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A Comparative Evaluation of FOKUS FGM projects in East Africa

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This report is dedicated to all the women and girls who have undergone FGM, and especially to those who have had the courage to fight this practice.

"We have a bitterness in us that motivates us to work against FGM, and we still ask ourselves why it was done to us".

Village facilitator in Tanzania

Acknowledgements

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Front-page photo: Former circumcisers in Tanzania during focus group discussions.
Photo: Hanne Lotte Moen

Abbreviations

APDA	Afar Pastoralist Development Association
ARP	Alternative rites of passage
CBO	Community Based Organisations
DIAC	Dodoma Inter-African Committee on Traditional Practices Affecting the Health of Women and Children
EGLDAM	YeEthiopia Gojji Limadawi Dirgitoch Aswegaj Mahber (The former NCTPE – the National Committee for Traditional Practices in Ethiopia)
FGM	Female genital mutilation
FGM/C	Female genital mutilation/cutting
FOKUS	Forum for Women and Development
GARWONET	Gardo Women Network
HTPs	Harmful traditional practices
FGD	Focus group discussion
IAC	The Inter-African Committee on Traditional Practices Affecting the Health of Women and Children IEC Information, education and communication materials
NCA	Norwegian Church Aid
NGO	Non Governmental Organisation
NLC/o	New Life Community/organisation
SCN	Save The Children Norway
SIAC	Singida Inter-African Committee on Traditional Practices Affecting the Health of Women and Children
SNNPR	Southern Nations and Nationalities People's Region, Ethiopia
SRHR	Sexual and Reproductive Health and Rights
TBA	Traditional Birth Attendant
TGNP	Tanzania Gender Networking Programme
WILDAF	The Women in Law and Development in Africa
YWCA	Young Women's Christian Association

Excecutive Summary

Introduction
FOKUS, including involved member organizations and partners, are in the process of developing a thematic FGM programme in East Africa. In order to document results, learn from experience and provide advice for future decisions related to the FGM programme Nord/Sør-konsulentene was contracted by FOKUS to carry out a comparative evaluation of FOKUS' FGM projects in East Africa.

The evaluation team consisted of one international, one Tanzanian and one Ethiopian consultant, and field work was carried out in Tanzania and Ethiopia in October 2012.

The overall purpose of the evaluation is to analyse and compare the various approaches used and the achievements of the FOKUS supported FGM projects.

The main scope of the evaluation was the three following projects, which were visited by the evaluation team:

- **New Life Community Norway/NLCO Ethiopia**
- **The women's front/SIAC, Tanzania**
- **The women's front/DIAC, Tanzania**

Data was collected primarily through document study, interviews and focus group discussions.

The following projects were mainly assessed based on former evaluation reports[1]:

- The Development fund/APDA
- KFUK Global/KFUK Kenya
- Somalisk Forening for kvinner og barn/GARWONET

The main objectives of the evaluation were to assess achievements, approaches used and to give recommendations.

Approaches to FGM work implemented by the FOKUS partners
All the FOKUS projects are using a variety of approaches in their work to combat FGM. The approaches are generally based on local traditions and sound knowledge of the social context in which they operate. Many of them are addressing various parts of the communities, stimulating discussions and engagement among the community members themselves. This is in line with current trends and research advocating for the importance of a holistic approach based on strong local ownership, local control and participation.

All the projects are bringing awareness raising to multiple stakeholders in the local communities in which they work. Awareness raising and training among the local populations are important elements. However, measuring the impact of the awareness raising activities appears to be a challenge in many of the projects.

DIAC and SIAC have introduced alternative rites of passage (ARP) to substitute traditional celebrations, which included the practice of FGM. This approach is also used by YWCA Kenya. Although research shows mixed results from this approach the positive experiences encountered by the FOKUS project partners suggest that in these contexts the ARP is perceived to be an adequate strategy.

1 Recommendations from the earlier evaluation reports may have been acted upon recently, and subsequently positive changes may therefore have gone unnoticed by this report.

All the projects are working with circumcisers in order to make them stop carrying out the procedure, and if possible turn them into advocates for the abandonment of the practice.

Experience from Tanzania, Ethiopia and Kenya indicate that the use of theatre plays and films contribute to attract people to come for FGM sensitisation. Informative documentary films can prove to be an effective good source of information, particularly for men, who are often not aware of the details of the procedure.

YWCA Kenya and DIAC have positive experiences with inviting media to alternative rites of passage celebrations. This is contributing to attract attention to the alternative celebrations and the anti FGM work.

Main achievements
The FOKUS projects have above all contributed to putting FGM on the local agenda, making people engage in open discussions about an issue formerly not talked about, changing people's attitudes, and increasing awareness about the harmful effects of FGM. The mere existence of the projects and the fact that they disseminate information and create a pressure to abandon FGM is important in itself.

The projects may also have contributed to the reduction of FGM observed in many of the areas where they work. Results reported by project staff, community members and written reports point in the direction of drastic reductions of the FGM prevalence.

Key success factors are identified as:

- Local ownership
- Sustained interventions
- Targeting key people

The main common challenge
Assessing the exact achievements and results of the FOKUS projects is challenging. Except for recent baselines developed by KFUK Kenya none of the projects are based on baseline data. While a lot of solid and innovative work is being done on the ground, the results are often not accurately captured in the reports. Moreover, several of the projects appear to be largely focusing on activities and outputs with insufficient attention to outcomes and impacts, leading to potential underreporting of achievements and the missed opportunity to measure, learn from and exploit the impact of the programme. This results in problems related to identify what changes have actually occurred, and what changes can possibly be attributed to the specific projects.

Main recommendations

1. Future FOKUS support should build systematically on the existing experiences and lessons learned from partner organisations as well as updated research and the experiences of other organisations currently engaged in similar work, which has been evaluated and studied.

2. All FGM efforts should promote a rights based approach seeing the work against FGM as a relational gender issue, being relevant to both men and women. FGM interventions should focus on the social mobilisation of multiple stakeholders within the communities through an open dialogue.

3. All FGM interventions should emphasise local ownership through the involvement of relevant formal and informal social structures, such as government bodies, traditional CBOs and local leaders.

4. Interventions should be based on long-term commitment, and they should have clear exit strategies with concrete and realistic plans for handing over to the local communities.

5. In Tanzania it is seen as crucial to continue support of health initiatives addressing the widespread belief in FGM as the cure to vaginal and urinal infections, locally named Lawalawa.

6. FOKUS should play a more active role in strengthening the administrative capacity of the supported organisations in order to improve their results based management. National experts/organisations should be identified to undertake the necessary training or provide advisory services.

7. There is a need for all the FOKUS supported projects to improve the documentation of achieved results. It should therefore be a requirement for all FGM projects to develop baselines against which they will be able to measure results.

The way forward: Towards a consolidated FGM programme

FOKUS is currently in the process of developing a thematic FGM programme in East Africa together with relevant member organisations and partners.

The formulation of a thematic FGM programme may benefit FOKUS, the member organisations and their partners in various ways. A programmatic approach may provide increased opportunities to work more strategically, strengthen the possibility for learning through sharing experiences across organisations, and give FOKUS a stronger voice for advocacy work through easy access to a broader and more consolidated grass roots experience.

Cost efficiency would potentially be enhanced through the sharing of materials and through common advocacy and capacity building efforts. A programme approach would let the individual projects keep their independence at the same time as they would get the opportunity to work together on a more overarching level and on certain common thematic issues.

A thematic FGM programme will demand strong coordination from FOKUS, particularly during the initial phase, in order to build and consolidate a coherent programme.

In order to build a strong programme of high quality FGM work it would be necessary to supplement the existing organisations by creating strategic alliances with strong FGM organisations and networks at the regional and country levels. FOKUS, the members and partners would have to identify regional and national organisations that are willing to take on an advisory and possibly coordinating role relating to the FGM programme. Depending on the objectives of the programme and its perceived added value, areas for the programme to focus on should be developed jointly by the parties concerned.

A potential challenge related to a thematic FGM programme covering East Africa is to establish and maintain a sense of programmatic belonging and creating synergies across several countries.

Recommendations

1. A thematic FGM programme should be based on an FGM programme strategy, stating the goals, objectives and the added value of the programme. The programme should build on

existing knowledge accumulated within the FOKUS portfolio. However, it would be important to supplement lessons learned internally with updated knowledge and research on FGM work. In line with recent research and the FOKUS FGM Policy the programme should promote a rights based approach seeing the work against FGM as a relational gender issue.

2. FOKUS should consider the existing project portfolio and strategize around the choice of partners and projects to ensure that the future portfolio meets the required criteria. To build a strong FGM programme the existing portfolio should be complemented with strategic collaborations with national expertise on FGM in the programme countries. FOKUS, the members and partners would have to identify regional and national organisations willing to take on an advisory and possibly a coordinating role relating to the FGM programme.

3. FOKUS should carefully consider the maximum number of countries to be included in the FGM programme. A geographical concentration limiting the number of countries to two or three should be considered.

4. The programme should entail both grassroots projects and advocacy efforts, as two complementing approaches.

5. Depending on the objectives of the programme common issues to work on within the programme should be identified.

6. The programme should focus on results based management and baselines should be developed for all projects included in the programme. This way results may be documented and used for learning and advocacy purposes.

Contents

Introduction

Background

FOKUS, including involved member organizations and partners, are in the process of developing a thematic FGM programme in East Africa. In order to document results, learn from experience and provide advice for future decisions related to the FGM programme Nord/Sør-konsulentene was contracted by FOKUS to carry out a comparative evaluation of FOKUS' FGM projects in East Africa. The evaluation will be used as a basis for further project support within the frame of a holistic FGM programme.

The overall purpose of this evaluation is to analyse and compare the various approaches used and the achievements of the FOKUS supported FGM projects. The purpose of the input from the various projects in this report is therefore to inform the overall analysis, rather than to conduct a traditional evaluation of the specific projects. Findings, conclusions and recommendations related to each project are therefore to be interpreted in that context.

FOKUS' FGM portfolio in East Africa consists of 8 projects in 4 countries, of which the project cooperations written in bold letters have been the main scope of this evaluation:

Ethiopia:

- **New Life Community Norway/NLCO Ethiopia**
- The Development fund/APDA
- IAC networking and advocacy activities[2]

Kenya:

- KFUK Global/KFUK Kenya
- Pawa (Pan African Women's Union)/ MICONTRAP (Started mid 2011)[3]

Somalia:

- Somalisk Forening for kvinner og barn/GARWONET

Tanzania:

- **The women's front/SIAC**
- **The women's front/DIAC**

Objectives

The main objectives of the evaluation are:

1. Achievements: *The evaluation will: Collect success stories and investigate the reasons behind the successes*

2. Approaches: *The evaluation will: Reflect upon the various approaches used to combat FGM and assess their relevance, effectiveness, efficiency and sustainability.*

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2 Support to the IAC headquarters in Addis Ababa and Geneva with administrative expenses such as salaries as well as grass roots initiatives in five countries of which only one (Uganda) is located in East Africa. As this support is outside the scope of this evaluation it is not included among the projects assessed in this evaluation.

3 This project is not part of the evaluation as it was started very recently

3. Recommendations: *Provide FOKUS and relevant member organisations and partners with recommendations for future programme development on FGM in East Africa.*

Methodology

The evaluation is based on the methodology described in the Terms of Reference and elaborated on in the Inception Report of 15.09.2011. The evaluation was carried out in Norway, Tanzania and Ethiopia from September to November 2011.

The following data collection methods were used:

For the literature review:

- A desk study of current research and recent evaluations

For the project evaluation:

- Desk study
- Semi structured individual interviews
- Focus group discussions
- Observation
- Debriefing sessions

Information about APDA, YWCA Kenya and GARWONET was primarily collected through studies of project documents and former evaluation reports. Interviews were held with the Development Fund's offices in Norway and Ethiopia, and with Somalisk Forening for Kvinner og Barn.

For DIAC, SIAC and NLC the evaluation questions were addressed primarily through the use of a qualitative evaluation design. In addition to the study of project documents the evaluation relied on a participatory approach using the mapping of success and achievement as a key basis for learning, putting the results of the intervention at the centre stage.

Focus group discussions (FGDs) with a wide range of participatory methods were implemented, particularly in Tanzania. This method generated lively discussions among people in the project villages and gave the team fruitful information. The evaluation team received positive feedback from people met in the field for applying this approach. Individual and group interviews were also conducted throughout the fieldwork. Discussions were held with project staff and volunteers and with a multitude of stakeholders in the local communities.

In Ethiopia the project to be assessed ended in 2009. This influenced the number of people available for interviews and the methodological approach, relying mainly on individual and group interviews. In addition to interviews related to the NLC project other organisations working with FGM were visited. This was feasible in Ethiopia as the team was based in the capital and time was not as strained as in Tanzania.

In Norway representatives of member organisations and FOKUS staff were interviewed.

All together 251people were met during the evaluation (215 in Tanzania[4], 28 in Ethiopia and 8 in Norway). 141 of them were women, 110 men.

Limitations

According to the materials available for this evaluation none of the projects assessed had conducted a baseline study against which achievements can be measured. Therefore the assessments are largely based on people's perceptions through interviews and focus group discussions in addition to project documents and earlier evaluation reports.

Six projects are assessed in this report. Only three of them have been visited by the evaluation team during a two weeks fieldwork (DIAC, SIAC, NLC). Due to the limited time spent with each project it has not been feasible to go into depth on all issues related to each project.

For the three projects that were not visited for this evaluation (YWCA Kenya, APDA, GARWONET) the evaluation team has for a large part had to rely on earlier evaluation reports, and has not had the possibility to verify all the findings with the people concerned. Moreover, the information available has not covered all the questions related to this evaluation. Information about these projects is therefore not as comprehensive as one would wish. Furthermore, recommendations from the earlier evaluation reports may have been acted upon recently, and subsequently positive changes may therefore have gone unnoticed by this report. We know that this is the case for YWCA Kenya, as the organisation has implemented many of the recommendations from the 2008 mid term review, on which this report for a large part is based.

4 The high number of people met in Tanzania is due to the participatory approach applied for the collection of information implemented in the villages.

Part I: FGM - the larger picture: A literature review

1.1. Background

Female genital mutilation comprises all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons. FGM is a practice deeply rooted in tradition and culture and persists because it is a social convention upheld by underlying gender structures and power relations[5]. The practice is mostly carried out by traditional circumcisers. Increasingly, however, FGM is being performed by health care providers.

four major types of FGM

Type 1: Clitoridectomy- partial or total removal of the clitoris and/or the prepuce (the fold of skin surrounding the clitoris).
Type 2: Excision- partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (the labia are "the lips" that surround the vagina).
Type 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.
Type 4: Other- all other harmful procedures to the female genitalia for non-medical purposes, e.g. pricking, piercing, incising, scraping and cauterizing the genital area.

Source: www.who.org

The justification for FGM varies across communities, but they usually follow the following arguments: FGM ensures a girl's or woman's status, her marriageability, chastity, health, beauty and the family honour. In addition religious, personal and societal beliefs contribute to sustain the practice. *"In communities where it is practised, FGM is not viewed as a dangerous act and a violation of rights, but as a necessary step to raise a girl 'properly', to protect her and, in many instances, to make her eligible for marriage. Parents have their daughters cut so as to secure the best possible future for them"*[6].
Even if not intended as a violent act, FGM is recognized internationally as a violation of the human rights of girls and women. It conflicts with a number of fundamental gender equality principles, in particular the principle that women have the right to control their own bodies, sexuality and health[7]. The practice reflects deep-rooted gender inequalities. FGM has no health benefits, and it harms girls and women both physically and psychologically.

Implications of FGM

FGM has no health benefits for girls and women, and causes physical and psychological harm that can be extremely severe and often irreversible. For many girls and women, FGM is an acutely traumatic experience that leaves a lasting psychological mark and may adversely affect their full emotional development. The procedure can cause severe bleeding, problems urinating and later, potential sex life problems, childbirth complications and newborn deaths. In extreme cases FGM is fatal.

Source: WHO fact sheet 2011 and UNICEF 2005/8

5 http://www.unfpa.org/gender/practices3.html

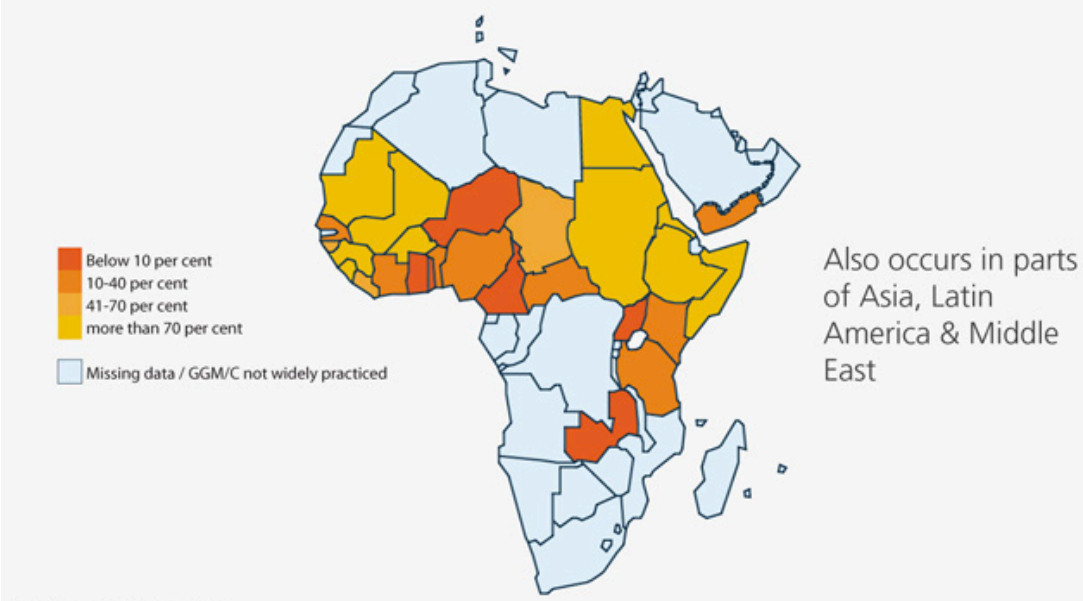
6 UNICEF 2010, p 2

7 . The Norwegian Action Plan to combat female genital mutilation 2008-11

1.2. FGM prevalence

It is estimated that about three million girls undergo the procedure every year, and that 100 to 140 million girls and women worldwide are currently living with the consequences of FGM. The majority are under 15 years of age when cut, but there are great variations[8]. In some countries FGM is performed on infants, other places after marriage. The practice is most common in the western, eastern, and north-eastern regions of Africa, in some countries in Asia and the Middle East, and among certain immigrant communities in North America and Europe. FGM exists among Christian and Muslim groups and across social divides.

Prevalence of FG/C among women 15-49 years old, source: www.unfpa.org



1.3. Conceptual discussions

There are conflicting views on the terminology to be used when describing the practice. FGM (female genital mutilation), FGC (female genital cutting), and female circumcision are used interchangeably. Whereas "female circumcision" fails to separate this practice from the very different male circumcision, the use of the word "mutilation" reinforces the idea that this practice is a violation of girls' and women's human rights, and thereby helps promote national and international advocacy towards its abandonment. The word "mutilation" is, however, by many seen as judgemental. Locally the more neutral word "cutting" is therefore often used[9]. Documents issued by Norwegian ministries use the term FGM, to emphasise that this is a serious violation of girls and women. FOKUS' documents similarly refer to FGM. In this report the term FGM will therefore be applied, although the words circumcision and cutting will appear in quotes and sometimes when referring to people's statements, as these are often the words that the community members use.

8 http://www.unfpa.org/gender/practices3.html

9 UNICEF 2005/8

1.4. Laws and policy frameworks

Norway

In 1995 Norway passed a law prohibiting female genital mutilation, and the government's first action plan against female genital mutilation was launched in 2000. The object of the action plan was to prevent genital mutilation of girls in Norway, help girls and women who had already undergone genital mutilation, establish cooperation with organisations and individuals, and contribute to the elimination of female genital mutilation internationally. The current Norwegian Action Plan to Combat Female Genital Mutilation is valid from 2008-2011[10]. It is recently extended with new action points for in 2012. During 2012 the work will be assessed and the way forward will be decided.

International frameworks and human rights commitments

FGM conflicts with fundamental human rights, and several international declarations call for the abandonment of the practice. The right to good health is grounded in the Universal Declaration of Human Rights of 1948. The Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) prohibits discrimination on the basis of gender and contains provisions of significance for reproductive health and female genital mutilation. The Convention on the Rights of the Child calls for the protection of children, and directs member states to safeguard the child's health and abolish traditions that can harm the child's health.

The commitments from the declarations are reiterated in the plans of action from the 1994 International Conference on Population and Development, the 1995 Fourth World Conference on Women and the 2002 United Nations General Assembly Special Session on Children. The Maputo Protocol of 2003 is the first legal instrument to protect women in Africa from all forms of violation, including genital mutilation. Furthermore, to achieve the Millennium Goals number 4 and 5, aimed at decreasing child mortality and improving maternal health, FGM should be addressed and abandoned[11].

Female genital mutilation is prohibited by law in many of the countries where it is practised, such as Ethiopia, Eritrea, Kenya, Uganda, Tanzania, and Sudan.

1.5. Approaches to the work against FGM

Efforts to abandon FGM in Africa were first seen at the beginning of the twentieth century when missionaries and colonial authorities emphasized the health risks and named the practice uncivilized and barbaric[12]. Many African communities saw this as colonial imperialism and responded to the critique with resistance. Attempts in the 1970s and 1980s by western feminists to persuade Africans to abandon the practice were also met with mixed feelings. They were perceived as imposed by foreigners with lacking cultural sensitivity and knowledge of the reasoning of the people concerned. At the same time African initiatives to eliminate FGM started to emerge.

Since then the increasing importance of African women's groups in pursuing economic, political, and social advancement and their interaction with the international community has led many women to become activists for the abandonment of the practice. FGM has increasingly become an issue of global concern, and the last decades numerous interventions have been implemented as collaborations

10 The Norwegian Action Plan to combat female genital mutilation 2008-11.

11 UNFPA 2008

12 Path 2005

between nations, international donors, international, regional and local NGOs, individuals, and communities. The FOKUS supported organisation IAC[13] has been working against FGM since 1984.

The following section presents a brief assessment of some of the approaches and methods commonly used in the work against FGM. It is important to note that the term "approach" is used according to the ToR and the FOKUS FGM policy, to describe different ways of engaging in the work against FGM. It comprises both ideological ways of thinking and practical ways of engaging various target groups. The various approaches described may be complimentary and are often used in combination.

The health risk approach

For a long time efforts to end FGM focused mainly on the health risks associated with the practice. This strategy applied a community-based education approach of health personnel delivering messages on the adverse health effects and medical complications of FGM. This approach has been based on the assumption that knowledge about health risks would be enough to influence the abandonment of the practice.

Although these efforts often succeeded in increasing awareness of the consequences of the practice, health education campaigns have largely failed to motivate large-scale behaviour change. In circumcising communities people are often already aware of many of the potentially dangerous health outcomes but feel that the risk is worth taking in light of the social and cultural norms in the society[14].

Research indicates that as a result of the health risk messages, some parents have turned to medical practitioners to perform FGM on their daughters or choose less severe forms of FGM. This "medicalization" of the practice has often been perceived to address both health and marriageability concerns. It reduces the immediate health complications, yet does not compromise the possibility for the girl to get married[15].

Critics argue, however, that when used alone, the health risk approach rarely leads to the abandonment of the practice itself. It rather tends to *"legitimize the practice while obscuring the fact that it is a violation of the rights of women and girls"*[16]. While medicalization may improve the conditions under which FGM is performed, it does not address the long-term issues including medical, psychological, and psychosexual complications and how FGM violates women's human rights. Furthermore, it contradicts two of the most important principles of professional health ethics, notably to do no bodily harm and to preserve the healthy functioning of the body organs unless they carry life-threatening disease.

The human rights approach

The human rights approach focus on how FGM violates women's reproductive and sexual rights as outlined in several international instruments. They include the right to be free from all forms of gender discrimination, the right to be free from torture, the right to health and to bodily integrity, the right to life, and children's right to special protection. As the human rights may be considered abstract, western, and not easily transferable to local realities, the rights based approach has proved more difficult to introduce in the FGM debate than addressing the public health implications.

The human rights approach sees FGM as a relational gender issue concerning both men and women. Traditionally, however, in most practicing areas FGM has been perceived as "women's business". Work

13 The Inter-African Committee on Traditional Practices Affecting the Health of Women and Children IEC Information, education and communication materials

14 Shell-Duncan 2008

15 UNICEF 2010

16 UNICEF 2010, p 8

against FGM has therefore largely been carried out by female local community members or women's organisations, supported by international organisations and networks. Men have rarely been involved in the anti FGM interventions. *"The failure to analyse FGM as a gender issue, concerning both sexes and not only women, may help explain why the practice has still not been entirely abandoned after a quarter of a century of determined public efforts"*[17].

When applied in isolation, the human rights approach is said to have had limited effect[18]. However, when used as part of a comprehensive strategy this approach can prove as an effective measure to foster an informed dialogue, influence gender relations, and mobilize for social change: *"An in-depth analysis of experiences that have led to wide-scale abandonment of harmful practices shows that addressing FGM/C within a broader framework of human rights allows communities to review the social norms and conventions that have endured in local tradition and culture. Introducing human rights transforms the discussion about FGM/C by providing the space for individual and communal reflection, which helps to revise social conventions and norms"*[19]. When using the human rights approach it is critical to include women and men, opinion leaders, religious leaders, and other stakeholders such as community institutions, women's groups, community education programs, and other local initiatives. Youth can play a central role in changing attitudes regarding FGM, but they are often marginalized in the local communities, by virtue of the authority of the elders.

Alternative sources of income for circumcisers as a method to combat FGM

Many efforts have been made to educate circumcisers about the health risks associated with FGM and to provide them with alternative means of income. Circumcisers have often been trained as change agents meant to inform the community and families that request FGM about its harmful effects. In many of these efforts there has been no awareness campaign for the general public, meaning that the supply of circumcisers has been reduced, but not the demand for FGM. Subsequently parents have searched for circumcisers from other areas instead of abandoning the practice. *"While conversion efforts may—at best—get a few individual practitioners to stop performing FGM, they have no effect on demand"*[20].

Sometimes it has been found that the circumcisers have continued performing FGM despite alternative training. Moreover, even though the new income-earning activities give the circumcisers an alternative source of income, it fails to address the status and recognition that often accompany their role. This approach should therefore be accompanied by other interventions that address the community as a whole and promote community consensus to abandon the practice.

Alternative rites of passage as a method to combat FGM

Alternative rites of passage involve substituting coming-of-age ceremonies in a way that preserves local customs but eliminates FGM. Results suggest that this approach may be successful where FGM is practiced as part of an initiation ritual. The alternative rites of passage approach has for instance worked well in Maasai communities[21]. In many areas, however, girls undergo FGM at a very young age, and FGM is often conducted privately. In other communities where FGM was once part of a rite of passage, there is now a trend towards girls being mutilated at increasingly younger ages with no accompanying ritual. *"The fact that initiation rites are fading but FGM/C remains suggests that the initiation rite in itself does not motivate the practice"*[22].

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17 Mottin-Sylla et al 2011, p 7

18 Path 2005

19 UNICEF 2010, p 8

20 Path 2005, p 26

21 Path 2005

22 UNICEF 2010, p 8

This approach has often been targeting individual girls. Research suggests that these efforts generally have limited impact as the girls belong to communities that may still strongly believe in FGM. The relative success of the alternative rites approach has therefore been dependent on a comprehensive approach involving the entire local community including parents (men and women) and village leaders.

Legal approach as a method to combat FGM

As signatories to a number of International human rights and gender equality agreements, many African countries have established laws criminalizing FGM. Penalties vary and law enforcement has generally been poor. Critics argue that legislation can drive the practice underground, making it harder to address. It may discourage treatment by trained health care providers and institutions in cases of medical complications, due to fear of being penalized, and it may lead to underreporting of FGM in national surveys because respondents are unwilling to report having carried out an illegal act.

Advocates for criminalization argue that the laws may lead to the abandonment of FGM by discouraging circumcisers and families who want to adhere to the laws. Moreover, it is held that the legal backing may help health care providers justify their engagement in abandonment programs and give them a reason to reject the medicalization of the practice and to refuse to comply with demands for re-infibulation after delivery.

Lessons learned show that laws alone are unlikely to change traditions. Laws prohibiting FGM are most effective if they are seen as an expression of popular will, and if enforced adequately by the relevant authorities. To have an impact on the prevalence of FGM they must be complemented by multifaceted programs at the community level.

Media and communication

Radio and TV are effective means to reach a wide range of people, including illiterate audiences in remote areas. Radio and TV soap operas, talk shows, panel discussions, public debates, and phone-ins in local languages have been widely used in the work against FGM. According to studies and evaluations these efforts have often been effective, particularly in creating debate. Local language radio stations are for example hosting debates featuring experts discussing the issues, where women and girls can call in anonymously and tell how FGM has affected them. "*These initiatives promote bottom-up social change and create a venue where people feel free to discuss and debate issues concerning the practice – a crucial step in generating community ownership of change*"[23].

The use of information technologies including social media such as Facebook and Twitter has also been applied in the work against FGM. Access to computers and the internet increases rapidly, and mobile phone coverage in African countries is now close to 95%[24], although with significant variations. Social media give opportunities for interaction, discussion and dialogue with people from across the globe, and are especially effective in addressing and engaging adolescents. Moreover, social media has the potential to unite people and to work as a mobilizing force.

Although media is frequently used for debates, to present stories about social change efforts, and to disseminate information about alternatives to harmful social norms, it can also be counterproductive. It is highly important that correct information is given in a culturally sensitive manner.

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23 UNICEF 2010, p 29

24 Mottin-Sylla et al

1.6. Latest trends in the work against FGM - What works?

Throughout the last decades there has been a lot of uncertainty and debate regarding the most effective ways of ending FGM. For a long time no method or approach was seen to be superior, and studies showing the impact of the various interventions were scarce. This resulted in a number of scattered projects often concentrating on one single dimension of FGM. The interventions often focussed on religious leaders, information campaigns and lobbying towards governments to criminalize the practice through laws. Initiatives *"were often carried out as a 'fight' against local traditions"*[25]. This has in some places led to resistance among community members, who saw the interventions as an attack on their culture and values.

Towards a holistic approach

Recent research, evaluations and statistics reveal that the narrow approaches focusing on individuals or on one or a few dimensions have not triggered the desired changes. The last few years, however, new evidence has documented positive experiences that have emerged from a combination of approaches to the abandonment of FGM. A recent UNICEF study[26] argues that the positive changes on the individual, communal and societal levels have come about precisely due to a more holistic approach, using a multitude of entry points and target groups focusing on stimulating open discussions among the community members themselves. Various approaches addressing a variety of target groups in different ways is now by many scholars seen as the most fruitful way to address FGM. The sharp divide that has traditionally existed between a heath risk approach and a human rights based approach is no longer perceived as the most fruitful outlook. Addressing the health risks within a human rights framework is possible and desirable, as is the combination of approaches an methodologies in general.

Evidence from the UNICEF study suggests that the holistic approach used to support the abandonment of FGM can also contribute to reducing other gender inequalities, violence against girls and women as well as the abandonment of other harmful practices, such as forced and child marriage: *"The analysis suggests that these are governed by social norms that are similar to those linked with FGM/C. Like FGM/C, they are influenced by expectations of rewards (approval, respect and admiration) and sanctions (shame, exclusion, disapproval and rebuke) associated with conforming or not conforming to a socially accepted norm."*[27]

Social convention theory

The holistic approach aiming for a community-driven collective abandonment of FMG is often based on social convention theory, anticipating change from within the community itself. According to social convention theory people's choices depend on the social context and the mutual expectations within the community. A choice made by one family is affected by, and affects the choices made by other families. FGM is seen as a social convention or norm, and breaking the social norms can lead to stigma or social exclusion. Therefore people will not abandon FGM until they know that the other people in the local community will do the same. This way the theory explains why it is so difficult for individual girls or families to abandon FGM on their own and why people continue to practise it.

Therefore, to motivate a community to consider abandoning a deeply rooted practice such as FGM, abandonment programs must address the social norms, the beliefs, and the attitudes of communities as a whole. This means that the communities themselves are encouraged to review the norms and conventions that have been embedded in local tradition and culture and to find alternatives to harmful practices.

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25 UNICEF 2010, p 48

26 UNICEF 2010

27 UNICEF 2010, p 48

This approach requires the engagement of all groups in the community, including those who are often not heard, such as young girls, as well as influential individuals such as religious leaders, in the discussions. It will benefit from the use of a variety of entry points to address FGM. Moreover, efforts to support the abandonment of the practice need to address issues of sexuality, gender roles and marriageability. To address marriageability it is vital that interventions include work with inter-marrying groups to ensure that social change is occurring across villages and clans.

Social convention theory - FGM abandonment process

FGM/C abandonment typically begins with an initial core group of individuals who set in motion a dynamic of change. As this group becomes ready to abandon the practice, they then seek to convince others to abandon. The members of this critical mass spread the knowledge of their intention to abandon to others through their social networks – a process known as 'organized diffusion' – until a large enough portion of the intra marrying community is ready to abandon FGM/C, described in this text as the 'tipping point'. After this point, the abandonment would become stable because it would permanently change social expectations. Community members would be expected to not cut their daughters, and would be socially rewarded or sanctioned accordingly.

Source: UNICEF 2010

Collective declarations of abandonment

In order to achieve a shift in the social norms a critical mass of people ready to change their behaviour is necessary. Families *"will not abandon the practice as long as they believe that others still expect them to cut their daughters. They will act only when they believe that social expectations have changed, and that most or all others in their community will make the same choice around the same time"*[28]. It is crucial that people have a guarantee of the commitment of others to abandon FGM too. A collective announcement of the community's commitment to abandon the practice has therefore proved to be a vital part of the process. Critics do, however, argue that people may practice FGM despite public declarations.

Community Conversation as a tool to implement a holistic approach

Community conversation or community dialogue is increasingly used in the work against FGM, and results are described as promising[29]: *"In several countries, this participatory process has led communities to organize public commitment to abandon FGM/C[30]".* This systematic methodology is being used extensively by Tostan in Burkina Faso, Djibouti, Mali and Senegal as well as by many organisations (UN and NGOs) in Ethiopia and other countries. Community conversations use a wide range of participatory methodologies and culturally sensitive strategies, such as story telling, active listening and strategic questioning, to generate a deep and complex understanding of the nature of FGM within communities. It empowers people to think through how their behaviour, values and practices, and those of their families and neighbours, affect people's lives. It allows the community members to reflect on and discuss these issues with others and to redefine the social conventions related to FGM. Community conversations require systematic facilitation over time.

28 UNICEF 2010, p 9

29 UNFPA 2008

30 http://www.unicef.org/protection/57929_58002.html

Conclusion - A momentum for change

Although FGM prevalence rates are still estimated to be high in countries like Egypt, Ethiopia and Sudan, studies show a slight decline in the practice and a significant change in attitudes about FGM in all three countries. A similar shift in attitudes has been seen among Kenya's Somali population[31]. Similarly there is a trend towards collective abandonment of FGM in many local communities. Some scholars even express that we are currently facing a momentum for change and may be on the verge of a breakthrough in the work to abandon FGM[32]. The main challenge now is seen to upscale the efforts based on holistic approaches in the local communities, and to ensure long-term commitment and funding.

Despite differences within and across countries, several common elements appear critical to cater for the collective abandonment of FGM. The decision-making process regarding FGM is complex and does not solely rely on individuals' preferences, but is strongly influenced by culturally embedded belief systems and depends on mutual expectations within communities. It has been found that the most effective programmes are those that involve the whole community and incorporate a number of different elements, which on their own are insufficient to create the desired change. Within a holistic approach, a combination of these elements can ultimately lead to abandonment of FGM.

31 UNICEF 2010

32 Berggrav 2011

Part II: The FOKUS FGM portfolio

2.1. An overview of the FOKUS FGM projects in East Africa

This chapter looks at six FOKUS supported FGM projects in East Africa, implemented in four different countries, Tanzania, Ethiopia, Kenya and Somalia.

There are great variations among the target countries in terms of political stability, economy, culture, and religious beliefs. FGM prevalence and type also differ between and within the countries. The age of the girls when undergoing FGM and the traditions and rituals related to the practice varies greatly from one area to the other. The prevalence and nature of the traditions are also changing over time. All these factors are important and need to be considered when assessing the FGM interventions. The figures related to FGM prevalence are estimates and should be understood accordingly.

FGM in Tanzania

In Tanzania 15% of women aged 15 – 49 have undergone some form of FGM. Prevalence rates are slightly lower for younger women in the 15–19 age group (9.1% compared to 22.9% among women aged 45-49) indicating a decline in the practice. The practice varies significantly by region and income levels. Almost 18% of women living in rural areas are circumcised against 7% of women living in urban areas. The highest percentage of women who have undergone FGM can be found in the regions of Manyara (81%) and Dodoma (68%). In Singida 25% of the girls are mutilated, but among some communities the practice is much more widespread. In many areas, including Dodoma and Singida, girls commonly undergo FGM in early puberty, and it is celebrated as a rite of passage highly valued by the communities. FGM is, however, increasingly being performed secretly on babies shortly after birth.

The most common type of FGM performed in the project areas of Singida and Dodoma is type II characterized by the removal of the clitoris with partial or total removal of the labia minora and/or the labia majora.

In Tanzania the Sexual Offences Special Provisions Act of 1998 (SOSPA) prohibits female genital mutilation (FGM) from being performed on girls under the age of 18. Law enforcement is, however, weak.

Source: UNICEF, Tanzania fgm/c country profile 2006 (Based on DHS data 2004/5):

FOKUS PROJECT:	**Combating Female Genital Mutilation**
Norwegian organisation:	The Women's Front of Norway
Project partner:	Dodoma Inter African Committee (DIAC)
Period:	2002-2012
Volume:	Approximately NOK 170 000 per year
Project Goal:	To reach Zero tolerance on FGM by the year 2015, locally, nationally and internationally. Hence, improved health and human rights status of women and children. The overall goal will then be achieved: Empowerment of women.

FOKUS PROJECT:	**Combating Female Genital Mutilation**
Norwegian organisation:	The Women's Front of Norway
Project partner:	Singida Inter African Committee (SIAC)
Period:	2003-2012
Volume:	Approximately NOK 170 000 per year
Project Goal:	Zero tolerance to FGM by 2015. Empowerment of women through education and economic independence hence increase participation in decision making in the issues of women`s and children`s human rights.

Description

DIAC and SIAC are Tanzanian chapters of The Inter-African Committee on Traditional Practices Affecting the Health of Women and Children (IAC), an international non-governmental membership organisation with National Committees in 28 African countries. IAC advocates for the elimination of harmful traditional practices (HTPs) including FGM.

SIAC and DIAC work to eliminate harmful traditional practices, including FGM, through the involvement of local stakeholders. The core of the projects is building capacity of DIAC/SIAC members and other community members to effectively engage in the fight against harmful traditional practices such as female genital mutilation, early marriage, and wife inheritance. DIAC and SIAC are targeting religious leaders, local politicians, circumcisers, teachers and health workers, emphasising sensitisation of youth and provision of alternative rites of passage. They work in 24 and 21 villages respectively.

FGM in Kenya

It is estimated that between 50 and 60% of Kenyan women below 50 years of age have undergone FGM. An estimated 38% of Kenyan women between the ages of 15 to 49 years had undergone FGM in 1996, and this dropped to 32% in 2003, indicating a decrease in the practice. The FGM prevalence rate is highest among the Somali, Kisii, Kuria and Maasai communities (90-97%). Other tribes, which practice FGM, are Taita Taveta (62%), Kalenjin (48%), Embu (44%), and Meru (42%). The age at which FGM is performed differ from tribe to tribe with Taita Taveta doing it at birth while most tribes do it between the ages 4 - 35 years. The average age is 12- 15 years of age for most tribes.

In the project target areas of Kisii, Maasai and Meru the common type of FGM performed is Type II, characterized by the removal of the clitoris with partial or total excision of the labia minora.

Girls below the age of 18 are legally protected from FGM by the Children's Act of 2001. However, knowledge of the law and its enforcement is poor.

Source: YWCA project application 2010 and Ingdal 2008

FOKUS PROJECT:	**Practice Reduction and Awareness of Female Genital Mutilation (FGM)**
Norwegian organisation:	Norwegian YWCA
Project partner:	YWCA Kenya
Period:	2006-2012
Volume:	Between NOK 1.3 million (2006) and NOK 900 000 (2011) per year
Project Goal: Kajiado	Reduce the practice of FGM in specific villages in Kisii, Meru and

Description

The project is implemented by YWCA Kenya in the three districts Meru, Kisii and Kajiado, and has five main components; training of trainers, training of girls and graduating them in alternative rites of passage (ARP), information and media work, construction of rescue shelters, and income-generation for former circumcisers.

FGM in Ethiopia

In 2005 74% of women in Ethiopia had undergone FGM, with differences in prevalence varying significantly by region, ethnicity and levels of education. More than half of the girls who have been subjected to FGM (54 per cent) were cut before reaching their first birthday, with the age of cutting varying across ethnic groups. Despite high prevalence rates, the practice is declining. Between 2000 and 2005, the rate of FGM declined from 80% to 74%.

FGM and other harmful practices are recognized as violations of human rights under Ethiopian law. The country's Constitution reflects many of the principles found in major international human rights instruments. The 2005 Criminal Code includes detailed provisions on FGM.

The government promotes the abandonment of harmful practices in a number of national policies that cover population, health and women's issues. In December 2008, an inter-ministerial body was established to prevent and respond to gender-based violence, including harmful practices. However, although laws are in place criminalizing FGM and other harmful practices, a comprehensive strategy or a national plan of action to promote the abandonment of harmful practices has yet to be developed.

Source: UNICEF 2010

FOKUS PROJECT:	**Prevention of Harmful Traditional Practices (HTPs) with emphasis on Female genital mutilation (FGM)**
Norwegian organisation:	New Life Community (NLC) (NLC is a diaspora organisation established and run by Ethiopians living in Norway).
Project partner:	New Life Community organisation (NLC)
Period:	2007-2009
Volume:	Approximately NOK 520 000 per year
Project Goal:	Reduction to harmful traditional practices that affects to the health and well being of the community in the project area, particularly of women and girls

Description

FOKUS supported the project in Akaki-Kality outside Addis Ababa for three years from 2007-2009. From 2010 the Prevention of harmful Traditional practices – with emphasis on Female Genital Mutilation (FGM) has been supported by FOKUS in Dale district of Southern Nations and Nationalities People's Region (SNNPR). The projects aim to eliminate FGM by promoting behaviour change and building local capacity to prevent HTPs. Strategies include community participation and the involvement of key community leaders, door to door visits, and alternative sources of income for former circumcisers.

FOKUS PROJECT:	**Campaign to End Female Genital Mutilation in Zone 3, Afar Region**
Norwegian organisation:	The Development Fund
Project partner:	Afar Pastoralist Development Association (APDA)
Period:	2007-2012
Volume:	Approximately NOK 400 000 per year
Project Goal:	Contribute to stopping the harmful practice of FGM/ C and enhancing women's participation in their own development in Zone 3 in the woredas of Dullassa, Ami Bara and Buurimudayto (30 kebeles).

Description

The project is located among pastoralists in the Afar region and aims to support efforts to stop FGM through awareness raising and improving the status of women as advocates and activists in the local community. Strategies include training of TBAs/FGM practitioners and religious leaders, and community literacy training by local trained teachers and women extension workers. Moreover, the community leadership is trained to conduct community conversation and workshops aiming at behaviour change.

FGM in Somalia

In Somalia the FGM prevalence is about 95% and is primarily performed on girls aged 4-11. FGM remains deeply embedded in the Somali culture, and the belief is widely held that FGM is necessary to "cleanse" a girl child. 80% of the girls undergoing FGM in Somalia are infibulated. After receiving information of the harmfulness of infibulation some communities are said to change to the type I, which is referred to as "Sunna".

The former government's stance against FGM was never translated into national law. In November 1999, the Parliament of the Puntland administration did approve legislation making the practice illegal. There is no evidence, however, that this law is being enforced, and according to an article dated November 3, 2011: "Women's groups in the Somali town of Galkayo are lobbying the authorities in the self-declared autonomous region of Puntland to enact a law banning female genital mutilation/cutting (FGM/C)".

Source: www.unicef.org and www.unhcr.org

FOKUS PROJECT:	Eradication of Female Genital Mutilation
Norwegian organisation:	Somalisk Forening for Kvinner og Barn (a diaspora organisation established and run by Somalians living in Norway).
Project partner:	Gardo Women Network (GARWONET)
Period:	2009-2012
Volume:	Approximately NOK 330 000 per year
Project Goal:	Create a more open environment among Somalians in Somalia to discuss FGM

Description

Garwonet is a network consisting of 9 Somalian NGOs. The project is conducting a wide range of information and education activities such as awareness-raising workshops for the local population, primary and secondary schools and women's organizations. Furthermore the project has provided community awareness raising through house visits, training of nurses, sensitisation of religious leaders, support and provision of medical treatment care to FGM victims, awareness raising through the media and websites, as well as advocacy and lobbying.

2.2. Approaches to FGM work implemented by the FOKUS partners

The FOKUS FGM portfolio in East Africa represents a variety of approaches to the work against FGM. There are also many similarities between the projects, and the reasons for the differing approaches are often the varying contextual settings. The following chapter gives an overview and assessment of the main approaches used by the FOKUS supported FGM projects. The information provided in this chapter is mainly building on the three projects visited for this evaluation (DIAC, SIAC and NLC), but information from the three remaining projects is also included (WYCA Kenya, APDA and GARWONET), for a large part based on former evaluation reports.

It is important to note that in the following the term "approach" is used according to the ToR and the FOKUS FGM policy, to describe different ways of engaging in the work against FGM. It comprises both ideological ways of thinking and practical ways of engaging various target groups. The various approaches described are complimentary and often used in combination.

Engaging the community through awareness raising

"Eradicating FGM in the Dodoma region is very difficult. We have to use various approaches and cover area by area". DIAC project staff

All the FOKUS projects are in some ways trying to involve the community members in order to create ownership and sustainable change. The two projects of SIAC and DIAC in Tanzania seek to build the capacity of community members to effectively engage in the fight against harmful traditional practices such as female genital mutilation, early marriage, and wife inheritance. DIAC staff admit that their initial work was focused on preaching about the negative consequences of FGM and trying to persuade individuals to abandon FGM without proper participatory processes. This approach was met with strong resistance and threats, and they had difficulties in reaching the communities. The staff explains that, *"No one had really questioned this practice at that time, and it was difficult for the people to understand. Many people were against us".* Over time the strategies have been refined and a variety of approaches are now implemented in order to foster change.

Real community participation and ownership is highlighted by the DIAC project coordinator as the key to success. In each of the project villages in Singida and Dodoma the community selects village facilitators, who receive training on FGM and other harmful traditional practices. The village facilitators act as local change agents, facilitating discussions among various groups in the community. Subsequently the communities decide on what practices they regard as harmful and what they want to do about it.

DIAC and SIAC seek the involvement of traditional and religious leaders, law enforcers, the elders, teachers and health workers through advocacy meetings. They sensitize traditional birth attendants on women and girl's health, HTP's and the common local belief in FGM as a cure for vaginal and urinal infections locally named Lawalawa[33] (See box below). Moreover, they target families for discussions related to the beliefs in Lawalawa, encouraging parents to take their daughters to the heath facilities for treatment of such infections. SIAC and DIAC also target girls and boys in primary and secondary

33 The definition of Lawalawa is taken from Lie et al 2004

schools, who receive training by the village facilitators and establish youth clubs where they debate issues of life skills, reproductive health, and harmful traditional practices like FGM.

Lawalawa and FGM in Tanzania:
-The importance of awareness and treatment of vaginal and urinal infections in the fight against FGM

Many girl children in the areas of Dodoma and Singida suffer from bacterial diseases such as urinary and vaginal infections. This is mainly a result of poor cleaning of the girl child's genital parts due to lack of water as well as the practice of cleansing the genital areas with sand. Sometimes sexually transmitted infections are also found in girls, possibly contracted at birth. Locally these infections are named "Lawalawa", and the traditional belief is that FGM is the only cure, without which the child might die. Therefore, as soon as a girl child has fever or rashes in the genital area there is a pressure, particularly from the elders, to have her undergo FGM.

The strong and persistent belief in Lawalawa is seen to be one of the main factors contributing to sustain the practice of FGM in the Singida and Dodoma areas. Therefore it is of crucial importance to bring out awareness and information about medical treatment of urinary and vaginal infections.

As in the Tanzanian projects, awareness raising among the local population was the main strategy adopted in New Life Community's FGM project implemented in Akaki-Kality sub-city outside Addis Ababa. Increased awareness of the harmful side effects of FGM was subsequently expected to create behaviour change. At the start of the project 34 local people were given training as community facilitators. The facilitators were supervised by a steering committee consisting of local Christian and Muslim leaders and other key people such as Idirs (loal funeral associations), CBO leaders and people from the local government. The facilitators made door-to-door visits in their respective areas in order to raise awareness about the harms of FGM. Community trainings and discussions were arranged. Police officers and justice office personnel received training, as well as computers and stationary. Moreover, community leaders and health officials were trained. 10 girls' clubs were established in NLC run schools, and both government and privately employed teachers were educated.

A community facilitator in Ethiopia explain the procedure:

The circumsiser comes to the girls home for cutting the girl. The baby girl is cut when she is 7 days old or 40 days, depending on the culture. In rare cases it is done when she is around 10. Special food such as traiditional bear and bread is provided. They break egg and slaughter a sheep. Then the girl will be cut. There are lots of people around her to hold her so that she doesnt move. The circumciser is using a razor blade to cut off the clitoris. Sometimes two girls are cut at the same time, but more often it is done within the household of the girl. Usually only women are present when the cutting is done. But there are also men that circumsise the girls.

APDA is emphasising community dialogue among pastoralists in Afar Province of Ethiopia. Local communities are gathered quarterly for dialogue and conversation about issues like harmful traditional practices. APDA staff talked to explain that, *"We talk until midnight about marriage, FGM, gender based violence and such things."* Moreover APDA is supporting local literate women extension workers to be agents of change in their own communities. These extension workers based in the communities are trained to give literacy education and sensitisation on FGM and other HTPs to the local women. The involvement of religious leaders is one of the key project strategies adopted by APDA. As strong beliefs

persist among the general population that FGM is prescribed in the Koran, it is seen as crucial to get the Muslim leaders on board.

In Kenya training of key people in the community is one of the strategies adopted in the work to fight FGM. Church leaders, head masters in schools, chiefs, elders, parents, young men and boys and former circumcisers have all been targeted by training. Moreover, women based in the communities have been trained as change agents for work in the local communities.

Similarly, GARWONET in Somalia is carrying out awareness-raising workshops for the local population, primarily women, primary and secondary schools and women's organizations. Moreover, sensitisation is targeting nurses and religious leaders.

Assessment:

1. All the projects are bringing awareness raising to multiple stakeholders in the local communities in which they work. Awareness raising and training among the local populations are important elements. However, measuring the impact of the awareness raising activities appears to be a challenge in many of the projects. Moreover, awareness does not necessarily lead to behaviour change. Much anti FGM work has been implemented throughout the last decade, with awareness rising as the core element. Tangible results, however, have generally been relatively meagre, and the relationship between awareness and behaviour change needs to be explored further by all organisations involved in anti FGM work.

2. Without profound commitment from the communities involved fostering change in a social convention such as FGM is close to impossible. Real local ownership is therefore the most important element for achieving results. The community must be able to define and decide their stance and progress on the issues. The support from, engagement of and direct work with community leaders, Muslim and Christian religious leaders, the elders, health personnel, circumcisers, midwives, and teachers is key to bringing about the desired results. Through these key community members the men, women, children and youth can be reached. Project staff of DIAC highlight that the good relations with and the support form the local government structure has been vital in providing access to the villagers and venues for the dissemination of information. The New Life Community project has been struggling with sustainability issues after the end of the project due to inadequate handing over to local stakeholders. This experience is highlighting the complexity and the importance of ensuring real local ownership.

3. Most of the projects have adopted many of the elements included in the community dialogue/conversation approach mentioned in the initial chapter of this report. APDA and DIAC in particular are emphasising the importance of a thorough and open dialogue with the different levels of the community. The community conversation as prescribed by UNICEF guidelines is a method ensuring local engagement and ownership and should be carried out in a systematic way over time. It is meant to lead to a collective decision in the community to stop practicing FGM, as people will not stop practicing until they are assured that others have stopped. Although collective declarations are no guarantee for the abandonment of FGM, they are by many actors involved in FGM programming, seen to be the best indicator available. New research is promoting this method as perhaps the most effective way of achieving results in anti FGM work.

4. The community conversation methodology builds on the notion that FGM is a communal issue, which has to be dealt with collectively, unlike for instance HIV/AIDS, which is seen as an individual issue. Relating to this, it would be interesting to see documented effects of the door to

door-approach targeting individuals or individual families, which is used by some of the FOKUS organisations, such as GARWONET and NLC as compared to the community conversation approach targeting the community collectively.

Alternative rites of passage

"During the training for the alternative rites of passage the community decided that the alternative celebrations should be provided to both girls and boys". DIAC staff

DIAC and SIAC are particularly concerned with reaching youth and empower girls to be able to stand up against their parents and say "no" to FGM. Youth clubs are used to sensitise pupils about harmful traditional practices, HIV/AIDS and other sexual and reproductive health and rights issues. The youth selected for the clubs are meant to educate their peers in order to strengthen their abilities to stand up against the practice.

Moreover, DIAC and SIAC have introduced alternative rites of passage to substitute the traditional celebrations, which included the practice of FGM. This approach is also used by YWCA Kenya for *"…promoting the positive aspect of the cultural practise and passing on traditional wisdom while educating girls about sexuality, HIV/AIDS, relationships and family life."* [34]. According to DIAC staff and other people met the rites of passage are important events in the girl's lives: *"It gave them a sense of pride and let the world know that they were available and ready".*

The alternative rites of passage consist of a graduation ceremony after a series of trainings are conducted. Teachings of traditional songs, dances, values and responsibilities are part of the training. DIAC staff explain that the ceremonies have been well accepted and that some communities have decided that the training and ceremony should also be provided to boys. The ceremonies also provide a venue for sensitising the public about FGM and other harmful traditional practices, and it may involve the elders, and thereby provide an entry point for engaging a group, which is often resistant to change their views on FGM.

Assessment:

1. As research suggests ARP is generally not seen as the most effective approach in itself[35]. Many places, including Tanzania, FGM seems to persist, although the traditional ceremonies have largely disappeared. Mainly due to fear of the law against FGM, girls are increasingly cut in secrecy at very young ages without the ceremonial part. This indicates that the ceremonies in themselves are not what motivate the practice. Moreover, the ceremonies used to be an economical burden on the individual families, and some of the interviewees express relief that they are no longer performed.

2. However, in the light of the positive experiences encountered by the FOKUS project partners, using the ARP as a venue for anti FGM promotion seem to be an adequate strategy for reaching many people in the village, including the elders. Some studies suggest that the ARP has indeed proved to be a successful element in certain contexts, but always in combination with other interventions targeting the community at large and addressing the root causes of the practice.

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34 Mohamud et al, 2006:76 in Ingdal 2008, p.16

35 See literature review chapter in this report

Alternative sources of income for circumcisers

"In the past we were the ones who convinced others to let their daughters undergo FGM, now we are the ones to convince people not to do it". Ex circumciser Dodoma

All the projects are working with circumcisers in order to make them stop carrying out the procedure, and if possible turn them into advocates for the abandonment of the practice. SIAC and DIAC staff hold that many circumcisers have *"put their tools down"* and joined the anti FGM work. This is confirmed by interviews with government officials and community members including former circumcisers. "*Now we have stopped FGM because it causes pain and problems during deliveries",* an ex circumciser in the Singida region explained. SIAC staff also claim that getting the circumcisers on board the fight against FGM can be a good way of reaching the elders.

Tanzania: Two ex circumcisers about the practice of FGM:

In the old days FGM was a cultural thing. Every girl was expected to undergo FGM, and the community was looking forward to it. We were also looking forward to it. Twenty girls or so would be gathered, and one or two circumcisers were there to cut the girls. After the cutting the girls would be fed and cared for collectively in a communal place, healing for one month. Then the celebrations took place. The girls would be given presents, and we would receive a goat.

Performing FGM was not providing our bread and butter, just an additional income. But we had some prestige in the community, so when the Lawalawa issue came up we advised people to go for circumcision. I also did the FGM secretly due to Lawalawa, but only for a short period before I understood its cause.

We had been going through this pain ourselves, but we trusted that this is what life is like. As I became aware of the law against FGM I got scared and when I learned about the negative effects I stopped practicing. In 2004 I joined the project (SIAC). It is easier for us to reach out to other circumcisers. Many of the villagers are not aware, and in the more peripheral parts of the village they still perform FGM.

In Ethiopia New Life Community has targeted circumcisers with awareness raising and economic support. One former circumciser has been convinced to stop her practice, and reluctantly she has given up the practice after receiving alternative means of income in terms of two cows. She informs the evaluation team that many people including government officials, her own children and the project community facilitators tried to convince her for a long time. The law against FGM has also played a role. In the conversation with the evaluation team the ex circumciser explains it like this:

"After the law banning FGM I was always afraid that they would come and tell me that the baby had died. Even my own children told me not to do it, as they were afraid that I would be arrested for murder. I still needed to do it because I was poor. People are not happy that I stopped performing. People come from very far away, even with horses, begging me to do it. People want me to continue, but I better not talk about it".

A lot of effort has been put into persuading the circumcisers, but the NLC project volunteers have met strong resistance, and so far only one circumciser has stopped performing FGM. Still there are two other circumcisers practicing in the surrounding area: *"There is one male circumciser operating 3 hours walk from here. One time he even threatened to beat me because I came and interrupted him. He comes here to circumcise, and that is when we came into quarrel with him".* People in the local women's association hold that: "*We have not managed to convince the other two, because of our limited budgets.*

They have requested a lot of money in order to stop". This reflects the fact that the role of the circumcisers has changed from one of duty to their community into a means of income that they depend on for a living.

Targeting circumcisers is also a central element in the YWCA project in Kenya. Ex circumcisers have started savings groups and have received loans to start small-scale businesses[36]. Similar to the experiences of NLC the 2009 YWCA Kenya evaluation report hold that *"there is no doubt that it has been quite challenging for YWCA Kenya to recruit former circumcisers to their programmes"*[37], and: *"The main challenge with this component of the programme is to monitor that the enrolled circumcisers have actually abandoned the tradition. YWCA Kenya is acutely aware of this challenge, but has so far relied on reports from one or two leaders in the savings groups and not tried to systematically monitor how the former circumcisers are doing"*[38]. Moreover the report hold that *"Related to the FGDs the team had with some of the former circumcisers, the team was not convinced that there had been a "change of heart" in some of the groups. The main motivation seemed to be financial, which is fair enough, but it does not guarantee that they have abandoned their (former) work"*[39]. This illustrates very similar findings to what was experienced during conversations with the ex circumciser and other stakeholders in the NLC project in Ethiopia.

In the Afar region in Ethiopia APDA has been training TBAs/FGM practitioners about harmful traditional practices including FGM. After the training many of them have declared to stop performing FGM. They are also equipped with safe delivery kits, and as they are performing their role as TBAs they sensitise expecting mothers on FGM matters. Similar to the experiences from NLC and YWCA Kenya, the 2009 evaluation of APDA identifies several limitations to the approach of targeting circumcisers. Among them are the fact that many community members get the procedure undertaken elsewhere or beg the ex practitioners to perform FGM secretly. The evaluation also notes that: *"although those TBAs/FGM practitioners appear to be transformed personally and remained committed, there are large number of TBAs who could potentially perform FGM as long as there is community demand"*[40].

Assessment:

1. Reducing the number of available circumcisers might have a positive effect in itself. FGM becomes less available, and this may prevent the procedure from taking place. However, reducing the supply side cannot necessarily be translated into reduced demand. People can go elsewhere or bring in circumcisers from other areas to perform FGM on their girls. Moreover, many stories are told about circumcisers declaring that they have "put down their tools", but who still secretly perform FGM.

2. Performing FGM is not necessarily an income generating activity. In many instances the circumcisers are only receiving a symbolic gift for their services. Discussions with an ex circumciser in Ethiopia indicate that this might be changing. The fact that NGOs offer monetary compensations in exchange for quitting FGM appears to be a factor increasing the amount of compensation that is being requested by the circumcisers. However, ex circumcisers met in Tanzania hold that performing FGM did not provide a source of income for them. Therefore targeting circumcisers need to be done in an appropriate manner, according to context. Providing alternative sources of income is only one of several ways of including this group of stakeholders.

36 Ingdal 2008

37 Ingdal 2008, p. 24

38 Ingdal 2008, p. 25

39 Ingdal 2008, p.25

40 Hailu 2009, p. 28

3. The circumcisers often have a high standing among the community members, and in particular among the elders. Convincing the ex circumcisers to work as advocates against FGM is therefore by many perceived to be an adequate approach as people are inclined to listen to what they say.

4. Targeting circumcisers and providing alternative sources of income does not address the root causes of FGM and is neither a sufficient nor the most relevant approach to combat FGM. It may, however, be used as a supplement to other FGM related activities aiming to create community participation and commitment to stop the practice.

Legal approach

Consequences of FGM Legislation – The case of Tanzania

"If the government had been serious about eradicating FGM they would have worked harder to enforce the laws". DIAC staff

In Tanzania the Sexual Offences Special Provisions Act of 1998 (SOSPA) prohibits female genital mutilation (FGM) from being performed on girls under the age of 18. Upon conviction, the offender is liable to either a fine of maximum 300,000 Tanzanian Shillings or imprisonment of no less than five years and no more than fifteen years.

Although FGM has been criminalized for more than a decade the team was told that there is lacking awareness of the law among communities that practice FGM. Law enforcement is also said to be weak, and there is no legal protection from FGM for women above 18 years of age.

DIAC and SIAC are engaged in a coalition with national gender/feminist and human rights policy advocacy organizations, with a view of effectively advocating for the enforcement of the law against FGM and reaffirming the government's intentions to fight such practices. The coalition is implementing various advocacy efforts and have been commemorating the Zero Tolerance Day and Sixteen Days of Activism nationally.

DIAC staff and volunteer members sometimes assist villagers to take FGM cases to court. They share many stories of double standards and people appearing to be against FGM, and then bribing law enforcers not to prosecute them for mutilating their daughters: "*The biggest problem is the law enforcement. Law enforcement is degrading because of the bribes. Law enforcement is also male dominated. They may not take it seriously. We take the women to the police with their cases, but meet a lot of resistance from the police".* The stories indicate that the laws are not enforced as they should: *"There is a lot of frustration because the cases take so long. The villagers have to come to Dodoma and pay for transportation. The cases take forever, and it is difficult for the poor. Sometimes the case is also just cancelled in the end".*

Despite inadequate enforcement and the need for more awareness, many communities are aware that there is a law against FGM, and as a consequence of the law the practice is said to have gone underground. Increasingly infants are subject to FGM, rather than girls in their early teens, which has been the tradition. Open ceremonies demonstrating passage to adulthood have been changed with secret and private mutilations of children too young to protest or talk about it. The increasingly clandestine nature of FGM has led to uncertainty regarding the prevalence of the procedure. People are afraid to talk about it in fear of legal consequences, and it may also lead to people refraining from taking their girl children to health care facilities in fear of being punished for having performed FGM.

Although there are challenges connected with the anti FGM law, both DIAC and SIAC report of some positive changes since the FGM law was passed. They hold that "*In the past, when the rights of women were violated people would not report it. Now the sons and brothers want to see that action is taken".* Children met during the fieldwork are aware of the law and say that if they hear about FGM cases they know that they should report it to the authorities, so that the procedure can be prevented. Similarly, local government leaders express an interest in and a need for training in order to understand the laws better and to be able to speak up about FGM and enforce the laws.

There has also been a decline in FGM prevalence in the younger age groups in Tanzania during the last decade[41]. Some of the people interviewed hold that the law is preventing people from cutting their daughters in fear of legal consequences: "*In the beginning it was difficult to convince the elderly, who thought that this is contrary to our culture and traditions. When they were informed that there is a law against FGM they got scared and listened"*. In one of the control villages visited, which had not been exposed to FGM interventions by NGOs an elderly man explains that, *"The tradition was good, it did not harm anyone. Now we miss the celebrations, but we have stopped because we fear the law".* Whereas people in the project villages tend to underscore the health consequences as the main reason to stop practicing FGM, people in the control villages highlight their fear of the law.

Assessment:

1. Despite weak enforcement and negative issues to be resolved the FGM law seems to have had some effect in Tanzania. Still, there is a need for NGOs to continue lobbying for strengthened law enforcement, more awareness rising, and improved legislation, including protection for women above 18 years of age. DIAC should continue with advocacy work in collaboration with other NGOs and networks.

2. It is clear that the legal aspect alone is not a sufficient tool to tackle practices that are deeply rooted in social and cultural traditions, and that it will only work well in combination with other interventions. However, legal backing may be an important element in the fight against FGM, sending a strong message to the population that FGM is not accepted or tolerated.

3. Ethiopia and Kenya have laws banning FGM, but law enforcement seems to be even weaker than in Tanzania. In Ethiopia most people met do not perceive the law to have had much effect so far on FGM, although there has been marked improvements with respect to preventing other HTPs such as early marriage, where the girls themselves are empowered to report impending cases*: "People do not fear the law, they are more concerned with their cultural practices",* the team was told. Current renewed government commitment to tackle the issue of FGM might, however, lead to greater enforcement of the law in the future. In Kenya there is FGM legislation within the Children's Act of 2002. However, according to the 2008 evaluation report, *"…it is rarely applied and upheld"*[42]*.* Somalia does not have national laws against FGM, and women's groups are currently lobbying the Puntland authorities for legislation to ban FGM.

Media and communication

"In Africa, wherever there is singing and dancing, people will let go of everything and come". DIAC village facilitator

41 UNICEF 2005/8

42 Ingdal 2008

Finding suitable ways of transmitting the messages has proved to be crucial in the work to change social conventions such as FGM. Over time the close interaction with the communities have led SIAC and DIAC to work more strategically in terms of how they disseminate their messages. DIAC project staff hold that much more has been achieved when they have been using a more strategic and participatory approach.

As many of the villagers cannot read and write the SIAC and DIAC projects are using participatory methods: "*The villagers like theatre, poetry, singing and dancing, so we use these methods".* The children may be asked to make a play on the basis of the information they have received. Later the children perform the play for other community members. Role-plays and theatre performances are referred to as fruitful ways to convey messages on sensitive issues without explicitly using language that is associated with taboos.

Showing educational films about FGM is highlighted by many people interviewed in Tanzania as another powerful and eye opening tool provoking strong reactions from the audience. According to DIAC staff, *"Some of the participants are not able to look, some of them start to cry, saying if this is what is happening, we have to stop it".* SIAC staff is concerned about reaching a broader audience, as sometimes very few people turn up for the FGM event. They hold that they would like to use films and theatre plays more actively, arguing that this will lead to more people coming to the sensitisation sessions. Lack of equipment is, however a key challenge to SIAC.

Similar stories were told repeatedly in Ethiopia, as indicated by the following quotes from discussions with various community facilitators:

"The most effective method was the film. The community members, among them many elderly men, asked: "Why did you not show this to us earlier, we didn't know all this"".

"We were showing the film in front of a lot of people. It showed how the FGM arrangement was made and how she was cutting the body of the child. It was so scary and it touched a lot of us inside. It felt just like it happened to us, and we decided that this is something we had to work on".

"The film was very touching, some felt sad and some even cried. They promised to stop FGM and even to report those who do it".

Similarly, experiences from WYCA Kenya show that: "*The use of visual training aids seems to have been particularly successful among the men and opinion leaders. Seeing how an actual FGM is performed had left a deep and irreversible impression on some of the men interviewed during the review"*[43].

YWCA Kenya and DIAC have positive experiences with inviting media to alternative rites of passage celebrations. This is contributing to attract attention to the alternative celebrations and the anti FGM work. In Kenya (Meru) the celebrations have been covered by national television and several newspapers.

Assessment:

1. Experience from Tanzania, Ethiopia and Kenya indicate that the use of theatre plays and films contributes to attract people to come for FGM sensitisation. Informative documentary films can

43 Ingdal 2008, p. 20

prove to be an effective good source of information, particularly for men, who are often not aware of the details of the procedure. Video equipment, films and other visual materials are perceived to be expensive and hard to get hold of. It would be beneficial for all parties if organisations operating in the same areas share equipment and make use of available IEC materials developed by others.

2. Radio, television, and newspapers are effective means of conveying messages. During the fieldwork in Tanzania and Ethiopia people constantly referred to the media, particularly radio and newspapers as sources of information of harmful traditional practices including FGM. External organisations talked to, such as Save the Children Norway, who is a substantial actor on FGM in Ethiopia, has positive experiences with interactive radio discussion programmes as part of their FGM interventions. People can write letters and get responses over the radio. After the initial project is finished, they hand out radios for people to continue listening to the programmes. Moreover, T-shirts, attractive and colourful billboards and posters with simple messages visible in public spaces triggers discussion and this is by many organisations seen as another effective method.

2.3. Main achievements

"The silence is broken now" DIAC staff

The evaluation team conducted participatory workshops with DIAC, SIAC and NLC staff in order to capture their perceptions of the achievements of their work. Focus group discussion and interviews were also conducted with various stakeholders in the project communities/villages as well as with FOKUS staff. The following achievements were highlighted as the main successes of the projects. Information about the achievements of APDA, YWCA Kenya and GARWONET are mainly taken from recent evaluation reports.

Putting FGM on the agenda and raising awareness

"We managed to break the silence about FGM, now people dare speaking out". DIAC staff

In Tanzania education and capacity building of the communities have enabled the community members to speak much more openly about harmful traditional practices. Thus it is now easier to address issues of FGM, early marriage, gender based violence and other women's rights issues. Engaging communities in discussions of what was seen to be a taboo not long ago should be seen as an achievement in itself.

By far most people talked to during the fieldwork in Tanzania are informed about the negative consequences of FGM, including children and young people. Whether or not the awareness can be accurately attributed to the concrete projects is difficult to assess. Media, government laws and policies, and interventions by other organisations are all a part of these developments. However, it is most likely that the FOKUS projects are contributing to increased awareness.

A story told by a village facilitator in Tanzania

There was a lady who got married to a person in a very remote village. When she got married everyone said that it was time for her to undergo FGM. Her father, who had received FGM sensitisation, said to the in laws that "if you do not want her as she is, bring her back". As he was worried that they would circumcise her anyway, he came here to this village to report the plans to circumcise his daughter. She was not circumcised, but the in laws treated her badly. They finally sent her back to her family. Now she is living near her father, with the two or three children she had with her husband.

NLC staff in Ethiopia is highlighting increased awareness of the harms of FGM among various groups of stakeholders as the greatest achievement of the project: *"We have put FGM on the agenda, making people discuss it and think about it".* The project has sensitised community volunteers, religious and other community leaders, former circumcisers, girls in school clubs and the police. They hold that the girls are now speaking up for their rights, and that many Muslims have now become aware that FGM is not a requirement by the Koran.

In Kenya the most tangible results are said to be *"a number of much empowered girls, a few former circumcisers acting as good role models, and some local Chiefs speaking out in their own*

communities"[44]. Similarly, the APDA project has *"…contributed in terms of increased knowledge through community FGM workshops, the IEC materials especially the films shown at the end of the FGM workshops and APDA training. The clarification provided by religious leaders through the films reported to contribute to improvements towards positive changes in attitudes among some of community members such TBAs, association members and the religious leaders themselves"*[45].

Achievements of GARWONET highlighted in the 2011 evaluation report highlights the fact that the project has established a forum for exchange of experience. Beneficiaries interviewed hold that the project has changed their way of thinking around FGM issues. The report further notes that there is increased participation of women and girls in the fight against FGM, and a *"…renewed commitment among community members to abandon FGM; increased knowledge and understanding of the impact and effect of FGM, and; demonstrated willingness by the authorities to actively participate and play a role in eradicating FGM."*[46]

Changing attitudes among men

"We have tested the other women and they are different during sexual intercourse. We prefer those who are not circumcised". Community members, Singida

Most of the people talked to in Tanzania and Ethiopia argue that there has been a substantial change in attitudes towards FGM among the general population, and particularly among younger men. Whereas girls who had not undergone FGM used to be teased, excluded from social events, considered to be children, unclean, and unattractive for marriage, nowadays the opposite is sometimes the case. Many young men say that they prefer their wives not to be circumcised. There are also stories of men refusing to marry women when they learn that they have undergone FGM.

Putting the issue of Lawalawa on the agenda in Tanzania

"The community promised that they would stop performing FGM if there is another cure of Lawalawa"
SIAC project staff

In Tanzania the issue of Lawalawa is central to the fight against FGM, and SIAC reports on positive results after sensitising the village populations on this issue. After discussions with the villagers in one of the project sites it was made clear that the issue of Lawalawa was the main driver for the villagers to perform FGM on their girls. Not all the villagers know that what they call Lawalawa is a vaginal or urinal infection, which can be treated with antibiotics, and many people believe that FGM is the only cure. The villagers promised that if there really were another cure to Lawalawa they would stop performing FGM. After including sensitisation on health and hygiene the villagers have started to seek medical treatment for urinary and other infections in their girls. Similar stories are told by various stakeholders throughout the Tanzania fieldwork, indicating the importance of health education in the work to combat FGM in the Dodoma and Singida areas.

44 Ingdal 2008, p. 40
45 Hailu 2009, p. 31
46 Bihi 2011, p. 14

A male village facilitator tells a story about his daughter

After becoming a SIAC village facilitator I received education about the relationship between Lawalawa and urinary tract infections. Later my child contracted such an infection, and my wife wanted to have her circumcised. I had received sensitisation and wanted to take her to the heath clinic for treatment. This resulted in a conflict between us. Then I took the child to the health clinic and she was given treatment. After this I was assured and felt confident that SIAC was teaching the same as the medical practitioners would have taught us. When my child was cured my wife also became convinced that the cure to Lawalawa is not FGM.

Creating a functioning reporting system

"Because of this project we report it if we hear about FGM cases". Community facilitator, Ethiopia

A positive achievement of the NLC project in Ethiopia is the development of a reporting channel for FGM cases. Community members have been informed that they can report suspicion of FGM cases to the community facilitators. The facilitator will report the cases to the local governmental Women and Children's Affairs Bureau, which in turn will cooperate with the police to stop planned FGM procedures at the household level. This has also contributed to improve the law enforcement. The former community facilitators hold that even if the project has stopped they continue to report if they hear about FGM cases.

From awareness and change of attitudes to changing behaviour: Decrease in FGM prevalence

"FGM is very rare now"

The main achievement cited by most of the people talked to is the decrease in FGM prevalence as well as other harmful traditional practices such as early marriage in Tanzania and marriage by abduction in Ethiopia. The discussions during the fieldwork in Tanzania and the DIAC/SIAC project reports indicate very positive project achievements with dramatic reductions of FGM in the target villages. In one village a group of people discussed FGM prevalence and agreed that the practice is reduced by 95-100%. Similar statements came up in other villages visited. When investigating further the participants modified their statement and said that although the majority of the people in the central parts of the village may have stopped practicing FGM, it is still being done in the more peripheral areas of the village. During the conversation it became clear that many people still perform FGM due to Lawalawa, and that there is secret migration to have FGM performed in other villages. Clandestine FGM practice on infants and resistance to FGM sensitisation is also being highlighted as challenges, indicating that the practice may not have decreased as much as people are inclined to say initially.

FGM prevalence: A village nurse tells a story

Some people here say that there is no more FGM. However, in 2006/7 we decided to do an examination of all the young children who were brought to the clinic. We found that a large number of the girls were mutilated. When it became known that we did examine the children the women stopped coming to the clinic. Because we find it important that the women come to the clinic with their sick girls, we stopped the examinations. Therefore we do not know how many girls are being circumcised these days.

Similarly, when asked about the current FGM prevalence many people talked to in Ethiopia hold that *"FGM is almost non existent now".* However, when investigating further people often say that FGM is

still conducted, particularly in rural or peripheral areas. One member of the local women's association hold that *"We know that the situation has not changed completely because people are still begging her [the former circumciser] to come and circumcise. That is because they have not understood what we have said."*

FGM rates are undoubtedly declining in Ethiopia and Tanzania. To what extent these changes can be attributed to specific projects is not easy to determine. In both Ethiopia and Tanzania people refer to the media as an important source of information about the harms of FGM. Community facilitators in Addis Ababa say that, *"Times are changing anyway, but the project has also contributed to changes".* Moreover they argue that, *"Those who do not pay attention to the media will get info from the door to door visits", and* sums it up like this: "*There is very little FGM now. It is because we teach and because of the media also gives this message. Also there is a law and many people fear the law".*

According to the APDA evaluation report *"The intervention has brought considerable improvements in terms of positive change in the attitudes and practices among the members of the associations that have led them commit to end the practice. As per the informants in various discussions and interviews, they did not perform any form of FGM on their children/girls during the project period, and at the same time they don't intend to do FGM on their future children"*[47].

Assessment

The FOKUS projects have above all contributed to putting FGM on the local agenda, making people engage in open discussions about an issue formerly not talked about, changing people's attitudes, and increasing awareness about the harmful effects of FGM. The mere existence of the projects and the fact that they disseminate information and create a pressure to abandon FGM is important in itself.

The projects may also have contributed to the reduction of FGM observed in many of the areas where they work. Results reported by project staff, community members and written reports point in the direction of extremely good results in terms of drastic reductions of the FGM prevalence. However, when conducting interviews in control villages in Tanzania, which have not been targeted by NGOs with FGM interventions, results are found to be about the same. People report that FGM is hardly practiced anymore. Thus we do not know to what extent the changes in prevalence can be attributed to the projects. An interesting difference, however, is the fact that people in the control villages report the main reason for discontinuing the practice to be fear of the law. In the project villages people mainly refer to awareness of negative consequences of FGM. This can be interpreted as an indication that the awareness rising is having an effect, and one would assume that the health argument is more sustainable than merely fear of the law.

Assessing the exact achievements and results of the FOKUS projects is, however, challenging. None of the projects visited are based on baseline data. This results in problems related to identify what changes have actually occurred, and what changes can possibly be attributed to the specific projects, rather than being a result of government media campaigns, fear of the FGM laws, or other NGO interventions. The general lack of systematic documentation and simple tools for checking impacts of interventions makes it difficult to identify results against planned targets. These issues are elaborated on further in the chapter on Common Challenges.

47 Hailu (2009) p. 31

2.3.1. Key success factors

Project staff, volunteers and beneficiaries in the villages and communities were asked about the key factors being important for achieving results. The following are the main explanations for the achievement of the successes.

Local ownership

For the SIAC and DIAC projects the most important element for achieving results is the local ownership. Project staff highlight that the good relations with and the support from the local government structure has been vital for access to the villagers and for creating venues for the dissemination of information. The support from, engagement of and direct work with local government leaders, Muslim and Christian religious leaders, health personnel, circumcisers, teachers, midwives, and youth are key elements to bringing about the desired results. Without real commitment from the communities involved fostering change in a social convention such as FGM is close to impossible. DIAC staff in particular are highlighting the fact that the community itself must define the issues and find local solutions in their own time. This corresponds well with current research and knowledge on best practices related to FGM work.

Community participation is also viewed as a highly positive factor by NLC staff and volunteers. NLC engaged key community people in the project steering committee, monitoring the activities implemented by local community facilitators. One NLC staff put it like this: "*We have a very close relationship with the community, we are like family to the communities".* Religious leaders, people form the women's association and other volunteers showed commitment, knowledge and motivation in discussions with the evaluation team. Still, the FGM activities have not been sustained after the end of the project, as had been anticipated. This illustrates the fact that ensuring local ownership is a complex and time-consuming endeavour.

Voluntarism has been another key factor contributing to success for DIAC/SIAC and NLC. The three organisations rely heavily on volunteers to implement the majority of the project activities. This creates ownership and contributes to increased sustainability, but it also leaves the organisations vulnerable and dependent on the time and resources of the volunteers.

A female volunteer village facilitator tells about her motivation:

I use my own experiences in the work against FGM, because I was circumcised myself. It happened to me when I was five or six years old. It was terrible, and I hated it. My sister fainted for hours after she was circumcised, and the circumciser was scared that she would not wake up because she was bleeding a lot.

We have a bitterness in us that motivates us to work against FGM, and we still ask ourselves why it was done to us. I have a niece and when her parents wanted to take her for FGM, I told them that I am a facilitator and that it would be a shame to me if my niece would be mutilated. In the end I managed to convince them not to circumcise her.

Sustained interventions

FGM interventions are addressing deep-rooted traditions and beliefs and need to be implemented in a long-term perspective. Successes have been observed where organisations have worked continuously over time, such as DIAC and SIAC. In Ethiopia the NLC former steering committee members criticise the organisation for pulling out of the Akaki area after the first project period of 3 years, leaving the

volunteers with a sense of ending a process, which had barely begun. NLC hold that the project has done a great deal to sustain the efforts of the project voluneteers even after the withdrawal of the project. However, the conflicting picture given by the two parties may illustrate that three years is not enough to build ownership and sustain the work against FGM.

The YWCA Kenya evaluation report is making similar observations: *In studies related to what triggers behavioural change among communities that practice FGM, great emphasis is placed on continuously and systematically training communities in order to sustain the process of changing behaviour towards FGM. "…if organizatiosn are to engage in programming that leads to social change or that challenges social norms, they need to ensure that they can work in sustained manner with communities. That is, they need to make a commitment to accompany the communities in social change process"*[48].

Targeting the key people

Targeting key community members have proved to be important for the achievements of results. Many of the FOKUS organisations have involved key people such as the local government, religious leaders, health personnel, circumcisers, and teachers. During discussions in the field many people identify the elders and religious leaders as particularly resistant groups, and argue that it is therefore important to work strategically to find the exact entry points in order to get them on board. Religious leaders and the elders often have limited education and still they are the key bearers of traditions and can be powerful agents of change among community members. Elders have been recruited to perform alternative rites of passages in Tanzania and Kenya, and NLC, APDA and GARWONET have particularly targeted religious leaders.

The main focus for most of the projects is to train and empower girls and women. Women are the victims of the tradition of FGM and generally women are more involved in the planning of FGM and the actual procedure. Usually the circumcisers are women. However, as men are the key decision-makers at household and community levels they often exert influence over the decisions related to FGM. Therefore components addressing boys and men are integrated in many of the projects, and this is seen as relevant and even necessary in order to achieve change. Even though women may be more involved in the FGM process, men are generally involved in decisions around marriage. If men demonstrate a will to marry girls who are not mutilated, part of the rationale for performing FGM would disappear. The strategic involvement of men has for instance been seen as important in Ethiopia, as expressed by a community facilitator: *"We think that the first target group should be the husband and wife, if we talk to the wife only, it does not work. Even when we teach we go together one male and one female facilitator"*. As elaborated on earlier in this report FGM needs to be treated as a gender issue as opposed to a women's issue. The practice is concerning and affecting both women and men, and efforts to eradicate the practice need to involve all parties concerned.

48 Population Council Frontiers/Care and USAID, 2004 in Ingdal 2008, p.16

2.4. Common Challenges

Planning, monitoring and reporting: Weak documentation of results

"We are very good at engaging on the grass roots level, but we are not good at writing project proposals and reports". SIAC staff

The main organisational challenge faced by both SIAC and DIAC relates to project planning and results based management. The project documents reviewed have several shortcomings precluding the documentation of results against planned targets. While a lot of solid and innovative work is being done on the ground, the results are not accurately captured in the reports. Moreover, the projects appear to be largely focusing on activities and outputs with insufficient attention to outcomes and impacts, leading to potential underreporting of achievements and the missed opportunity to measure, learn from and exploit the impact of the programme.

Both SIAC and DIAC staff are aware of the shortcomings of the project documents and hold that they find it difficult to understand the questions and explanations in the FOKUS formats due to language problems. This can partly explain the weak documents, and should be looked into. Still, particularly the SIAC project plans and reports are not providing adequate information and reveal confusion around terminology as for instance activities are listed as results. Also from the discussions and observations in the field the evaluation team is left with an impression that planning processes could be better structured and work could be more systematic. More professional planning processes and better results monitoring would significantly enhance learning and better capture the results achieved. In order to better understand the implications of the specific interventions, to assess their actual results and work systematically towards the project goals, the projects need to establish a baseline against which one can measure progress.

NLC has similar challenges. The results framework in the applications and reports is weak and there is a need to convey the central messages more clearly. Moreover, there is confusion around terminology and a strong focus on the activities to be carried out, missing out on the actual results being produced. Activities such as "1000 leaflets produced" are for instance reported as a result, leaving out information on what is actually achieved through the dissemination of leaflets. It would be a great advantage to be more analytic, systematic and fact based in the monitoring and reporting. The lack of a baseline for the project combined with inadequate monitoring systems makes the measuring of actual results of the project very difficult.

As in Tanzania many people interviewed in Ethiopia hold that FGM is more or less abolished in the NLC project areas. However, according to national surveys the FGM prevalence in Addis Ababa has decreased from 70.2% to 52.2% (25,6% decrease) from 1997 to 2007. For the Oromia region, from which large parts of the target population is coming, the prevalence rate has been reduced from 79.8% to 58.5% (26.7% decrease) during same time period[49]. If the decline in the FGM prevalence proves to be substantially stronger in the project area than shown by the national data, it would be an interesting result, which needs to be substantiated further.

Similar challenges related to poor documentation of results and lacking baseline data have been found in the three remaining FOKUS projects. The APDA evaluation report holds that there is no baseline data

49 Egldam 2008

to measure results against, no clear monitoring indicators, no plan to track progress, and no clear objectives showing intermediate project results. The GARWONET project has no baseline, and shortcomings related to monitoring of the results are highlighted in the evaluation of 2011. The project report for 2010 is highly inadequate, possibly resulting in underreporting of results achieved. Similarly, the 2009 mid term review of the YWCA Kenya project states the following: "*Due to the lack of a baseline before starting up the project in 2006, it is impossible to establish with certainty how much of the behavioural change can be ascribed to YWCA Kenya's intervention, and how much is due to Kenyan authorities' legal measures, or efforts by other NGOs or churches"*[50]. YWCA Kenya has, however, acted on the recommendations from the mid term review and conducted a baseline survey in Kisii, Kajiado and Meru (2009).

Learning from experience

The organisations are making efforts to learn from past experiences. However, because of the absence of baseline data and due to inadequate strategic planning and monitoring there is a missed opportunity to learn from the successes and avoid repeating failures. More systematic documentation of lessons learned would benefit the development of the projects.

One example is the use of the door-to-door approach implemented by GARWONET and NLC. NLC is highlighting this method as a success in terms of creating awareness. It gives the community facilitators time to sit down with couples and families to discuss the issue of FGM. It is argued that the door-to-door approach has been effective, but no tangible evidence is presented. It would be interesting to have the door-to-door approach assessed and compared with the more common community dialogue/conversation approach based on open meetings where the community can share views and discuss, which by many is said to yield the highest results in the fight against FGM. In the case of NLC potential lessons learned through the door-to-door approach implemented in the former FGM project in Akaki should have been captured and fed into the development of the new FGM project currently being implemented in SNNPR. Moreover, the team is told that NLC has been implementing a community dialogue approach in their HIV/AIDS intervention, and it is not clear to the evaluation team what made the organisation chose a different approach for the FGM project.

Resistance

A common challenge cited across all the projects is resistance to changing the traditions related to FGM. Resistance may come from all community members, but the elders are said to be particularly hard to get on board. One village facilitator in Tanzania said that, *"Our main challenge is the elderly people. When you talk about secret things in public the elders feel that we do not respect them, and they refuse to attend."* People talked to suggest that the best ways to reach the elders might be through other respectable people such as peer elders, priests, and circumcisers. One villager holds that, *"The church should take the responsibility to take the education to the elders. They have more respect with the elders".*

Resistance from the elders - A young mother in Tanzania explains

The elderly wants us to circumcise our daughters. If the child is ill with diarrhoea or vomiting the mother in law will say that it is Lawalawa and that you have to go and get the girl circumcised. It happened with my daughter and my mother in law insisted that I take her for FGM. But I refused and took my daughter to the health clinic. The nurse said that she had an

50 Ingdal 2008, p. iii

infection because of unhygienic conditions. Then I was instructed of how to improve the hygiene. I am not on good terms with my mother in law now, but it is my child and my right to decide.

Resistance from the elders – A Community facilitator in Ethiopia explains

When we talk with the elderly women they justify FGM. They really think it is necessary. They say that if a girl is not circumcised she will break things, and she will be aggressive and disobey the husband. They are the push factors because they really believe in FGM, and they often convince the parents to take the children to the rural areas to circumcise them. We tell them that even the law is against it, and that is the only argument that they accept. They think of the prison sentence and the fines that they are expected to pay, and that might make them change their minds.

SIAC staff is also highlighting resistance among other community members when they invite people to come for FGM sensitisation: *"When we invite the boys to come, they come, when we teach they listen, but then they talk behind your back undermining the training".* Similarly, they say that, *"When we are teaching the circumcisers they pretend to be keen to know, but deep in their mind they might be sceptical. They might still continue to practice FGM even though they pretend that they are against it at the meetings".* More work could be done by several of the organisations to analyse resistance from particular groups of people in order to work strategically to find the right entry points to reach them.

Reaching remote areas

People interviewed in Tanzania and Ethiopia are citing the great distances as a main challenge. People living scattered and in distant villages are hard to reach. In Tanzania wild animals are posing a serious threat to the village facilitators when they are walking to remote villages, and the lack of means of transportation is hampering results.

FGM gone underground

"What is bothering us is how to tackle the small children being circumcised underground these days".

A problem highlighted particularly in Tanzania is the fact that FGM is increasingly performed in secrecy on infants. Escaping the law and the *"false belief in Lawalawa"* are cited as reasons for the clandestine practice. It is argued that the circumcisers perform FGM secretly although they might publicly say that they have stopped performing. SIAC and DIAC staff and volunteers hold that more strategic thinking is needed in order to find ways of tackling this challenge.

Allowances

"People only want to come for sensitisation if they get something in return."

Many of the people interviewed complain that it is hard to get people to come to FGM sensitisation: "*When it is farming time people do not attend. Also the fetching of water is time consuming and leads to sporadic participation".* Many people do also expect allowances in order to turn up at meetings: "*Some people think that we get a lot of allowances for being facilitators and others ask for allowances to take part in meetings. We tried to tell them that we are also volunteers, and that we have nothing to offer".*

In Tanzania SIAC and DIAC facilitators are trying to meet this challenge by giving FGM sensitisation in settings where many people are gathered for other purposes. Examples are community meetings arranged by the local government, the church and sports venues. Combining FGM sensitisation with the provision of services such as health services or literacy classes, which is being done by APDA and NLC is another way of reaching more people.

It is difficult for the facilitators to spend a lot of time doing voluntary work with only very small allowances in return. Some of them do receive simple farming tools and perhaps a bicycle. However, they find it difficult to spend the necessary amount of time going to remote villages without proper remuneration.

2.5. Concluding remarks

This chapter is summing up the approaches of the FOKUS FGM projects according to the DAC criteria. It seeks to reflect upon the various approaches used and assess their relevance, effectiveness, efficiency and sustainability[51].

All the FOKUS projects are using a variety of approaches in their work to combat FGM. The approaches are generally based on local traditions and sound knowledge of the social context in which they operate. Many of them are addressing various parts of the communities, stimulating discussions and engagement among the community members themselves. This is in line with current trends and research advocating for the importance of a holistic approach based on strong local ownership, local control and participation, as outlined in the initial chapter of this report. DIAC is one of the organisations most successful in trying to address the social norms, beliefs and attitudes of communities in a holistic way. This means that the communities themselves are encouraged to review the norms and conventions that have been embedded in local tradition and culture and to find alternatives to harmful practices. However, although all the projects have elements of this recommended holistic approach, they do not work systematically enough to address the deep-rooted traditions of FGM as effectively as they could.

Although working with all segments of the community, many of the projects still largely build on a traditional health risk approach based on the assumption that knowledge about health risks will be enough to influence the abandonment of the practice. According to recent research, health education campaigns alone have largely failed to motivate large-scale behaviour change[52]. There is also a concern that the health approach may lead to the medicalization of FGM or the move to a milder form of FGM, which may actually lead to more people being likely to accept the procedure. This has been observed among the APDA beneficiaries and in Somalia. Moving towards a rights based approach, arguing that the wellbeing and good health of all people depend on how human beings are valued and treated, brings in the dimension of gender relations and sees FGM as a form of gender based violence. From this perspective FGM is not only addressed because of its negative health implications but because of its violation of the rights of women. This approach is seen as fruitful when engaging in a holistic approach to combat FGM, and should be applied more systematically by the FOKUS projects.

Relevance

The extent to which the objectives of a programme are consistent with beneficiaries' requirements, country needs, global priorities and partners' and donors' priorities[53]

All the focus projects are highly relevant. The FGM prevalence remains high in the project areas, and interventions addressing this issue are increasingly perceived to be relevant by the target populations. Except for the project in Somalia, all the projects are supporting existing government policies and laws, and are therefore seen to be in line with the needs and priorities of the countries where they are implemented. The fight against FGM is a global concern as it conflicts with fundamental human rights, and several international declarations call for the abandonment of the practice, including the Maputo Protocol of 2003. It is also relevant to Norwegian law and the Norwegian government's action plan against female genital mutilation. All the approaches used are in line with the FOKUS Policy on FGM.

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51 The team has mainly been able to assess the DAC criteria of the projects visited. For the other projecs the team has only been able to assess the criteria where relevant information has been available in former evaluation reports.

52 Shell-Duncan 2008

53 Norad Development Cooperation manual

The relevance of the various approaches implemented is to a large extent dependent on the cultural context, and an in-depth knowledge about the local traditions is key to provide effective interventions. For instance the ARP approach is seen as relevant in some areas in Kenya and Tanzania where girls are traditionally mutilated in their early teens, accompanied by large village celebrations. This approach is, however, not relevant where the FGM takes place privately or where the girls are mutilated at a much younger age.

Efficiency

A measure of how economically resources/inputs are converted to outputs.

Some of the FOKUS projects receive little funding and project achievements largely result from voluntary work in the local communities. This contributes to ensuring ownership and community level involvement. In Tanzania DIAC and SIAC have only one full time paid staff each in addition to some secretarial assistance. The organisations therefore rely on volunteers to carry out the project activities, keeping costs at a minimum level. According to a former evaluation report assessing the DIAC project, *"DIAC uses few resources yet appears to get quality results and reach many people in the remote areas of the Dodoma region"*[54]. DIAC and SIAC work with existing local structures, and volunteer organization members build skills of local village facilitators, who carry out village level activities. This way they manage to do continuous outreach work in more than 20 villages each, largely based on enthusiasm and dedication to the cause by staff and volunteers. The use of public transportation and travel by bicycle or by foot is, however, time consuming, and lack of means for transportation prevents them from reaching remote villages. The very small allowances for the volunteers is perceived to be a challenge creating both discontent by the volunteers themselves and distrust in the community as other organisations do compensate volunteers for travel and the time spent implementing activities. As highlighted in the formal evaluation report it might be worthwhile looking into this issue: *"Cost effectiveness appears to have been interpreted as "low cost" and we noted that there appeared to be a need for further discussions around the relationship between objectives and costs"*[55].

The NLC project outside Addis Ababa was similarly relying on community volunteers, contributing to the cost effectiveness of the project. The main strategy employed by NLC has been the door-to-door visits by volunteers. APDA and GARWONET are also applying this method. NLC in Ethiopia is highlighting this approach as a success in terms of creating awareness, giving the community facilitators time to sit down with couples and families and discuss the issue of FGM. This approach is not costly in itself, although it is time consuming as large distances often had to be covered by foot and only one family was reached at the time. As was highlighted by some of the community volunteers interviewed, gathering more people for watching films or engaging in community discussions could have proved to be a more effective use of time. Considering the collective nature of decisions related to social conventions such as FGM one also has to consider whether the door-to-door approach is an effective method to motivate behaviour change. The application of the door-to-door-approach should therefore be based on evidence of the effectiveness of this particular method.

In Kenya a former evaluation report found that T-shirts and other visual aids are highly efficient ways of bringing the FGM message across. The use of volunteers and modest salaries were also found to contribute to cost-effectiveness in Kenya.

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54 Ternström et al 2011, p. 43

55 Ibid

In Kenya the building of shelters is, however, not considered to have been a cost effective component: *"The main weakness related to the project's efficiency is the construction of the two shelters in Meru and Kisii, which has suffered from inadequate planning; unrealistic budgeting and unforeseen external factors (increase in construction costs). The lack of a proper feasibility study and business plan has led to great delays and unnecessary costs and waste of human and financial resources*[56]*.*

On a general note, the alternative rites of passage and working with circumcisers are considered time consuming and relatively expensive, and are therefore not seen as the most cost-effective approach. Related to the ARP approach implemented in Tanzania and Kenya there is concern that without project support the communities will not have the economic means to carry out the ceremonies. In Tanzania some people expressed a relief that the traditional ceremonies have gone, as they were seen as an economic burden for the families involved. Unless more cost effective ways of celebrating the ARP is introduced it may be difficult to sustain this component in the long run.

Effectiveness

The extent to which the programme's purpose was achieved, or is expected to be achieved.

The general lack of baseline data and the scarce evidence of project achievements make the assessment of the project's abilities to achieve the planned results difficult. The achievements that are actually documented could also result from factors external to the projects. However, through the available information, including interviews and former evaluation reports, some issues emerge as central to the effectiveness of the projects and the approaches they have been applying.

Overall the projects are seen to have achieved their objectives of greater awareness and knowledge about the negative aspects of FGM and attitudes are seen to be changing. The projects might also have led to a decrease in the FGM prevalence in the areas where they work, which is a stated goal for all the projects except the project in Somalia. However, there is no solid evidence to support this assumption.

In Kenya the main project components such as awareness training, ARP, media and information are seen to have been relatively effective, according to the 2008 evaluation report. However, the effectiveness of targeting of circumcisers is seen to be varying from area to area. Some of the former circumcisers felt that they had lost their status in the community, others felt that they had gained prestige after stopping to perform FGM. The evaluators felt that economic incentives for abandoning FGM had been more important than *"an actual change of heart"*[57]. The evaluation team for this evaluation had a similar experience in Ethiopia. Lessons learned from the FOKUS projects indicate that involving circumcisers is a time consuming and challenging task, where culture and traditions play a strong role. This corresponds with recent studies on this issue. This approach should therefore only be a supplement to other approaches as it is not addressing the core of the problem of challenging the demand for FGM among the general population.

Several of the FOKUS FGM projects have the potential to increase their effectiveness. The following statement from the former evaluation of DIAC is relevant for all the three projects visited by the evaluation team. *"DIAC has the potential to significantly increase the project's impact by improving project management. Results based management can help DIAC get more impact without increasing cost or pressure on members, facilitator and staff. Greater contextual understanding will lead to better*

56 Ingdal 2008, p. 39

57 Ingdal 2008, p. 25

use of people's time, better use of the available budget and better coordination with other stakeholders. For this to be possible DIAC needs to continue investing in capacity building, including project management"[58]. Investing in organisational development and staff skills would increase effectiveness and may also help relieve high staff turnover as faced by for instance NLC.

Sustainability

The continuation of benefits from a programme after major development assistance has been completed. The probability of continued long-term benefits.

All the FOKUS supported projects are building capacity through training and sensitisation of a variety of stakeholders. The capacity built in the local communities, local government bodies, schools, and among health workers will remain after the projects are ending.

DIAC and SIAC's highly community based approach with strong community ownership and extended voluntarism increases the sustainability of the project. The villagers are building local structures for the FGM work and seem dedicated to the cause. The organisations' long-term presence, commitment and dedication have undoubtedly played an important role in this. However, it will be important to keep in mind that gains can easily be reversed if a proper exit strategy is not planned and implemented. Several of the people interviewed by the evaluation team express worries that people might revert to their old traditions when the project ends.

In Ethiopia the FGM programme in Akaki ended in 2009, giving the evaluation team the opportunity to assess the sustainability in retrospect. According to project reports the project was anticipated to continue after NLC phased out their support. Although local awareness, involvement and engagement had been built by the project, few activities have continued after the closing down of the project. Most of the former project community facilitators and steering committee members talked to say that they have not continued the activities due to poor handing over and a lack of ownership at the community level. They strongly felt that the closure of the project was not done in a constructive way. They say that they were not informed properly about the ending of the project, the project was not officially handed over to local institutions, and they have not been informed of what results they had received through their voluntary work throughout the three project years. The local Women's association seem to be the only organisation still working actively against FGM. However, their representatives also feel that the project left without appreciating the work done at the grassroots level. NLC staff agree that the exit was not as smooth as it should have been, although they do not share the gloomy picture told by the community members. NLC staff claim that the closure of the project was properly announced and known to all the people involved. Still, this story illustrates the importance of a well thought through exit strategy for the sustainability and continued work after the project is phased out.

At the organisational level several of the FOKUS organisations are small and vulnerable, often faced with high staff turnover and solely depending on FOKUS support for their work (DIAC/SIAC/GARWONET). SIAC project staff are thinking of ways of generating income to support office rent and remuneration of staff and volunteers. All the organisations should consider alternative sources of funding to sustain their work after the FOKUS funding is ending.

58 58 Ternström et al 2011, p. 39

2.6. Recommendations - FGM project support

1. FGM is a highly relevant issue for FOKUS, and support to FGM projects in East Africa should continue.

2. Future FOKUS support should build systematically on the existing experiences and lessons learned from partner organisations. In addition the FOKUS support should be based on updated research and current knowledge on the issue of FGM. FOKUS should learn from and make use of the experiences of other organisations currently engaged in similar work, which has been evaluated and studied.

3. All FGM efforts should promote a rights based approach seeing the work against FGM as a relational gender issue, being relevant to both men and women. FGM interventions should focus on the social mobilisation of communities through an open dialogue. They need to target multiple stakeholders within the community.

4. All FGM interventions should emphasise local ownership through the involvement of relevant formal and informal social structures, such as government bodies, traditional CBOs and local leaders.

5. Interventions should be based on long-term commitment, and they should have clear exit strategies with concrete and realistic plans for handing over to the local communities.

6. FOKUS should continue to support advocacy efforts working for legal and policy changes and promote reporting procedures.

7. FOKUS should support interventions using films and other visual materials in the sensitisation work. Moreover, FOKUS should continue funding efforts of using the media as radio, television and newspapers are powerful means to disseminate information. If context allows for it the use of mobile phones and the Internet, including new social media such as Facebook and Twitter would be potentially powerful ways of reaching adolescents, and should be explored.

8. In Tanzania it is seen as crucial to continue support of health initiatives addressing the widespread belief in FGM as the cure to vaginal and urinal infections, locally named Lawalawa.

9. FOKUS should play a more active role in strengthening the administrative capacity of the supported organisations in order to improve their results based management. This should include strategic project planning, monitoring and reporting. In addition FOKUS should invest in FGM/SRHR skills building in staff where needed. National experts/organisations should be identified to undertake the necessary training or provide advisory services.

10. There is a need for all the FOKUS supported projects to improve the documentation of achieved results. It should therefore be a requirement for all FGM projects to develop baselines against which they will be able to measure results. The nature of the baseline will have to be decided according to each project's specific context.

11. Each project should concentrate on areas where they can contribute with added value instead of trying to embrace all aspects related to FGM. Strategic collaboration with other organisations in the area should be explored for complimentary work and to avoid duplication.

Part III: The way forward - Towards a consolidated FGM programme

3.1. Background

FOKUS is currently in the process of developing a thematic FGM programme in East Africa together with relevant member organisations and partners. The 2008 Organisational Performance Review recommended such a programmatic approach:

"The idea is to work more programme-oriented, i.e. that the individual projects relate to a larger thematic work, and increase thematic and programmatic learning and exchange of experience. There is also some pressure to move towards a more geographical concentration. Norad has suggested that by reducing the number of countries, FOKUS may achieve more synergy between their projects. There are both internal and external pressures for this, both from the FOKUS Secretariat which can see that they could provide better professional advice if they were to be updated on contextual matters in a more limited number of countries[59].

The formulation of a thematic FGM programme may benefit FOKUS, the member organisations and their partners in various ways. A programmatic approach may provide increased opportunities to work more strategically, strengthen the possibility for learning through sharing experiences across organisations, and give FOKUS a stronger voice for advocacy work through easy access to a broader and more consolidated grass roots experience. Cost efficiency would potentially be enhanced through the sharing of materials and through common advocacy and capacity building efforts. A programme approach would let the individual projects keep their independence at the same time as they would get the opportunity to work together on a more overarching level and on certain common thematic issues.

3.2. FOKUS role

A thematic FGM programme will demand strong coordination from FOKUS, particularly during the initial phase, in order to build and consolidate a coherent programme. It would, however, give FOKUS an opportunity to systematically strengthen the partners and projects in terms of administrative skills as well as thematic issues related to FGM. When the programme is developed an African based organisation may be identified and be given the coordinating role. The programme should be based on a FGM programme strategy. The strategy should entail the rationale for the programme as well as clear goals, objectives, strategies and criterion for project support within the programme.

3.3. Choice of partners

The current FOKUS portfolio consists of a mix of small and medium sized projects generally implemented by small grass roots oriented organisations. In order to build a strong programme of high quality FGM work it would be necessary to supplement the existing organisations by creating strategic alliances with strong FGM organisations and networks at the regional and country levels. Advocacy organisations should be included. This is not to say that the smaller projects are less important. In the fight against FGM locally based grass roots organisations are vital both to engage community participation and ownership and to contribute to ensure a sustained pressure from all parts of society. However, many of the smaller organisations would benefit from advise and support from networks and larger organisations primarily engaged in FGM. In Ethiopia the two FOKUS supported organisations NLC and APDA primarily work on other issues than FGM. They would undoubtedly benefit from the

59 Aasen et al 2008, p. 39

experience and advise from organisations with stronger FGM expertise. In Tanzania SIAC and DIAC are small and vulnerable organisations with limited capacity and project management skills. Support, advice and the exchange of experience with larger networks and organisations would potentially enhance their capacity and effectiveness.

FOKUS, the members and partners would have to identify regional and national organisations that are willing to take on an advisory and possibly coordinating role relating to the FGM programme. There are several potential strategic alliances in Ethiopia and Tanzania. IAC headquarters in Ethiopia would be one possible partner in this respect. IAC staff talked to during the fieldwork responded positively to this idea. However, due to current internal processes the organisation is not considered ready to take on such a role at this stage. Egldam, a network organisation also being the national chapter of IAC in Ethiopia could potentially play a central role. NCA, Save the Children Norway and the Norwegian Embassy is currently working to support Egldam to become an important coordinating body for NGOs involved in FGM work and as an influential partner for the Ethiopian government. NLC is a member of Egldam, however, the NLC activity in the network has so far been modest. Egldam has informally confirmed that the organisation is providing advice and support to the member organisations.

In Ethiopia FOKUS' strategic partnership with NCA might provide an alternative entry point. NCA in collaboration with Save the Children Norway are important FGM actors with substantial experience and knowledge. In discussions with NCA staff the importance of sharing and collaborating between organisations working against FGM was strongly highlighted. In Tanzania the Tanzania Gender Networking Programme (TGNP) and the Women in Law and Development in Africa (WILDAF) are working nationally with women's rights issues including FGM, and may be potential partners within the FGM programme.

3.4. Selecting areas to work on

Depending on the objectives of the programme and its perceived added value, areas for the programme to focus on should be developed jointly by the parties concerned. Instead of embracing all aspects of FGM it could be useful to select one or two common issues for the programme to focus on each year. Some of the ideas for common areas of interest that came up during the fieldwork are:

- Assessing impact in small FGM projects, including the use of existing data and tools for developing and conduct baselines
- Results based management, systematic planning, monitoring and reporting
- How to work strategically to meet resistance to the FGM work
- FGM going underground: How to encounter this challenge
- Mainstreaming FGM into existing projects. Some of the FOKUS organisations are primarily working on other issues than FGM. Other projects might want to link up with service providers as entry points for mainstreaming FGM
- Advocacy – building strategic alliances

3.5. Geographical concentration – a challenge

A potential challenge related to a thematic FGM programme covering East Africa is the fact that the programme portfolio may become very scattered. As of today the FGM projects are located in four countries with very different contextual settings. Other countries may also be added depending on applications received from member organisations. It may prove challenging to establish and maintain a sense of programmatic belonging and creating synergies across several countries. Moreover, as described in the 2008 Organisational Performance Review geographical concentration has several positive side effects and would be easier to manage for FOKUS. An option would be to start with a pilot

FGM programme focusing on one country in order to establish programme routines, and then assess the experiences before scaling up to include other countries.

3.6. Recommendations - future FOKUS FGM programme

1. A thematic FGM programme should be based on an FGM programme strategy, stating the goals, objectives and the added value of the programme. The programme should build on existing knowledge accumulated within the FOKUS portfolio. However, it would be important to supplement lessons learned internally with updated knowledge and research on FGM work. In line with recent research and the FOKUS FGM Policy the programme should promote a rights based approach seeing the work against FGM as a relational gender issue.

2. FOKUS should consider the existing project portfolio and strategize around the choice of partners and projects to ensure that the future portfolio meets the required criteria. To build a strong FGM programme the existing portfolio should be complemented with strategic collaborations with national expertise on FGM in the programme countries. FOKUS, the members and partners would have to identify regional and national organisations willing to take on an advisory and possibly a coordinating role relating to the FGM programme.

3. FOKUS should carefully consider the maximum number of countries to be included in the FGM programme. A geographical concentration limiting the number of countries to two or three should be considered.

4. The programme should entail both grassroots projects and advocacy efforts, as two complementing approaches.

5. Depending on the objectives of the programme common issues to work on within the programme should be identified.

6. The programme should focus on results based management and baselines should be developed for all projects included in the programme. This way results may be documented and used for learning and advocacy purposes.

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Annex 2 People met

List of people interviewed during Field Work in Dodoma and Singida October 17-22 2011

	Institution	Name	Status	Sex
1	DIAC –Coordinating Office 17/10/2011	Columba Mapembe	Chairperson	F
2		Jennifer Chiwute	Project Coordinator	F
3		Getrude Mawalla	Project Secretary	F
4		Hilda Nhungu	Executive Member	F
5		Timothy Holela	Member	M
6	DIAC- Machenje Village 18/10/2011	Mohamed Juma	Village Government	M
7		Wilson Masigose	"	M
8		Erisha Kuta	"/Councillor	M
9		Mkangale	Teacher	M
10		Ernest Kuta	Facilitator	M
11		Petro Lemabi	Facilitator	M
12		William Maike	Parent	M
13		Denis Mololela	"	M
14		Maiko Mazengo	"	M
15		Ezekiel Chotile	"	M
16		Emanuel maile	"	M
17		E mmanuel Mawalla	"	M
18		Baraka Makobalo	"	M
19		Musa Maile	"	M
20		Habeli Mhuluka	"	M
21		Kedimoni Mdogo	"	M
22		Godphrey Lupulu	"	M
23		Wilfred Mbaigwa	"	M
24		Samson Msigwa	"	M
25		Andason Maile	"	M
26		David Lechipya	"	M
27		Samuel Chilauni	"	M
28		Ernest Maile	"	M
29		Charles Mazengo	"	M
30		Lenity Malolela	"	M
31		Maria Kuta	Facilitator	F
32		Anna Mahimjila	Facilitator	F
33		Veronica Chisanza	Parent	F
34		Rita Chilauni	"	F
35		Esta Mahinyila	"	F
36		Mariam Mhulula	"	F
37		Mariam Kuta	"	F
38		Anna Mahinyila	"	F
39		Maria Kuta	"	F

	Institution	Name	Status	Sex
40	DIAC: Mima Ward, Sazima Village	Gideon Kussenha	Facilitator	M
41		Jackson Chimosa	Facilitator	M
42		Yona Mchazo	Facilitator	M
43		Noah Maswaga	Facilitator	M
44		Charles Sijila	Opinion leader	M
45		Jerome Mshama	Church leader	M
46		Lamech Ngolika	Teacher	M
47		Herman Mgommela	Catekister	M
48		Leonard Mtumwa	Catekister	M
49		John Mataluma	Village government	M
50		Juma Chilangazi	Village Chairperson	M
51		Kedmoni Ilamba	Parent	M
52		Niza Makali	Parent	M
53		Sirano letama	Parent	M
54		Nelson Ndoji	Parent	M
55		Joyce Makali	Teacher	F
56		Beatrice Lolesi	Teacher	F
57		Veronica Bwasi	Teacher	F
58		Pelis Mwalongo	Teacher	F
59		Rukia Mkata	Parent	F
60		Zilipa Kazeuha	Parent	F
61		Rabeca Masaweni	Facilitator	F
62		Aksa Lemgolia	Facilitator	F
63		Monica Kaseuha	Traditional BA	F
64		Aksa Chuga	Traditional BA	F
65		Christina Mwituzi	Traditional BA	F
66		Selina Mlowosa	Facilitator	F
67		Suzana Malechela	Facilitator	F
68		Haikaeli Chande	Facilitator	F
69		Amanaeli Javani	Facilitator	F
70		Martha Mpilimu	Facilitator	F
71		Rehama Mkonoli	Facilitator	F
72		Jema Mkane	Facilitator	F
73		Teresia chamle	Facilitator	F
74		Victoria Sijili	Parent	F
75		Zawadi Ilamba	Parent	F
76		Julia Sambai	Parent	F
77		Olivia Ngolika	Parent	F
78		Rehema Mwanjila	Parent	F
79		Olivia Makali	Parent	F
80		Helina Mataluma	Parent	F
81		Jeska Ilamba	Parent	F
82		Foibe Msanjila	Parent	F
83		Magdalena Vicenti	Parent	F
84		Sara Kusenha	Parent	F
85		Helina Ligoha	Parent	F
86		Vaileth Kusenha	Parent	F

	Institution	Name	Status	Sex
111	DIAC –Mima Ward; Sazima Primary School 18/10/11	9 Boys, 16 girls		
136	DIAC Mima Ward: Igoji Primary School	9 Boys, 16 girls		
137	SIAC Coordinating Office 20/10/2011	Theresia Mwakasasa	Coordinator	F
138		Hadija Juma	Admin Secretary	F
139		Ibrahim Kisai	Accountant	M
140		Cecilia Munisi	Member	F
141		Emiliana Holdita	Member	F
142		Amour Jabir	Member	
143		Swaumu Mohammed	Member	
	SIAC Ikungi Ward: Dungunyi Village 20/11/11. FGD	Gabriel Fyuze	Medical Doctor	M
144		Alex Jwani	Village Exc Officer	M
145		Bakary Omary	Village Facilitator	M
146		Pankras Joseph	Youth	M
147		Local Kiya	Youth	M
148		Daudi Memba	Opinion Leader	M
149		Michael Diu	Opinion Leader	M
150		Gregory Mlunda	RC Catekister	M
151		Meshack Moses	Pastor TAG	M
152		Emmanuel Gabric	Member	M
153		Athanas Malandu	Member	M
154		Isaya Jibu	Member	M
155		Isamil Sarumbo	Secondary Sch Pupil	M
156		Emmanuel Paulo	Secondary Sch Pupil	M
157		Joseph Gaspary	Youth	M
158		Julitha Enock	Chairperson/Facilitator	F
159		Magdalena Peter	Opinion leader	F
160		Mwajuma selemani	Opinion leader	F
161		Emakulata Daudi	Youth	F
162		Theresia Sonyo	Facilitator	F
163		Mariam Athumani	Ex- Circumciser	F
164		Regina Emanuel	Youth	F
165		Happiness Tegeta	Teacher	F
166		Zainabu Mlanzi	Teacher	F
167		Elizabeth Alex	Youth	F
168		Marietha Njingu	Midwife	F
169		Philipina Sumbi	Opinion Leader	F
170		Elizabeth Alex	Pupil	F
171		Etronia Joseph	Pupil	F
172		Lucina Augustino	Pupil	F
173		Annastasia Muna	Opinion leader	F
174	SIAC –Ikungi Ward:	Dorcas Mkumbi	Nurses/Health Officers	M

	Institution	Name	Status	Sex
	Nkuhi Village 21/10/2011. Sector Group Interviews			
175		Shaban Ramadhani	"	M
176		Flora Gandi	"	F
177		Scholastic Byamungu	"	F
178		Fransis Duma	Village Government	M
179		Nehamia Irunde	"	M
180		Simon Labia	"	M
181		Naftari Michael	Elderly Leaders	M
182		Winfred Henry	"	M
183		Anna Daniel	"	F
184		Ally Shabban	Pupils	M
185		Bakari Ramadhani	"	M
186		Robert Peter	"	M
187		Juma Andrea	"	M
188		Grace Aroni	"	F
189		Saba Yesse	"	F
190		Pendo Andrea	"	F
191		Theresia Fimbary	Young Mothers	F
192		Locadia John	"	F
193		Jema Thomas	"	F
194		Sipora Juma	"	F
195		Rose Augustino	Ex-Circumciser	F
196		Elimaria Mura	"	F
197		Ramadhani Omari	Teachers	M
198		Eliezari Aroni	"	M
199		Adeline Manase	"	F
200		Rehema Mwalimu	"	F
201		Bosco Mtandu	Facilitators	M
202		Jafet Ramadhani	"	M
203		Benja Samuel	"	M
204		Neema Daniel	"	F
205		Agnes Jonasi	"	F
206		Emacullata Ndele	"	F
207	Ikungi Ward, Ulyampiti: Project Village not in the plan for visit. 21/10/11	Salehe Mohamed	Member of SIAC Village Committe	M
208	Youth Movement For Change (YMC) 21/10/11	Hamis Knalidy	Volunteer	M

	Institution	Name	Status	Sex
209		Anthonia Tango	Theatre Group	F
210		Anastasia Nyabhenda	"	F
211	Chamwino Ward: Chinangali Village Not Project target (Control) 21/10/11	Elderly		F
212		Elderly		M
213		Adult		F
214		Girl		F
215	Chamwino Ward: Manchali Village Not Project target (Control)21/10/11	Esther Ulange Magosha	Village Executive Officer	F

Total 215 people, 95 men, 120 women

List of people interviewed during Field Work in Addis Ababa October 24-28 2011

	Institution	Name	Status	Sex
1	NLC Main Office 24/10/2011	Tiblet Gizework	Social worker	F
2		Girmay Abadi	Program director	M
3		Getenesh Alayou	Gender and development project coordinator	F
4		Genet Loulseged	Director/founder	F
5	NLC Former Community Facilitators in Akaki-Kality Sub-City 24/10/2011	Addis Tesfaye	Former Community Facilitator	M
6		Aynalem Worku	"	F
7		Kidist Haile	"	F
8		Dereje Moges	"	M
9		Serkalem Desalegn,	Member of Womens Association and former Community facilitator "student"	F
10		Mitike Reba	Former Community facilitator "student"	F
11	Former NLC Steering Committee members 25/10/2011	Alemayehu Fekadu	Tesfa Ethiopia Association – youth association working with hiv/aids	M
12		Kobe G/Medhin	Women's Association	F
13		Daniel Alemu	Leader of the local Orthodox Church "	M
14		Haji Sultan Tahir	Former Chairman of the Steering Committee, Muslim Leader	M
15	Meeting in NLC former project area at the local Womens Association office, Kilinto Woreda 25/10/2011	Enesh Kebede women association (F)	Former Community facilitator	F
16		Desta Teshome	"	F
17		Genet Beyene	"	F
18		Zerihun Eshetu	"	M
19		Mushira Gebre	Ex circumciser and Former Community Facilitator	F
20	Egldam 26/10/2011	Mr Abate gudunffa,	Executive director	M
21		Hilina Abebe	FGM Network Coordinator	F

	Institution	Name	Status	Sex
22	Norwegian Church Aid 26/10/2011	Kidist Belayneh	Programme coordinator HIV/AIDS and FGM	F
23	Save the Children Norway 26/10/2011	Mohammed Jemal	FGM program officer	M
24	IAC HQ 27/10/2011	Linda Osarenren	Senior program officer	F
25		Diariatou Kourouma,	Program officer	F
26	Development Fund office in Addia Ababa 27/10/2011	Mussa Ahmed Ismael	APDA programme officer	M
27		Ayele Gebre Mariam	Development Fund Programme officer	M
28		Jon Erik Nygaard	Development Fund Director	M

Total: 28 people, 12 men, 16 women

List of people interviewed in Norway

	Institution	Name	Status	Sex
1	FOKUS	Anita Sæbø,	Programme adviser	F
2		Jon Rian	"	M
3		Anton Popic	"	M
4	Somalisk Forening for Kvinner og Barn	Zahra Ali Osman	Prosjektansvarlig	F
5		Ellen Alexandra Lothe	Evaluator	F
6	Utviklingsfondet	Lene Bakker	Programme officer	F
7	NLC	Mezmur Shiferaw	Prosjektansvarlig	M
8	Kvinnefronten	Agnete Strøm	Prosjektansvarlig	F

Total 8 people, 3 men, 5 women