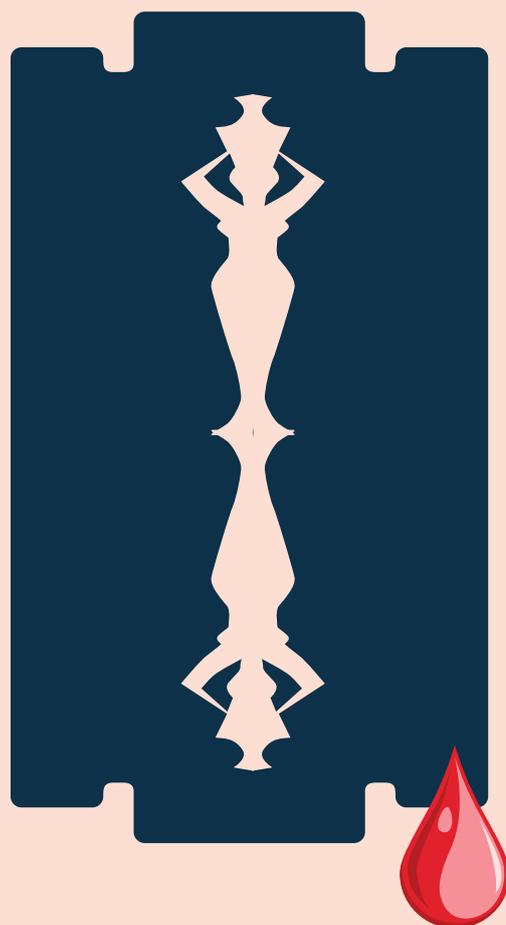


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Review of the realisation of Norway's
"Strategy for intensifying international
efforts for the elimination of female genital
mutilation for the period 2014–2017"

Commissioned by Norad

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Content

Acronyms	3
Foreword	4
Summary	5
1 Introduction.....	7
1.1 The Norwegian government's strategy.....	7
1.2 The assignment: scope and limitations	8
1.3 Method.....	9
1.4 What works	10
1.5 How to measure change and impact.....	12
2 Operationalisation of the strategy.....	13
3 Achievements and results.....	15
3.1 UNFPA-UNICEF Joint Programme	16
3.2 Tostan	19
3.3 Norwegian Church Aid (NCA) and Save the Children (SC) joint programme in Ethiopia ...	23
3.4 Norwegian Church Aid (NCA) and Save the Children (SC) joint programme in Somalia	25
3.5 Challenging Harmful Social Norms (CHANGES) in Somalia.....	27
3.6 Somaliland Family Health Association (SOFHA).....	29
3.7 AmplifyChange	30
3.8 Population Council.....	32
3.9 World Health Organization.....	34
3.10 Other NGOs.....	36
3.11 Some general observations.....	37
4 Review questions	39
5 Conclusion	44
References	45
Annexes	46

Acronyms

AC	AmplifyChange
CEM	Child and Early Marriage
CEFM	Child, Early and Forced Marriage
CHANGES	Challenging Harmful Social Norms
CSE	Comprehensive Sexuality Education
DFID	Department for International Development
DHS	Demographic and Health Survey
ETR	End-Term Review
FGM	Female Genital Mutilation
FGM/C	Female Genital Mutilation/Cutting
HP	Harmful Practices
INGO	International Non-Governmental Organisation
IPPF	International Planned Parenthood Federation
KFUK/M	Kristelig Forening for Unge Kvinner/Menn
MFA	Ministry of Foreign Affairs
MICS	Multiple Indicator Cluster Survey
MTR	Mid-Term Review
NGO	Non-Governmental Organisation
NCA	Norwegian Church Aid
Norad	Norwegian Agency for Development Cooperation
PC	Population Council
PRB	Population and Reference Bureau
RHR/HRP	Reproductive Health and Research/Human Reproduction Programme
SC	Save the Children
SDG	Sustainable Development Goals
SFS	Somali Family Service
SNaP	Social Norms and Participation
SOFHA	Somaliland Family Health Association
SRHR	Sexual and Reproductive Health and Rights
TASS	Tadammun Social Society
UNFPA	United Nation Population Fund
UNICEF	United Nations Children's Fund
WHO	World Health Organization

Foreword

This report was commissioned by Norad and the evaluation was realised by Chr. Michelsen Institute (CMI). Joar Svanemyr is the main author of the report. Camilla Gianella at CMI and Ragnhild Elise Johansen, external consultant to CMI, provided inputs to drafts of the report. Norad reviewed and commented on the draft report but the views and opinions expressed in this report are those of the author and do not necessarily reflect the official policy or position of Norad.

Summary

In 2014, the Norwegian government launched the *Strategy for intensifying international efforts for the elimination of female genital mutilation for the period 2014–2017*. This review is an assessment of to what extent the strategy has been realised, what the results are, and to what extent the channels and partners selected to implement the strategy has proved strategic to reach its objectives. According to the strategy, Norway's ambition is to "work to ensure that no girls are subjected to FGM, and that those who already have been are given the best possible care". Furthermore, it states, "The Government will now intensify Norway's efforts in this area by providing political, technical and financial support for the work to eliminate female genital mutilation." At an overall level, the government has realised these goals. It has increased its support to programmes aimed at ending FGM, it has expanded its support to civil society and international organisations and has continued to support the UNFPA-UNICEF Joint Programme. It has also bolstered Norway's efforts to eliminate FGM in Ethiopia and intensified its cooperation with the Somali authorities. Concretely, the government said it was going to "[d]ouble its allocation to civil society and international organisations working to eliminate FGM, from NOK 25 million to NOK 50 million, as of 2015". The objective to allocate NOK 50 million to civil society organisations and international organisations (excluding the support to the UNFPA-UNICEF Joint Programme) was achieved in 2015 and 2017. The government maintained the support to UNFPA-UNICEF Joint Programme, which received in total NOK 60 million over the three-year period. The main civil society agreement partners are Tostan, Norwegian Church Aid, Save the Children, and AmplifyChange. Smaller amounts were allocated to IPPF, BLESS, FORUT, FOKUS, KFUK/KFUM and Digni. In addition, the World Health Organization has received earmarked support to strengthen the health system response to FGM and the Population Council has received funds to assist other organisations in strengthening their monitoring and evaluation systems and in developing research projects.

The choice of channels and partners has been strategic in the sense that they have all documented promising results. The bulk of funding is channelled through organisations (i.e. NCA/SC and UNFPA-UNICEF Joint Programme) using approaches that are in line with a holistic, integrated, and multi-sectoral approach, which is now established as a 'best practice'. The selection of Ethiopia as a 'pilot country' has been successful in the sense that it has provided long-term specific funding for a nation-wide programme. The available data and reports are indicating that FGM has become less common in many parts of the country and the results are evidence of what can be achieved through sustained substantial presence and support in combination with a dedicated government.

A significant decrease in the prevalence rates have been documented in several of the countries where organisations supported by Norway are operating. There is still a need, however, for long-term commitment to initiate and sustain change and to build competency. It takes time for organisations to build capacities, structures, and systems, and it takes time to build experience, credibility, and trust in the context within which they operate. Continuity in the support and

approach clearly has a value in itself. The support to the pilot countries Ethiopia and Somalia should be sustained as well as the support to the UNFPA-UNICEF Joint Programme and to the WHO. Some modifications in the total portfolio may be considered. There is still a lack of data on the impact of many programmes, and further strengthening of the monitoring and evaluation frameworks as well as more research are all needed to enable clearer conclusions on the effectiveness of the various approaches.

1 Introduction

Female genital mutilation (FGM) is considered a violation of the human rights of girls and women, and its negative health consequences are significant and far-reaching. Norway has for decades supported programmes and organisations aiming at ending the practice. In 2003, the *Norwegian Government's International Action Plan for Combating Female Genital Mutilation* was launched, for the period 2003–2007 and later prolonged to 2013.¹ Under this action plan, most of Norway's support provided for preventive efforts and social mobilisation against FGM. Since 2007, Norway has channelled between NOK 40 and 60 million annually to the UNFPA-UNICEF Joint Programme on Female Genital Mutilation/Cutting and to a number of civil society organisations. When the previous *Action Plan* came to an end the government launched the *Strategy for intensifying international efforts for the elimination of female genital mutilation for the period 2014–2017*.^{2,3} This review is an assessment of to what extent the strategy has been realised, what the results are, and to what extent the channels and partners selected to implement the strategy has proved strategic to reach its objectives.

In the 30 countries with nationally representative prevalence data, around 1 in 3 girls aged 15 to 19 today have undergone the practice versus 1 in 2 in the mid-1980s. However, not all countries have made progress and the pace of decline has been uneven. Fast decline among girls aged 15 to 19 has occurred across countries with varying levels of FGM prevalence including Burkina Faso, Egypt, Kenya, Liberia and Togo. (<https://data.unicef.org/topic/child-protection/female-genital-mutilation/>)

In 2015, an estimated 3.9 million girls were cut. And because of population growth, this number is projected to rise to 4.6 million girls in the year 2030, unless efforts to end FGM are intensified. If FGM continues at the current rates, an estimated 68 million girls will be cut between 2015 and 2030 in 25 countries where FGM is routinely practiced and relevant data are available. (<https://www.unfpa.org/female-genital-mutilation>)

1.1 The Norwegian government's strategy

According to the strategy, Norway's ambition is to "work to ensure that no girls are subjected to FGM, and that those who already have been are given the best possible care". Furthermore, it states, "[t]he Government will now intensify Norway's efforts in this area by providing political, technical and financial support for the work to eliminate genital mutilation." More concretely, the government will "[d]ouble its allocation to civil society and international organisations working to eliminate FGM, from NOK 25 million to NOK 50 million, as of 2015."⁴ It will also "[c]ontinue to be a strong supporter of the UNFPA-Unicef Joint Programme on Female Genital Mutilation/Cutting and maintain its financial support".

¹ This Action Plan was evaluated in 2007 by Tonje Bentzen and Aud Talle.

² The strategy is attached (annex 2).

³ The Norwegian Government repeated its goal to contribute to abolish Female genital mutilation within one generation in its Action Plan for women's rights and equality in foreign and development policy 2016-2020 (Freedom, power and opportunities).

⁴ NOK 25 million was the estimated average allocated per year to INGOs in the preceding six-seven years.

The strategy has a number of points that specify what the government will do to intensify its efforts. In short it points out that the government will continue and expand its support to civil society and international organisations, the UNFPA-UNICEF Joint Programme, and work to strengthen the WHO's efforts to eliminate and treat FGM. It also states that it will use global normative processes to combat the practice of FGM, work through and with UN institutions and organisations, and cooperate with like-minded countries. The strategy states that the Government will seek to intensify its cooperation with the Somali authorities on enhancing prevention of FGM in Somalia, assess possible channels for more targeted support as of 2015, and continue Norway's efforts to eliminate FGM in Ethiopia. The strategy also says that it will strengthen the links between efforts to combat FGM in Norway and abroad and seek ways to exchange experience from efforts to combat FGM in Norway and abroad. It should be noted that the strategy does not contain any specific objectives in terms of quantifiable results at outcome or impact level. The only target that results and achievements can be compared to is the overall goal of eliminating FGM and providing care to survivors of FGM. Consequently, our interpretation is that the question whether the choice of channels has been strategic is a question about the results these channels have been able to document separately and aggregated.

1.2 The assignment: scope and limitations

The objective of the end review is threefold:

- i) Assess to what extent the Strategy against FGM has been operationalized. In particular if and to what extent the points stated under "the Government will" in the strategy have been undertaken/achieved. The focus should be on the programmes of intervention partners.
- ii) Assess the results of efforts undertaken by Norway against FGM during the period 2014 – 2017, with emphasis on the below questions:
 - a. Have the funding channels set forth in the Strategy proved strategic to achieve the objectives of the Strategy, separately and collectively?
 - b. Have the funding channels selected by Norad proved strategic to achieve the objectives of the Strategy, separately and collectively?
 - c. What are the methodologies used and the results achieved by the civil society organisations selected, separately and collectively? Is the work of the organisations mutually reinforcing or overlapping?
 - d. With emphasis on the work of the civil society organisations with which Norad and MFA have contracted: What are the results achieved in the two pilot countries, and are these satisfactory given the context? Has there been an added value of selecting Ethiopia and Somalia as pilot countries in the Strategy?
Norway has been funding two joint programmes implemented by civil society in Somalia: One joint programme by NCA and Save the Children, funded by Norad's department for civil society and one JP with DFID, implemented by a NGO

consortium led by Save the Children. How do the methods and the results of these two programmes compare? Do the programmes complement or overlap each other? Looking forward, should both of these programmes be continued?

The end review should conclude with recommendations for future Norwegian priorities for our international work against FGM and address these points:

- a. What Norway should prioritize in future efforts against FGM, with emphasis on types of programmatic interventions and funding channels;
- b. Whether the model with priority countries should be continued, and if so, whether the pilot countries should remain the same as in the Strategy 2014 – 2017
 - i. If the pilot countries should remain the same, what type of programmatic interventions and funding channels are recommended?

The review has not assessed Norway's advocacy efforts at a global level. The strategy said, "Norway will intensify its efforts to combat FGM by making more active use of relevant arenas where Norway has a certain standing and can exert influence." The extent to which Norwegian officials have mentioned FGM in presentations and speeches and have raised the issue in talks at senior official and political levels is not documented systematically and is thus difficult to assess.

Several of the organisations supported are combining FGM prevention with prevention of child marriage, gender-based violence, general empowerment of women, changing gender norms, and general child protection. The assessment of approaches and results here is restricted to the FGM part of their programmes. To assess the work and results for such other issues is beyond the scope of this review. Equally, it goes beyond what was possible for this review to explore if it is best to work on FGM in isolation or in combination with other SRH and women's issues.

1.3 Method

This review has been realised as a desk review combined with interviews. We have systematically read, and analysed plans, frameworks, reports and evaluations related to programmes aiming to prevent FGM and/or to support victims of FGM that have been supported by Norad or the MFA. We have also consulted relevant scientific literature and data on FGM prevalence. We have also talked to a number of key staff members in organisations receiving support and at the Norwegian Embassy in Nairobi.

We considered making a field visit to Somalia, but we decided against doing so for two reasons. First, we did not find a qualified consultant who had the necessary security clearance. Second, the value of a field visit only one year after the start of the CHANGES programme would have been limited.

To analyse the various programmes, their approaches and achievements is a challenging task because data and solid evidence on impact on behaviour is still limited. This is the case not only for the programmes supported by Norway, but a general problem for FGM interventions. However, in addition to DHS and MICS providing survey data, some organisations have realised their own surveys that provide more data and insights. This is the case for Tostan and NCA/SC, which gives data on the impact of their programmes, whereas SC commissioned a baseline survey in Somalia as part of the CHANGES programme.

1.4 What works

To assess the programmes Norway has supported, it may be useful to look briefly at what evidence we have about effective approaches, programmes and policies. Solid evidence is still very limited. As illustrated by an assessment completed by the Population Council in 2017 of the quality of studies of FGM prevention interventions, even high-quality studies lack base-line data and tend to rely on reported opinions and attitudes. Very few collect data on FGM practices.⁵ To clarify the lessons and insights learned since 2000 from efforts to end FGM, the Population Reference Bureau (PRB) published a desk review in 2013 of evaluations, studies, and systematic reviews that was combined with key informant interviews with recognized experts in the field.⁶ The review concluded:

Interventions should focus on holistic, integrated, and multisectoral approaches that bring together the advocacy, policy-level work, and community-level transformation of social norms. Evidence and experience from various interventions show that approaches should be holistic, multisectoral, long-term, and owned by the community. Stand-alone approaches are not able to create the change needed at the individual or community level. Communities should drive the intervention, allowing for buy-in, and design and implement an approach that appreciates the language, culture, and positive social norms of the community. (p.17)

As pointed out in the quote, no stand-alone approaches have had any lasting significant effect on FGM practices. Alternative income-generating activities for cutters, teaching women about the health consequences of FGM, legal reforms, and media campaigns are examples of interventions that have had little or no effect when done in isolation. Ethiopia and Burkina Faso have demonstrated how a combination of long-term political will, community mobilisation involving many sectors of society, mass media campaigns, enforcement of laws, and establishment of

⁵ Esho, T., Karumbi J. and Njue, C. February 2017. "Rapid Evidence Assessment: Quality of Studies Assessing Interventions to Support FGM/C Abandonment." Evidence to End FGM/C Programme: Research to Help Girls and Women Thrive. New York: Population Council.

⁶ Feldman-Jacobs, C. (2013). Ending female genital mutilation/cutting: Lessons from a decade of progress. Population Reference Bureau, Washington, DC.

support services can, when combined, lead to a reduction in support for the practice as well as reduced prevalence.⁷

Each organisation may not be required to have a holistic approach, but where that is the case, they should document established collaboration and coordination with other actors working with other dimensions and sectors. The UNFPA-UNICEF Joint Programme is contributing to such coordination that also includes some of the organisations supported by Norway.

It is generally agreed that certain social norms motivate people to continue the practice of FGM and that these norms must be addressed. In addition to legal and policy reforms, it has become a common approach to try to change social norms through awareness building and community dialogues/conversations. For one variety of this approach, public declarations of abandonment of FGM and other harmful practices is both a goal and a means for change in communities. This approach builds on the theory that FGM is a social convention and that most will end the practice if they believe both that many others are ending the practice and that FGM is no longer necessary to get girls married.⁸ In a contested article, Efferson and colleagues from the University of Zurich argue, "[t]he claim that a public declaration will reduce cutting lacks empirical foundation".

A public declaration of abandonment runs the risk of merely assembling families who already place a low intrinsic value on cutting, while the families who give it high intrinsic value will remain unconvinced. Public declarations indicate neither widespread abandonment nor that a program has coopted coordination incentives in a way that will lead to reductions in cutting. (p.1447)⁹

One should note that Efferson and his colleagues do not reject the idea that there are social norms influencing peoples' behaviour concerning FGM, nor do they propose to cease organizing community declarations. What they contest is the idea that FGM can be changed through *coordinated action*. Despite community leaders and parts of the population declaring abandonment of FGM, a large part of the population may still believe FGM is beneficial for the girls' health, morality and marriageability, and is a religious or cultural requirement. Furthermore, even if public declarations are the culmination of a process involving community conversations and information campaigns and even if the declarations give an important message to the community, it may not be a reliable *indicator* of normative changes among common people, let alone of real behaviour change. Particularly, such results may vary among

⁷ In Burkina Faso, 58% of the women in the age group 15-19 years had been cut compared to 89% of the women in the age group 45-49 years (DHS/MICS 2010). The corresponding numbers for Ethiopia are 47% vs 75% (35-49 years) (DHS 2016).

⁸ Social conventions are commonly defined as unwritten rules for behavior, but the key is that they lead to coordinated action by the majority of people in a group or community and that the benefit of following the rules relies on the effect of coordination.

⁹ Efferson, C., Vogt, S., Elhadi, A., Ahmed, H. E. F., & Fehr, E. (2015). Female genital cutting is not a social coordination norm. *Science*, 349(6255), 1446-1447.

different contexts and cultures, leading us to question its validity as a global indicator.¹⁰ The UNFPA-UNICEF Joint Programme has moved away from the language of 'social conventions' and concentrates the focus on social norms changes, but still uses public declarations as one of several indicators of change. The UNFPA-UNICEF Joint Programme recognizes, however, that public declarations are not an ultimate indicator of social norms change and that a public declaration means different things to different communities. Accordingly, the Joint Programme has developed tools to measure social norms change related to FGM.¹¹

1.5 How to measure change and impact

The ultimate goals of FGM prevention work are first to reduce the number and share of girls who are mutilated each year and second to put a definite end to the practice. Documenting changes in FGM as a practice is particularly challenging for a range of reasons. One problem is that data normally relies on self-reporting. Unlike child marriage and foot-binding, it is not possible for others to see whether a girl has been cut (except for health personnel if she is subject to a clinical observation). There are questions related to the reliability of self-reporting in a context where the community members may feel under pressure to hide the practice. Under-reporting of FGM has been documented in Ghana, Burkina Faso and Senegal, which has been explained as a reaction to prohibitions and sanctions against the practice.¹² Studies in Ethiopia have found that indirect question techniques reveal that more people support FGM than would admit to supporting it when asked directly, which is the most common way to gather data about attitudes and opinions.¹³

In countries where less severe forms are conducted on infants, such as in Eritrea and Ethiopia, many girls/women are not aware of their status with regards to FGM. In Somalia there is a tendency to count only infibulation as FGM.

As discussed above, changes in attitudes reported in surveys and public declarations are for various reasons not very reliable as proxy indicators of changes in the practice. Still, they indicate

¹⁰ UNFPA-UNICEF Joint Programme claims that a 2017 study of public declarations in Burkina Faso validated their usefulness as a proxy for social norms change. (UNFPA-UNICEF Joint Programme on Female Genital Mutilation 2017 Annual Report, p. 42). The study would have to be replicated in other places for verification.

¹¹ In December 2016, UNFPA-UNICEF Joint Programme started a consultative process to develop a global monitoring and evaluation framework known as the "ACT Framework" for tracking and measuring changes in social norms. UNICEF has established a partnership with Drexel University to deliver this work.

¹² Jackson EF, Akweongo P, Sakeah E, et al. Inconsistent Reporting of Female Genital Cutting Status in Northern Ghana: Explanatory factors and analytical consequences. *Stud Fam Plann.* 2003;34:200–209. Shell-Duncan, B., Wander, K., Hernlund, Y., & Moreau, A. (2013). Legislating change? Responses to criminalizing female genital cutting in Senegal. *Law & society review*, 47(4), 803-835. United Nations Children's Fund (UNICEF): Female Genital Mutilation/Cutting: A statistical overview and exploration of the dynamics of change. New York, July 2013.

¹³ De Cao, E., & Lutz, C. (2015). *Measuring attitudes regarding female genital mutilation through a list experiment* (No. 2015-20). Centre for the Study of African Economies, University of Oxford. Gibson, M. A., Gurmu, E., Cobo, B., Rueda, M. M., & Scott, I. M. (2018). Indirect questioning method reveals hidden support for female genital cutting in South Central Ethiopia. *PLoS one*, 13(5), e0193985.

that there are social processes going on, which in turn provide grounds for further efforts and give hope for future changes.

Another challenge is related to delays in reporting. The standard measurement of FGM prevalence, including the indicator used in the SDGs under Target 5.3, is the percentage of girls and women aged 15 to 49 who have undergone FGM. If the mean age at cutting in a country is one month old, respondents aged 15 to 19 are reporting on an event that took place an average of 15 to 19 years before the survey. This means that it does not capture changes in behaviour until 10-15 years after they have occurred. However, the age at cutting varies largely between countries, so that the time-delay also can vary accordingly. In a few countries, such as Sierra Leone and Egypt, FGM is happening at such a late age that girls from the 15-19 age group may not yet have been cut. The more recent surveys include questions to mothers on whether their daughters have been subjected to FGM, but these numbers cannot be compared directly to the number of adult women who report they have been cut themselves.

Finally, attribution is a challenge when many actors are involved and when the practice may change due to factors such as economic changes, access to education, violent conflicts, and migration. Some organisations who are influential on the ground may not be able to capture the effect of their efforts in surveys and other studies.

To document changes and better understand variations in FGM practices, further studies are needed, including studies using clinical observations of women attending health services and qualitative studies in the communities. The WHO (RHR/HRP) is developing a facility-based surveillance system in collaboration with the Centers for Disease Control and Prevention (CDC). In 2016, the National Program for the Fight against FGM in Mali carried out a study on the prevalence rate of FGM in two regions based on clinical examinations.

2 Operationalisation of the strategy

Table 1 clearly demonstrates that the support to civil society and international organisations has been sustained and increased. The total support went down from 2015 to 2016 before going up again quite significantly in 2017. For the total, the difference between 2015 and 2016 is largely due a larger disbursement to the UNFPA-UNICEF Joint Programme the first year followed by a smaller amount the second year.¹⁴ The support to civil society organisations also went down from 2015 to 2016 but went up in 2017 to a level well above that of 2015. The government said it was going to “[d]ouble its allocation to civil society and international organisations working to eliminate FGM, from NOK 25 million to NOK 50 million, as of 2015”. The objective to allocate NOK 50 million to civil society organisations and international organisations (excluding the support to the UNFPA-UNICEF Joint Programme), was achieved in 2015 and 2017. When we

¹⁴ The low level of disbursements in 2016 was partly due to budgetary restrictions related to a foreseen high influx of Syrian refugees, which costs should be covered by the budget for international aid.

compare allocations in 2015 and 2017, we see that the number of partners is smaller in 2017 and that two new programmes are supported with more substantial amounts: an increase to the NCA/SC joint programme in Ethiopia and DFID in Somalia (CHANGES).

As can be seen in the table, the main civil society agreement partners are Tostan, Norwegian Church Aid, Save the Children, and AmplifyChange, and to a lesser extent IPPF, BLESS, FORUT, FOKUS, KFUK/KFUM and Digni. The support channelled through DFID in Somalia goes to a programme (CHANGES) implemented by SC in partnership with a number of other organisations. In addition, some organisations not included do use general SRHR funding to some extent to address FGM. In terms of targeting countries, Ethiopia and Somalia received the largest amounts (NOK 19,9 million and 18,3 million respectively in 2017).

Table 1: Organisations supported to implement FGM programmes according to recipient country. Amounts in 1000 NOK. (Source: Norad's department for statistics)

Recipient country NO	Agreement partner	2015	2016	2017
Egypt	BLESS	1 545	750	750
Ethiopia	NCA ¹⁵		13 001	13 000
	SC Norway	4 042	-205	6 947
Gambia	Tostan	1 140	1 140	985
Guinea	Tostan	1 144	640	994
Guinea-Bissau	Tostan	1 333	640	1 184
Kenya	Digni	2 175	968	
	FOKUS	525	515	540
	KFUK-KFUM Global	3 272		
	NCA	528		
Mali	NCA	1 270		
	Tostan	1 207	800	789
Mauritania	Tostan	1 176	780	
Sierra Leone	FORUT	829	825	765
Somalia	DFID			10 000
	NCA	7 388	9 677	7 727
Senegal	Tostan	1 400	1 400	1 189
Sudan	NCA	1 439		
Tanzania	FOKUS	1 535	1 505	1 537
	NCA	204		
Sub-Saharan Africa regional	NCA	240		
	Tostan	1 400	1 400	360
Afrika regional	AmplifyChange	6 600		6 000

¹⁵ The total budget for the NCA/SC joint programme in 2015 was NOK 9,311,567.00. With this amount included, the total amount budgeted in 2015 for the civil society organisations will be approximately 49,9 million.

Somaliland, Mauritania and Sudan ¹⁶	IPPF	4 000	2 900	1 196
Sub-total		44 391	36 735	53 961
Global unspecified	Population Council	3 102	2 298	3 000
	UNFPA	26 000	14 000	(20 000 ¹⁷)
	WHO	5 000	5 000	5 000
TOTAL		78 493	58 033	81 961

The support to UNFPA that is indicated in the table concerns Norway's support to the UNFPA-UNICEF Joint Programme on Female Genital Mutilation. The strategy said the government will "maintain its financial support for the programme in the 2014–2017 period through an annual allocation of NOK 20 million". The disbursements have not been equal each year, but the total amount is the same as planned.

The Department of Reproductive Health and Research (RHR) in the World Health Organisation (WHO) was given earmarked funding for 2015, 2016 and 2017 to support building the evidence on a health sector response to FGM.

3 Achievements and results

In terms of results, we will focus on the implementing partners and first of all on the UNFPA-UNICEF-Joint Programme and its main civil society recipients Tostan, Norwegian Church Aid (NCA), Save the Children (SC) and AmplifyChange (AC). We also include assessments of the support to the Population Council, World Health Organization (WHO), Somaliland Family Health Association (SOFHA), and, briefly, the smaller NGOs. We first describe the programmes and their approaches followed by a description and assessment of the results. It should be noted that the assessment of the results is based on the organisations' own reporting of available data, but where relevant we refer to survey data such as DHS and MICS.

It should also be noted that the supported organisations have very different set ups and are not directly comparable. UNFPA-UNICEF Joint Programme and Tostan are multi-country programs and have staff present in the countries. UNFPA-UNICEF Joint Programme works directly with the Ministries but also through local NGOs, whereas Tostan is working directly with the communities. AmplifyChange is also a multi-country programme but provides financial and other types of support to smaller grassroots organisations from a UK-based office. NCA and SC have a narrower geographical focus on Ethiopia and Somalia, although NCA has had more limited FGM projects also in Mali and Kenya. Both are represented by country offices in Ethiopia and Somalia. BLESS, FOKUS, FORUT, DIGNI and KFUK/KFUM (YWCA/YMCA) each have

¹⁶ Most of this was earmarked support to Somaliland Family Health Association (SOFHA), which is a member association of the International Planned Parenthood Federation (IPPF).

¹⁷ That NOK 20 million was allocated to UNFPA in 2017 is based on a confirmation from MFA that UNFPA-UNICEF Joint Programme received in total NOK 60 million over the three-year period.

small one-country programmes implemented by local partners. Population Council is involved with research and capacity building for M&E whereas WHO is leading research on the health consequences of FGM and the health sector response to the need for treatment and support for girls and women living with FGM.

3.1 UNFPA-UNICEF Joint Programme

The *UNFPA-UNICEF Joint Programme on Female Genital Mutilation: Accelerating Change* had its Phase II implementation period from 2014–17.¹⁸ Norway allocated in total NOK 60 million to the programme for this three-year period. In addition, Norway is an important contributor of core funding to both organisations and provides funding to relevant country programmes in Egypt, Ethiopia, and Niger, among others. Together with Norway, the European Union, Finland, Germany, Iceland, Ireland, Italy, Luxembourg, Sweden, and the United Kingdom support the UNFPA-UNICEF Joint Programme.

An evaluation of the implementation and results of this phase is ongoing, and the final report is expected to be published in February 2019. This end-review is limited to a description and assessment of its key activities and achievements as documented in the programme's annual reports, the phase II report, and other programme documents. The programme is too multi-faceted for this review to present a full description and assessment of all the activities and achievements, and the evaluation report is expected to give a much more complete picture.

The UNFPA-UNICEF Joint Programme has continued supporting 17 countries to implement an integrated and holistic approach towards ending FGM. The 17 participating countries are Burkina Faso, Djibouti, Egypt, Eritrea, Ethiopia, Gambia, Guinea, Guinea-Bissau, Kenya, Mali, Mauritania, Nigeria, Senegal, Somalia, Sudan, Uganda, and Yemen. The programme is informed by a social norms perspective and sensitivity to sociocultural constructs, with interventions focusing on policy and legal environment, service provision, and galvanizing social dynamics. The programme's Theory of Change emphasizes the process of establishing and consolidating a new positive "norm of keeping girls intact" perspective, with a focus on supporting positive change from within. The programme works at many levels, from the local to the global, and through many actors. As such, it is in line with the recommended holistic comprehensive approach.

The UNFPA-UNICEF Joint Programme is an important actor at regional and global levels through its contribution to regional networks, its partnership with the Pan African Parliament, African Union, Arab League, and Organisation of Islamic Cooperation, technical input to UN resolutions, and development of manuals and guidelines. The programme was instrumental in ensuring that the Sustainable Development Goal includes a target (5.3), which specifically commits Member States to ending FGM. It is supporting evidence generation and learning

¹⁸ Until 2016 the program was called *UNFPA-UNICEF Joint Programme on Female Genital Mutilation/Cutting (FGM/C)*. 'Cutting' was deleted from 2017 to reflect UN resolutions.

through in-depth analysis of FGM data (DHS, MICS), demographic projections, and knowledge sharing.

In phase 2 much focus has been on ensuring ownership and sustainability by governments, civil society organisations, and communities through supporting policy dialogue at the international level and policy reforms at country level; improving coordination between different actors; encouraging capacity building through training and experience-sharing; and supporting education, dialogue and public commitments towards the elimination of FGM. The number of countries establishing national budget lines to specifically address FGM increased from six in 2013 to thirteen in 2017.

During the programme period, five countries (Egypt, Eritrea, The Gambia, Nigeria and Uganda) adopted or amended national anti-FGM legislation, an amended version of a draft law is pending passage in the parliament in Mauritania, and Somalia, Sudan, and Mali introduced draft legislation in 2017. From 2014 to 2015, the number of legal actions taken against individuals implicated in FGM increased more than four-fold, from 115 to 498. In the programme period, a total number of 639 cases were brought to court, which led to 301 convictions. The JP contributed to the development of tools and guidelines for prevention, protection and care services, and in 2017, 7,572 service delivery points reported applying tools developed with support from UNFPA-UNICEF Joint Programme. The programme management claims that the movement to end FGM is "consolidated in most of the countries covered by the Joint Programme".

Another focus area has been strengthening the M&E system. In 2015, a new online monitoring platform, the DevInfo database, was rolled out, and 1,831 programme experts, monitoring and evaluation officers, and managers were trained in evidence-based programming and on how to use the DevInfo platform. In line with the focus on norms, the programme started experimenting with approaches to measure shifts in attitudes and expectations. In collaboration with Drexel University, the program started a consultative process in 2016 to develop a global monitoring and evaluation framework for tracking and measuring changes in social norms. The programme also commissioned a number of evaluations in various countries to determine whether target populations were experiencing shifts in attitudes towards FGM as a result of programme interventions.

The annual reports present overall figures as the ones quoted above and give many examples of achievements from the programme countries to which the UNFPA-UNICEF Joint Programme has contributed. Due to the way data is presented, it is difficult to compare program achievements across the various countries. The aggregated numbers at the global level conceal the fact that for some of the indicators, there has been little progress in most of the programme countries. The 2016 annual report, for example, summarizes that "[i]n 2016, more than 1.5 million (1,547,378) girls and women received services for protection and care related to FGM/C,

bringing the total number of girls and women who have received services since 2014 to nearly 2.4 million. Thus, the target for Phase II has already been achieved" (page VI). The great majority, however, of women and girls who received services can be found in Guinea, Eritrea, and Ethiopia, whereas in Kenya and Uganda for example quite few women received services. This is despite Guinea and Eritrea having much smaller populations than Kenya and Uganda. Another example is the number of communities having made public declarations of support for abandonment. The number of communities in Burkina Faso by far exceeds the numbers in any other country, whereas in Egypt, Kenya, and Gambia few communities made declarations.¹⁹ The reports do not give any indication of how these large variations can be understood. According to the programme coordinator (personal communication), they can to a large extent be explained by factors external to the programme, such as different social structures, the ethnic and religious composition of communities, and varying quality and coverage of health services. Another explanation concerning the use of health services is a lack of standardized tools and indicators and varying quality of the data resulting in underreporting from some of the countries. This does not rule out the possibility that the differences also could be due to varying performance of the programme and its partners across countries.

The programme operates with four 'key programme indicators', which are 1) Number of communities in programme areas having made public declarations of abandonment of FGM, 2) Number of women and girls receiving services for prevention, protection, and care services related to FGM, 3) Number of countries with a budget line to implement legislation and policies to eliminate FGM, and 4) Number of countries implementing a comprehensive legal and policy framework to address FGM. In line with these indicators, the 2016 and 2017 annual reports and the final report for phase II contain 'country profiles' indicating 'key achievements' in the year, including among others the number of arrests, the number of girls and women who were provided FGM-related services, and the number of communities that made public declarations of abandonment. It is not possible to assess programme performance based on these indicators, which capture achievements that can only partially and in various degrees be attributed to UNFPA-UNICEF Joint Programme. To assess how the programme performs for example in Senegal as compared to Mali, one would have to look at country reports and explore contextual factors, which was beyond the scope of this review. The ongoing evaluation will give more precise and specific information, but the numbers indicate that the programme and its partners perform quite unequally across countries.

For the future, it would be useful to ask for an analysis of these differences so that the UNFPA-UNICEF Joint Programme and its partner organisations can learn more about what works and what does not in specific contexts. Do these variations suggest that the methods are not properly adapted to the local contexts, is it a matter of capacity of the staff, or are the local factors so

¹⁹ Sources: A presentation of highlights from the 2017 report to the steering committee in April 2017 and *Performance Analysis for Phase II* (UNFPA-UNICEF, August 2018).

different that work in some countries is more challenging? Another question is, as discussed above, whether the number of public declarations is a relevant global indicator of progress.

The programme has acknowledged the need to provide more and better data. In its programme for phase 3 that started in 2018, they emphasize the challenge to document changes through surveys that do not capture changes in behaviour until 10-15 years after they have occurred. Another problem mentioned is that national surveys do not capture changes in more limited geographic areas. The programme has planned a number of activities to improve the situation, including building information management systems to track and share data on FGM, and piloting a social norm measurement framework. It has also funded research in Burkina Faso, Djibouti, Eritrea, Guinea, Senegal, Somalia, Sudan, Senegal, and Uganda.

The programme has a holistic and comprehensive approach operating at all levels from the global to the local communities. It engages with politicians and religious leaders, strives to improve access to health and support services for FGM survivors, and works to strengthen the enforcement of laws. In terms of strengthening policies and systems at national and regional levels, the programme is unique and has an important role, in collaboration with multiple actors and activists. In sum, there is no doubt that UNFPA-UNICEF Joint Programme has had a crucial role in lifting FGM onto the agenda internationally and in many countries. It has contributed with essential building and strengthening of capacities, systems, institutions, and commitment on many levels. However, more efforts are needed to collect solid data on real changes in the practice. As the leading global programme for FGM prevention, the UNFPA-UNICEF Joint Programme has a special responsibility to develop adequate methods to generate these data. It has in the last years taken important initiatives to provide more evidence in this area.

3.2 Tostan

Tostan is an INGO founded in 1991 in Senegal. Tostan takes a holistic approach to development by facilitating a human rights-based, non-formal education program called the Community Empowerment Program, which aims to empower communities to lead their own development. The model has been implemented in 22 languages across eight African countries (Senegal, Guinea, Guinea-Bissau, The Gambia, Mali, Mauritania, Somalia and Djibouti). Norway has for many years provided general support under a human rights umbrella. In 2014, Norad entered into a partnership with Tostan to support an initiative called *Generational Change in Three Years; An Ambitious Project to Empower Millions in West Africa* (acronym: GC3Y). "This project aimed to significantly accelerate the abandonment of FGC and other harmful traditional practices and to further the empowerment of girls and women and the promotion of human rights." (Final report 2014-2016).²⁰ Tostan was chosen as partner based on a limited bid.

²⁰ One may note that Tostan, unlike UNFPA-UNICEF Joint Programme, uses 'Female genital cutting' (FGC) and not 'Female Genital Mutilation' (FGM).

The key element in the Tostan approach is to facilitate community conversations that allow community members to discuss their vision for the future of their community and address what their needs and challenges are for achieving their goals. The way they are working is described as follows:

The Community Empowerment Program (CEP) consists of non-formal education classes designed to provide participants with comprehensive information on areas of key importance. Tostan's CEP provides community members with essential learning and skills that enable them to take direct control of their own community's development. The program uses a strategy of "organized diffusion", which encourages participants and communities to share new information and ideas with their friends, families, neighbors, and social network. (p.4)

The CEP covered 280 communities in six West African countries in the programme period 2014-2016. In terms of results for this period from the Norad-supported initiative, Tostan reports on the number of declarations:

A key result after the three-years of learning and organized diffusion activities (adopt-a-learner, community sharing events, inter-village meetings, sharing seminars, regular radio programs, and other social mobilization activities) were the six declarations for abandonment of FGC and child marriage by all 150 participating communities and 208 sensitized communities reached through organized diffusion activities. [...] In December 2016, 358 communities – Guinea (106), Guinea Bissau (102), Mali (73) and Mauritania (77) – organized to publicly declare the abandonment of the deeply entrenched practices of female genital cutting (FGC) and child/ forced marriage" (p.7)²¹

Tostan reports that in Guinea awareness-raising prevented 248 girls aged between 12 and 18 from being cut, but similar numbers are not given from the other countries, and it is not stated how this was documented. Anyhow, such data may be unreliable as there commonly is a large age-span during which girls can be cut. Saving them one or three years may not secure that they will not be cut at a later stage.

The belief that the chosen approach to promote the abandonment of FGM is effective relies to some extent on studies realised in the past in Senegal. In 2008, UNICEF realised a study of communities eight to ten years after their public declaration of abandonment using mixed methods, which concluded that "circumcision still exists in all villages, but its frequency has strongly decreased in intervention villages. By contrast, in control villages, practices and

²¹ They also report: "By the end of 2016, 420 communities in Mali, Mauritania, Guinea, Guinea Bissau and The Gambia had declared the abandonment of FGC and child marriage".

opinions remain favorable to circumcision" (p. xiii).²² Similarly, a study from 2004 led by Population Council found that "There was a dramatic decrease in the approval of FGC" and "the prevalence of FGC reported among daughters aged 0 – 10 years decreased significantly among women directly and indirectly exposed to the program" (p. i).²³ Similar studies that include questions to the respondents about FGM performed on girls have not been realised after the 2008-study or in other countries, which casts some doubt on the sustained effect on FGM practices.²⁴

Tostan has been in a partnership with the Bill and Melinda Gates Foundation to improve its monitoring and evaluation systems since 2014. Most relevant for the FGM component is that the new M&E system includes data collection and analysis concerning participant and adoptee attitude and behaviour change, as well as community-level attitude and behaviour change. In 2016/17, a survey was conducted to collect data on changes in knowledge and attitudes in beneficiary communities, sensitized communities and control communities. Among other results, it found a considerable development in knowledge about human rights and in women's participation in decision-making. In relation to FGM, these are some of the major findings:

- Regardless of the country under consideration, the level of disapproval of the practice of FGC is significantly higher in sensitized communities than in control communities and the percentage of respondents who cite negative consequences of the practice is higher among participants than among randomly selected community members.
- Attitude change was largely attributed to Tostan's lessons learned at the level of beneficiary and sensitized communities. At the level of control communities, Tostan is often cited as a source of change in personal attitudes towards the practice of FGC.
- Many more in beneficiary communities as compared to control communities would stop the practice of FGC in their families if they had the opportunity to do so, but the change between the Mid-Term Evaluation and Final Evaluation was smaller.

²² UNICEF: Long-term evaluation of the Tostan programme in Senegal: Kolda, Thiès and Fatick regions. United Nations Children's Fund Section of Statistics and Monitoring, Division of Policy and Practice, New York, 2008.

²³ Population Council: The TOSTAN Program. Evaluation of a Community Based Education Program in Senegal NJ Diop, M Mbacke Faye, A Moreau Jacqueline Cabral, H Benga, F Cissé, B Mané, I Baumgarten, and M Melching. Population Council, GTZ, TOSTAN, August 2004. See also: Diop, N. J., & Askew, I. (2009). The effectiveness of a community-based education program on abandoning female genital mutilation/cutting in Senegal. *Studies in Family Planning*, 40(4), 307-318

²⁴ A study was also conducted in Burkina Faso, but in that case the researchers were not able draw conclusions about the effect on the FGM practice since a transition towards abandonment had already started before the intervention. They found, however, that the education program contributed to strengthening the existing measures and to improve the level of awareness of human rights and reproductive health (USAID 2004). Yet another study commissioned by UNICEF was realised in Guinea-Bissau in 2013 but the report is not published. The main finding was that the Mandinga ethnic group had largely abandoned FGM, whereas there was much more resistance among the Fula, including both common community members and religious leaders.

These data indicate that the Tostan programme has been largely successful in changing *attitudes* related to FGM at individual and community level. The changes in attitudes indicate a positive development, but as discussed above, the question is still open about to what extent people really stop performing FGM and to what extent the practice is changing towards cutting the girls at an earlier age or doing it secretly.²⁵ Survey data from Senegal, and more recently from Mali, show that fewer adolescents have undergone FGM compared to older women and that support for the practice has declined.²⁶ In countries such as Guinea, Guinea Bissau, and Mauritania there has been no change or only small changes in prevalence rates but, as discussed above, it may take years before changes will be evident in national surveys.

When compared to the comprehensive, holistic approach initially described as a 'best practice', Tostan's programmatic approaches focus on community conversations and empowerment of women aiming at changing social norms and conventions. Local and administrative authorities and religious and traditional leaders are sensitized and included in the programme. The reports do not include information on activities aiming at leaders at higher levels such as policy makers and the government, but Tostan is working closely with the governments in all countries (personal communication). It is also part of national alliances that are coordinating the various programmes against harmful practices. To provide girls who have already been subjected to FGM the best possible care is a priority for Norway according to the Strategy. Involvement with the health and education sectors is limited. Health personnel are involved with vaccination and contribute to teaching about nutrition, hygiene, and the consequences of FGM. Tostan does not offer health personnel training in prevention and treatment of FGM, but this is done by other organisations operating in the same countries. There is no report of Tostan being involved in referring girls and women with FGM complications to health services or in providing medical or psychosocial support to survivors of FGM. They do claim however, to coordinate with local health clinics and contribute to identification of women with fistula who are referred (personal communication).

The Tostan strategy for a global development of communities with empowerment of women as a central piece is very ambitious. It is a holistic approach to community capacity building in the sense that they work in areas as diverse as democracy, human rights, health and hygiene, reading, writing, arithmetic, income generating activities, and abandonment of harmful practices. Various reports concur to confirm that Tostan has been successful in increasing literacy, improving hygiene, prevention of intimate partner violence, and increasing women's participation in the communities. When it comes to FGM, the evidence of impact in terms of reduced prevalence of FGM is more mixed. Even though the support for the practice has apparently diminished strongly in the West-African communities where Tostan is operating, further studies are required to build evidence on the effect in the various contexts.

²⁵ They chose not to ask whether the respondents themselves or girls in their family had been subjected to FGM because the difficulty of knowing whether people tell the truth (personal communication).

²⁶ According to DHS and MICS data from 2014-2016 compared to data from 2010-2011.

3.3 Norwegian Church Aid (NCA) and Save the Children (SC) joint programme in Ethiopia

Save the Children Norway-Ethiopia (SCN-E) and Norwegian Church Aid/Ethiopia (NCA/E) have implemented a joint anti-FGM/HP programme in Ethiopia since 2006. The programme was initiated as part of the effort to support Ethiopia as a pilot country for Norway's FGM efforts. Phase I lasted from 2006-2010 and Phase II from 2011-2015. The program was implemented at the national and regional levels and in six out of nine regional states and two city administrations (Somali, Afar, SNNPR, Harari, Amhara, Tigray, Oromiya regional states). A third phase of the program is covering the period 2016 - 2020. The management of the support was transferred from the Norwegian embassy in Addis Ababa to Norad for the new programme period. The programme is currently a project within NCA's frame agreement with Norad, and SC has an agreement with NCA. This phase has been implemented by 10-11 partner organisations called 'implementing partners,' ranging from well-established and solid NGOs and faith-based organisations working mainly at national level to smaller local partners as well as local Bureau of Women, Children and Youth Affairs.

The programme that started in 2016 is described in the following terms:

To bring about the expected attitudinal change in the community and at individual level, different community dialogues, mass awareness raising events and radio programmes will be conducted. The programme will initiate and strengthen community-based structures such as child-led groups and anti-FGM committees for the protection of women and girls from FGM. Further, capacity building trainings and technical support will be provided to community-based structures to enable them to take organized action against FGM. In order to ensure improved health services for women and girls affected by FGM and promote the engagement of health institution in zero tolerance to FGM, the programme will organize discussions among health professionals, train health extension workers and midwives on FGM case management and support research activities on Reproductive Health (RH) and other effects of all forms of FGM practiced in different regions.²⁷

A key element, particularly for NCA has been the involvement with faith-based organisations, institutions and religious leaders. SC is also working with influential people such as religious and clan leaders. As for the Tostan programme, community dialogues leading to public declarations of abandonment of harmful practices is a central element. NCA and SC have good working relations with relevant government Ministries and bureaus at national, regional and local levels. Both NCA and SCI are members of the steering committee of the national alliance to end FGM

²⁷ NCA/SC report on the number of girls referred for fistula treatment as if this is a service offered to women with FGM. Obstetric fistula is mostly not caused by FGM but by narrow birth channels, which in this context normally are due to early pregnancy and stunting. The Hamlin Fistula Hospital in Addis Ababa estimates that approximately 3% of the fistula cases they treat are caused by FGM (personal communication).

and Child Marriage (CM) and both organisations support the alliance technically and financially. They also report to have a close relationship with UN agencies, particularly with UNFPA and UNICEF, in ending FGM and CM.

NCA and SC commissioned an end/baseline survey in 2015, which was carefully designed and rigorously conducted by a team of experienced researchers.²⁸ It provided quantitative and qualitative data indicating that the programme had had a considerable impact in terms of changes in attitudes and reduced cutting rates. The survey found that there had been a significant decrease in FGM prevalence in all program areas (from 18 to 46 per cent points reduction) but also confirmed that the rates continue to be high in several regions and in particular in Afar, Amhar, and Somali regions.²⁹ It also found that in several districts close to half of the parents intend to circumcise their daughters.

The End-Term Review (ETR), conducted by Svanemyr and Takele in October 2015, concluded that:

The joint program has achieved impressive changes in terms of reducing the incidence of FGM in the intervention areas, changing peoples' attitudes towards opposing the practice, mobilizing religious and community leaders, and in putting the issue of FGM and other harmful practices on the national agenda. (p.7)

The ETR found that these promising achievements resulted from a comprehensive multi-level and multi-component approach addressing a wide range of factors and involving a similar wide range of stakeholders from the level of the government to local communities. Thus, the approach applied by the programme is very much in line with the recommendation in the PBR review quoted above.

A key aspect of the Joint NCA/SC programme is the learning and exchange of methods, tools, documentation, reviews and reporting among partners participating in the programme. Mutual learning and sharing expertise and resources helps to avoid duplication and enhance efficiency. The joint activities have also increased the program visibility at the national level.

The progress report for 2016 shows that the programme continues on the same good track with involvement of various duty bearers and rights holders including youth and other community members, health professionals, and religious leaders. The programme has expanded to more districts. The uneven degrees of change and considerable resistance against changing the practice within some ethnic groups may be an indication that the programme needs to refocus towards using more resources where the resistance against change is stronger. It may also

²⁸ Ababeye B and Disasa H. Baseline/End line Survey: Female Genital Mutilation (FGM) Situation in Six Regions of Ethiopia. Norwegian Church Aid/Save the Children International, 2015.

²⁹ Prevalence of FGM was measured employing an item that asked if respondents had circumcised their daughter in the last one year. There have been discussions whether what was measured in the survey was incidence rather than prevalence.

indicate a need to explore more in depth to what extent the approach is successful in different contexts. The programme has yet to be subjected to an external and independent in-depth evaluation.

In 2016, NCA and SC initiated discussions with the Population Council on the development of a common M&E framework to track the FGM programme results and to strengthen the M&E capacity of local partners. It is expected that this will provide more solid data on the outcomes and impact of the programme (see section below on Population Council).

3.4 Norwegian Church Aid (NCA) and Save the Children (SC) joint programme in Somalia

This programme started with a pilot phase for the period 2014-2015, whereas the second phase was officially launched in May 2016. As for the Ethiopia joint programme, the management of the fund was transferred from the embassy to Norad in 2016 and included in the frame agreement with NCA. The objectives are to transform dominant social norms, make communities and faith actors commit to end FGM and Child Early & Forced Marriage (CEFM), ensure access to adequate and appropriate support services for women and children exposed to harmful practices, and contribute to the improvement and implementation of laws, policies and budgets to end FGM.

The programme covers six districts in Gedo and Puntland. NCA and SC have different national partners. SC's partner is Tadamun Social Society (TASS) and NCA's main partner is KAALO (KAALO AID for Development). The partners were selected based on partners' capacity assessments. The plan is to implement the programme in Bosasso, Gardo, Garowe, and Eyl in Puntland, and in Garbaharey and Belet Hawa in the Gedo-region in Jubaland over a five-year period (2016- 2019). The objective is to reach 7500 rights holders directly. The project will focus on three main strategies: providing psychosocial and medical support services for girls and women who are most vulnerable and with identified needs, mobilisation and capacity building, and advocacy work at the local and national level. Mobilisation and capacity building target religious and community leaders, government officials, local authorities and community groups through community dialogues, theological reflections, trainings, and campaigns.

The focus and the approaches are building on the experiences made in the NCA/SC joint programme in Ethiopia, including a strong focus on community dialogues and engagement of religious leaders. The situation, however, is more complex and challenging in Somalia with much higher prevalence rates, a more widespread and stronger resistance against changes, a preference for a change to the Sunna type of FGM and with infibulation as the most common type of FGM (at least historically).³⁰ Studies have found that some of those who have stopped or

³⁰ Traditionally the 'Sunna' type does not include infibulation and consists of the removal of the retractable fold of the skin and the tip of the clitoris.

are against infibulation instead perform or support less severe forms of FGM (type I or II). Also, in contrast to Ethiopia, the legal and political commitment to abandon the practice is less firm, even though the Somalia constitution banned FGM in 2012 and draft legislation was introduced in 2017. Some Government officials are quite instrumental in supporting the FGM abandonment, mainly the Federal Ministry of Women and Human Rights Development. That Ministry has no operational mandate, but there is overall a lack of institutional capacity, resources and skills. The Norwegian Embassy in Nairobi finds that the Government is committed and has taken a number of initiatives to address the issue even though they have to be cautious when dealing with religious leaders. In Puntland, the government leaders (including the President) and district and local authorities are well involved in the fight against FGM. Whereas Ethiopia currently experiences political stability and no major violent conflicts, Somalia is characterized as one of the most fragile, high risk operating environments in the world.

An external consulting company did an evaluation of the pilot phase period (2014-2016) and found rather mixed levels of achievement and progress.³¹ The evaluation report highlighted that the project brought on board 42 religious leaders to influence behaviour change through community dialogues and mosque sermons and that these leaders became important leaders of the project and strategic role models. Anti-FGM messages delivered through community dialogues, print materials, media and by religious leaders resulted in 60.1% of right holders stating that FGM should be discontinued. The report, however, does not discuss whether there is reason to believe that this represents progress or whether this figure is higher or lower than in no-intervention areas. The report points out that the decline in the support of the extreme form (infibulation) may conceal support of the less extensive 'Sunna' type, which is still preferred even among some religious leaders. The evaluation found regional differentials in the achievement of the objectives. In Puntland, declarations against FGM (Fatwas) were made and government policy level support was mobilized, whereas in Gedo, Jubaland, various stakeholders questioned the readiness of the community to make anti-FGM declarations. The evaluation only focused on the project locations which were in urban areas.

Among the early achievements in the second phase have been collaboration with the Ministry of Women, Development and Family Affairs in the rollout and training of community groups and networks on the contents of the anti-FGM policy in Puntland, engagement and capacity building of religious leaders through cross learning and experience sharing between Somali religious leaders from Somalia and the Somali region in Ethiopia, training of media personnel, and improved engagement of men and boys. Several activities have also been undertaken to improve referral and access to health services and to improve health workers' skills and knowledge on basic treatment of FGM complications. According to staff, the programme will go through some modifications this year by implementing community conversations with a more open approach allowing community members to discuss any topic that concerns them.

³¹ Evaluation Report, Basemark consulting, Nairobi, March 2016.

Despite an extremely challenging operating environment, the programme seems to be on a promising track, and a good foundation is being built through the training and involvement of leaders and collaboration with the authorities. As in Ethiopia and as recommended by the PRB review, a “holistic, integrated, and multisectoral approaches that bring together the advocacy, policy-level work, and community-level transformation of social norms”, is applied. The limited coverage of the programme and a very limited number of other organisations addressing FGM, particularly in rural areas indicate that a long-term investment is required and that more resources are needed for scaling up to have measurable impact on a national level.

3.5 Challenging Harmful Social Norms (CHANGES) in Somalia.

CHANGES is part of The *Social Norms and Participation* (SNaP) programme that started in November 2015 and aims to increase women’s participation in decision-making and to challenge harmful social norms in Somalia. The programme will achieve this by providing support for two key delivery components:

- 1) The United Nations Joint Programme on Women’s Political Empowerment – which increases women’s voice and representation in Somali political and peacebuilding processes by creating an enabling legal and policy framework for women’s participation;
- 2) CHANGES – which challenges gender-discriminatory social norms to reduce violence against women and girls, including Female Genital Mutilation (FGM) and Child Early Forced Marriage (CEFM).

SNaP is a consortium dealing with a wide range of development issues, but it is not clear to what extent FGM prevention activities are integrated with, for example, economic empowerment activities. They do report that there is an opportunity for the “work on women’s political empowerment to link more strongly with work of the CHANGES consortium” to support the work to change social norms (SNaP annual report 2017, p.7).

Norway is co-funding CHANGES with a contribution of NOK 30 million for 2017-2019. CHANGES started in 2017 to deliver three strands of innovative intervention models. The strands are intended to work together to achieve social norm change and a framework is assumed to integrate the three approaches to maximise impact and ensure complementarity. The three strands are:

1. CHOICES (led by Save the Children) – a curriculum-based programme of creative, participatory activities that seek to lead a shift in gender norms among 10- to 14-year olds;
2. Engaging Men and Boys (led by CARE International) – a variety of approaches including identification of positive role models and testimony sharing from men, challenging gender norms;

3. Economic and Social Empowerment – will support women by encouraging them to increase their access to capital through village savings and loan associations, increasing their decision-making power within the home (to become operational in 2018).

The three strands are based on a business case drafted by DFID, and DFID is managing the programme. A Save the Children-led consortium is the implementing partner for DFID and Norway.³² The local partners play a key role specifically in undertaking community-level advocacy, mobilisation, sensitization and outreach. The consortium's historical presence in Somalia has yielded strong, trusted relationships with key stakeholders and acceptance among the target communities, and the combination of partners means that the programme can achieve a wide coverage in 14 districts across Somalia. Since the programme has been running for a little more than year, it has still little to report in terms of results and impact.

The programme covers six of the seven federal Member States of Somalia, including urban and rural populations and hard-to-reach areas. The project seeks to challenge harmful social norms including FGM, Child Early and Forced Marriage (CEFM), and Gender Based Violence (GBV) and to increase women's social and economic empowerment through interventions at the individual, household, community, and societal levels. Transforming social norms to support gender equality in Somalia is set as an outcome and will be achieved through three key output areas:

1. Enhanced civic engagement to support greater gender equality for women and girls;
2. Improved knowledge and attitudes of men, women, girls and boys on gender discriminatory social norms;
3. Increased social and economic empowerment of women and girls.

The first year has been dominated by research and training activities. During the design phase of the project a comprehensive baseline survey was conducted by the consortium. CHANGES produced two research papers (findings from the baseline survey and a Political Economy Analysis). The progress the first year was heavily affected by a drought, and the programme spent many of its resources to support people who were affected.

It is too early to assess the results of the programme, but many activities have been initiated. At the outcome level, the first annual report (2017) claims that "[s]ignificant progress has been made at the community level, engaging traditionally conservative members in conversations on the negative consequences of harmful social practices, but impact on the overall rate of FGM and

³² The other partners are Care International and International Rescue Committee (IRC), and they are working with the following NGOs: Save Somali Women and Children (SSWC), Mudug Peace and Human Development Organisation (MPHDO), Nagaad (an umbrella organisation), Somali Women's Studies Centre (SWSC) (a research centre), Galkayo Educational Centre for Peace and Development, and We Are Women Activists (WAWA).

CEFM, along with the perception of safety, will take more time" (p.5). It is further reported that "the consortia have managed to: facilitate widespread community-level discussions; stimulate the emergence of activists who want to work for broader change; and stand-up platforms that can plan and prepare actions to secure for medium-term changes to the social norms and behaviours that restrict the social, civil and political rights and wellbeing of women and girls." 726 district level champions have been identified and have received training on leading FGM and CEFM advocacy work that will directly target policymakers.

Compared to the NCA/SC joint programme in Somalia, CHANGES also puts much emphasis at addressing social norms and mobilisations of community leaders and members. The central element in the CHANGES programme is to challenge and change *gender* norms, which has a less prominent place in the NCA/SC programme. CHANGES underlines that they are identifying and training 'activists' and 'champions', which NCA/SC talks less about. The NCA/SC programme has a narrower scope with a focus on preventing FGM and early and child marriage whereas CHANGES aims at addressing a wider range of gender norms and practices and to increase women's social and economic empowerment. NCA/SC includes activities that aim at influencing the policy level and dealing directly with policy makers, whereas several CHANGES partners are working to change policies and laws. CHANGES claim to provide a platform for CSOs to exert their influence and campaign for change at both the national and local level. A key component for NCA/SC is to improve access to relevant services for survivors of FGM, which is not part of the CHANGES programme. The NCA/SC programme addresses to a larger extent all levels whereas CHANGES is more holistic in the sense that it is challenging the social and gender discriminatory norms more broadly. SC's involvement with both programmes opens up a comparison of somewhat different approaches and the possibility of bringing lessons from one programme to the other one. The programs are complementary in the sense that they operate in different geographical areas and there is little risk of overlapping or duplication. CHANGES has much wider geographical coverage and more resources than the NCA/SC joint programme.

3.6 Somaliland Family Health Association (SOFHA)

SOFHA is an associated member of IPPF and primarily focuses on providing antenatal care and family planning services to Somaliland women.³³ The project 'Empowering a First Generation of Somalis to Abandon FGM' is part of their efforts to provide information and education on harmful traditional practices. They have been running a range of initiatives that can be divided into four categories: research, advocacy, health, and education. IPPF/SOFHA was chosen as partner based on a limited bid.

SOFHA's FGM/C baseline research was done in partnership with Population Council. In terms of advocacy, they have started developing a five-year strategy toward the eradication of FGM in Somaliland (2016) through workshops for Sheikhs/religious leaders and the Ministry of

³³ <http://www.somalilandfamilyhealth.org/>

Religious Affairs, and through the establishment of a project task force and project orientation to the line ministries. They are also working with Population Council to establish and harmonize meaningful national indicators for FGM for Somaliland.

A number of activities are targeting the health sector and the need for health services. In 2016, nurses and midwives from three regions received training aimed to equip the participants on how to protect and support women and girls who have been subjected to female genital mutilations and those at risk by developing social and psychological support services and care. In addition, health education including the short term and long-term consequences for FGM has been conducted for 750 women as part of SOFHA regular programming, and in 2017 SOFHA provided 1951 FGM/C services. SOFHA has used a compilation of FGM guidelines (WHO, UNFPA) put together by a consultant, along with its own expertise to conduct trainings. In 2017, IPPF commissioned the development of FGM/C guidelines to be used across the globe based on this work.

In the education sector, they have recruited volunteer members from the national universities, organized sensitization forums and conducted training workshops for youth in Somaliland. Workshops on FGM/C advocacy were organized for Primary and Secondary teachers in Togdheer Region, Somaliland, and they trained 200 teachers on FGM/C and the role of teachers. In November 2017, SOFHA started the project's primary school intervention, targeting in particular parents of girls in grade 1 to 3, and conducted school interventions that reached over 4000 young people and almost 2000 parents. They have also started development of a teachers' training manual on FGM and advocating for adoption in schools. This document is still in progress and is being informed by the ongoing training of teachers on FGM/C.

It is difficult to assess the quality and the importance of these activities based on the program's reports. The work with the education sector is commendable and can be an important source of inspiration for other organisations that so far have not included activities targeting teachers and learners. The role of coordinator for the development of a five-year strategic plan and national indicators is important, and the products can become important contributors to a consolidation of national efforts for the abandonment of FGM.

3.7 AmplifyChange

AmplifyChange (AC) is a Sexual and Reproductive Health and Rights (SRHR) advocacy fund set up to help secure universal recognition of SRHR as a human right, enabling women, men and young people to realise their full potential in safe and supportive environments. AC was launched in September 2014 and is managed by a Fund Manager, which coordinates a consortium of three organisations: Mannion Daniels (lead, located in Bath, UK), Global Fund for Women and the African Women's Development Fund. AC runs a model of grant-making that provides competitive grant-funding to organisations of various sizes via four grant types. The focus is on advocacy and small grassroots organisations, but they are also providing network grants and

support INGOs. AC covers five priority themes, including FGM within its wider Gender-Based Violence theme, and is as such not an FGM-specific funding mechanism. AC was chosen as partner based on a limited bid.

At a general level, AC grantees organise their project results frameworks around five core outcome areas – Movement Building, Policy & Law Change, Access to SRHR Resources, Information and Services, Social Norms Change and Increased Awareness of SRHR as a Human Right. Movement building and social norms change are results most frequently prioritised by AC grantees, especially those working closer to community levels through AC's Opportunity and Strengthening grants. The outcome areas are all relevant for efforts to prevent FGM, but we do not have information about what has been the focus of the organisations working particularly with FGM.

AC also assists beneficiaries in building networks and linking small groups together. As pointed out by the Mid-Term Review, the Fund supports work that is focused on the longer term and change cannot be expected after two years of implementation. As a follow up, AC is preparing to offer long-term, results-based financing to support existing successful grantees to build on and further develop their initial projects.

Norway advocated for a stronger emphasis on FGM within the SRHR frame and offered AC the possibility to apply for earmarked funding for FGM. This gave AC the possibility in mid-2016 of running a small grant-funding round just for FGM and child, early, and forced marriage. In July 2017, AC submitted an addendum request that proposes an 'enhancement project' that will focus on improving the effectiveness and institutional capacity of current FGM grantees and developing and disseminating the knowledge generated from their work. Partnerships and interaction have been established with other organisations specialising in FGM and GBV such as the Orchid Project, which will be developed to further strengthen technical support offers to FGM grantees.

Based on its experience and reports from beneficiaries, AC has produced a 'learning memo' on FGM. It states, "AmplifyChange is supporting 48 grants to end and prevent Female Genital Mutilation / Cutting". The grants cover 20 countries in Sub-Saharan Africa and South Asia. The memo summarizes challenges and successes in seven points and eight strategies they consider successful.³⁴

³⁴ One may note that the successful strategies identified by AC are very much in line with the approach recommended in the PRB report presented above. In particular, "a holistic and sustained response to FGM/C is required, one that adopts a rights-based approach and is rooted in the local context and communities and which transforms social norms that drive the practice". Furthermore, "all relevant stakeholders need to be involved, including young women and men, parents and other family members, religious and traditional leaders, community-groups and NGOs, faith-based organisations, activists, cutters, medical professionals, educators and government officials". AC also emphasises the need to support for women and girls who have been cut.

AC reports focus on the outputs of the fund manager and the activities of the recipients. In terms of outcomes and impact, the data is anecdotal in form of short case stories highlighting successful examples. The beneficiaries claim that the combination of funding, capacity building, networking, and sharing the fund offers is of great value.

According to the fund's theory of change, mobilisation at the grassroots level and advocacy will lead to normative change in the communities as well as changes in policies and laws. The Mid-Term Review published in 2016 concluded, "Eventually, the Fund should be evaluated based on the change that the grantees will manage to make" (p.32).³⁵ As mentioned, examples of such changes are given in the reports. Given its set-up and the fact that it is branded as an 'advocacy fund,' it should not be expected that AC will be able to produce data on how many cases of FGM have been prevented or how much FGM has been reduced due to support from the fund. Most likely, there will be large variations regarding the extent to which 'change is happening', and more data and evaluations are necessary to document that.

In the meantime, the interest of the fund is to contribute to supporting, strengthening and connecting small organisations that otherwise might not have been able to access funding. Many of the supported organisations are reported to make important contributions at local and national levels in terms of mobilisation, awareness building, and de-mystification of FGM. To obtain lasting effects at national levels, smaller organisations such as those supported by AC will mostly depend on collaboration with other actors to create a coordinated, holistic approach. The reports have little or no concrete information on these aspects. AC has proved its value in terms of building capacity, networks and coalitions. Whether these achievements give reason to expect results that are more concrete in the future remains an open question.

3.8 Population Council

With financial support from Norad, since 2016 Population Council (PC) Nairobi has led a FGM Research Capacity Building project that aims to improve the quality, effectiveness, and efficiency of policies, programmes, and investments for the elimination of FGM. PC was chosen as partner based on a limited bid. The project aims to: (1) strengthen the use of indicators and measurement processes and (2) intensify the use of research-based evidence in decision-making. The project provides technical support to NCA and SC and their project partners in Somaliland, Somalia, and Ethiopia. As PC rightfully points out, for actors working on FGM, lack of routine tracking, documentation and reporting of programme activities has been a known challenge. Like the CHANGES programme, PC started their activities early in 2016, and it is too early to expect reports on concrete results of the support.

³⁵ Mid Term Review of AmplifyChange. Ministry of Foreign Affairs Netherlands / MDF Training & Consultancy BV, the Netherlands, December 2016.

PC has assisted Somaliland Family Health Association (SOFHA) to identify its needs in terms of M&E and provided technical support to strengthen its systems and develop its capacities.³⁶ In the first phase the collaboration concentrated on developing an M&E plan and data collection tools. A simple Excel-based management information system was designed to track FGM interventions and programme indicators. In 2017 PC could focus on assessing the uptake of technical assistance to implement their new M&E functions and review the programme design and its theory of change. PC facilitated an orientation workshop for partners to cascade the documents. A series of workshops aimed to build capacity of SOFHA staff, youth volunteers as well as junior staff from the Ministry of Employment Social Affairs and Family (MESAF). In Somaliland, PC has worked with the Ministry of Labour and Social Affairs (MOLSA) to come up with a draft of National FGM indicators. PC has also had several consultation meetings with key ministries in Ethiopia, Somaliland, and Puntland that highlights the importance of the need to track and measure performance of multiple partners seeking abandonment of FGM in the region.

In February 2017, PC also initiated technical support to the NCA-SC team in Puntland and South Central, Somalia. In May 2017, basic training on M&E for FGM programming was given to field staff, implementing partners, and government stakeholders. In August, PC brought seven staff from the NCA/SC team along with some implementing partners to Nairobi to participate in a capacity-building workshop. The project was then in a no-cost extension phase up to June 2018. After discussing with NCA and SC about the possibilities of streamlining their data and improving their data management information system, PC proposed an automated management information system (MIS) that would aid easy tracking of programme indicators and data accessibility amongst all levels of program staff for course correction and decision making. An MIS prototype was developed and put into use in September 2018. The system is reported functional with some limitations.

In Ethiopia, NCA/SC staff developed a new M&E system with technical guidance and quality assurance provided by PC. In 2017, PC facilitated M&E training for NCA/SC and partners including indicator definition and revision, and a M&E plan was developed. PC conducted capacity building and experience sharing with the Somalia partners. A comment from NCA/SC is that there were high expectations on PC to provide research-based evidence on FGM specifically, which were not fully met. The fact that both NCA and SC already have their own M&E system in place with M&E staff created some confusion and overlap.

In terms of research, PC has, in close collaboration with the Orchid Project, supported SOFHA to complete a baseline for their project and led discussions with NCA/SC around programme gaps and needs for evidence. A knowledge-sharing workshop, involving over 40 policy makers and programme implementers working to end FGM in Somaliland, aimed at piloting a new

³⁶ SOFHA is affiliated with IPPF and has received earmarked funding for FGM prevention through Norway's support to IPPF.

approach to disseminating research findings to increase the impact of research findings on decision making in programme, policy, and investments in FGM. Otherwise, due to busy implementation schedules, implementing partners have not had the capacity to initiate research activities in 2017. PC recommends further training in generation of high-quality research and use of research evidence.

PC and SC Nairobi have organised two research workshops that have resulted in two concept notes but plans to advance this work further do not exist and PC's possibility of contributing is not clear since Norway's support has ended.

According to PC, the "project has made a lot of progress in terms of improving partners' capacity to measure, document and report on the implementation of their FGM/C projects." (Annual report for 2017, p.19). SOFHA and NCA/SC's implementing partners in Somalia are apparently the organisations that have benefitted most. The project has shown that due to limited resources and short-term funding, the smaller implementing partners find it difficult to prioritise having dedicated staff members to conduct M&E tasks and research activities. NCA and SC both have solid M&E competence and appreciate PC's input and presence at several meetings. SC Nairobi, however, reports that they have received some useful input, but not much more than that. NCA reports that rather than general M&E competency, it would have been more useful to get more specific and specialised competency in FGM monitoring and particularly in how to use qualitative methods. According to PC, efforts to arrange more specialised competencies and one-one technical support were a challenge with NCA/SC Somalia, given staff were working on multiple projects, were based in the field, and had busy schedules.

Norway's Strategy did not state that Norway will invest in building evidence and strengthening M&E systems, but investments in better M&E systems – and research – will be key to guide further funding and programmatic efforts. It still too early, though, to assess the real value of the PC contribution since no report has yet been produced by the partners based on the new M&E frameworks. The moderate satisfaction expressed by NCA and SC indicates a need to rethink how PC best can support larger organisations before further support should be considered. Staff turnover and limited capacity in smaller organisations such as SOFHA demonstrates the need for continuous external support in this area.

3.9 World Health Organization

Norway has provided earmarked FGM funding since 2015 to the Department for Reproductive Health and Research where the Human Reproduction Program is located.³⁷ During this period,

³⁷ The documents reviewed for this assessment present the activities of the programme in general terms and do not specify how the Norwegian funding has been used or how Norwegian funding compares to the overall funding of FGM related activities. In addition to Norwegian funding, the FGM activities have been sponsored by UNFPA-UNICEF Joint Programme.

RHR/HRP has scaled up its FGM related programme, an effort that has led to important resources for the health sector, such as clinical guidelines for health service providers, a clinical handbook on prevention and care, and scientific evidence through primary research and reviews of the evidence published in peer-reviewed scientific journals.³⁸

In terms of resources for the health sector, in May 2016, WHO launched the "WHO guidelines on the management of health complications from female genital mutilation", the first evidence-based clinical guidelines on the management of complications of FGM. This has been realised in collaboration with the UNFPA-UNICEF Joint Programme. Ten quantitative and four qualitative systematic reviews were finalised to inform the development of recommendations for the guidelines. In 2018, WHO launched a new clinical handbook to help health care workers provide health care to meet the specific needs of girls and women who have been subjected to FGM. This handbook transforms the evidence-based recommendations of the WHO FGM guidelines into a practical tool for everyday use to aid health care providers to prevent and manage the health complications of FGM. It includes separate chapters on how to provide support and care on mental health and sexual health issues and how to communicate effectively with patients. The guidelines and handbook have been disseminated at workshops and seminars for member countries at regional offices in Europe and Africa at meetings of professional associations (e.g., International Confederation of Midwives, International Federation of Gynaecology and Obstetrics) as well as other international conferences and meetings. For the future, RHR/HRP should be asked to report on the use of the various tools and guidelines and whether the use of them has any measurable positive effect.

WHO has published numerous evidence reviews to inform clinical decision-making and care, including a systematic review summarising the existing measurement tools for assessing knowledge, attitudes, and practices (KAP) of health care providers in caring for women living with FGM.

WHO is contributing to the prevention of FGM by providing technical support to countries in the development of action plans that include prevention activities and in generating evidence on prevention interventions. So far, there have been few initiatives to respond to the need to prevent the medicalisation of FGM, which is increasing in many countries. A commentary on the issue was co-authored by RHR's director and a published systematic review describes the motivations of health care providers in the medicalisation of FGM. Since 2017, WHO is carrying out a multi-phase, multi-country implementation research study in three countries to test the implementation of a prevention intervention targeting nurses and midwives working in antenatal care settings at the primary health care level. This research initiative will provide much needed evidence about the potentially important role of the health sector in promoting prevention of FGM. RHR/HRP is supporting five countries currently (more to be added) to

³⁸ Links to the various publications can be found on this webpage:
<http://www.who.int/reproductivehealth/publications/fgm/en/>

implement activities around prevention of medicalisation using the four pillars of activities outlined in the global strategy against medicalisation. In Sudan, the global strategy against medicalisation has been operationalised and they are using this experience as a case study to inform the active support of the other five countries. Recently a formative research study was completed in Guinea to understand the medicalisation of FGM and the current health system approach to address the health complications of FGM.

RHR/HRP is developing a facility-based surveillance system to be piloted and implemented in health facilities in high prevalence countries and in diaspora countries receiving immigrants from FGM practicing areas. They are also leading a health and economic cost study to quantify the health and economic costs of FGM and the potential cost savings to countries of implementing prevention programmes and evidence-based interventions to prevent and reduce the negative health consequences of the practice among women and girls living with FGM.

The guidance and tools as well as publications and accompanying activities clearly show that RHR/HRP has become an important actor in terms of documenting the health burden of FGM and strengthening health systems' response for prevention as well as care and treatment of women and girls living with FGM

3.10 Other NGOs

Several Norwegian organisations and one Faith Based Organisation in Egypt have received smaller amounts to support FGM projects.

Table 2: NGOs supported to implement FGM programmes according to recipient country. Amounts in 1000 NOK. (Source: Norad's department for statistics)

Recipient country NO	Agreement partner	2015	2016	2017
Egypt	BLESS	1 545	750	750
Kenya	Digni	2 175	968	
	FOKUS	525	515	540
	KFUK-KFUM Global	3 272		
	Kirkens Nødhjelp	528		
Mali	Kirkens Nødhjelp	1 270		
Sierra Leone	FORUT	829	825	765
Sudan	Kirkens Nødhjelp	1 439		
Tanzania	FOKUS	1 535	1 505	1 537
	Kirkens Nødhjelp	204		

BLESS is an acronym for *Bishopric of Public, Ecumenical and Social Services* that was founded by the Coptic Orthodox Church. As part of its health and environment programme, they organize seminars and health classes that have combating FGM as one of its aims. More generally, to raise

the awareness of people on health and environmental topics they organize public meetings, health classes, and home visits.

FOKUS is supporting projects to increase understanding in communities on the effects of FGM, as well as legislation against the practice and its application in project districts in Tanzania and Kenya. They are also training health workers to integrate information about the causes, effects, and prevention of urinary tract infections and 'lawalawa' in dialogue with the community/patients.³⁹

DIGNI worked for the period 2012-2016 with the Free Pentecostal Fellowship in Kenya (FPFK) to mobilise churches in southern Kenya to advocate for the end of FGM and early and forced marriages. The approach was to enable 'gender discussions' in local decision-making bodies in Maasai areas, to introduce alternative passage rites, to mobilise Maasai churches to spearhead awareness and advocacy activities, and to enable church leaders and members to become anti-FGM champions. They have also worked to persuade 49 circumcisers to end their practice. The project report states, "the evaluation report provides evidence and qualified assessments to support the conclusion that the project has achieved a fair degree of impact in the area" (p.52). It also states, "while the churches have shown promising leadership, it remains to see how effectively the results may be sustained" (p.52).

KFUK/KFUM have phased out their FGM programmes, and we have not been able to assess the FGM interventions they have supported. This is also the case for the NCA projects in Mali and Tanzania. In Sudan, NCA ran awareness and media activities that reportedly have changed attitudes among those who were reached. Forut does not have a specific FGM program in Sierra Leone but is addressing FGM in a broader program for women's health and gender-based violence.

Overall, the documentation of the effect of such small-scale projects is weak and there is reason to believe that the impact in many cases is quite limited and not sustainable. As for the organisations and projects supported through AmplifyChange, they can make a valuable contribution if there is a well-coordinated holistic effort, and they can help to put the issue on the political agenda locally, nationally and globally. Similarly, the support can be important for the benefitting organisations in terms of building experience and capacity. A decision, however, to cut support should be based on more thorough assessments and evaluations of each programme and their respective achievements than what was possible for this evaluation.

3.11 Some general observations

Methods and approaches

³⁹ 'Lawalawa' is used to describe certain vaginal and urinary tract infections. One of the reasons that FGM is being practiced in Tanzania includes the belief that *lawalawa* is cured by *FGM*.

Many organisations are using similar approaches on the ground. They are combining community mobilisation, training and involvement of community and religious leaders, with advocacy work at district, national, and regional levels. Most programmes and particularly those working at a large scale also aim at changing policies and seek to influence the governments' position and support to end FGM. All the supported organisations support and work in collaboration with local NGOs and community-based organisations and emphasise capacity building and local ownership.

The UNFPA-UNICEF Joint Programme, NCA/SC and FOKUS address the need to improve access to relevant health services and to train health personnel. Although Tostan collaborates with health workers for vaccination and education activities, Tostan and CHANGES have little involvement with the health sector as such. Only UNFPA-UNICEF Joint Programme and WHO address the medicalisation of FGM, but even then, only to a limited extent.

In Ethiopia, NCA/SC engages boys in the intervention areas to decide publicly to be change agents and protect girls from all forms of FGM, and in Somalia they train male youth/boys to serve as role models and change agents. Tostan also teaches boys and men about the consequences of FGM and has them participating in their *Community Empowerment Program* (CEP). The CHANGES programme is seeking to involve boys and men in the gender norms programme. The other programmes appear not to have any particular focus on involving men and boys.

M&E and research

UNFPA-UNICEF Joint Programme, Tostan, and NCA/SC have all made important efforts to improve their M&E systems and have combined this with surveys to collect data on attitudes and to some extent on behaviour. This is an interesting and commendable development since there has been a lack of data on the effect of most programmes. The Population Council contributes to further professionalisation of this work, but reports based on their input and suggested monitoring frameworks have yet to be submitted. Developing solid M&E frameworks and routines takes considerable resources, as some of the NGOs that the Population Council works with in Somalia have experienced. Organisations with more resources and more technical staff are more likely to be able to document their results and to use this information to further improve their programmes. Smaller organisations need partnerships and external assistance that they do not have to pay for.

Particularly in the case of Tostan and the UNFPA-UNICEF Joint Programme, but also with respect to NCA/SC, these organisations base their programmes on a belief that public declarations of abandonment serve as an indicator of changes in the practice, but none of them have conducted studies providing solid evidence on this. Reduced cutting rates have been found in studies that compared Tostan intervention villages to control villages in Senegal, and NCA/SC has recently documented reduced cutting rates in many parts of Ethiopia. However, the evidence

of the importance and effect of public declarations *in different contexts* is still weak. As pointed out above, Tostan and UNFPA-UNICEF Joint Programme also have data showing that attitudes to FGM have changed significantly, but a few studies question the validity of surveys asking directly about attitudes towards FGM.

Norwegian Knowledge Centre for the Health Services in 2012 conducted a review of the effectiveness of FGM interventions. One of their conclusions was that “[t]he low quality of the research designs of the studies evaluating FGM/C interventions points to the need for additional and stronger research” (Berg and Denison 2012: 143).⁴⁰ Similarly, the Population Council assessment of the quality of intervention studies concluded, “the body of evidence from January 1, 2000 through August 31, 2016 produced by studies investigating the impact of interventions to end FGM/C is of low quality” (p.19).⁴¹ The findings of this review corroborate the conclusion that we have huge gaps in the research regarding the effect of the various programmes and approaches. We still need more rigorous research and in-depth evaluations to be able to tell what works and what does not work in terms of preventing FGM in various settings. More surveys and studies are needed to document changes in the practice. There’s a need to develop new methods to investigate attitudes and practices, to realise facility-based surveillance systems, and to provide more qualitative studies in communities where FGM is common.

4 Review questions

- What should Norway prioritise in future efforts against FGM, with emphasis on types of programmatic interventions and funding channels?

There is a need for long-term commitment to initiate and sustain change and to build competency. Continuity clearly has a value in itself. It takes time for an organisation to build capacities, structures and systems and it takes time to build experience, credibility, and trust in the context within which these would operate. No approach to FGM has been shown to give results in the short term. Although we still lack solid data in most countries on effects of programmes in terms of lasting reductions in cutting rates, we have good indications of changes in attitudes and opinions that provide good ground for further efforts. It would be hard to defend reducing the support to any of the organisations included in this end review based on their performances. However, there is reason to question the effect and sustainability of the contribution of smaller organisations and programmes.

In terms of programmatic and intervention approaches and channels, the focus should clearly be to continue supporting comprehensive, holistic programmes. Some programmes such as Tostan and CHANGES may need to look at the need to contribute to the provision of health and support services for women living with FGM. Given limited and slow change in several countries, the

⁴⁰ Berg, R. C., & Denison, E. (2012). Effectiveness of interventions designed to prevent female genital mutilation/cutting: a systematic review. *Studies in family planning*, 43(2), 135-146.

⁴¹ Esho et al, 2017.

search for innovation and adaption of intervention methods and approaches has to continue. Larger organisations with more M&E capacity and higher geographic coverage are better placed to contribute to this than the smaller ones.

There are few – if any - alternative funding channels. An important actor and potential partner is the London-based Orchid Project, but they are already involved as partners for Tostan, AmplifyChange, and Population Council (in Somalia). Thus, the question is rather if a concentration of the support to a smaller number of projects and organisations would be more efficient and yield more impact. This is an omnipresent question concerning all types of development cooperation.

Questions have been raised whether to link FGM more closely to the general Adolescent Sexual and Reproductive Health and Rights (ASRHR) agenda and to programmes for Comprehensive Sexuality Education (CSE). Where both Early and Child Marriage (ECM) and FGM are common, the organisations normally aim to end both in the same programme. We have, however, not much evidence of how integration of ASRHR and FGM programmes can best be done. In countries and places where FGM is prevalent, ASRHR and CSE interventions ought to include components addressing the health consequences of FGM, as well as children's and young people's right to protection against harmful practices. Young people need information and interventions addressing social norms related to sexuality and sexual behaviours, and FGM is part of that picture. FGM should be integrated in general ASRHR and CSE programmes, but FGM interventions also need to address other ASRHR issues such as early pregnancies, sexually transmitted infections, and sexual violence. Adolescent girls may become parents within a few years, and influencing their opinions has the potential to prevent FGM of their own girls. Where FGM is prevalent adolescents will in most cases already have been subjected to FGM, so care must be taken not to stigmatise or give additional burden to young girls already cut.

In terms of gaps, more efforts are needed to prevent and stop medicalisation of the practice and to involve the health sector for prevention of FGM and treatment of complications. The UNFPA-UNICEF Joint Programme is taking the lead to prevent the medicalisation of FGM but has so far engaged in a limited number of activities. Much more is needed to raise awareness among the existing health work force, to prosecute health personnel performing FGM, and to include FGM prevention and care in the training programmes for health personnel. Organisations that do not have the capacity to target the health sector can contribute to raising awareness and resources for care and support for women living with FGM. A comprehensive approach at the community level includes working not only with community mobilisation and community leaders, but also with the health and the education sector. However, several of the organisations supported by Norway do not take such comprehensive approaches. More organisations should aim at involving men and boys, and there is a need to document and share promising approaches to involve men and boys.

- Whether the model with priority countries should be continued, and if so, whether the pilot countries should remain the same as in the Strategy 2014 – 2017.

Ethiopia has since 2004 been a 'pilot country' for Norway's support to end FGM, which means that it has been the only country receiving long-term specific funding for a nation-wide programme (NCA/SC Joint Programme). Norway started the work in Ethiopia with a separate action plan and a strong involvement from the Embassy supported with technical advice from Norad and an external expert group. A large number of actors have received Norwegian support to end FGM in Ethiopia (UNFPA-UNICEF Joint Programme, NCA/SC, Care Norge, Digni). In fact, all Norwegian civil society organisations working in Ethiopia were requested to implement the Action plan through their operations across different fields of development in 2003. The available data and reports are indicating that FGM has become less common in many parts of the country where the NCA/SC programme has operated, and it has become less common at the national aggregated level as well. The beneficiaries of the support have also played an important role in ensuring an institutionalised response and coordinated efforts from the government. The results are evidence of what can be achieved through sustained substantial presence and support in combination with a dedicated government. There is little reason to believe that similar results would have been possible if the same amounts of support were divided among several countries or if Norway had changed the pilot country every fourth or fifth year. Even though significant progress has been made, there are still many needs in Ethiopia. It is preferable to continue to build on what has been achieved and to maintain momentum. It is a large country with a large population, and there has been only modest progress particularly in the regions where there is more resistance to change, such as in the Somali and Afar regions. Shifting from Ethiopia to another country could potentially undermine what has been achieved so far.

A question one may ask is whether the Ethiopian government now should be expected to take over responsibility for funding FGM prevention, which would make it possible for Norway (and others) to focus on other countries with even fewer resources. That would require a carefully designed phase-out period to avoid losing the momentum and risking that what has been achieved could fall apart. The Ethiopian government is coordinating the work against FGM and other harmful practices, and the community health workers have an important role on the ground. The NGO's still rely on other sources to support their community programmes and would certainly prefer not to depend on the government. Norwegian support is not only about financial support, but also about capacity building and strengthening of organisations and structures. One must consider carefully what the consequences of ending or reducing substantially the support can have on these aspects.

Somalia was added as a pilot country for the period 2014-2017. Compared with the embassy's efforts in Ethiopia, the Norwegian embassy (in Nairobi) is less involved and the support is more limited to the funding of activities. It is too early to assess whether the approach will work the same way as in Ethiopia. Ethiopia has a strong and dedicated government taking the lead in

ending harmful practices whereas Somalia is very unstable and has a government that has been less able or willing to take the lead. Somalia is struggling with the aftermaths of decades of violent conflicts, and some areas are still not accessible due to the security situation. This provides for very different working environments for the joint programmes of both NCA/SC and UNFPA-UNICEF.

An option can be to establish one more pilot country and to reduce the involvement with the multi-country programmes of Tostan and AmplifyChange (and the UNFPA-UNICEF Joint Programme). This may allow for a more concentrated effort enabling the recommended holistic and multi-sectoral approach. If feasible and acceptable, support for the multi-country programmes could be earmarked for specific countries on which Norway wants to focus. A country that could be a candidate is Mali, where Norway has some history of development cooperation and where NCA has been present for a long time, working on GBV including FGM. Mali has high prevalence rates, and little progress has been observed at a national level. Data indicate a rise in the use of infibulation. Tostan reports that there is currently no law prohibiting the practice of FGM, but the government has opted for awareness-raising activities to reduce this practice. A National Program for the Fight against FGM/C was established in 2002. Like most of the countries on the stretch from Somalia to Senegal, Mali has an unstable political and security situation, making for a difficult working environment.

Another option could be to take a regional or cross-country approach and instead work with population groups that can be found in various countries, such as the Somalis who, outside of Somalia itself, have large populations in Ethiopia and Kenya as well as Djibouti, Eritrea, and Sudan.

Another question is whether Norway should give priority to countries where the government is willing and able to take a leading role such as in Ethiopia. Collaborating with such governments gives a higher chance of success. A counter argument could be that support is most needed where the government is weak and not able to take the lead. In such contexts, NGOs and the UN has a very important role both in providing interventions and services, but also in advocacy towards the government and in capacity building for officials and other leaders. People interviewed for this review report that the Government of Somalia has responded to the combination of dialogue, input, and pressure from NGOs and diplomatic representatives and now shows more commitment to address FGM.

- If the pilot countries should remain the same, what type of programmatic interventions and funding channels are recommended?

Above all, there is a need to continue strengthening, improving, expanding, and documenting what has so far yielded promising results. NCA/SC should be allowed to build on their experience in Ethiopia. It is too early to conclude whether the approaches and the channels chosen in

Somalia will be effective. Progress in the implementation of their programmatic interventions has so far been good.

- Have the funding channels set forth in the Strategy proved strategic to achieve the objectives of the Strategy, separately and collectively?
- Have the funding channels selected by Norad proved strategic to achieve the objectives of the Strategy, separately and collectively?

The total portfolio on FGM has an interesting mix in terms of types of organisations and programmes that are supported. NCA/SC and CHANGES as well as FOKUS, FORUT, and KFUK/M are focusing on one country (or perhaps two countries), whereas AmplifyChange, Tostan, and UNFPA-UNICEF Joint Programme are supporting work in many countries. AmplifyChange has a special profile and mission through their support of small NGOs and CBOs. One interesting aspect of supporting organisations operating in many countries is their possibility to facilitate networks and the sharing of lessons across country borders, as in the case of AmplifyChange, Tostan, and the UNFPA-UNICEF Joint Programme, and to a smaller extent, of NCA and SC.

In sum, one may conclude that the total portfolio has been an important contribution to the work to end FGM and in that sense the choice of funding channels has proved 'strategic'. However, the question may very well be raised for how long Norway should continue to support organisations that have been receiving large amounts for several years, notably Tostan, without more solid data on effects in terms of abandonment of the practice. For several reasons, public declarations and attitude changes are not solid enough as indicators of behaviour change. However, interesting initiatives have been undertaken the last number of years to provide more evidence. NCA/SC has produced data on self-reported changes of behaviour in Ethiopia, which is a good step forward. The UNFPA-UNICEF Joint Programme is working both to improve their M&E system, to develop tools to measure norms change, and to conduct smaller surveys that can provide more context-specific data. Population Council contributes to strengthening M&E frameworks, as well as strengthening competency and research initiatives. Tostan, the UNFPA-UNICEF Joint Programme, and probably AmplifyChange all face the same challenge in terms of uneven progress across countries, which raises questions about the consequence of spreading resources widely instead of having a narrower geographical scope. Concentrating funding and efforts in only a few countries could allow focusing for example on countries with less progress and/or countries where the government has not been willing or able to take a lead. A negative consequence of such a strategy could be reduced possibilities for networking, sharing of lessons, and partnerships across countries.

5 Conclusion

The general conclusion is that the government has realised what it said it would do in the strategy, which at an overall level was to “intensify Norway’s efforts”. Norway has expanded its support to civil society and has continued to support the UNFPA-UNICEF Joint Programme. It has also upheld Norway’s efforts to eliminate FGM in Ethiopia. Furthermore, it has, through the support to the NCA/SC joint programme and the CHANGES programme combined with dialogue with the government of Somalia, intensified its cooperation with the Somali authorities. Additional funding to WHO has served to strengthen the health sector response, whereas the Population Council has contributed to monitoring, evaluation, and research activities of supported organisations.

The choice of channels and partners have been strategic in the sense that they have all documented promising results. The bulk of funding is channelled through organisations (i.e. NCA/SC and UNFPA-UNICEF Joint Programme) using approaches that are in line with a holistic, integrated, and multi-sectoral approach, which is now established as a ‘best practice’. A reduction of the prevalence of FGM has now been documented in several countries where organisations supported by Norway are operating, but progress is still limited in other countries.

We have not assessed efforts at the political level. Norwegian officials are, however, addressing FGM and other harmful practices in high-level dialogues with the governments of Ethiopia and Somalia, and in relevant international meetings, including in the UN. In general, Norway is considered as an important voice for the promotion of SRHR and the abandonment of FGM at the global level.

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Annexes

Terms of Reference

Terms of Reference End Review Norwegian efforts to combat Female Genital Mutilation

The Norwegian Agency for Development Cooperation (Norad) will undertake an end review of the Norwegian contributions towards the elimination of Female Genital Mutilation (FGM). The end review should assess Norway's efforts against FGM over the period 2014 – 2017, in light of the Norwegian strategy for increased international efforts against FGM of girls for the period 2014 – 2017 ("Strategi for styrket internasjonal innsats mot kjønnslemlestelse av jenter for perioden 2014 – 2017"). Based on this assessment, the end review should conclude with recommendations for future Norwegian priorities for our international work against FGM.

Background:

The Norwegian Strategy against FGM 2014 – 2017⁴² sets out the background, ambition, role, method and main funding channels for the Norway's international work to end FGM. The Strategy also defines Ethiopia and Somalia as "pilot countries". Norad would like to undertake an end review of the Norwegian efforts against FGM during the period 2014 – 2017. The objective of the end review is threefold:

- i) Assess to what extent the Strategy against FGM has been operationalized. In particular if and to what extent the points stated under "Regjeringen vil" in the strategy have been undertaken/achieved.⁴³
- ii) Assess the results of efforts undertaken by Norway against FGM during the period 2014 – 2017, with emphasis on the below questions:
 - a. Have the funding channels set forth in the Strategy proved strategic to achieve the objectives of the Strategy, separately and collectively?
 - b. Have the funding channels selected by Norad proved strategic to achieve the objectives of the Strategy, separately and collectively?⁴⁴

⁴² Strategi for styrket internasjonal innsats mot kjønnslemlestelse av jenter for perioden 2014 – 2017

⁴³ This point includes the political, financial and substantial competence ("politisk, finansiell og faglig") dimensions of the Strategy to the extent possible. However, Norad wishes to prioritize review of programmes in this end review (see paragraph under "Scope").

⁴⁴ Point ii a and b should in particular be seen in relation to point 3 and the points under "Regjeringen vil" in the Strategy. Norad is interested in learning whether the most strategic funding channels/organizations have been selected to leverage the work for elimination of FGM as a whole (in terms of programmatic results, advocacy work, visibility including media coverage, change of opinions (local, national, global level). Are there strategic ways to address FGM that should have been funded?

- c. What are the methodologies used and the results achieved by the civil society organizations selected, separately and collectively?⁴⁵ Is the work of the organizations mutually reinforcing or overlapping?⁴⁶
 - d. With emphasis on the work of the civil society organizations contracted by Norad and MFA: What are the results achieved in the two pilot countries and are these satisfactory, given the context? Has there been an added value of selecting Ethiopia and Somalia as pilot countries in the Strategy?
 - i. Norway has been funding several programmes in Somalia since 2014, including two joint programmes implemented by civil society.⁴⁷ How does the methodology and the results of these two programmes compare? Do the programmes complement or overlap each other? Looking forward, should both of these programmes be continued?
- iii) Based on the assessments described under point i and ii, conclude the end review with recommendations on the following:
- a. What Norway should prioritize in future efforts against FGM, with emphasis on types of programmatic interventions and funding channels.
 - b. Whether the model with priority countries should be continued, and if so, whether the pilot countries should remain the same as in the Strategy 2014 – 2017.
 - i. If the pilot countries should remain the same, what type of programmatic interventions and funding channels are recommended?

Scope:

The end review should answer the objectives and questions listed above but focus on the programmatic support provided by Norad and MFA, including Norwegian Embassies, to civil society organizations. Further, assessments of the work in Ethiopia and Somalia should be prioritized as these are the two pilot countries set forth in the Strategy. Somalia was a new pilot country in the Strategy for 2014 – 2017, and Norad would therefore like to place particular emphasis on Somalia in this review.

The end review should be based on existing reports, assessments and evaluations to the extent possible. The UNFPA-UNCIEF Joint Programme against FGM (JP) is an important part of the Norwegian portfolio against FGM. An evaluation of the JP is ongoing, commissioned by UNFPA and UNICEF. The findings of this evaluation should be included in the end review commissioned

⁴⁵ The results achieved by the CSOs should be assessed for each organization with specific programmes against FGM where each organization's results should be assessed against the targets they set forth in their proposal and results framework. The CSO portfolio as a whole should also be reviewed to assess to what extent the collective CSO support has been strategic to achieve the objectives in the Strategy.

⁴⁶ This is particularly relevant for Somalia, where Norway supports both the NCA and Save the Children joint programme against FGM and child marriage, as well as the NGO Consortium led by Save the Children against harmful social norms and practices (SNaP).

⁴⁷ One joint programme by NCA and Save the Children, funded by Norad's department for civil society and one JP with DFID, implemented by a NGO consortium led by Save the Children, funded by the Norwegian Embassy in Nairobi.

by Norad, given that it is made available within reasonable time for the Norad commissioned end review to conclude. Norad will not commission a parallel evaluation or review of the JP.

Timeframe:

The end review should be approved by Norad within 4 months after the call-off has been signed by both parties.

Travel:

Travel to one or more countries can be undertaken as a part of the end review. The need to conduct travels should be decided in dialogue with Norad after the first phase of the desk review.

Language:

The end review shall be written in English.

Norwegian strategy for increased international efforts against FGM

Strategy for intensifying international efforts for the elimination of female genital mutilation for the period 2014–2017

What is female genital mutilation?

Female genital mutilation (FGM) is a practice related to culture, tradition and religious belief. Its origins are not known for sure, but it is most often linked to a wish to preserve girls' and women's chastity, ensure that they are accepted for marriage, and control their sexuality. FGM is a violation of the human rights of girls and women, and its negative health consequences are significant and far-reaching.

Definition.⁴⁸ A distinction is usually made between the following four types of FGM, depending on how invasive the procedure is:

1. Clitoridectomy: partial or total removal of the clitoris
2. Excision: partial or total removal of the clitoris and the labia minora (the inner 'lips' that surround the vagina)
3. Infibulation: narrowing of the vaginal opening through the creation of a covering seal. The seal is formed by cutting and repositioning the inner, or outer, labia, with or without removal of the clitoris.
4. Other: all other harmful procedures to the female genitalia for non-medical purposes, e.g. pricking, piercing, incising, scraping and cauterising the genital area.⁴⁹

Recently, we have seen a move away from infibulation to a practice known as 'Sunna' in several regions where infibulation has traditionally been carried out. In purely surgical terms, 'Sunna' is supposed to be a minor procedure, but the degree of cutting varies.

The terms used have been the subject of much debate. Many people consider it appropriate to use the term 'genital mutilation', as this makes their standpoint on the practice plain and clearly reflects how it differs from male circumcision. Others are of the view that the term 'female circumcision' gives a more accurate impression of how those engaging in the practice experience it and understand it. In Norway, the term 'genital mutilation' is generally used in public documents, and it has also been selected as the term to be used in this strategy document.

⁴⁸ Report by Marit Berggrav published by the Norwegian Agency for Development Cooperation (Norad), September 2011, in Norwegian only (Rapport 13/2011 Diskusjon: Kjønnslæmlesting. Hva skjer, og hva gjør Norge? Erfaringsnotat av Marit Berggrav)

⁴⁹ Definitions here taken from WHO fact sheet No. 241 on female genital mutilation, updated February 2014. Available here: <http://www.who.int/mediacentre/factsheets/fs241/en/>

Norway's ambition

Norway will work to ensure that no girls are subjected to FGM, and that those who already have been are given the best possible care.

1. The current global situation

According to WHO estimates, **between 125 and 130 million women alive today have been cut, and more than three million girls are at risk of being subjected to FGM annually.** In a number of countries where minority groups carry out the practice, there has been a decline. This can be seen when statistics for different age groups are compared. For example, in Kenya and Tanzania, women in the age group 45–49 years in the ethnic groups that carry out the practice are three times more likely to have undergone FGM than girls in the age group 15–19 years. In Sudan and Somalia, the majority of women have undergone FGM, and in countries like these there has been little or no decline in the practice. Although we are witnessing a decline in FGM in most countries where the practice is widespread, the World Health Organization (WHO) has registered an increase in the actual number of girls subjected to FGM, due to population growth. The practice is often closely associated with child marriage and too-early pregnancy, because FGM is the ritual seen as preparing girls for sexual activity. The practice is most prevalent in Africa, in a band that stretches across the continent from Ethiopia in the east to Senegal in the west. FGM follows ethnicity and cultural affiliation, and is practised mainly by Muslims and Christians, across all social classes. In North Sudan and Somalia, it is estimated that more than 90 % of women have been subjected to FGM. The practice is also found in diaspora communities in a number of European countries and in the US. Monitoring developments in the practice is difficult.

Experience from efforts to combat FGM so far has shown that other problems, such as a lack of water, food and education, are often felt to be more pressing.⁵⁰ Having said this, other development efforts can have positive ripple effects for the work to combat FGM. Education helps give girls higher social status, as well as the knowledge and power to make their own choices, and the ability to support themselves – and in due course their families.

Several studies indicate that the practice of FGM is changing, in that the girls who are subjected to it are steadily becoming younger. Paradoxically, in some places this may be due to the introduction of legislation prohibiting FGM, as it is easier to carry out an illegal procedure on a younger girl without being discovered. Moreover, there is a growing medicalisation of FGM, i.e.,

⁵⁰ Report by Marit Berggrav published by the Norwegian Agency for Development Cooperation (Norad), September 2011, in Norwegian only (Rapport 13/2011 Diskusjon: Kjønnslemlesting. Hva skjer, og hva gjør Norge? Erfarings notat av Marit Berggrav)

it is increasingly being performed by healthcare personnel. It is estimated that around 18 % of cases of FGM are carried out by healthcare professionals, and this is a growing trend.

2. Global momentum for intensified efforts for the elimination of FGM

Over the last ten years, there has been a breakthrough with regard to efforts to combat FGM, and in many of the most affected countries there seems to be growing momentum for change.⁵¹ Many years of work in this field have led to effective methods being found, which in turn are expected to lead to investments in measures that may have a greater impact. These methods draw on social convention theory, according to which genital mutilation is seen as a social norm – something people do because others do it, and to avoid social exclusion. In order to encourage behavioural change, it is important to create arenas for dialogue on FGM in local communities; arenas that facilitate collective reflection on the communities' own practices and enable the people to find their own solutions. It is easier to establish dialogues of this kind in programmes that focus more broadly on health, gender equality, education and other aspects of local community development.

Another important breakthrough in this work was the adoption by the UN General Assembly in 2012 of the resolution Intensifying global efforts for the elimination of female genital mutilations, which was cosponsored by the African Group. The resolution is an important global instrument that can promote the development of concrete policies at country level in the fight to eliminate FGM.

3. Norway's role and international efforts to eliminate FGM

In the Government's political platform, the work to prevent female genital mutilation is specified as a priority. Norway is already one of the main contributors to efforts in this field. In 2003, the *Norwegian Government's International Action Plan for Combating Female Genital Mutilation* was launched, for the period 2003–2013. Under this action plan, most of Norway's support has been provided for preventive efforts and social mobilisation against FGM. Since 2007, Norway has channelled between NOK 40 and 60 million annually to the UNFPA-UNICEF Joint Programme on Female Genital Mutilation/Cutting and to a number of civil society organisations.

The Government will now intensify Norway's efforts in this area by providing political, technical and financial support for the work to eliminate genital mutilation.

4. How will Norway seek to intensify efforts to eliminate FGM?

a) Channels to be given priority

⁵¹ *Female Genital Mutilation/Cutting: A statistical overview and exploration of the dynamics of change*. UNICEF report, July 2013.

Norway will continue to provide support through many of the same channels as it does now, but it also intends to increase its support to civil society organisations, including diaspora organisations and international organisations working to eliminate female genital mutilation.

The Government will:

- **Double its allocation to civil society and international organisations working to eliminate FGM, from NOK 25 million to NOK 50 million, as of 2015.**

The UNICEF and UNFPA Joint Programme on Genital Mutilation/Cutting is the world's largest programme against genital mutilation. UNICEF and UNFPA have supported the authorities at country level in coordinating efforts to combat FGM and they also play an important role in monitoring developments. Norway is a strong supporter of the programme and worked actively to establish it in 2007. Norway has concluded a new agreement for the period 2013–2017, under which it will provide an annual allocation of NOK 20 million. The programme, which cooperates with a range of civil society organisations, covers 15 African countries and has helped to ensure that several thousand local communities have publicly declared that they have stopped practising FGM. The programme has also supported the development of national laws and policies prohibiting FGM or aiming to eliminate the practice. To a large extent, its role has been one of contributing to the coordination of efforts, providing guidance, and promoting the exchange of experience and the development of policies.

The Government will:

- **Continue to be a strong supporter of the UNFPA-Unicef Joint Programme on Female Genital Mutilation/Cutting and maintain its financial support for the programme in the 2014–2017 period through an annual allocation of NOK 20 million.**

The World Health Organization (WHO), given its global mandate in the field of health, is a relevant channel in the context of efforts to prevent FGM and treat medical complications arising from the practice. In Norway's view, WHO has an important role to play in helping to enhance knowledge about FGM and promoting the training of health workers. Health care personnel still have too little knowledge about the prevention of FGM and how to treat the medical complications caused by it. Health workers, in their meetings with individuals and in their dialogues with local communities, can play an important role in preventing FGM. They also play a key role in treating those who have been subjected to FGM, by dealing with acute complications such as bleeding and infections, and long-term effects such as pain, cysts and problems related to intercourse, pregnancy and childbirth. Moreover, health workers have an important role to play in dealing with the psychological effects of FGM, and in offering treatment for women who want surgery to correct the damage caused by FGM.

The Government will:

- Work to strengthen WHO's efforts to eliminate FGM, including its efforts to combat the medicalisation of the practice
- Support competence-building measures for health workers in the prevention of FGM and treatment of medical complications caused by the practice

b) Relevant arenas and synergies

Norway will intensify its efforts to combat FGM by making more active use of relevant arenas where Norway has a certain standing and can exert influence.

This means that the issue of FGM will be mentioned in presentations and speeches and will be raised in talks at senior official and political level.

FGM is often a matter of controlling female sexuality, and efforts to combat the practice need to be seen in the context of gender equality, and as an important component of efforts to promote sexual and reproductive health and rights.

The UN system plays a key role in setting norms and providing guidance, and as an arena for international cooperation. Norway can play an active role in a range of UN organisations by participating in their boards and in other forums. The mandates of many of these organisations touch directly on the issue of FGM.

The post-2015 agenda

It is crucial that the issue of FGM is included in the post-2015 agenda, so that the abandonment of FGM is included in the national goals of countries where it is practised.

The Government will:

- **Use global normative processes to combat the practice of FGM**
- **Give priority to active participation, cooperation and mobilisation in the UN Commission on Population and Development, the UN General Assembly, the UN Human Rights Council, the UN Commission on the Status of Women and World Health Assembly with a view to intensifying efforts to eliminate FGM**
- **Cooperate closely with UNICEF, UNFPA, UN Women and WHO in their efforts to combat FGM, and seek to cooperate with the African Union to promote follow-up of the UN resolution on intensifying global efforts for the**

elimination of female genital mutilations (2012) and of other relevant international instruments

- **Work for the inclusion of the issue of FGM in the efforts to promote sexual and reproductive health and rights**
- **Cooperate with like-minded countries, in the first instance countries where FGM is practised, with a view to intensifying efforts to combat FGM**
- **Enhance synergy between the efforts to combat FGM and other development policy priority areas, for example through follow-up of the forthcoming white paper on human rights and in the white paper on education and development.**

c) Strengthening the links between efforts to combat FGM in Norway and abroad

Some of the diaspora communities in Norway originate from countries that are among those with the highest prevalence of FGM, such as Eritrea, Ethiopia and Somalia. Many of the people in Norway originating from these countries are actively engaged in the issue of FGM, and engage in efforts to combat the practice in Norway as well as in their countries of origin. In our view, it is clearly worthwhile to exchange experience from efforts to combat FGM in Norway and abroad. Together with the Ministry of Children, Equality and Social Inclusion, we will seek to find ways of doing so in our continued work in this area.

d) Pilot countries

In addition to engaging in multilateral efforts to combat FGM, Norway intends to strengthen its cooperation with specific countries that have clear links to diaspora communities in Norway, and that are among the priority countries for our support to the UN.

Somalia

Somalia is one of the countries with the highest prevalence of FGM. According to UNICEF, 98 % of girls in Somalia have been cut. However, while the prevalence of FGM in Somalia is almost universal, recent research⁵² indicates that the prevalence of the practice in the Somali diaspora in Norway is declining dramatically. This is thought to be due to greater awareness of the negative health effects and of the lack of a basis for the practice in Islam, as well as the social environment in Norway. In Somalia, Norway is providing support for projects to combat FGM run by civil society actors and international organisations.

⁵² Gele, Abdikadir Ali; Kumar, Bernadette. N; Hjelde, Karin Harsløf; Sundby, Johanne (2012). Attitudes towards female circumcision among Somali immigrants in Oslo: a qualitative study. *International Journal of Women's Health*, 2012, Volume 4.

The Government will:

- **Seek to intensify its cooperation with the Somali authorities on enhancing prevention of FGM in Somalia**
- **Assess possible channels for more targeted support as of 2015.**

Ethiopia

Norway has been engaged in efforts to eliminate FGM in Ethiopia since the mid-1990s. Currently, Norway supports two projects in Ethiopia under the UNFPA-UNICEF Joint Programme. This support will be continued. In addition, Norway supports a strategic partnership launched by Save the Children Norway-Ethiopia and Norwegian Church Aid-Ethiopia, to fight FGM in the country. There has recently been an evaluation of the UNFPA-UNICEF Joint Programme and a mid-term review of the strategic partnership (in 2013), and both initiatives received favourable reviews.

The Government will:

Continue Norway's efforts to eliminate FGM in Ethiopia.

This report was commissioned by Norad and the evaluation was realised by Chr. Michelsen Institute (CMI). Joar Svanemyr is the main author of the report. Camilla Gianella at CMI and Ragnhild Elise Johansen, external consultant to CMI, provided inputs to drafts of the report. Norad reviewed and commented on the draft report but the views and opinions expressed in this report are those of the author and do not necessarily reflect the official policy or position of Norad.

Chr. Michelsen Institute (CMI) is an independent, non-profit research institution and a major international centre in policy-oriented and applied development research. Focus is on development and human rights issues and on international conditions that affect such issues. The geographical focus is Sub-Saharan Africa, Southern and Central Asia, the Middle East and Latin America.

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