to its compliance with the Islamic Law, a movement that was highly contested with a priority contribution of the JP, supporting mobilization against that change both supporting political defenders of women’s rights, grassroots organizations and media. In connection with this period and theme, the alleged intention of the MB to send mobile caravans to cut girls in rural villages provoked an outcry in media, supported by FGM detractors including the JP. The visibility of this push back is important, as it contributes to opinion building and political reactions in Egypt.

-In June 2012 there was a second attack on the 2008 law. The PMU channelling JP support at government level worked intensively in the legal framework, in this case coordinating or supporting different actions: the medical and obstetrician society made a statement, media attacked the parliamentarian for refuting the law, NGOs signed petitions to the Parliament, and the Parliament managed to keep the law. In 2013 the Constitutional Court stated that the 2008 law is constitutional.

-In June 2013 Egypt had its first trial related to FGM. The case of Soheir El Batea, a girl who died while suffering FGM, with the doctor who performed it initially acquitted thanks to a settlement. The JP was instrumental in reopening the case, not only through the contribution to visibility of the case and public reaction, but with the direct exposure of high senior officials to FGM in the launch of the JP Phase II in Rome. Shocked by the high FGM figures of Egypt, more worrying than many Sub-Saharan countries, it directly sparked the will to do something about the situation, which in turn enabled the reopening of the case by the General Attorney, which resulted in the first FGM conviction in Egypt in 2014.

UNFPA in collaboration with the NPC and the office of the General Prosecutor continued its training program for law enforcement agents on FGM that was launched in December 2014 for prosecutors, judges and forensic medicine experts. Under the agreement, which was made with the Egyptian National Centre for Judicial Studies (NCJS) in 2015 to integrated FGM in the curricula, all trainings were integrated and implemented by NCJS a total of 500 law enforcement agents were trained in 2016. The curriculum was

developed as a collaboration between the NCJS and the NPC which not only goes over the legislation and social aspects of FGM but it also centres on practical cases, such as that of Soheir El Batea. The aim of the training was to raise awareness on all issues related to FGM and to identify gaps in the current legal proceedings and administrative oversights which hinder litigating relevant cases according to the FGM criminalising penal code, and finally to give the appropriate tools to law enforcement agents to avoid falling in the legal loopholes.

-This interaction had also a positive effect in the collaboration between the JP and Egyptian government for the draft of the **National Strategy for the abandonment of FGM in the country.**

-On the 26th of May 2016, Mayar Moussa –a young girl- died from FGM practice at the hands of a doctor in a private hospital in Suez Governorate. A statement was released by the United Nations calling “for review of current legislation and enforcement of Egyptian laws to ensure the rights of women and girls are fully protected and looks forward to the results of the investigation on the death of Mayar so that the perpetrators of such dreadful crimes are brought to justice.” Following the death of Mayar, the Egyptian People’s Assembly in August 2016 adopted a stiffer legislative amendment criminalizing FGM that the Joint Programme in collaboration with the National Population Council had been pushing for, through engagement with the law enforcement entities since December 2014. The Joint programme played a crucial role in the work leading towards the amendment of the law on FGM. The legal task force headed by the NPC and fully supported by the JP has brought together all legislative parties including the General Prosecutor's office, Ministry of Justice, Ministry of Interior, Ministry of Health and Population, as well as the Supervising department of private health facilities and clinics. Through the work of this group, as well as through the trainings completed with the district attorneys and the Ministry of Justice, specific recommendations for strengthening the FGM law was put forward²³⁷.

-On August 31, 2016, the Egyptian People’s Assembly approved the amendment of article 242 of the Penal Code. Article 242 (bis) criminalizes the act of female genital mutilation (FGM). Previously, article 242 (bis) covered FGM as a misdemeanour. It imposed the penalty of imprisonment between three months and two years on practitioners who commit the offense. Under the new amendment, individuals committing this crime will be punished with a period of imprisonment of between five and seven years. The article also punishes, with a penalty of imprisonment between one and three years, any individuals who escort the victims of such crimes to the perpetrators. Furthermore, the amendment punishes the crime with up to 15 years’ imprisonment if the act of FGM leads to the death of the victim or a “permanent deformity.” In addition, a joint statement was prepared by UNFPA, UNICEF and UNDP and was widely disseminated (https://www.unicef.org/egypt/media_11034.html)

The connection between visible cases and legal progress is very strong in Egypt and the JP has capitalized on this phenomenon

The previous narrative shows how the mortal victims of FGM may have the potential to act as a catalyst for state action and legal progress, as long as there is proper visibility, media coverage and the ensuing public pressure. This dynamic was capitalized by the JP, being at the right place at the right moment, thanks to its previous positioning combined with high responsiveness.

However, convictions are still extremely rare, and there is insufficient evidence to show whether the strengthening of laws against FGM acts as an accelerator or obstacle regarding FGM.

²³⁷ Numerous sources confirming JP contribution, including JP staff, key researchers, CSOs, JP final report 2016

Convictions due to FGM are still extremely rare –only 2 since 2008 in a framework of wide practice. This poses the question on whether law strengthening in a context of a dissonant social norm has a positive or negative effect.

On the one hand, the passing or strengthening of laws against FGM constitutes a social statement, which in the long term might have positive effects such as questioning of the practice, deterrence (given the appropriate circumstances), or enforcement (if the social norm acquires sufficient critical mass and an enabling environment). On the other hand, the creation or strengthening of the law may have counterproductive effects, such as dissuading law enforcers (judges, prosecutors, lawyers) even more from enforcing a law they do not believe in, as a higher punishment for a socially accepted practice is perceived as even more unfair. In addition, it can cause FGM to be practiced underground, making its practical eradication harder to observe, to follow up and to work upon.

The most prestigious academic studies²³⁸ about the interplay between legal and social norms show credible findings that this interaction is at best extremely delicate, with significant risks of it being counterproductive. The literature on this subject is presently exploring questions such as whether law matters for social change, and is investigating the ways in which, and the mechanisms through which, law influences social change. However, presently there are very few studies dedicated to the interaction and mechanisms between law and social change in the specific FGM field.

The added value of the global dimension of the JP at is emphasised by key interviewees in Egypt, especially in a framework where it is important not to present FGM as a Western ideology to be imposed on Egypt or a shameful issue that is better to keep silent (with the concomitant disincentives to act upon it).

By framing FGM as a global issue affecting many countries that is also fought against globally, with the collaboration of different partners. The importance of this dimension and how to capitalize it in Egypt cannot be emphasised enough.

In a profoundly religious country as Egypt, the religious normative framework is often even more important than the legal normative framework. It should be clarified that what matters the most in terms of FGM practice is not just the religious laws in themselves –unknown by most of the practitioners, but the perception of what those laws prescribe, both by the people in general and by the imams and priests, *de facto* conveyers of such interpretation in most cases. In addition, religious leaders convene in general a prestige and influence that is itself crucial in the formation of collective will and social norms.

In this context, the JP has emphasized the work with religious institutions and religious leaders in the fight against FGM, both with Muslim and Christian (Coptic) communities and institutions. The main findings and milestones in relation with this work are the following:

The JP has an excellent positioning both in Muslim and Coptic institution. The partnership of the JP with key figures in the prestigious Al Azhar University, reference point for the whole Muslim Sunni world and with BLESS, the executive body of the Coptic Church in Egypt constitute an achievement in itself. The JP has been able to identify a niche of work that is complementary to the already established actions of these institutions, through methodologies, pedagogical tools, relevant trainings, etc.

²³⁸ Posner, Eric A. *Law and social norms*. Harvard University Press. (March 8, 2002); Acemoglu, D. and M. Jackson. “Social norms and the enforcement of laws”, NBER Working Paper No. 20369. 2014; Albiston, C.R., Leachman, G.M. “Law as an Instrument of Social Change”. In: James D. Wright (editor-in-chief), *International Encyclopedia of the Social & Behavioral Sciences*, 2nd edition, Vol 13. Oxford: Elsevier. pp. 542–549. 2015.

The work with Muslim Imams shows mixed results. The evaluation found strong conviction against FGM in important and influential Al Azhar professors. Also, a strong narrative against FGM developed based on Muslim norms, in particular Quran sacred texts and Prophet Hadiths. This work and collaboration constitute an essential prerequisite for an effective work in the country. The inclusion of FGM as an issue to be clarified as harmful and non-religious in Friday prayers by the Awqaf Ministry constitutes also an important element, even if its implementation is reportedly irregular (see below).

Despite the JP support to Al Azhar trainings and messaging against FGM, the Muslim religious hierarchy is highly decentralized, and Imams in the different governorates show different levels of conviction²³⁹, from true champions who take the fight against FGM as a personal battle, to those who still believe in the moral appropriateness of FGM, passing through an array of intermediate positions (there is lack of quantitative data or results-oriented information so as to know precisely the proportions in each category). It is important to note that a neutral position is ineffective for change in a context of high prevalence where the default position is often “in favour of FGM”. Some interviewees even acknowledge that social pressure puts them in a position to refer to doctors the persons who come to them for advice, shifting away their responsibility. One factor contributing to lack of conviction is the previous disagreements regarding religion and FGM between the Grand Mufti and the Grand Imam of Al Azhar. Even if today there is consensus between these two prestigious Muslim institutions about the non-religious obligation of FGM, the disagreement still remains the Imams’ memory, creating confusion. The existence of lay preachers in informal mosques –zawya- outside of the direct hierarchical influence of Al Azhar or the government creates an additional obstacle.

The collaboration with the Coptic Church work reportedly shows very positive results²⁴⁰ in the conviction of priests who in turn exert a strong influence on their communities (there is lack of quantitative data or results-oriented information so as to know precisely the proportion, but a high consensus among interviewees). These positive achievements are probably due to a clearer theological doctrine on FGM, higher consensus on its interpretation, a more centralized structure of the church and –possibly- social factors. Having said this, it is worth remembering that the scope of the Coptic Church reaches 12% of the Egyptian society.

Assumption 2.2

Service providers provide timely, appropriate and quality services to girls and women at risk or having experienced FGM in select districts in programme countries;

Medicalization of FGM is a worrying concern in Egypt that is addressed by the JP

The shift towards health professionals performing FGM, known as the medicalization of FGM, is a particularly important issue in Egypt as, currently, 78.4% of incidences of FGM are medicalised. A dramatic shift has been noticed from 2008 to 2014 in this practice. The last data show that health providers performed FGM on 82% of girls younger than 19 years old, compared to 37.9% of women in the reproductive age group 15 to 49²⁴¹. In this respect, rates of FGM medicalization (i.e. performance of the

²³⁹ Interviews and Focus Group discussions with Imams in Assiut, Qena, key informants, Al Azhar professors and trainers and CSOs.

²⁴⁰ Interviews and Focus Group discussions with Priests in Assiut, Cairo, key informants, BLESS responsables and CSOs.

²⁴¹ Egypt Demographic and Health Survey 2014

practice by medical personnel) in Egypt are more extensive than in any other country where FGM is practiced²⁴².

Medicalization violates medical ethics given that FGM is a harmful practice and it may also confer a sense of legitimacy to FGM or give the impression it is without health consequences, when this is not true. Whereas it is true that some typical medical complications of FGM Type I and II are often avoided through medicalization (i.e. accidental cut of the clitoral artery, infections, clitorideal cyst and shocks caused by severe pain in the absence of anaesthesia), the most important effect is not avoided²⁴³: all the psychosexual results on the one hand and the human rights limitations on the other. Medicalization of a harmful practice such as FGM institutionalizes and normalizes it, making the process of complete abandonment more difficult²⁴⁴.

The JP has correctly prioritised a response to the knowledge/awareness aspect of medicalization targeting medical personal

In Egypt, the medical staff experiences a complex combination of different incentives to perform FGM. Social incentives are important, as a doctor is often perceived in rural areas as a service provider who earns their trust to give them services. Refusal to perform an FGM when asked can have as a consequence the loss of credibility/authority and that the community does not consider him/her their doctor any more. Economic incentives are also important, as the performance of FGM means a substantial source of income, especially due to its frequency. Lack of knowledge within medical personnel is an essential factor, as in medical school students are not taught sexual health, let alone medical or moral implications of FGM.

The JP has responded to this situation focusing on the essential knowledge aspect, through the initiative “Doctors against FGM”. The initial focus on training of doctors has been progressively improved in order to achieve larger impact. In this respect, the JP has been lobbying for the inclusion of FGM in the Egyptian medical University Curriculum through the NPC and the supreme council of universities. There have been significant delays due to the change in management at the NPC. However, in 2016 the JP supported the NPC in hiring a consultant to work on the curriculum and a consultative meeting was held in Cairo inviting all key faculty heads of Gynaecology and Public Health and Forensic medicine departments in leading medical schools, in addition to high level member of the Supreme Council of Universities to introduce the idea of integration of the curriculum.

This initiative has had some important achievements such as the development of the curriculum for medical students, its submission to the Higher Committee for Medical Education to Integrate in Medical Education Programs and the approval of its integration, which affects all Universities in Egypt²⁴⁵, in a process by which the Deans decide on its effective implementation on their respective universities. At present, all the obstetrics departments have the obligation to explain the issues related to FGM to medical students, both the medical part and the legal aspects. The model has the potential to serve as a model for other health systems, and at the present moment Doctors against FGM is in contact with Kenyan colleagues, through the “Evidence on FGM” project, who are actively waiting for the results of the implementation.

²⁴² Female Genital Mutilation/Cutting: A statistical overview and exploration of the dynamics of change. New York: UNICEF. 2013.

²⁴³ Dr. Abdel Hamid Attia and other doctors consulted throughout the FGM mission.

²⁴⁴ A repeat call for complete abandonment of FGM. Askew I, Chaiban T, Kalasa B, Sen P. 2016. Journal of medical ethics, medethics. 2016.

²⁴⁵ Dr. Abdel Hamid Attia and other doctors consulted throughout the FGM mission.

The next steps to this process of curriculum application would have been the effective implementation by professors, appropriate training and monitoring, however the NPC block has impeded the continuation of this work in the last semester and everything is in a hiatus.

On a more technical level, it is worth noting that the approval of the curriculum will need to have associated actions, as doctors will need to learn not just about FGM but about sexual health in general in a comprehensive manner and about human treatment to patients and how to speak to them constructively in such a sensitive issue. All these steps depend on the solution of the NPC current halt.

Other incentives to medicalization – understanding them and wider strategies need

As explained above, whereas the knowledge element is an essential one to stop medicalization of FGM, the economic and social incentives are also very strong drivers. Just for illustrative purposes, if we established an imaginary scale of incentives from the point of view of the medical doctor or staff, we would encounter something similar to the following mosaic of drivers among different doctors:

1. Those with a complete lack of knowledge of sexual reproductive health, as it is absent from his/her medical education at university.
2. Those in favour of FGM. Doctors are also part of society with 92% prevalence of FGM.
3. Those who are not particularly in favour or against, but do it for the economic incentive
4. Those who are not particularly in favour or against, but would do it due Social pressure, as they cannot afford to lose their whole credibility and subsistence as a doctor.

Apart from these four clear-cut groups there would be many more situations that fall under a large number of nuances, for example:

5. Some would not do it themselves but would have a colleague doing it.
6. Some will think: I would not do it if nobody did it, but if I don't do it, others would do it anyway, so I might as well do it and at least get paid.
7. I don't want to do it, but if I don't do it, they will go to a daya (TBA). I better do it myself, so I can minimize the harm to her.
8. Cosmetic. I find it is much more beautiful this way (it is hard to determine from another culture the relation between harm and beauty).

In this context, the evaluation finds that the initial concentration of the essential and primary knowledge aspect is strategically appropriate, especially given the resources and capacity of the JP. However, the complex interaction of drivers affecting doctors (lack of awareness, economic incentives, social pressure, cosmetic beautification) and the need of only few doctors to sustain the FGM practice, confers the medicalization problem a magnitude that can only be tackled through determined political will at national level. It calls on the one hand for whole reform of the public health system due to the financial incentives medical doctors have and on the other a shift in the social norms of the society as a whole, because working only on the providers side will always be insufficient as long as there is a substantial demand. In this respect, it is important to note that even if some doctors have the courage to become advocates and convince other people in the village, if a village manages to have nine doctors refusing to perform FGM and one who still does it, the practice would continue. Conversely, a critical mass of the community refusing to perform FGM can attract the rest to join the majority in a social norm shift. Media has also an extremely important role and it is essential to incorporate nurses in any action directed to medical personnel –not just doctors- as otherwise the practice would in all probability shift from doctors to nurses.

Phase III of the JP plans to address the trend of medicalization by galvanizing health professionals to champion the end of FGM as a human rights violation and will focus on creating a cadre of service providers advocating to end the medicalization of FGM. Also, in order to address the medicalization of FGM, a partnership will be established with medical syndicates and associations to enforce policies and legislation, including legal sanctions for health professionals who engage in FGM²⁴⁶. An analytical study on doctors' incentives could be a JP contribution to be considered.

Access to Justice: the Joint Programme has been an instrumental actor within the strengthening of the legal framework in Egypt.

It lobbied for the amendment of an article of the penal code that criminalises FGM/ C to enforce stricter punishments for the offence, which successfully resulted in an amendment to article 242 of the Penal Code in 2016. The change criminalises the act of FGM so that it is a felony (rather than a misdemeanour) and extended the penalty of imprisonment from 3 months – 2 years, to 5-7 years. It also punishes any individuals who escort the victims to the perpetrators and punishes the crime with up to 15 years imprisonment if the act leads to the death of a victim²⁴⁷.

However, implementation of the law and its enforcement remains a challenge²⁴⁸. Some arrests have been made and isolated cases brought to court. Convictions are limited to high profile cases and impose lighter sentences than the law permits²⁴⁹. Whilst the law sends an important message and influences social norms²⁵⁰, without the appropriate enforcement it does not carry sufficient weight²⁵¹.

In recognition of this, the JP has worked to engage with law enforcement entities since December 2014; providing capacity building throughout Phase II to law enforcement agencies and continuously scaling up work with prosecution, forensic department and the Ministry of Justice. This has contributed to system strengthening, as well as successful lobbying efforts to strengthen the law. Since 2014, 225 law enforcement entities were reached and over 2000 law enforcement agents were trained to deal with cases of FGM in their work²⁵².

The JP is also working to raise awareness about the legal aspects of FGM within community work²⁵³. The importance of working on the 'demand side' of law enforcement is vital. As one government stakeholder stated 'we have the law and systems, but we now need people to respond and use them. So, it's about awareness raising and a change of mentality so that reporting happens'. The JP work at the sub-national level (through organisations including YPEER, Caritas, ACDA) involves raising awareness about the legal frameworks and reporting system, as one 'tool' within wider community awareness/ social norm work.

²⁴⁶ Theory of Change Document. Phase III Joint Programme.

²⁴⁷ 28 TooMany, Egypt: The Law and FGM, 2018

[https://www.28toomany.org/static/media/uploads/Law%20Reports/egypt_law_report_v1_\(june_2018\).pdf](https://www.28toomany.org/static/media/uploads/Law%20Reports/egypt_law_report_v1_(june_2018).pdf)

²⁴⁸ Ibid and supported by frequent findings within interviews with Government staff, CSOs and UN staff

²⁴⁹ See: 28 TooMany, Egypt: The Law and FGM, 2018

[https://www.28toomany.org/static/media/uploads/Law%20Reports/egypt_law_report_v1_\(june_2018\).pdf](https://www.28toomany.org/static/media/uploads/Law%20Reports/egypt_law_report_v1_(june_2018).pdf)

²⁵⁰ As observed by the Evaluation Team in Qena and Assuit, a high frequency of beneficiaries when asked open questions cited that as it was 'against the law' as a key reason not to undertake FGM. In addition, it has been observed by the Ministry of Health outreach team that in the past when parents chose not to circumcise their daughters, they did not want to tell people, but since the law feel that they are justified because it is against the law

²⁵¹ UNICEF, 2015, Mid Term Review Strategic Reflections on FGM Programme, consistent view by UN staff, CSOs

²⁵² UNFPA/ UNICEF Joint Programme, Egypt UNFPA-UNICEF JP on FGM: Accelerating Change, Phase II: Final Annual Report 2014-17

²⁵³ The integral way in which legal aspects are considered within the awareness raising and community mobilisation work is apparent the JP annual reports (2008-17) and corroborated with findings from interviews with NGOs and UN staff

Rural pioneers highlighted how the law is used to show what is tolerated within society. As one Adolescent Peer told us “A villager will say ‘it’s tradition’ and I respond ‘but it’s against the law and there is a fine. Doctors go to prison and you’ll also go to prison by taking your daughter to be circumcised. I also provide a newspaper cutting of a doctor from Upper Egypt that was put in jail”. This is discussed further in 2.3.

Challenges in law enforcement persist and include²⁵⁴:

- girls being too young when they are cut to report it;
- the criminalisation of parents - girls not wanting to get their parents into trouble and so failing to report FGM;
- doctors need to be ‘caught in the act’ to be arrested;
- the practice of FGM ‘going underground’/ being done in secret;
- a lack of awareness of the law and that FGM is a crime, especially in rural areas;
- a lack of education and support among justice agents, such as police and judges ²⁵⁵
- lack of centralised monitoring system to track the number of cases

Assumption 2.3

A majority of individuals, families and communities in programme areas accept the norm of keeping girls intact

Whereas the overall prevalence of FGM in Egypt is still very high, the prevalence among girls under 19 has declined

A comparison of the data collected by the last DHS on FGM show that the overall prevalence in Egypt was 91% in 2008 and 92% in 2014, the last DHS implemented. This shows practically the same prevalence from a statistical point of view. However, it should be taken into account when reading the data that overall prevalence is cumulative –i.e. a girl that was cut in 2008 remains cut in 2014 and for her whole life- taking generations to offer significant changes. The DHS scheduled for 2018 has yet not been published, which constitutes an important limitation to the interpretation of data.

According to the Secondary Analysis of the Egypt Demographic and Health Survey Module on Female Genital Mutilation/Cutting (2005 – 2014), the decline occurred mainly in Lower Egypt, followed by Urban Governorates and least in Upper Egypt. There is also a marked difference between actual prevalence and those expected to be circumcised. The Secondary Analysis shows the least improvements in Upper Egypt, where most of the FGM abandonment programmes and interventions are concentrated. Therefore, the reported decline trend can’t be directly attributable to the development work done. Despite variations in the level of association in each region, according to the Multivariate Analysis, overall the most significant cutting determinants are mainly related to the mother’s characteristics. In particular, mother’s circumcision status, mother’s attitude towards the continuation of circumcision, mother’s age and age at

²⁵⁴ 28 Too Many, Country Profile: FGM in Egypt, 2017 <https://www.28toomany.org/egypt/>, 28 TooMany, Egypt: The Law and FGM, 2018 [https://www.28toomany.org/static/media/uploads/Law%20Reports/egypt_law_report_v1_\(june_2018\).pdf](https://www.28toomany.org/static/media/uploads/Law%20Reports/egypt_law_report_v1_(june_2018).pdf) and elicited from meetings with UN staff and NGOs

²⁵⁵ 28 Too Many, Country Profile: FGM in Egypt, 2017 <https://www.28toomany.org/egypt/>

first marriage. Discussion of FGM in the last year, urban-rural residence and wealth quintile, are also reported amongst the most important determinants of daughters' FGM status²⁵⁶.

The fact that it is not possible to establish a direct attribution for this improvement to the JP or any of the programmes against FGM functioning in the country, does not mean that there is no contribution to this achievement, it mainly means that there is insufficient qualitative data existing both at national level and at intervention level to show the specific factors behind abandonment. Having said this, the field visits and interviews done by the evaluation indicate important contributions to abandonment or intermediate achievements towards abandonment²⁵⁷.

Whereas general attribution to the decline in FGM is not possible, the field visits and interviews done by the evaluation indicate important contributions to abandonment or intermediate achievements towards abandonment²⁵⁸

The JP has been contributing at community level with a focus on social norm shift against FGM through different NGO implementing partners, such as Assiut for Childhood and Development Association (ACDA), Caritas Egypt, Port Fouad Baby and Family Care Society and the more recent incorporation of PLAN. To give an idea of the scope, in 2016 ACDA's activities are implemented in Assiut Governorate in 76 villages and Y-PEER activities are implemented in 200 villages in ten governorates (Aswan, Qena, Sohag, Assiut, Minia, Beni Sweif, Qalyoubeya, Gharbeya, Port Saeid, and Fayoum). In addition, the JP trained 60 women teachers from 30 community schools in three districts in Assiut governorate namely; Al-Badari, Al-Fath, and Al-Sahel²⁵⁹.

Also, in order to give an idea of the scope of work, 2016 can be taken as a reference for reach out. Reportedly²⁶⁰, in 2016, UNICEF and Assiut Childhood and Development Association (ACDA) worked in Assiut on a number of community mobilisation activities, which aimed to change behaviour towards FGM and decrease the acceptance of the practice. Consequently, during this reporting period, UNICEF and ACDA conducted 79 outreach events addressing FGM abandonment in 76 communities in Assiut. The outreach activities included awareness raising sessions and seminars targeting women and men, reaching during 2016 3,111 women and men with 1,080 families publicly declaring the abandonment of FGM, and 132 of the families that circumcised the first daughter do not intend to circumcise their current/next daughters who are at the age of FGM. These figures are analytically examined in the points below.

FGM is an extremely complex phenomenon that incorporates many of the most complicated obstacles for social change enrooted in collective cultural practices. In this context intermediate achievements in the gradual path towards total eradication should be acknowledged, such as a significant increase of awareness (a precondition for change), breaking the taboo around discussing FGM (not an ultimate goal, but a very valuable milestone), or Public Declarations (not an ultimate goal, but an indicator of social norm shift).

1. Very significant increase of awareness in intervention areas.

²⁵⁶ Factors and Determinants of Circumcision of Daughters Aged 0-17 Years: A Secondary Analysis of Egypt Demographic and Health Surveys (2005 – 2014) by Dr. Fatma El-Zanaty, December 2015.

²⁵⁷ Mainly interviews and focus groups in Assiut and Qena at grassroots level or with CSOs, complemented by key interviews with FGM researchers and decision makers in Cairo.

²⁵⁸ Mainly interviews and focus groups in Assiut and Qena at grassroots level or with CSOs, complemented by key interviews with FGM researchers and decision makers in Cairo.

²⁵⁹ JP Final Report 2017.

²⁶⁰ JP Final Report 2017.

Awareness of FGM has increased at community level in JP areas. The consultations made with different kinds of stakeholders²⁶¹ indicate strong and general awareness at community level in the JP areas about the harmful effects of FGM. This is a significant achievement to be credited both to the long-standing effort of CS actors before the JP and to the JP itself, allowing the strengthening and sustained effort needed for change. In order to understand the positive weight of awareness in the FGM context, it is necessary to first understand the very low initial baseline in many communities, where even traditional birth attendants (TBAs) in constant contact with the girls, would not make the causal connection between FGM and medical complications, not to speak about men, for whom in many cases FGM was just an abstract name that they could not connect with the real practice nor be able to visualize it in realistic terms, even if it happens in their own communities for time immemorial. These low initial baselines and differences within communities have important implications in the effectiveness of the strategies to raise awareness and in the strategies for the continuation of the interventions.

The awareness achieved is more specifically referred to **three critical aspects of awareness** that are in turn related to behaviour change: **a)** Awareness of the causality link between the FGM practice and the medical complications suffered by women in the community; **b)** Awareness of the fact that religious texts do not approve FGM; **c)** Awareness that the laws condemn and punish FGM. However, the level of awareness and the weight of *each* of these factors in relation to behaviour change varies from community to community and also within communities (see below heterogeneity and its consequences).

2. Change of behaviour and abandonment of FGM has increased at community level in JP areas.

There is a high consensus among the persons consulted in the different communities²⁶² stating that there is a strong behaviour change towards FGM. Even if it is not always complete, it is perceived as general. This change is characterized by two main elements: firstly, at community level, there is a positive change of social norm and secondly, at individual level, there is a large proportion of the community that fully abandons the practice or substitute it by less harmful types of FGM.

The change of social norm means a shift from “General appreciation of FGM” to “General condemnation of FGM”. The change of social norm at community level, be it through formal declarations or a general consensus about it by the main leaders of a community, constitutes a tangible and visible achievement in JP areas in a task that is extremely difficult, technical and time-consuming. However, FGM abandonment, as most processes related to social behaviour change, are rarely abrupt. They tend to happen in a gradual pattern (and not always linear) that contains different milestones until the total abandonment of a practice is fully achieved. In that gradual scale, a change of social norm at community level does not automatically imply a change of behaviour in each member of the community –the ultimate goal-, but it constitutes a very significant milestone. The adoption of a new social norm at community level is not only very difficult to achieve in its own sake, but it also has tangible consequences in the path of full abandonment (see below). As such, this milestone should not be underestimated.

Some of the tangible changes provoked by the change of social norm at community level are as follows:

(i) Weight of proxy for individual behaviour. A vast majority of leaders and community members interviewed declare the abandonment and condemnation of FGM in the community. In more collective societies, where important decisions are taken at collective level and little space is left for individual

²⁶¹ Mainly interviews and focus groups in Assiut and Qena at grassroots level or with CSOs, complemented by key interviews with FGM researchers and decision makers in Cairo.

²⁶² Finding generally supported by interviews and focus groups with community members –both girls and boys, married and unmarried- traditional leaders, religious leaders and local CSOs.

deviations, this milestone of social norm change constitutes a very reliable proxy for individual behaviour change. Also, in the context of the study of a phenomenon that cannot be observed physically, the assumption that collective communities that declare abandonment of FGM have effectively abandoned the practice at individual level in most cases is highly plausible. In less collective communities, this proxy is less solid, but still important for other reasons (see below).

(ii) Taboo breaking. The vast majority of girls and boys interviewed speak openly about FGM and their consequences, even in public settings. This is a very significant change when considering previous situations where just mentioning the word “FGM” or similar equivalents would be considered a strong taboo with even violent attacks against those even trying to speak about FGM. This is important both as proxy of social norm change in itself and as a factor to encourage further social change. As a proxy of change, it shows that members of the community no longer expect social punishment for talking about the issue or for talking against FGM. As a factor to encourage further social change, the discussions in public permit others to observe and learn from those who speak, something that was impossible previously. The fact that some share with pride that, for example, they are uncut, and that they do it without fear for punishment or less chances of marriageability constitutes a remarkable change, that also enables a better transmission of messages within the community against the practice. More importantly, not only the members of the community speak openly about FGM, but they do so in an unequivocal condemnatory way, a remarkable element given the hundreds of years that the FGM practice has been embedded in the collective psyche. This taboo break is a very solid indicator of social norm change, in line with the results framework of the JP and its theory of change.

Another consequence of the taboo break is that stakeholders working against FGM at local level, mainly CSOs, are allowed to work and have the chance to further impulse change, something that would be impossible in the previous scenario, when the mere mention of FGM would mean physical expulsion of these organisations from the villages. Finally, it is worth mentioning how those who change from being convinced of the practice of FGM to being against it are particularly well placed –experientially and in terms of credibility as peers- to become advocates against FGM, one of the most convincing tool for other members in the community, as repeatedly stated by CSOs working in JP intervention areas.

3. At individual level, there is a large proportion of the community that fully abandon the practice or substitute it by less harmful types of FGM. The exact number of persons who abandon the FGM practice is not known, due to the limitations of the existing monitoring systems, quality of data and the invisibility of the phenomenon once it becomes illegal and/or condemned by a majority of the community. Having said this, the practical totality of interviews made with different kinds of stakeholders both in Assiut and Qena where the JP operates, show a radical change in the social norm as accepted by the majority, and a strong change also in the majority of individuals regarding the practice of FGM.

The abandonment of FGM by a majority of the community in the JP areas constitutes an impressive success in what can be considered a relatively short period of time when we consider the difficulty of behaviour change in practices deeply enrooted in societies for hundreds of years. This abandonment takes place both in leaders (both religious and traditional in terms of ideology) and in a majority of the community (both ideologically and physically). Full abandonment is supported by many examples of credible statements by community members, leaders and religious leaders that explain not only their own experience, but also that of the rest of the community in general.

The testimonies of women who circumcised their first daughter but not the second one, are particularly significant as an indicator of change²⁶³.

The Joint Programme is not benefiting from lessons about collective positive deviance

The understanding of collective positive deviance – how a whole social group, town or region changes from high FGM prevalence to low – is extremely important:

(i) Understanding a phenomenon from the exclusive analytical perspective of a negative process (such as high prevalence) followed by its extrapolation into the contrary situation is not necessarily an accurate path to understand positive change. The observation of a positive process, followed by extrapolation and adaptation to other contexts provides valuable insights, especially when combined with understandings of the negative process.

(ii) The analysis of existing positive cases of low prevalence (such as Damietta in Egypt or other areas in other countries that show a collective change process from high to low prevalence) offers new advocacy possibilities with positive messaging to inspire and motivate actions. In the context of a hard-to-eradicate phenomenon, the positive effect of local examples that show “*change is actually possible, and it has happened!*” is powerful.

The extreme heterogeneity of FGM demands a more precise and practice-specific understanding of the FGM causality model, focusing on mechanisms and contexts.

Whereas the Joint Programme acknowledges key variables for FGM abandonment (e.g. community dialogue, religious and traditional leaders, doctors, peer youth, law enforcement agents, among others) the extreme heterogeneity of FGM makes this knowledge insufficiently precise in many contexts. The significant differences affecting drivers of change even among communities belonging to the same ethnic group and even among households within the same community has important practical consequences.

The operational tendency to seek predetermined strategies to be applied and rolled out in all countries is understandable, given the efficiency promised by this approach. However, to acquire the level of precision required to ensure effectiveness at community level, the Joint Programme would need to move from a model of linear causality based on some predetermined strategies, to a more precise causality model focusing on the understanding of both *change mechanisms* and *specific contexts* at national, sub-national and community level.

In Egypt, there are CSOs such as ACDA or PLAN that are already working in this direction, but this is not an aspect systematically incorporated by the JP and benefiting the implementation as a whole, but attempts made by local CSOs based on their own experience pushing them into more profound identification processes and adaptation of their strategies.

In this context, it would be necessary to improve in general terms the understanding of the precise *mechanisms* of change in each specific FGM change process (not just the generic drivers of change) and to be ready for a deeper identification process for each *specific context* in the areas of intervention to adjust the strategies accordingly. To this effect, the Joint Programme could consider – in cooperation with implementing partners – the development of tools (such as a standard protocol for the establishment of ‘community profiles’) to systematically capture the essential elements of each specific context.

Accordingly, the right mechanisms and approaches to be used in each specific situation can be identified. It should be noted that even if this level of identification demands considerable effort, the intervention

²⁶³ Multiple testimonies both in Assiut and in Qena.

could be not only more effective but also cheaper, as it would focus only on those actions that are necessary and sufficient. It is worth considering that there are some implementing partners that already have developed valuable examples with partial elements of this suggested approach.

Mechanisms: understanding the exact *mechanisms* that are at work for change is crucial. For example, we already know that working with imams is potentially good (step 1 already achieved by the Joint Programme), but understanding the exact process that generates the change in the different communities – the mechanism – is also needed (step 2- understanding who talked to whom, who convinced whom, in what pattern, etc.). Focusing on understanding the different *mechanisms* and building a repository or catalogue of the different variations (step 3), would allow a more accurate identification of potential leverage points to generate change. The Joint Programme is in the position to coordinate feedback from field experiences into such a repository (see cycle in Figure 1, next to step 3). Finally, these mechanisms can be disseminated among the different implementing partners (and other partners) so as to improve their approaches.

Contexts: Understanding each specific context is the second element that needs to be understood to generate change in a framework of Generative Causality (Context + Mechanism = Outcome). Indeed, even if potential *mechanisms* of change are identified accurately, what generates actual change in FGM abandonment is the combination of both *mechanism* and *context*. FGM is highly heterogeneous, offering a large number of specific contexts: with differences within communities belonging to the same ethnic group, or even within the same community.

To understand the difference between mechanism and context, the example of striking a match on a red phosphorous surface can be illustrative. Striking a match may look as a mechanism that always produces fire; however, the level of humidity, the type of phosphorus or the inclination of the surface will play a role that, if ignored, will not produce fire. FGM is considerably more heterogeneous than striking a match, offering a very large number of specific contexts, with differences even within the same community.

“We know that social norms are key to change the FGM practice, but the decision makers, reasons and ways of doing FGM vary not only community by community, but even street by street and household by household... It is extremely difficult to find the right strategy unless we adapt it to each specific family and community...” (An experienced local NGO worker in Egypt – this quote echoes similar examples from Ethiopia, Senegal and Kenya).

Proposed steps for addressing understanding of contexts are illustrated in figure 1 and elaborated as follows:

Step 1. Distinguish general and specific identification processes. There are Joint Programme goals that, following a proper analysis and a general understanding of context (national and sub-national level would be enough), can be considered as generally needed in a country intervention without the need of a thorough community level analysis.[5] In contrast, community-based actions and social norms change require a deeper identification process with additional steps (2 and 3, below).

Step 2. Application of a standard protocol to community-based interventions. Those interventions that are designed for social norm change in communities, either urban or rural, cannot be predetermined. What *can* be predetermined is a standard protocol to systematically capture at the design phase the essential elements of each specific context; and the right mechanism to be used for a specific community profile. This would involve a specific identification process in each community, following a standard protocol so as to determine the contextual profile of each community and more effective path of intervention.

A standard protocol would need to cover critical aspects both at community and household level, such as: critical mass status (community percentage for/against FGM), social norm paradigm (public practice vs.

underground practice, etc.) specific drivers for FGM and for its abandonment in the community, community leadership profile, specific sensitiveness to specific messages, decisions makers at household level, etc.).

The Joint Programme is in a position to capitalize on its convening role to develop such *standard protocol*. Some local NGOs (e.g. ACDA or Plan International in Assiut) are already using this kind of approach – although not necessarily standardized and with different gaps – which means that existing *quasi-protocols* could be used as a basis to work upon.

Step 3. Community profile documents. The application of a standard protocol in each community where the Joint Programme intervenes would result in a *community profile*, and a better understanding of which mechanisms would fit this profile. While this level of identification demands considerable up-front effort, more tailored interventions are better placed to deliver overall value-for-money.

NB. See analysis on specific work with youth under sustainability, 5.2.

Evaluation question 3

To what extent do the JP country regional, and global initiatives and holistic approach create synergies that accelerate efforts to end FGM? **Criteria:** *Effectiveness, Co-ordination and Sustainability*

Assumption 3.1

Management arrangements and coordination between UNFPA, UNICEF, national authorities and programme partners have facilitated both agencies to leverage their relative strengths and capacities for more effective programme implementation.

Both UNICEF and UNFPA are highly committed to the principle of collaborative working, and this has been testing at times

Both UNICEF and UNFPA (at all levels of staff spoken to) expressed their commitment to working together, in theory. The Joint Programme was described by senior managers within UNICEF and UNFPA as ‘a way to ensure coherence and complementarity’, ‘a binding framework to ensure that planning, monitoring and advocating together’ and ‘an integrated and coherent framework’²⁶⁴. There is, however, recognition that although the principle is right, that it has been testing at times. Co-ordination within Phase II was hampered by staffing issues. There was a period of approximately 1 ½ years when UNICEF did not have anyone in post²⁶⁵. Furthermore, when staff were in post, the focal points were of different staffing grades, and responsibilities and workloads were not appropriately divided. This situation has now improved considerably as there is now a dedicated focal point within both agencies and both are of the same (or equivalent) grade. The UNFPA focal point has considerable experience and institutional memory, and the focal point at UNICEF is relatively new to the role but very engaged; and the working relationship appears strong with the UNICEF focal point appreciating the significant support and leadership role from UNFPA which in time should balance out with more parity of workloads. The staffing issues that have occurred during Phase II highlight the need for a formalised framework setting out clear roles and responsibilities.

In terms of each organisation drawing on its own strengths and working together in a complementary way, it is useful to consider both the geographical and technical work areas. Geographical coverage in Phase II

²⁶⁴ Interviews with Senior staff at both UNICEF and UNFPA

²⁶⁵ As communicated by current focal points at UNICEF and UNFPA

was based upon the geographical priority areas for each agency, and it does not appear that this was co-ordinated adequately to take advantage of possible synergies. UNICEF largely works in Assuit, UNFPA primarily in Assuit and Sohaj (and in response to requests by the PMU) and other governorates. In recognition of this, for Phase III it is planned that in the governorates in which they are both working, they will co-ordinate better (e.g. linked services as appropriate) and invest in intensified way for greater synergies.

Technical focus was based to an extent upon mandate areas, for example in Phase II UNFPA worked on reproductive health (gynaecological curriculum change), and UNICEF worked upon the links with violence against children²⁶⁶ and more recently child protection. Some joint work was carried out such as the successful development of the YPEER manual²⁶⁷. However, other work was carried out in the same technical areas separately and the rationale for this is unclear. Both worked (separately) with the media on awareness-raising on TV and radio, both worked on prosecution and law enforcement, and advocacy with religious leaders. There are also some anomalies for example UNFPA worked with vaccine clinics to include information about FGM (as requested by the national counterpart) and it would be expected that this would be a role that UNICEF would more naturally undertake.

In terms of the programme cycle, the evaluation found that the various stages in Phase II involved working independently and coming together at key stages, whilst for Phase III the work is co-ordinated in a more ongoing way. For example, in Phase II the planning was carried out by UNICEF and UNFPA with the national counterpart (the PMU), whilst the planning for Phase III has been a more in-depth joint planning process, facilitated by a consultant commissioned by HQ²⁶⁸, a process valued by the Focal Points which provided the opportunity to reflect upon lessons from Phase I. The evaluation considers the lack of involvement of Implementing Partners in the planning process (either by being consulted in the lead up to the evaluation, or indeed the planning event itself) as a missed opportunity to draw upon their grassroots knowledge.

Implementation has been carried out independently, which in theory is appropriate dependent on the degree of co-ordination to avoid overlaps in activities. Implementation was separate, and there is evidence of (some limited) duplication within youth peer work which requires improved co-ordination across Implementing Partners²⁶⁹. There are plans to link up IPs to a greater extent to reduce such issues. There is scope for improved synergies in implementation in Phase III.

Monitoring has been conducted separately by each agency of their own activities (and is discussed more in EQ 4.3) and combined in monitoring reports for the Joint Programme²⁷⁰. However, the process of reporting has led to a useful process of developing a unified view of the definitions which will stand the team in good stead for future monitoring²⁷¹. There are plans to conduct some joint implementation during Phase III in governorates where both agencies are implementing, by visiting activities together which is highly recommended as an opportunity to observe each agencies work, reduce the scope of double counting and reflect upon further scope for co-ordination.

²⁶⁶ UNICEF, 2015, Violence Against Children in Egypt: Quantitative Survey and Qualitative Study in Cairo, Alexandria and Assiut. See https://www.unicef.org/mena/sites/unicef.org.mena/files/press-releases/mena-media-Violence_Against_Children_in_Egypt_study_Eng-UNICEF_NCCM_1002015.pdf

²⁶⁷ YPEER manual, available in Arabic

²⁶⁸ Drawn upon interviews with focal points

²⁶⁹ As reported by staff responsible for monitoring peer adolescent work

²⁷⁰ This is clear from the JP Annual Reports and backed up by discussions with staff

²⁷¹ As communicated by the JP focal points

The limited co-ordination found in Phase I and II is backed up by a review of the JP monitoring system in 2017 which found that during Phase I and Phase II there was ‘limited proper coordination and synergy between the JP programme activities across various agencies and at different levels’²⁷² and that ‘it is clear from the documents that each organization is working in its own agenda with minimal coordination’²⁷³.

The table below summarises how steps are being taken towards more co-ordinated work.

	Phase I and II	Phase III
Planning	Shared planning (combining work areas into a shared work plan)	Joint planning (facilitated by HQ)
Implementation	Separate implementation	Separate implementation
Monitoring	Independent monitoring of own work areas	Plans for joint monitoring
Reporting	Combined reporting	N/K (no reporting as yet)

It is clear from interviews with staff that the Joint Programme positively facilitates greater awareness across each agency’s programmes areas and the evaluation found that there is more information sharing across the two agencies than if the Joint Programme did not exist. There is also important joint work going on to develop a shared conceptualisation/ framing of FGM so that there is a coherent message across the two agencies, specifically related to FGM within a broader girls’ empowerment framework²⁷⁴

Working with national systems to support national ownership has been integral to the JP approach, however this has been challenging given the nature of the systems in place

From the outset, the Joint Programme has - appropriately - considered it important to work with national systems and processes to foster national ownership and build capacity. The body that has long been responsible for co-ordinating FGM within the Government is the Programme Management Unit within the National Population Council (housed within the Ministry of Health and Population and prior to 2011 in the National Council of Childhood and Motherhood). It has provided a useful lead mechanism for channelling funds and co-ordinating FGM work, with relevant networks and links. However, the sustainability and national ownership of the Programme Management Unit has been questioned as it was set up on 2003, supported financially by the EU under a UNDP programme and is effectively parallel to the main systems of the National Population Council²⁷⁵.

It is important to highlight that the Programme Management Unit (PMU) has not been functioning since February 2018, given a breakdown in communications with the Government²⁷⁶. This caused initial confusion and disruption to the Joint Programme, with concerns about how funds would be channelled, and the JP resourcefully found an alternative solution to channel funds through ‘umbrella’ INGOs that have

²⁷² El-Zanaty & Associates LLC , 2017, Review of Female Genital Mutilation/Cutting Monitoring System and Performance Indicators Validation
Second Phase of The UNICEF-UNFPA Joint Programme

²⁷³ Ibid, pp 13

²⁷⁴ UNFPA and UNICEF and developing a conceptualisation

²⁷⁵ Interviews with stakeholders from Government and UN staff

²⁷⁶ Interviews with UN staff , government stakeholders, CSOs

contracts and relations with many CSOs. Some aspects however have still not been possible to continue such as the work with Universities to mainstream FGM within medical curricula²⁷⁷.

Implementing Partners are important partners for the JP enabling social mobilisation and outreach, and the JP could benefit from tapping into their grassroots knowledge and facilitate greater knowledge exchange across actors

The Programme partners include Y-PEER and Plan (UNFPA) and Caritas and ACDA (UNICEF). Working with such agencies who have relationships and links with many CSOs, means that the JP has greater outreach (particularly in an environment in which it is difficult for foreign agencies to work with CSOs – see 3.3). They provide a high level of capacity for community level work and social mobilisation. The evaluation focused upon two partnerships key in Phase I and II: YPEER and ACDA

Co-ordination with YPEER

Coordination between UNFPA, national authorities and programme partners have facilitated leveraging the relative strengths and capacities of YPEER for more effective programme implementation. UNFPA have worked since YPEER in Egypt since 2002, and it has been a key partner on the Joint Programme since Phase I. YPEER is a global education network of organizations and institutions, working in the field of sexual and reproductive health in 52 countries throughout the world. They use peer-to-peer education using alternative methods of education (such as youth camps, theatre-based techniques, role games, simulations, etc.). Key activities of the YPEER's work in Egypt with the JP have included:

- Trainings for peer trainers on FGM abandonment messages to raise their communication skills and level of knowledge in order for them to later train a generation of peer educators. This approach provides young people with the tools to become leaders in their own communities and build partnerships with adults in order to advocate for change generally, and on the specific issues of FGM abandonment. Many young people start as participants in seminars and become the next generation of trainers later
- UNICEF supported the Y-PEER network to advocate against FGM through the production of a handbook and the application in Upper & Lower Egypt.
- In 2013 UNICEF and UNFPA contracted the Y-PEER network to prepare a Training Manual for Peer Educators on FGM. The manual provides a comprehensive tool to build capacity for youth, peer educators and facilitators seeking to disseminate information on FGM as a step towards changing behaviours to eradicate harmful practices against girls and women²⁷⁸.
- In addition, in 2017, UNFPA organized and supported large-scale national advocacy campaigns promoting the youth role in initiating public awareness and opening a dialogue with decision makers to address Egypt's challenge of population growth as well as FGM.

The evaluation team visited YPEER in Qena, Assuit, Luxor and Greater Cairo and found them to consistently have: a high level of commitment; very detailed understanding of the heterogeneous drivers of FGM in the locations in which they are working, highly adept at understanding the different messages that are required

²⁷⁷ Discussed by the JP focal points within interviews

²⁷⁸ El-Zanaty & Associates LLC , 2017, Review of Female Genital Mutilation/Cutting Monitoring System and Performance Indicators Validation

for different audiences in changing mindsets²⁷⁹. A review in 2017 found that Y-PEER activities are well-organized and planned, and that... [training of] trainers is consistent and well-structured²⁸⁰.

An indication of the extent to which the YPEER work is valued to the JP and the strong working relationship is that UNFPA worked throughout 2017 on a sustainability plan to enhance the structure and role of the Y-PEER in Egypt. In collaboration with the Human Rights and Research Center at Assiut University, UNFPA established and launched the Y-PEER Innovation and Life Skills Center integrated in the university's organogram to provide technical support to national universities as well as other interventions using Peer to Peer education to deliver information on harmful practices and FGM to young people in addition to other SRH issues.

The co-ordination between UNFPA and YPEER is strong, with a YPEER co-ordinator within UNFPA. "Working with the UN gives trust in our programme in terms of quality and funding."²⁸¹ One area that is unclear is the relationship between YPEER and other NGOs who are adopting the YPEER approach (including UNICEF funded ACDA) in terms of the relationship and co-ordination of initiatives, for example some (limited) duplication of efforts has been found in cases where YPEER educators have visited a community to find that ACDA has carried out a similar training²⁸². Greater co-ordination and clarity should be sought at national and subnational levels.

Co-ordination with Assuit Childhood and Development Association, (ACDA)

UNICEF 's partnerships with ACDA began in Phase I. Examples of some of the work carried out include:

- Intensive community mobilization intervention activities to change behaviour towards FGM and decrease the acceptance of the practices; seminars and group discussions for educational dialogue promoting abandonment of FGM; outreach events about prevention and protection from violence against children including FGM in Assiut.
- Campaigns including a "Hear us" campaign for boys and girls to raise awareness, teach boys the difference between male circumcision and FGM and transfer the correct knowledge to adults at home through the adolescents, as well as to raise acceptance of girls who have not undergone FGM in the society. Other initiatives that were related to FGM abandonment included a "Protect Her" campaign with the goal to educate adolescents about FGM and sexual harassment.
- Through a separate project, as stated earlier, UNICEF supported ACDA to pursue the Y-PEER education approach to train an additional 160 peer educators on the FGM abandonment material. They reached 5,219 peers through cultural seminars, sports days, and youth initiatives. Such activities were implemented in collaboration with the Ministry of Youth and Sport Directorate in Assiut. It is unclear to the evaluation team as to the rationale of UNICEF supporting another organisation to conduct the same work (using the same manual, and in governorate in which was already covered by YPEER) and whether there was sufficient consideration of potential overlap.

For ACDA the JP has benefitted them (apart from funding), in gaining knowledge and practices on how to work in a more scientific way, and how to assess the outcomes and to know the impact. "Before we had a good heart, but we were not systematic". It was recognised by a UN staff member that their management

²⁷⁹ This was a consistent finding across the focus group discussions and semi-structured interviews with YPEER trainers and peer educators in Luxor, Qena, Assuit and Cairo

²⁸⁰ El-Zanaty & Associates LLC , 2017, Review of Female Genital Mutilation/Cutting Monitoring System and Performance Indicators Validation

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²⁸¹ YPEER manager

²⁸² As raised by YPEER co-ordinator

information systems require further strengthening and that they could benefit from capacity development in data collection and analysis²⁸³. Challenges raised by ACDA include delays in payments and the supply of equipment.

In sum, community awareness raising and mobilisation through partners provides outreach and is significant to the achievements of the Joint Programme and its presence and understanding of the issue. However, given the prevalence rates are so high, in order to achieve significant results on the ‘demand side’, any significant contribution to reducing FGM rates would need to be on a very large scale. It is sensible that the community awareness work is conducted as part of a wider portfolio in which more ‘supply side’ changes are also made.

As discussed in 1.3. greater collaboration is required within UNFPA and implementing partners, and between IPs so as to improve co-ordination and synergies. In addition, it is vital to harness the grassroots knowledge of heterogeneous and dynamic FGM status within national planning and decision-making. In addition, they should be further incorporated into more qualitative studies and assessments around what is working well, and what’s working less well.

Assumption 3.2

The global programme has effectively developed and leveraged partnerships and collaborations with other development actors to amplify efforts, particularly with regards to more in-depth research on social norms change and its linkages to changes in individual and collective behaviours.

The Joint Programme evolution from Phase I with its focus on community awareness and legislative change, to Phase II with its broader focus on social norms and more recently, Phase III including gender empowerment and transformation, is reflected within the programme areas, stakeholders engaged with and partnerships fostered.

The diagram below shows the types of stakeholders that the JP is engaged with:

²⁸³ As raised by one UN staff member who is familiar with ACDA monitoring systems



The summary table in the introduction provides an overview of the JP programme areas, and the specific stakeholders that have been engaged with²⁸⁴. We discuss each stakeholder group in turn.

Medical Actors. Given the critical issue of medicalization within Egypt (as discussed in 3.2), the JP is working on key strategies and has engaged with an evolving range of **medical actors**. Within Phase I the JP focused upon training medical professionals (doctors, nurses, health workers) in partnership with the Ministry of Health. However, in order to inculcate a more mainstreamed and sustainable approach the JP strategically – and appropriately - changed its focus towards advocating to integrate FGM in the national medical curriculum at higher education level in universities. In 2017 the Supreme Council of Universities granted the approval to integrate FGM curriculum. Several Universities were piloted; including Assiut, Ain Shams, Zagzig and Sohag, where they have fully integrated FGM in the curriculum for school year 2017/2018. There is not yet universal take up by universities because it is up to the discretion of universities as to whether they adopt curriculum changes. This work has been delayed due to state of the PMU, and the focus should be on reaching out to other Universities when the situation has improved.

The JP also supported Doctors Against FGM in 2017, in a collaboration encompassing Ministry of Health, doctors, academics and other experts which seeks to train and enhance the capabilities of doctors to offer medical advice to families so that they abstain from carrying out the operation (expanded upon in 3.2).

Faith based Organisations. Given the influence of religious leaders in Egypt and the misconception that circumcision is required by religion, the Joint Programme has responded by fostering relationships with Faith-based Organisations. A number of initiatives have been carried out with partners by the Joint Programme²⁸⁵ (see analysis under 2.1):

²⁸⁴ This table is developed, drawn from the JP annual reports from 2008-17

²⁸⁵ JP FGM Egypt, 2017, Annual Report on FGM: Accelerating Change and corroborated during interviews with UN staff and religious leaders (Al Azar, Coptic Orthodox Church)

- A pioneering partnership between UNICEF, Al Azhar and the Coptic Orthodox Church led to a significant publication called “Peace...Love. Tolerance”²⁸⁶ which discusses 11 types of violence - FGM is one of them - and refers to the teachings in the Koran and the bible. This was followed by a joint public declaration by The Grand Sheikh, The Pope, Minister of Religious Endowment, Minister of Social Solidarity and key religious and opinion leaders of Egypt. The JP (via UNICEF) provided financial and technical support to develop and implement a dissemination plan which included a capacity building programme for 1,000 religious leaders, the production of a docudrama video series; production of a documentary film on the joint role of religious leaders and development of a tool and training package²⁸⁷.
- Cooperation between UNICEF and the International Islamic Centre for Population Studies and Research (IICPSR) of Al Azhar University led to a training manual based on an IICPS publication “Female Circumcision (FGM) between the Incorrect Use of Science and the Misunderstood Doctrine.” Over 80 religious leaders from Assiut were trained in 2015 and 2016. The JP FGM annual report also describes how UNFPA have worked with IICPSR to roll out a capacity building programme for over 480 religious leaders based on the manual. However, there is no explanation as to the links between these two areas of work by UNICEF and UNFPA.
- Through the ongoing relationship with ACDA, UNICEF also provided capacity trainings on FGM abandonment 1,200 traditional, religious and community leaders to support them to lead actions towards the elimination of violence against children and FGM practices. In addition, UNICEF and ACDA, in cooperation with Ministry of Endowment (Awqaf) have held two meetings for local imams and priests, which were moderated by Muslim and Christian religious leaders in Assiut, to discuss violence against children in general and the issue of FGM in particular.
- Another important partner - BLESS, the development wing of the Coptic Orthodox Church in Egypt - continued to build the capacity of religious leaders in Cairo, Assiut, Sohag and Minya with support from the Joint Programme. The capacity building initiative covered 735 churches since 2014 and 3079 religious leaders while the community seminars reached over 200,000 church members. The capacity building programme with BLESS has successfully integrated GBV and FGM becomes an integral part of religious leaders’ daily work and service, to this end in 2017, 30 churches declared being anti-FGM.

The engagement of religious leaders at the central and local levels has demonstrated the important influence they have on the communities, confirming the need to continue expanding this specific outreach mechanism. However, key considerations for the partnerships with faith-based organisations going forward are:

- analysis of the extent to which the messages are reaching the grassroots and whether innovative methods are being used e.g. working with young female sheikhs
- whether the partnerships are perceived to be agency based (i.e. UNFPA or UNICEF) or by the Joint Programme and how well co-ordinated they are
- whether the partnerships are sustained and consistent

²⁸⁶ Peace, Love, and Tolerance - Key Messages from Islam and Christianity on Protecting Children from Violence and Harmful Practices; including FGM abandonment. https://www.unicef.org/egypt/eg_Azhar_book_high_res_Eng.pdf , https://www.unicef.org/egypt/eg_Christian_Book_high_res_Eng.pdf

²⁸⁷ JP FGM Egypt, 2017, Annual Report on FGM: Accelerating Change and 2017

Media Actors. Recognising that TV is a primary source of information for women and families to get messages regarding their health and wellbeing (according to the EDHS 2008 and 2014) and correspondingly the JP has been working with the media. Examples of work areas include:

- An FGM campaign with the slogan “Enough FGM” was developed in 2014 by UNFPA and NPC and broadcasted in 2015 by a number of donors including UNFPA and UNICEF. The campaign comprised TV spots, Radio spots, and street billboards (The JP also supported the broadcasting the remaking of the spots on the Egyptian radio networks during prime time hours during the holy month of Ramadan which is a very strategic month to reach high audiences and throughout the day on 14 June 2015; the National zero tolerance day against FGM target audience were young parents and age groups of 24-40 year).

The evaluators found an appetite amongst the media to revitalise the role of media in the abandonment of FGM²⁸⁸. In particular it was found that ‘without the national counterpart’ there are no opportunities to work on FGM but that the JP/ the UN more broadly could play a significant role. In particular it was felt that possible routes would be:

- Organise media forum, for example there was a useful forum about FGM, sponsored by UNICEF and NCCM in 2015-16 including (sociologists, academics, journalists)
- Foster a direct link between journalists and UN agencies. It is generally through NCCM or NPC but if there is an issue (e.g. national programme stopped) there is very limited media engagement
- Create the space for journalists to meet the stakeholders (Imams, priests, doctors against FGM, etc.) and expose journalists to materials on FGM (data, information)
- If there are new information/ reports, share with journalists so that there is new material to communicate
- Launch an award from UNICEF and UNFPA, advertised in the Journalists Syndicate (e.g. there was a regional award for child rights and the topic got a lot of attention from media)
- Name a goodwill ambassador for the abandonment of FGM

Academic and Research Bodies. As discussed in 1.3, a finding of the evaluation is that the programme is not sufficiently evidence-based particularly in key areas. This is partly due to the uncondusive environment for robust research given government restrictions on research (particularly quantitative research). However, there are also untapped opportunities for research (particularly qualitative research) and relationships with **academic and research bodies**.

The Population Council’s DFID-funded research project Evidence to End FGM would be the natural choice of partner in many ways, however there is currently limited collaboration²⁸⁹. A closer working relation (including regular meetings) would enable the JP to help to shape research in ways that would be relevant and useful for JP decision-making. Simultaneously, the Population Council would benefit from a better understanding of real implementation situations, concerns, gaps and questions, a material that is highly valuable at academic level. Issues for the Joint Programme however are the length of time for research to be conducted, and cost.

As explained in 1.3, given the scope and number of remaining evidence gaps, creative (and cost-effective) solutions need to be considered to complement the work of standard research institutions. One possibility to explore could be the engagement with Universities to involve junior researchers, PhD or Masters

²⁸⁸ The findings emerged within a focus group discussion with 5 media representatives conducted as part of the evaluation

²⁸⁹ This finding emerged in interviews with the JP focal points, Population Council and other stakeholders

students in some of these research gaps.²⁹⁰ Assuit University where there is an established relationship would be a natural choice to 'test' the approach.

Engagement with Relevant Ministries. The multi-dimensional approach to FGM within the JP, has led to successful engagement with various Ministries beyond the national counterpart:

- Ministry of Social Solidarity – working on unified curriculum as regards FGM for social workers, supporting referral process²⁹¹
- Ministry of Local Development –ensuring alignment between the JP strategies and local development²⁹²
- National Council of Women – successfully supported the development of the Women's Empowerment Strategy²⁹³ which includes FGM as the Fourth Pillar on 'Protection'

The evaluation also found Ministries for which it was felt the relationship could be strengthened:

- Ministry of Higher Education – in the wider context of increasing urbanisation, more women becoming educated and higher social mobility, it is recommended that stronger sustained links are forged with the Ministry of Higher Education in order to reach the more educated men and women who are likely to go on and have children in coming years. (Lower income groups can also be reached given that there is an emphasis now within families of trying to get their children to get educated)²⁹⁴. Challenges have been found to date in terms of sensitivity to changing the curriculum around sexual reproductive health²⁹⁵.
- Ministry of Education – links could be strengthened so that there are opportunities to raise awareness of FGM in school age children. Community awareness programmes have highlighted difficulties in access in reaching schools²⁹⁶.
- Ministry of Justice –build stronger links and advocate for stronger monitoring of executive bodies²⁹⁷

The JP recognises the importance of working with other relevant agencies UN agencies to ensure alignment and 'one UN', however this is hampered by limited opportunities for collaboration.

Relationships across different UN agencies do not mirror the multi-sectoral approach evident within the strategies of the JP. The 'lead agency' on FGM in Egypt is UNDP and is (confusingly) also referred to as the Joint Programme (referring to a joint programme between UNDP, government and EU) which ended in 2017 and is in the process of potentially being re-funded²⁹⁸. The UNFPA/ UNICEF JP has worked with them in key areas for example for the change of Law (as part of a Taskforce), changes to the medical curriculum and also adolescent peer work²⁹⁹. However, there is recognition by the UNFPA/ UNICEF JP that there is a need to work more closely together particularly as the programmes have different approaches and may

²⁹⁰ These opportunities were identified by the JP focal points

²⁹¹ JP FGM Egypt, 2017, Annual Report on FGM: Accelerating Change

²⁹² Ibid and discussed in meetings with UN staff

²⁹³ See <http://ncw.gov.eg/wp-content/uploads/2017/04/womens-stratagy.pdf>, pp 52

²⁹⁴ This finding emerged within interviews with UN staff and other stakeholders

²⁹⁵ This was highlighted by two different UN staff members

²⁹⁶²⁹⁶ This finding emerged in meetings with YPEER, as well as UN staff. However, it was also highlighted that the Ministry of Education is sensitive to changes in curriculum.

²⁹⁷ The importance of strengthening links with the Ministry of Justice was highlighted by one UN staff member

²⁹⁸ As per discussions with EU and UNDP

²⁹⁹ As found within Annual Reports and interviews with UNDP, UNFPA and UNICEF

create confusion (UNDP's message is focused on 'ending FGM now' rather than integrating FGM within a more positive narrative of girls' empowerment). There is frustration on the part of UNFPA and UNICEF with the limited opportunities to collaborate and weak alignment, and the lack of convening role that the UNDP has played, however UNDP considers the collaboration to be strong³⁰⁰.

There was some collaboration with UN Women in Phase II (and UN Women provided funds to UNDP for a period). The evaluation did not find any involvement with the World Health Organisation, which is surprising given that FGM is clearly also a health issue.

There is widespread recognition of the need for the UN agencies to work together as 'One UN' with harmonized programming. Government stakeholders also discussed the high transaction costs of working across various UN agencies and staff³⁰¹. It is recommended that the Resident Co-Ordinator who now is positioned 'above' all the UN agencies and has a coordinating role could help to send a message that enhanced co-ordination and working together is required.

Given limited resources, working strategically with more influential partners is vital in Phase III.

It was found that the JP is working with diverse partners through diverse strategies to address (multivariate and heterogeneous) FGM. Whilst the multi-sectoral and multi-stakeholder approach is felt to be appropriate, given the limited resources the programme is felt to be lacking a comprehensive strategic partnership plan in order to decide where best to allocate resources so that they are used in the most efficient way. This is particularly the case as Phase III will include furthering wider of partnerships involving child protection actors, and those working on youth issues, to a greater extent.

It is recommended that an exercise is carried out to develop a professionally-designed advocacy plan, including:

- mapping key stakeholders in a comprehensive way, analyse the influence of those actors upon FGM, and to assess the current state of the partnership and where emphasis should be placed
- tailor-made advocacy steps for key actors
- identification of key points where global, regional or national influence may contribute

Assumption 3.3

Joint Programme acted as a catalyst for established and emerging actors to strengthen the response to end FGM, at national, regional and global levels, including e.g. other UN agencies, other programmes, new donors and funders, national governments, regional bodies, civil society and implementing partners.

The JP has been instrumental in mainstreaming FGM within each agency.

There is significant work within each agency to co-ordinate and mainstream FGM within other areas of work in their portfolios (which goes beyond the remit of the JP). As one UN staff member stated "The Joint Programme funds helps to connect the dots and make sure that FGM is integrated in other areas"³⁰². A good example of this is within UNFPA work in family planning (e.g. integrating FGM in family planning and advice, training of outreach health workers in FGM, the provision of talks on FGM within 'Women Health Clubs in Family Planning Units). This is also the case for new work: UNICEF have recently received funds

³⁰⁰ These divergent perspectives were found within respective meeting with multiple interviews with staff of different levels with UNICEF and UNFPA; and one staff member n UNDP

³⁰¹ As shared by two government staff who liaise with the JP

³⁰² Senior UNICEF staff member

from the EU for Child Protection strengthening and have negotiated the integration of FGM/ harmful practices into it.

Funds for FGM (and girls' empowerment) have successfully been leveraged, building upon the work of the JP

Indeed, UNICEF have successfully raised \$4m from USAID for FGM abandonment and girls' empowerment. UNICEF and UNFPA are also working on a joint concept paper to frame FGM within a broader girls'/ women's empowerment, with one aim of potential resource mobilisation. Given the need and growing expectation for raising funds, yet the challenges in doing so (particularly in this case as Egypt is categorised as a Middle Income Country and thus falls out of some donors' priorities for Low Income Countries) there is a need for capacity building support for the country office e.g. around mapping donors, identification of funds, proposal writing.

In section 2.2, we also discussed the way the multitude of actors that the JP has engaged with to strengthen the response to end FGM within FGM. Notable relationships fostered in which the JP acted as a catalyst are:

- sustained support to adolescent peer work through YPEER, supporting institutionalisation with a YPEER centre
- adding momentum to ACDA to intensify efforts in Assiut
- supporting partnership between religious leaders building upon previous relationships
- supporting Doctors Against FGM, as an emerging voice of medical actors and experts

Areas in which there is more scope for catalytic work includes:

- reinvigorating the role of the media
- focusing attention to social media

The programme is also referring families in need to relevant services using the Child Help Line managed by NCCW. Through the Child Protection Committees at national, district and community levels, UNICEF supports the enforcement of the amended child law that includes a clause banning FGM, of the decree from the Ministry of Health banning the practice, and of the more recent constitutional requirements.

Evaluation question 4

To what extent does the Joint Programme draw on the relative strengths of each organization, promote efficient programme implementation to amplify the Programme contribution? **Criteria:** *Efficiency/ Co-ordination*

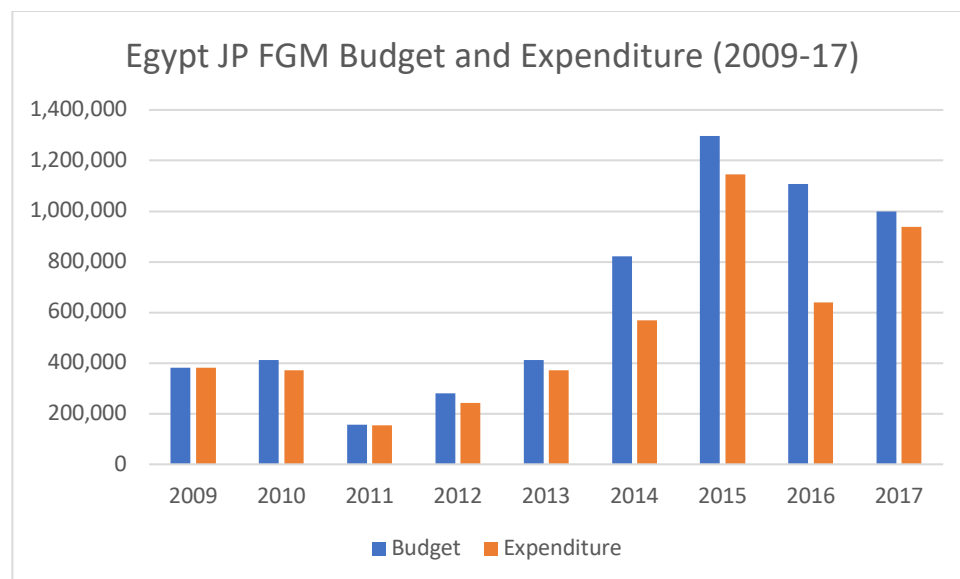
Assumption 4.1

Joint programme financial systems and structures enable the efficient and timely flow of resources to support implementation and achieve planned results.

The total budget for the Egypt Country Office was \$5,868,368.00 (from 2009-17), and expenditure was \$4,798,124 (from 2009-17).

The year-on-year trend of funds allocated to the Egypt country programme is shown in Graph 1 below and shows that since 2011 there has been a steady increase in budget (and expenditure) with a decline since

2015. Utilization rates have been generally high (except in 2016 which coincides with lack of staffing in UNICEF).



Given the high prevalence rates in Egypt, these funds are not sufficient even when considered that they are used as part of a catalytic approach³⁰³.

The insufficient level of funding given the scale of the issue was raised by many stakeholders in the interview process³⁰⁴. The Country Programme works hard to make the resources have the greatest impact, for example by mainstreaming FGM issues within the wider portfolio (with the provision of some ‘seed money’ to other UNFPA or UNICEF programme areas³⁰⁵).

The one- year funding cycle is found by the Country Programme to be limiting, creating a focus on disbursement and short-term planning rather than on longer term outcomes as required by the intractable nature of FGM. This is exacerbated by the inability to roll over unspent funds from one year to the next³⁰⁶. This finding was also within the Phase I evaluation³⁰⁷ and has not been resolved.

There are issues of delayed payments to partners. Implementing Partners report that payments are received late “Sometimes we finish an activity and report, but the funds arrive one or two months later”³⁰⁸. The delays also reduce the disbursement period further. It is unclear whether this is fully due to the delayed payment from the global level to the country office, or whether there are other delays at the country office level. One Implementing Partner also reported that deliveries of supplies (e.g. desks, chairs, computers etc.) are often late³⁰⁹.

³⁰³As per discussions with UN staff, government staff and other stakeholders

³⁰⁴ Consistently raised by UN staff and other stakeholders

³⁰⁵ See 3.1 for examples of how funds are being used

³⁰⁶ As reported by UN focal points

³⁰⁷ UNFPA/ UNICEF, 2013, Joint Evaluation of the UNFPA-UNICEF Joint Programme On Female Genital Mutilation/Cutting: Accelerating Change 2008-2012

³⁰⁸ As reported by one Implementing Partner

³⁰⁹ As reported by Implementing Partner

The evaluation also heard from Implementing Partners that it would be beneficial to have training on ‘systems’. Although there is technical training on substantive issues, it would be useful to have capacity building for accountants on any new financial methods, approaches and tools.

Assumption 4.2

Oversight by the Joint Programme Steering Committee to the Joint Programme has contributed to efficient implementation.

The input that the Country Programme receives from the global HQ is valued for its technical advice and support³¹⁰.

Visits from HQ to the country office are highly valued, and it is felt by the country office that there is a good ongoing working relationship, for example that HQ can be contacted directly if clarity/ further support is required. This was particularly the case during Phase II when personal relations with those in the HQ team (who have now left HQ) were very strong and informal. It is notable that the HQ have helpfully ‘stepped in’ when improved co-ordination was required. The recent visit by a Consultant who was supporting the design of Phase III at the country level was highlighted as significant and an exercise that they would like to repeat in the future, as it gave the opportunity to spend dedicated time together, have a guided discussion and reflect upon lessons. There is also a sense that the country office would like to know more about the work at HQ on a more regular basis³¹¹.

At the regional level, UNICEF Middle East and North Africa Regional Office (MENARO) and UNFPA regional office (Arab States Regional Office (ASRO) have a positive working relationship and aim to ensure co-ordination across the two agencies at the regional level. MENARO only joined the JP in 2017, with the recruitment of a senior specialist in Harmful Practices and a child protection specialist.

ASRO has a well-established work portfolio, for example they are working upon advocacy at the regional level on medicalization (with African Union, Arab League, doctors’ syndicates, other medical associations,) ³¹². It is also working with faith-based organisations at the regional level which has culminated in the Regional Faith Based Network Against FGM, which also significantly led to the National Faith Based Network Against FGM in Egypt (and other countries)³¹³. Cross-border work and FGM is also a focus (Djiboutis across Ethiopia and Somali borders). MENARO is focusing on addressing and measuring social norms, and has developed guidance for Country Offices. This was identified as a top priority for support across 14 MENA countries in a survey conducted by MENARO in May 2017. It is not clear as to whether there are sufficient linkages and synergies between the work of the regional level and uptake in the country office, and it would be helpful if the annual reports in the future considered the way in which they link to the regional level. A Regional Framework on FGMC has been developed under the lead of UNFPA³¹⁴.

Joint work on TA/support to COs: UNICEF MENARO and UNFPA ASRO has coordinated and provided joint communication, feedback and technical support calls to COs as needed and in particular during the Mid-

³¹⁰ As discussed within interviews with focal points

³¹¹ ³¹¹ As shared by UN Staff (focal points)

³¹² ASRO, 2016, JP Annual Report

³¹³ ASRO, 2016, JP Annual Report and Ahfad University for Women in Collaboration with UNFPA-Arab States Regional Office, “The Engagement of the Arab Regional Faith Based Organizations Network against Female Genital Mutilation Workshop” as well as interviews with religious leader and UN staff

³¹⁴ MENARO, 2017, Annual Report of the JP

Year Review and during the contextualization process for Phase III of the FGMC programme. Furthermore, UNFPA and UNICEF engaged in a joint mission to Djibouti.

As a result of the above, the communication between both ROs and COs in the joint programme has been strengthened and increased coordination and communication at all levels

UNICEF MENARO participated in and supported two major events: the FGMC Global Programme Consultation in Uganda and the Medicalization event in Sharm el Sheikh, led by UNFPA. The Uganda global consultation was an excellent example of joint collaboration as ASRO could not attend, and requested MENARO to represent both agencies.

The regional offices also facilitate co-ordination at the country level. As a link between the global and country offices, examples of support include planning, logframe development, monitoring and reporting at the country level including during the contextualization of Phase III. A recent example that was referred to possibly by several interviewees was the regional organization of a workshop focused upon Data for All as an opportunity to increase familiarization with the platform, provide feedback and notably – as an aside - to share insights and experience on programming issues with other country offices in the region. They have also facilitated co-ordination if countries involvement in the Burkina Faso conference in October 2018³¹⁵.

As the ‘middle layer’ between the regional and national levels, they provide a ‘feedback loop’ to HQ, for example the Global Programme Co-ordination team ask the regional focal points to elicit feedback on new programming tools. However, the regional level finds that HQ sometimes bypass the regional office and only send information to the country offices, which means that the regional office cannot support them in those aspects. The JP (as a whole) could benefit from defining roles and information flows and respecting them from the global, regional and country.

MENARO’s Annual Report (2017) highlights that there is still room for improvement in respect to making processes more efficient and finding the best ways to coordinate reviews and inputs between the HQ, RO and CO level between the two organisations³¹⁶. An area for improvement which was identified within the evaluation was that it would be beneficial if regional offices consistently developed new initiatives in participatory/ consultative ways. The regional offices place requests/ demands upon the country office which are not considered a priority within the national context yet take time and resources (e.g. the recent COMBI plan). The survey conducted in May 2017 regarding priority issues is an example of good practice.

Evaluation question 5

To what extent does Joint Programme programming lead to sustainable change for the eradication of FGM?

Criteria: *Sustainability*

Assumption 5.1

The Joint Programme supports national ownership of efforts to eradicate FGM by building institutional capacity and by integrating programming into established national systems and processes.

Egypt shows an unpredictable political scenario and discontinuous political will towards abandonment of FGM.

³¹⁵ As communicated by RO staff

³¹⁶ MENARO, 2017, Annual Report to the JP

The last 10 years in Egypt have been characterised by strong changes of regime, with different implications towards FGM. The following can be distinguished in a simplistic manner:

1. Mubarak times until 2011. Strong fight against FGM attached to Susannes's Mubarak initiative. The political will show at the highest level was very positive for effective work on FGM, but the fact that it was perceived as attached to the previous regime –which was hated by many- has also had negative implications today, plus the stigma of association of the fight against FGM with Western values.
2. January 25, 2011 Egyptian revolution. Uncertainty and freezing of FGM programmes.
3. Muslim Brotherhood period 30 June 2012 – 3 July 2013. Regression.
4. Al Sisi Regime. 3rd July 2013-present. Initial uncertainty, followed by stabilization. Some political will or lack thereof depending on specific events, but we cannot speak of a systematic fight against FGM.

The changes of regime plus the high turnover within ministries (four different leaders at the NPC and five different Ministers of Health in the past four years) create discontinuity in a path towards eradication of FGM that is harmful in a context of processes that need continuity of efforts. The investment made under Susanne Mubarak could be lost if not properly continued in the immediate future.

The Joint Programme has capitalized on opportunities to contribute to national strategies and commitments against FGM, a cornerstone for sustainability

The Joint Programme has been, in general, strategic in its support to existing efforts and trends, complementing or strengthening them through approaches such as facilitating technical assistance, secondary analysis or resources and contributing to the integration of FGM into national development plans. This approach is not only much more effective than parallel interventions, but also increases the probabilities of sustainability beyond the programme duration.

Having said this, the work of the JP at national level has been stopped for more than a year now, due to lack of understanding between senior management within the related government institutions. This puts the JP in a difficult predicament about what counterpart to choose.

Given the unpredictability it is worth considering working with more than one counterpart, which would mean sacrificing part of the efficiency of the JP in exchange for a diversification in terms of sustainability. Most interviewees coincide in pointing at the importance of improved flexibility and at the following institutions as some of the most appropriate options: (1) National Council of Women: with the advantage of its mandate to mainstream gender within the different ministry's systems and its strategic institutional position, but with the disadvantage of having no track record of implementing programmes. (2) The National Population Council has been a positive partnership in the past, but its suspension for such a long time is untenable, creating important disruptions in the continuity of the implementation. Also, the fact that it is placed within the Ministry of Health presents constraints to the agenda in the framework of medical issues. (3) The National Council for Childhood and Motherhood is another important institution, with a focus on childhood and with a previous experience of partnership with UNICEF.

Mainstreaming based on issues with existing political will deserves further reflection. It is not always easy to identify the main priorities of a government and to find the best niche to incorporate FGM without diluting its effectiveness. The Agenda 2030 which is aligned with the SDGs helps to push the issue of FGM. However, the National FGM Strategy has been developed, but not costed, which is a strong obstacle to sustainability. In addition, the hiatus at the NPC and the continuous need for stronger impact and sustainability makes further reflection on this question more pressing for the JP.

The interest of the Egyptian government in reducing population growth presents important opportunities, such as making the case for links between FGM, early marriage and population growth. The high interest deserves further reflection on niches that allow the inclusion of FGM without paying the price of diluting an influential message. Also, connecting FGM with Child Protection issues in a creative manner, like the investment in preventing violence against children with savings in GDP for the country (UNICEF is already developing the National Strategic Framework “Ending violence against Children in Egypt”) is another path that deserves consideration. Finally, the effort to mainstream FGM in education curricula, both at general education systems level and within medical schools is a continuous challenge that should not be abandoned.

Advocacy plans have room for improvement. The disconnect between the magnitude of the FGM issue and the level of funding available make collective action a prerequisite for success. The Joint Programme is uniquely placed to engage with and convene key constituencies to tackle FGM, due to its comparative strength in working at global, regional, national and sub-national levels. The evaluation acknowledges the significant contribution of the Joint Programme in convening the political will and resources of other actors across relevant sectors. Notably, there is substantial in-country evidence of successful engagement with religious and traditional leaders, medical associations and doctors, law enforcement agents and media amongst others. Having said this, the Country Office does not have means to acquire a systematic understanding of advocacy opportunities, a global analysis on where to focus advocacy efforts or specific advocacy plans including technical advocacy aspects such as tailor-made messaging to target key selected actors, ideal frequency of interaction with such actors, appropriateness of level of interaction, documentation and measurement of advocacy process, etc. In this context, professionally-designed advocacy plans are an important consideration for Phase III so as to optimize the convening potential of the Joint Programme.

Achievements in the context of medicalization and follow up. Actions like the development of a curriculum on FGM for medical students and its inclusion of FGM in the medical curriculum of the universities of the country constitute a significant and sustainable achievement, which deserves accompaniment in its roll out and implementation. In this context, the evaluation sees as a positive step the fact that Phase III includes as one of its priorities addressing the trend of medicalization by focusing on creating a cadre of service providers advocating to end the medicalization of FGM. Also, in order to address the medicalization of FGM, the JP plans to establish a partnership with medical syndicates and associations to enforce policies and legislation, including legal sanctions for health professionals who engage in FGM³¹⁷.

Assumption 5.2

The Joint Programme promotes changes in social norms at the community level that are sustained over time and that lead to improvements in gender equality dynamics between men and women.

The JP has been considering Public Declaration against FGM as an intermediate/proxy indicator of FGM abandonment. This centrality has been severely criticized by most interviewees of the fight against FGM in Egypt, including CSOs in the field.

Most criticisms mention the emptiness of many of those declarations that are just done in isolation from process, for purely appearance when the practice continues, and without the right steps and inclusiveness. Lack of due process constitutes the most general criticism, with testimonies stating that people did not

even now what was the event about, or criticizing a strong dilution of the FGM issue in too big events that are not designed for debate or reflection on such a complex and sensitive matter.

In this respect, the evaluators consider that the problem does not lie in the consideration of Public Declarations as an indicator itself, but in two specific errors, namely: (i) the interpretation of the indicator in a mechanistic manner as guarantee of abandonment, when an indicator is not supposed to go that far, but just “indicates” a change of paradigm that needs to be further examined through other means. (ii) the treatment of this indicator in isolation, without associating it with other process indicators (such as engagement in the process leading to the declaration, inclusiveness, frequency of encounters before the declaration, etc.). Methodologically, most indicators cannot convey alone the existence of change in complex contexts. It is the collective interpretation of a group of indicators that offers explanations about a phenomenon. FGM is not an exception.

Looking at the experience of the different stakeholders involved in the fight against FGM in Egypt, including communities, we can conclude that Public Declarations can be very important (see effects below) when they constitute the end result of a substantive process with high involvement, inclusiveness and an intensive process of smaller meetings working with different sub-groups and specific themes in an strategic pattern. They are rarely effective or significant when they constitute the start of a process or an isolated event.

As explained under 2.3, the work of the JP in the areas of specific intervention is solid in its processes and with a strong basis for sustainability.

Positive achievements regarding social norms also imply a change of paradigm regarding strategies to fully eradicate FGM in the areas of intervention.

The shift of the social norm from “General appreciation of FGM” to “General condemnation of FGM” is a considerable achievement, but it also has important implications at social and individual level. This shift requires a change of paradigm in the strategies to address FGM towards full eradication in areas where general awareness and public declarations have already been achieved and there is a need for a different approach in the intervention. The JP has not sufficiently understood and addressed this change of paradigm.

An analysis of this scenario shows that after general awareness on FGM negative implications is achieved in a community, there is a second phase characterized by substantial changes both in *empirical* expectations and in *normative* expectations. *Empirical* expectations can be defined as expectations on how other people will behave in a specific situation, whereas *normative* expectations are those related to what other people think one should do in a specific situation³¹⁸. Some of the main changes in said second phase after awareness success are:

a) A minority continues FGM practice despite being aware of the disadvantages of FGM, which makes an awareness focus no longer a priority or insufficient. Also, this minority can be presumed to be, by definition, different from the majority and with specific characteristics that need to be considered in any effective strategy. To effectively challenge behaviours that are against the new social norm of the community, two specific elements need to be understood: (a) the specific reasons that drive that behaviour in those specific individuals, who assess reality in ways that are different from the rest of the community, and (b) the social profile of that group as to understand the most effective way of exerting either influence or pressure given that specific profile.

³¹⁸ Bicchieri, Cristina. *Norms in the wild. How to Diagnose, Measure and Change Social Norms*. Oxford University Press. 2017.

b) The practice of FGM **shifts from being visible and public to being underground and invisible**, which constitutes a radical change of paradigm both from a social point of view (a phenomenon that is not easily observable and is banned is socially transmitted in a different way) and from a strategic point of view. This characteristic has also implications in higher difficulties for monitoring.

c) The **heterogeneity** of the profile to be addressed is extremely high. Again, whereas a level of heterogeneity of FGM is already widely known, distinguishing for example the diversity of practice in different countries and even in different regions within the same country, there is an additional level of heterogeneity that is still underestimated, with communities that are separated by only a few kilometres presenting different profiles and requiring differentiated strategies so as to achieve effective results.

The importance of including economic drivers of FGM in the JP intervention. Some interventions in Egypt, (e.g. Plan in Assiut governorate) consider adequately economic drivers of FGM making them an integral part of the intervention. This contrasts with the general situation in other countries, where there is insufficient attention to the economic drivers of FGM, which are better articulated for Child Marriage (e.g. Ethiopia). The fact of the matter is that it is very difficult to detach the economic situation and dowry institution from FGM. In addition, in practical terms, it becomes extremely difficult to gain the sustained attention of a community undergoing severe economic circumstances, if basic economic needs are not met first.

Enabling environment for CSOs/NGOs work. In November 2016, the Egyptian Parliament passed a new law on NGOs which is much more restrictive than the previous one on NGOs. This only increases the already existing challenge to work with NGOs in Egypt, where there had already been great delays and refusals of approval for NGOs to receive international funding. Many human rights organizations under which women rights organizations are categorized continue to struggle with restrictions to operate. While the Joint Programme can work under the NPC network of NGOs as way to overcome this challenge, it is still restrictive in terms of partnerships.

A focus on youth is an important strategy for sustainability. In a context of limited resources, the investment on youth implies an investment on the decision makers of the coming 40 years, plus a target group that remains in general more open to new ideas. The emphasis of the JP on youth and the quality intervention through Y-Peer constitutes one of the most strategic areas for the sustainable fight against FGM. These programmes have been successful in building the capacity of trainers in delivering a high-quality program to deliver messages on FGM through peer-to-peer techniques. The programme often obtains results that go beyond the specific training on FGM, contributing to empowerment and providing the tools for young girls and boys to become leaders in their own communities and build partnerships with adults in order to advocate for change.

The intention of the JP to focus on women and girl empowerment in Phase III is considered very positive and strategic by the evaluation. The explicit logic of this focus is also shared by the evaluators, namely the fact that being FGM a discriminatory social norm, change requires a more explicit focus on girls' and women's empowerment, by which they can claim their rights and provide the central source of energy for changing social norms at the community level. This strategy needs to be combined with the continuous work with political, religious and other community leaders to provide legitimacy for the Programme focus on social norms change.

Considerations for the overarching global thematic level

Consideration 1. Evidence gaps and links to implementation can be better addressed

Different paths should be considered to mitigate the existing research gaps in FGM. (i) Given the scope and number of remaining evidence gaps, creative solutions could be explored. For example, the involvement of sub-national research or academic institutions and of university students, could widen the scope of research in areas that are less demanding from a technical capacity point of view but that require extensive research efforts in quantitative terms. This strategy would allow the coverage of aspects that are too expensive or inefficient to target with top research institutions. (ii) The existing collaboration with the Population Council could be better capitalized through a closer working relationship at the different stages of research (as opposed to a donor-implementing partner relationship focusing only on final products). This closer working relationship would, on the one hand, facilitate a better understanding of the Population Council of the practical concerns and limitations of the JP based on their field experience. On the other hand, it would allow the JP to constructively influence elements of the Population Council research when is still in the design stage, so as to make it as relevant as possible. (iii) The evaluation has found that the Joint Programme does not yet have effective systems in place to collect key information on lessons learned (although the ongoing Drexel pilot may inform some of these issues). In this sense, qualitative studies could be conducted by the Joint Programme to draw upon valuable and untapped knowledge, mostly at the grass roots level, on social norms processes, gender dynamics and drivers of change.

Consideration 2. Extreme Heterogeneity of FGM demands significant adaptations in strategy and conceptualization

1. Heterogeneity in a framework of *Generative Causality* (vs. *Multi Dimensional Linear Causality*). The FGM phenomenon rarely responds to linear causality, not even multidimensional. Generative causality (Context + Mechanism = Outcome) is much more appropriate to capture the FGM phenomenon. In this context, a stronger focus needs to be given to *mechanisms* and *contexts*, as opposed to *variables* in linear causalities.

2. Extreme heterogeneity of FGM vs. pre-determined strategies. The extreme heterogeneity of the FGM phenomenon – different not only by national, sub-national or ethnic group levels, but also community by community and HH by HH, demands the separation between strategies that can be generally predetermined (DHS, medical curriculum, law enforcement officials) from those that depend on specific contexts and cannot be predetermined. These ones require specific identification processes with standard protocols covering aspects such as: critical mass status (social norm paradigm for/against FGM), specific drivers in the community, community leadership profile, sensitiveness to messages, decisions makers at HH level, etc.

3. The learning focus should not be on specific experiences, but on **standard protocols** to understand *contexts* and *mechanisms* in approaching FGM. The JP can take the key role of developing said protocols, refining them through the JP grassroots experiences, improving them through JP expertise and elevating them to feed Public Policy and work by other actors.

4. Predetermined global indicators assume a level of homogeneity that does not exist at lower levels of implementation and does not exist at results level. They create high *Campbell law* risks, such as artificial atomization of the interventions or perverse diversion of the attention towards feeding global indicators vs. learning and improving from lower level results-oriented indicators.

Consideration 3. JP Convening-Catalytic roles and advocacy plans

Advocacy plans should be developed by country offices (using external expertise) so as to map and prioritize influential actors and set out advocacy paths. These could include aspects such as: (i) formalized comprehensive mapping of influential actors (including those that might undermine progress) and prioritization of strategic partners; (ii) tailor-made advocacy paths, messages and specific steps for key actors (including monitoring of advocacy outcomes); (iii) Identification of key opportunities where global, regional or national influence may offer support at national level in order to capitalize upon the Joint Programme convening role.

Consideration 4. The Joint Programme is not benefiting from lessons about collective positive deviance

The Joint Programme is exclusively targeting areas with high prevalence of FGM, as it happens with the vast majority of programmes against FGM. This excludes the possibility of observing and learning from examples of collective positive deviance. Consider investing in learning from examples of collective positive deviance so as to learn lessons to accelerate abandonment and being able to offer positive messaging for advocacy purposes,

Consideration 5. Results-oriented follow up vs. activity based

Results-oriented follow up based on indicators of effective change vs. activity-based follow up to understand what works, what does not work and why. It is also worth mentioning that the focus on social norms, their specific functioning and related indicators is highly technical and relatively new for UN agencies, especially when comparing it with more developed and better tested indicators such as those on nutrition or health. Social norms and their technical implications are still insufficiently understood by UN agencies themselves. The contextualization of the global programme to the different country contexts is important to ensure that the programme is relevant and appropriate. A global menu of indicators for the Joint Programme is identified at the outcome and output levels for planning processes and the results framework. Whilst the global alignment of indicators is recognised as important for aggregation across the programme, it is felt that the indicators are too numerous and in cases inappropriate to national contexts. Furthermore, the pressure exerted by the need to respond to global indicators, which may or may not be relevant to the specific country, brings the JP further apart from a focus on understanding the factors for real change in the ground.

Consideration 6. Extreme heterogeneity of the FGM phenomenon and implications: connecting community learning with policy and research

The knowledge acquired through interventions at community level needs to be connected to policy level and to research institutions in an effective and timely manner. The convening role of the JP can be particularly beneficial in this dimension, linking knowledge in the field with the needed understanding at programmatic or policy levels. In this context, the knowledge generated by the JP at grassroots levels needs to be strategically collected and systematized so as to be actionable at higher levels of intervention and programming.