EVALUATION REPORT

Joint Evaluation of the UNFPA-UNICEF Joint Programme on the Abandonment of Female Genital Mutilation: Accelerating Change

Phase I and II (2008–2017)

Volume 2

Evaluation Offices of UNFPA and UNICEF

2019

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Acronyms

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

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Annex 1: Terms of reference (short version)

To see full version of the ToR, click here: https://www.unfpa.org/admin-resource/joint-evaluation-unfpa-unicef-joint-programme-abandonment-female-genital-mutilation

Introduction

The Evaluation Offices of UNFPA (lead agency) and UNICEF will jointly conduct an independent evaluation of the UNFPA/UNICEF Joint Programme on the abandonment of Female Genital Mutilation (FGM). The joint evaluation will commence in the first quarter of 2018. The present terms of reference (ToR) were based on an extensive document review and consultations with key stakeholders. The ToR aims to provide key information for the evaluation, including background of UNFPA and UNICEF support, the objectives and scope of the evaluation, the proposed methodological approach, including the sampling approach for the case studies, and the expected deliverables and indicative timeline.

An external, multidisciplinary team comprised of evaluation and thematic experts, will support the UNFPA and UNICEF Evaluation Offices carrying out the evaluation. The selected evaluation team is expected to conduct the evaluation in conformity with the present terms of reference, under the overall leadership from the evaluation management group, chaired by the lead evaluation manager of the UNFPA Evaluation Office (for details on the management of the evaluation see section 7).

The main users of the evaluation include staff members at UNFPA and UNICEF (at the global, regional and country level), partner countries, the Joint Programme steering committee members, civil society (including non-governmental organizations, feminists and women's rights activists, gender equality advocates). In particular, the evaluation will provide useful information to the managers and the steering committee of the UNFPA/UNICEF Joint Programme on female genital mutilation.

UNFPA and UNICEF Joint Programme on FGM: Accelerating Change

In 2007, UNFPA organised a Global Consultation on FGM which led to the creation of the UNFPA - UNICEF Joint Programme on Eliminating Female Genital Mutilation. Since its launch, the Joint Programme has given greater prominence to the issue, mobilized substantial additional resources, and provided new impetus to the global movement to end the practice. In line with the UN General Assembly Resolutions related to the abandonment of FGM as well as the adoption of the Sustainable Development Goals, the programme directly contributes to the achievement of Goal 5, related to gender equality. Notably, the Joint Programme has provided technical inputs to the Commission on the Status of Women and treaty bodies such as the Committee on the Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW) and the Committee on the Rights of the Child (CRC), while collaborating with WHO and UN Women ongoing policy and programmatic development.

2.3.1 Phase I (2008-2013)

The first phase of the Joint Programme was implemented over the course of six years (2008-2013),[1] supported by multi-donor funds received by the governments of Austria, Iceland, Ireland, Italy, Luxembourg, Norway and Switzerland.[2] In 2008, the programme began operating in Djibouti, Egypt, Ethiopia, Guinea, Guinea-Bissau, Kenya, Senegal and Sudan. The Joint Programme was then extended to Burkina Faso, the Gambia, Uganda and Somalia in 2009 and by 2011 also included Eritrea, Mali and Mauritania. By the conclusion of the first phase, the Joint Programme was operating in total of 15 countries.

[1] The Joint Programme was originally only to span four years (2008-2012), but was extended through 2013 to meet resource mobilisation targets and fulfil implementation obligations.

[2] UNFPA-UNICEF Joint Programme on Female Genital Mutilation: Accelerating Change, Summary Report of Phase I 2008-2013

The objective of the first phase of the Joint Programme was "*to contribute to a 40 percent reduction of the practice among girls aged 0-15 years, with at least one country declared free of FGM by 2012*".[3] The proposal also indicated that the Joint Programme was intended to be strategic and catalytic, holistic, cross border and sub-regional, human-rights-based and culturally sensitive, and based on a theoretical understanding of FGM as a social convention/norm.[4]

In 2012/2013, a joint evaluation was conducted on the implementation thus far on the first phase of the Joint Programme.[5] The results and lessons learned that emerged from this exercise then informed the formulation of the second phase of the Joint Programme. The evaluation concluded that: (i) the Joint Programme showed significant strengths, including its emphasis on pursuing a holistic and culturally sensitive approach and addressing global, national and local levels simultaneously however with some challenges in operationalizing the regional dimension; (ii) the available evidence supports several of the key assumptions shaping the theory of change of the first phase, but also highlights a knowledge and evidence gap with regards to the linkages between changes in FGM social norms to changes in individual and collective behaviours to changes in FGM prevalence; (iii) the results for the first phase were overall positive, where the Joint Programme achieved varying degrees of progress in strengthening legal and policy frameworks at national and sub-national levels, enabling change in the awareness and knowledge of FGM by key actors and general public, and increasing the commitment of community leaders and members to FGM abandonment.

Drawing on lessons learned from the findings of the Phase I evaluation, the Joint Programme introduced the following strategies to enhance its effectiveness:

- Increased focus on addressing social norms that result in harmful practices by supporting large-scale social transformation and positive social change at the household, community and society levels. The Joint Programme invested in more in-depth research on social norms and its linkages to changes in individual and collective behaviours. The Joint Programme provided capacity building to governments, civil society organizations, and UN staff members in the use of a social norms approach.
- Strengthened systems and tools, capacities and resources available for longer-term data collection and analysis to provide solid monitoring data on the effectiveness of the Joint Programme's different strategies. Steps included developing 17 nested databases linked to a global database called DiMonitoring, training 1,260 data managers from governments, civil society, and UNFPA and UNICEF staff to roll out the database, and setting realistic programme targets and results-based management programming.

2.3.2 Phase II (2014-2017)

[3] 2008 Annual Report for the UNFPA-UNICEF Joint Programme on Female Genital Mutilation: Accelerating Change.
[4] For detailed information on the proposal for the Joint Programme, please see: http://www.unfpa.org/publications/female-genital-mutilationcutting-accelerating-change-original-proposal-2009.
[5] For more information on the Joint Evaluation UNFPA-UNICEF Joint Programme on Female Genital Mutilation: Accelerating Change (2008-2012) please see: http://www.unfpa.org/admin-resource/unfpa-unicef-joint-evaluation-unfpa-unicef-joint-programme-female-genital

Phase II of the Joint Programme began in 2014 and ran through to the end of 2017. The objective, revised from Phase I[6], is to *"contribute to the acceleration of the total abandonment of FGM in the next generation (i.e. next 20 years) through a 40% decrease in prevalence among girls 0-14 years in at least 5 countries and at least one country declaring total abandonment by the end of 2017."*[7]

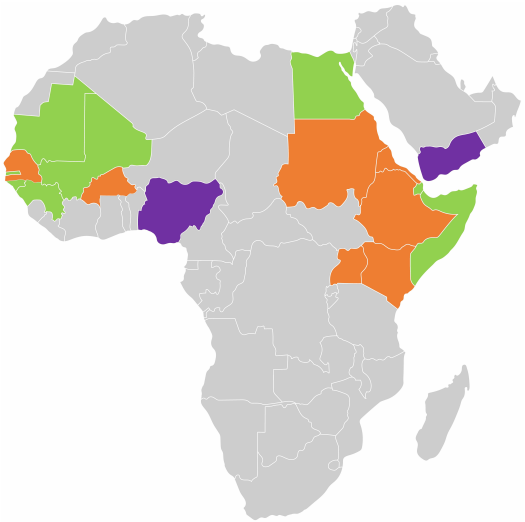
Building on the knowledge gained from the first phase, the second phase made revisions to its results framework, while maintaining a social norm perspective and including human rights and cultural sensitivity principles to guide the programming. For further details on the evolution of the results framework from Phase I to Phase II and from Phase II to Phase III please see Annex 7.

The second phase of the Joint Programme operates in 17 countries, which includes the original set of 15 countries from the first phase of implementation and the addition of Nigeria and Yemen in 2014.

Table 1: Programme Countries for Joint Programme Phase II

2008	2009	2011	2014
•Djibouti •Egypt •Ethiopia •Guinea •Guinea Bissau •Kenya •Senegal •Sudan	•Burkina Faso •Gambia •Uganda •Somalia	•Eritrea •Mali •Mauritania	•Yemen •Nigeria

Figure 1: Joint Programme phase II geographic coverage[8]



Based on the results of the evaluation of Phase I the Joint Programme the second phase introduced a cluster approach, where the countries have been grouped into three clusters: "accelerated," "emergent," or "new" countries.

The three clusters are intended to reflect the different pace of acceleration in the abandonment of FGM (with regards to policy and legislation, civil society capacity and community ownership) that is expected in these programme countries.

[6] For Phase 1, reaching a given level of abandonment within one generation was articulated as an outcome. Based in part on the judgment of the evaluation of phase 1 that this was an unrealistic outcome, a slight modification of that outcome was moved instead to the objective line.

[7] UNFPA-UNICEF Joint Program on the Abandonment of Female Genital Mutilation: Accelerating Change Funding Proposal for a Phase II January 2014 – December 2017.

[8] For more information on the cluster approach, please reference the UNFPA-UNICEF Funding Proposal for Phase II of the Joint Programme on FGM.

Table 2: Countries supported under the Joint Programme

	Cluster 1 – Acceleration countries	Burkina Faso, Eritrea, Ethiopia, Kenya, Senegal, Sudan, Uganda
	Cluster 2 – Emergent countries	Djibouti, Egypt, Gambia, Guinea, Guinea Bissau, Mauritania, Mali, Somalia
	Cluster 3 – New countries	Nigeria, Yemen (Yemen on hold as of 2015 due to conflict)

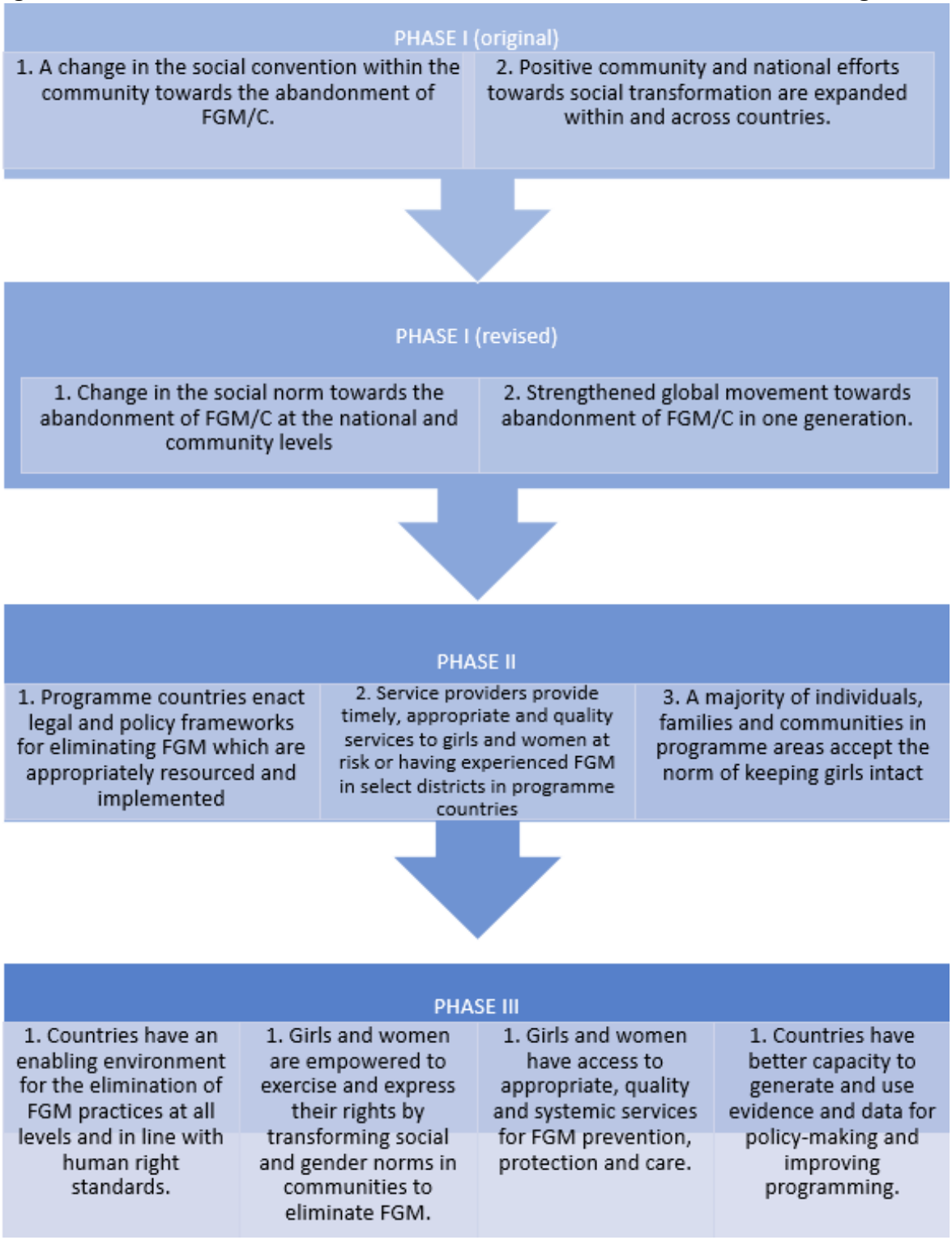
The intervention model pools international resources to enable existing national actors working on FGM elimination, such as the government, CSOs and NGOs, to progress in delivering interventions within each component (see annex for examples of interventions delivered).

2.3.3 Phase III (2018-2021)

As the Joint Programme moves into its third phase of implementation, it will seek to build on the lessons learned from the implementation of the previous (and current) phases, whereby this evaluation will play a critical role in its realization. The third phase will continue to embrace a holistic and multi-sectoral approach to support the elimination of FGM at all levels (from household to global level). It will also introduce new elements to the programme in an effort to scale up interventions and further accelerate change. In Phase III, the Joint Programme will place a greater emphasis on gender norm transformation (versus just social norm change to keep girls intact) in order to address gender roles and power relations that often are underlying factors for FGM. To this end, the empowerment of girls and women and the engagement of boys and men will specifically be addressed.

Moreover, the third phase will also introduce a new outcome on evidence generation and data utilization for policy making and programme effectiveness, elevating an element of phase II that was previously embedded in outputs of its outcome 1. In this new outcome, however, the focus will broaden to the piloting a social norm measurement framework and establishing a global knowledge hub. Annex 7 provides an illustration of the results framework from the current phase to the proposed third phase to be launched in 2018. Figure 2 provides an overview of the outcomes from the inception of the programme to the development of the third phase, illustrating how outcomes over time have evolved.

Figure 2: Outcomes from Phase I – Phase III of the UNFPA/UNICEF FGM Joint Programme



Source: Adapted from results frameworks of Joint Programme

2.3.4 Governance of the Joint Programme

UNFPA and UNICEF co-manage at global, regional and country levels with overall governance by a Joint Programme steering committee. This committee meets at least twice a year and is composed of members of the programme and technical divisions of both UNFPA and UNICEF as well as donors that are contributing to the programme.

The role of the Joint Programme Steering Committee is to:

- Facilitate the effective and efficient collaboration between participating UN Agencies and donors for the implementation of the Joint Programme;
- Review and approve the Joint Programme Document, including M&E framework & implementation plan, and any subsequent revisions;
- Approve the consolidated joint work plan and consolidated budget on an annual basis;
- Instruct the Administrative Agent to disburse funds, as per the approved budget;
- Review the implementation of the Joint Programme;
- Review and approve consolidated financial and narrative reports;
- Review evaluation findings for appropriate communication and future planning;
- Support advocacy and resource mobilization efforts.

Overall technical and management oversight is provided by a coordination team, led by a programme coordinator of each agency at their headquarter offices. The responsibilities of the coordination team include administration and financial management, partnership, knowledge management of the Joint Programme, encompassing the production of annual reports, conference reports, brochures, dissemination of relevant material to regional, sub-regional and country offices; capacity development and technical assistance to regional and country offices. Activities are undertaken in collaboration with relevant units within the respective organization, including the UNICEF Programme Division (especially the Child Protection Section and the Data and Analytics Section, DRP and C4D) and the UNFPA Gender Human Rights and Culture Branch and the Population and Development Branch.

In the programme countries, UNFPA and UNICEF Country Representatives develop a plan of action in line which serves as the basis for budget allocations. Approval of country-specific allocations is done by the Joint Programme Steering Committee based on consolidated UNFPA and UNICEF work plans agreed at country level and based on fund availability. Similarly, in Regional Offices where the programme operates, UNFPA and UNICEF offices also develop a plan of action to support sub-regional and country efforts. The Joint Programme continues to use the pass-through fund management mechanism, whereby UNFPA continues to be the Administrative Agent (AA).[9]

Evaluation purpose, objectives and scope

The evaluation will provide an opportunity to demonstrate accountability to partner countries, donors and other key stakeholders on the Joint Programme's performance in achieving results, to support evidence-based decision making, and to contribute to the learning and sharing of good practice.

> The **purpose** of the evaluation is to assess the extent to which, and under what circumstances, the Joint Programme has contributed to accelerate the abandonment of FGM in the joint programme countries over the last 10 years (since the start of the joint programme in 2008); and provide recommendations on how to accelerate progress in ending FGM.

[9] The Administrative Agent is responsible for the following: Signing of a new Memorandum of Understanding with UNICEF for Phase II; Negotiating and signing a Standard Administrative Arrangement with donors contributing to the Joint Programme; Receiving contributions and disbursing funds to UNICEF, in accordance with annual work plans, budget availability and decisions of the Joint Programme Steering Committee; Preparing consolidated narrative progress and financial reports, incorporating content of reports submitted by UNICEF, and submitting them to the Steering Committee.

The **primary objectives** of the evaluation are:

- To assess the relevance (including programme design), effectiveness, efficiency, and sustainability of the UNFPA/UNICEF Joint Programme of the Abandonment of FGM, Phase I and Phase II;
- To assess the adequacy of the governance structure of the Joint Programme, including the quality of the inter-agency coordination mechanisms that have been established at the global, regional and country levels; identifying lesson to strengthen the management of the Joint Programme;
- To identify lessons learned, capture good practices and generate knowledge from phase I and II, to inform the implementation of phase III of the Joint Programme; including identifying what packages of strategies and interventions to continue and/or discontinue and in what context, and providing corrective actions on the gaps and opportunities.
- To assess the extent to which UNFPA and UNICEF, through the Joint Programme, have effectively positioned themselves as key players in contributing to the broader 2030 development agenda, in particular Goal 5, Target 5.3 relating to FGM.

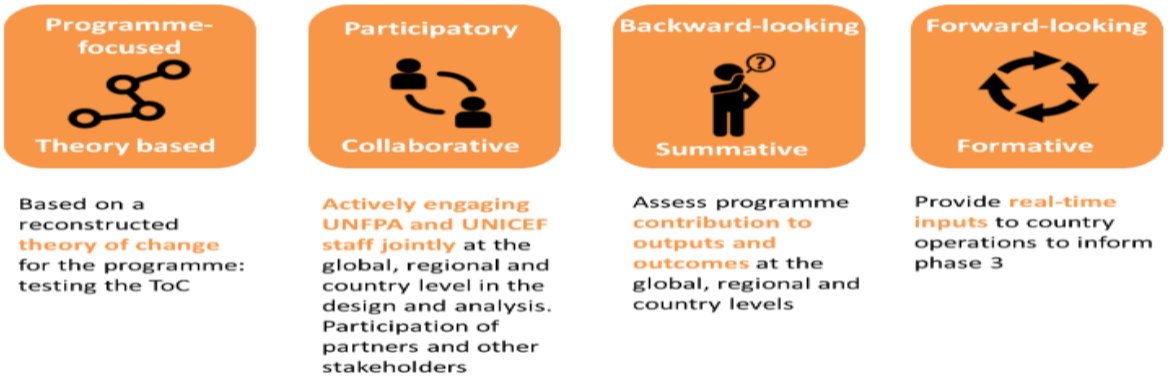
The evaluation will cover the implementation and the results of the UNFPA/UNICEF support during the period 2008-2017 with particular emphasis on Phase II of the Joint Programme, as Phase II has not been evaluated. The evaluation will carefully review follow-up to the Phase I evaluation recommendations.

The evaluation scope will address all four programme levels – global, regional, national and community – and their interconnections. The evaluation will cover all activities planned and/or implemented during the period under evaluation in all programme countries. The evaluation will focus primarily on the progress towards achieving outputs and contribution to outcomes in the results frameworks presented, while taking into account the evolution of the Joint Programme (see annexe 7).

Evaluation approach and methodology

The evaluation will be both backward-looking to review the performance and results of the Joint Programme (phase I and II) as well as forward-looking to identify lessons learned to inform the implementation of the third phase. The evaluation will apply an adaptive learning and utilisation-focused approach. This overall approach is depicted in the figure below which calls for a hybrid exercise comprising of a summative evaluation (backward-looking) and a formative evaluation (learning-focused, forward-looking) that is grounded in a reconstructed theory of change.

Figure 4: Evaluation design and approach



Evaluation criteria and questions

The evaluation is informed by evaluation criteria endorsed by the OECD-DAC:

Relevance	to national needs, the needs of affected populations, government priorities and UNFPA and UNICEF policies and strategies, and how they address different and changing national contexts
Effectiveness	the extent to which intended results (outputs and outcomes) were achieved
Efficiency	in terms of how funding, personnel, administrative arrangements, time and other inputs contributed to, or hindered the achievement of results; how well inputs were combined
Sustainability	the extent to which the benefits from the Joint Programme are likely to continue, after it has been completed

These criteria have been translated into 8 evaluation questions and included in the Evaluation Matrix (see Annex 1.1).

Evaluation process

5.1 Inception phase

In view of the extensive preparatory work, which included the development of evaluation design, the exercise will commence with the preparation of a **short methodological note** and work plan for the data collection.

Drawing on the ToR, the evaluation team will:

- develop a reconstructed theory of change
- review and refine the evaluation matrix (evaluation questions, assumptions and indictors)
- review and further develop the methods and tools for data analysis
- review all documents housed in the document repository provided by the UNFPA-UNICEF offices and any other documentation outside of this which may be relevant to the evaluation.

The draft methodological note will include the reconstructed theory of change, key data collection tools, including interview protocols, questionnaire for online survey, a tool to record and organize all data collected, as well as a work plan for the data collection and field work for the pilot mission. Finally, the note will include comments on any challenges or difficulties which might have arisen in structuring and conducting the evaluation, suggesting solutions when applicable.

The **pilot mission** case study will be conducted over a course of 3 full weeks (15 working days), where the evaluation team is expected to test and validate the theory of change and the evaluation matrix (in particular, the evaluation questions, assumptions and indicators), assess the availability of data, and pilot the data collection tools.

On completion of the pilot mission, the evaluation team is responsible for **finalizing the methodological note** building on the experience from the pilot mission. This will include refining the reconstructed theory of change and evaluation matrix and finalizing the data collection tools (e.g. interview protocols, survey questionnaire) used in the evaluation, making adjustments to the Theory of Change as appropriate, and developing a concrete work plan for the remaining phases of the evaluation

5.2 Data collection and field phase

The data collection and field phase, will open with a three-day induction workshop bringing together the evaluation team and the evaluation managers to prepare for the data collection and field phase.

Guided by the methodological note and finalized work plan, this phase will carry out the remaining three country case study missions as well as undertake desk-based reviews for the remaining 12 country case studies. The evaluation team will continue an in-depth documentary review, conducted in-person and remote interviews and undertook a survey.

Each **in-country mission** – Egypt, Senegal, Kenya (including cross boarder work with Uganda) and Ethiopia (including cross boarder work with Djibouti) - lasted 3 full weeks (15 working days). At the end of each mission, the evaluation team provided the country office and the national evaluation reference group with a debriefing presentation on the preliminary results of the case study, with a view to validate preliminary findings and test considerations to feed into the joint evaluation report. While conducting the country case studies in Egypt, Senegal, Kenya (and taking the opportunity that the team will be in-country) interviews were conducted with the respective regional offices.

For each country case study (field and desk-based), the evaluation team will prepare a **case study evidence table** (16 tables in total). The tables will follow the structure set out in Annex 6. These tables are internal documents used to inform the evaluation report.

The evaluation team is expected to present the results of the data collection, including the case study findings (both field and desk-based), the results of the survey to the evaluation reference group (see calendar).

Drawing from the data collection, the evaluation team will prepare a **3-5 page action brief** that: (1) will discuss the key emergent findings so far and (2) highlight priority areas that call for immediate attention and other operational suggestions to feed into the current and ongoing implementation of phase III of the Joint Programme.

5.3 Reporting phase

The reporting phase will open with a **3-days analysis workshop** bringing together the evaluation team and the evaluation managers to discuss the results of the data collection. The purpose of this analysis workshop is to generate substantive and meaningful comparison between the different case studies. The objective is to help the various team members to deepen their analysis with a view to identifying the evaluation's findings, main conclusions and related recommendations. The evaluation team will then proceed with the drafting of the findings of the report.

The **first draft of the evaluation report** (no conclusions and recommendations yet) will be submitted to the evaluation management group for comments. If the quality of the draft report is satisfactory (form and substance), the chair of the evaluation management group will circulate it to the reference group members for review and comments. In the event that the quality is unsatisfactory, the evaluators will be required to produce a new version of the draft report.

Prior to the submission of the second draft final evaluation report, a **4-days workshop** will be organized with the evaluation team and evaluation managers to review the findings, agree on the conclusions, and discuss elements of the recommendations.

The evaluation team will then present the **second draft report** to the evaluation reference group.

Based on the inputs and comments from the meeting, the evaluation team will make appropriate amendments and prepare the **final draft of the evaluation report.** To ensure all comments from the reference group meeting have been fully addressed, the evaluation team will prepare an **audit trail** of their responses to the comments.

The **evaluation report** (executive summery in English, French and Spanish) along with the management response, will be published on the UNFPA/UNICEF evaluation webpage.

Management and governance of the evaluation

The responsibility for the management and supervision of the evaluation rests with the **evaluation management group** chaired by the UNFPA EO lead evaluation manager. The evaluation management group is composed of staff members of the UNFPA and UNICEF EOs. The evaluation management group has overall responsibility for the management of the evaluation process, including the hiring and managing the team of external consultants. The evaluation management group are responsible for ensuring the quality and independence of the evaluation in line with UNEG Norms and Standards and Ethical Guidelines.[10]

The evaluation management group, with the support of a research evaluation associate, are expected to:

- lead the hiring of the team of external consultants, reviewing proposals and approving the selection of the evaluation team
- convene evaluation reference group meetings
- supervise and guide the evaluation team all through the evaluation process
- participate in the data collection process (conduct interviews, facilitate group discussions and focus groups) both at inception and data collection phases, including in field missions
- review, provide substantive comments and approve all evaluation deliverables

The progress of the evaluation will be followed closely by the **evaluation reference group** consisting of members of UNFPA/UNICEF and other external stakeholders who will be directly interested in the results of this evaluation. The reference group will support the evaluation at key moments of the evaluation process. The main responsibilities of the reference group are to:

- contribute to the scoping of the evaluation
- provide comments and substantive feedback from a technical expert perspective on the evaluation deliverables
- facilitate access to informants and documentation
- participate in meetings with the evaluation team as required
- play a key role in learning and knowledge sharing from the evaluation results, contributing to disseminating the results of the evaluation as well as to the completion and follow-up of the management response

[10] See: http://www.unevaluation.org/document/guidance-documents

The evaluation team

The evaluation will be carried out by a highly qualified, multi-disciplinary team with extensive knowledge and experience in evaluation of development programming. Specific experience in evaluating programming to prevent, respond to and eliminate harmful practices and FGM were required.

The team will demonstrate a clear understanding of the UN system and ensure that the evaluation is conducted in line with the UNEG Norms and Standards for Evaluation in the UN System and abided by UNEG Ethical Guidelines and Code of Conduct as well as any other relevant ethical codes UNEG Guidelines. UNEG guidance on Integrating Human Rights and Gender Equality in Evaluation will also be reflected throughout the evaluation.[11]

Deliverables

- Methodological note and work plan
- 3-5 page action brief
- Evaluation report and PowerPoint/ Prezi presentation of the evaluation results (written in English; professionally designed and printed)
- Executive summary translated in Spanish and French (professionally designed and printed)

[11] See: http://www.unevaluation.org/document/guidance-documents

Terms of reference annexes

Annex 1.1: Evaluation Matrix (revised and final version post-pilot mission)

The matrix is intended as a framework for the collection and analysis of data as well as reporting. The evaluation matrix presents the evaluation questions and breaks them down into assumptions, indicators associated to these assumptions, sources and tools for data collection. The column on sources of information links the evaluation questions with the stakeholder mapping and paves the way for the production of the interview protocols, the tool that links the evaluation matrix with data collection.

An Evaluation Matrix was developed during the preparatory phase and was presented in the terms of reference for this evaluation. The evaluation team carefully reviewed the initial Evaluation Matrix to validate its logic and completeness and has proposed several changes, as follows:

- The order and positioning of evaluation questions and assumptions have been modified to facilitate a more logical flow of analysis within the final evaluation report.
- The number of evaluation questions has been reduced from eight to five to better group them around themes/ criteria.
- The wording of some of the evaluation questions and assumptions has been modified to increase the completeness and clarity of the question or statement.
- The global online survey has been added as a data collection source wherever relevant.
- Additional assumptions have been in response to issues that emerged within the Ethiopia desk review, and the virtual case studies
- Some additional indicators have been added and others removed to ensure that the most relevant indicators are used to test assumptions.

Evaluation Question 1: To what extent is the programme (approach, design, strategies) relevant, responsive, and evidence based to contribute towards accelerating efforts to abandon FGM globally, nationally, and sub-nationally (including in cross-border regions)? **Criteria:** *Relevance*		
Assumptions to be assessed	**Indicators**	**Data Collection Sources and Tools**
Assumption 1.1 The Joint Programme design (including approach, strategies and interventions) is aligned with global, national and sub-national priorities and is flexible enough to be responsive to different local contexts and to changing realities and priorities.	• Alignment of the Joint Programme with global/regional frameworks addressing FGM (e.g. CEDAW, SDG Goal 5, relevant UN GA resolutions, Maputo Protocol, etc.) • Degree to which programming is aligned with the priorities and frameworks of national governments, UNICEF and UNFPA. • Evidence of contextualization of strategies and interventions, including through national and local level consultations, situation analysis,	*Documents* • Extended desk review • Country case studies • Minutes of country/regional level coordination meetings • Administrative data from implementing partners; MIS; DHS and other surveys *Interviews/Discussions*

	needs assessments, gender assessments, identification of drivers, stakeholder mapping assessments • Number of countries where affected populations, including local partners, community/traditional leaders, local civil society actors, participate in the identification, prioritization and programmatic planning to address FGM. • Evidence that country work plans are adjusted over time to respond to changes in needs, priorities, and context of communities of interest to address FGM. • Evidence that Human Rights and equity principles guide the formulation of measurable goals, targets and indicators in programming.	• Joint Programme coordinators • UNFPA/UNICEF management teams (ROs/COs) • National/sub-national authorities • Sub-national community structures (religious, traditional) • Implementing partners (INGOs, local NGOs) Online Survey
Assumption 1.2 The Joint Programme approach is based on its comparative strengths, taking into consideration the roles and comparative strengths of other actors working in this field.	• Degree to which programming is based on an assessment of the comparative strengths of UNICEF, UNFPA, national governments, civil society, and other actors working in this field. • Evidence of linkages/synergies of interventions with other UN agencies/partners or other actors working to address FGM and harmful practices more broadly (e.g. child marriage).	*Documents* • Extended desk review • Country case studies • Country work plans • Minutes of country/regional level coordination meetings *Interviews/Discussions* • Joint Programme coordinators • UNFPA/UNICEF management teams (ROs/COs) • National/sub-national authorities • Sub-national community structures (religious, traditional) • Implementing partners (INGOs, local NGOs) Online Survey

Assumption 1.3 Joint Programme interventions at the global, regional, national and sub-national levels are based on a comprehensive analysis of all available evidence (e.g. situation analysis, needs assessments, gender assessments, identification of drivers of change, stakeholder mapping) of the populations of interest in programme countries and of the factors that create barriers and promote drivers of change to end FGM.	• Evidence that programming (programme approach, resulting strategies and interventions) is informed by research and evidence generated by programme partners and other actors working in this area to identify drivers of change and meaningful strategies and interventions. • Evidence that an analysis of gender norms was conducted and taken into account in the design of the Joint Programme. • Evidence of interventions that include a comprehensive gender analysis in the design phase, that address barriers and promote drivers of change to end FGM. • Evidence of interventions that include specific design components that are intended to target underlying causes of gender inequality and discrimination that often drive FGM. • Evidence of cross-border work (e.g. co-ordination meetings involve relevant stakeholders; work plans and monitoring reports include co-ordination mechanisms and issues) to address barriers to end FGM. • Evidence that interventions are designed to reach the most marginalized populations to reduce disparities, reverse discrimination and right power imbalances. • Evidence that the programme invested its considerable funding for the biggest change.	*Documents* • Extended desk review • Country case studies • Country work plans • Minutes of country/regional level coordination meetings *Interviews/Discussions* • Joint Programme coordinators • UNFPA/UNICEF management teams • National/sub-national authorities • Sub-national community structures (religious, traditional) • Implementing partners (INGOs, local NGOs) • Sister UN agencies working to address FGM Online Survey

Evaluation Question 2: To what extent has the programme contributed to supporting governments, communities, and the girls and women concerned towards the abandonment of Female Genital Mutilation/Cutting through the establishment of conducive legal and policy environments, support for the provision of FGM health services, and the shifting of social norms?"

Criteria: *Effectiveness and Sustainability*

Assumptions to be assessed	• **Indicators**	**Data Collection Sources and Tools**
Assumption 2.1 • Programme countries enact legal and policy frameworks for eliminating FGM which	• Number of countries that have passed laws against FGM. • Number of countries that are working on passing laws against FGM.	*Documents* • National FGM policies and strategies

are appropriately resourced and implemented (in line with AU and UN Resolutions);	• Number of countries that have FGM policies and/or national strategies. • Number of countries with an FGM budget line. • Degree of judicial capacity to implement FGM laws • Evidence of cases of enforcement of the FGM law (sub indicators: number of arrests, cases brought to court, convictions, and sanctions). • Evidence of national level health (and other sector) systems that track FGM (prevalence and impact) • Evidence of capacity development support around FGM data collection provided by the Joint Programme to national systems • Evidence of regional efforts (training, producing, sharing data, supporting legal interventions) to support the elimination of FGM •	• National FGM laws and legal frameworks • Programme reporting documents • Joint Programme country work plans • Minutes of country/regional level coordination meetings *Interviews/Discussions* • Joint Programme coordinators • National/sub-national authorities • Implementing partners (INGOs, local NGOs) • Sister UN agencies working to address FGM Online Survey
Assumption 2.2 • Service providers provide timely, appropriate and quality health services to girls and women at risk or having experienced FGM in select districts in programme countries;	• Evidence that the programme has clearly conceptualized the nature of services for FGM prevention, protection and care and has an explicit strategy to leverage other services for prevention work for integration into the service package. • Number of service delivery points with at least one service provider trained in prevention, protection, and provision of care services. • Number of service delivery points that apply tools developed by the Joint Programme. • Evidence of use of services by affected populations (behaviour). • Evidence services are perceived by women and girls to meet their care needs to high standards of care and protection • Extent to which the capacity of healthcare professionals (including midwives) has been increased to provide	*Documents* • Programme reporting documents • Joint Programme country work plans • National FGM health data (if available) • Minutes of country/regional level coordination meetings *Interviews/Discussions* • Joint Programme coordinators • National/sub-national authorities • Implementing partners (INGOs, local NGOs)

	health education and health services around FGM.	• Sister UN agencies working to address FGM • Healthcare professionals (including midwives) • Community members • Women affected by FGM <u>Online Survey</u>
Assumption 2.3 • A majority of individuals, families and communities in programme areas accept the norm of keeping girls intact	• Proportion of population (girls/boys/women/men) in focus areas who participate regularly in education dialogues promoting the abandonment of FGM in and out of school, and in adult learning programmes. • Number of community to community outreach events in programme areas to expand the abandonment of FGM. • Number and types of community groups working to raise awareness about FGM (i.e. youth groups, men's groups, etc.). • Number and types of media coverage of FGM abandonment efforts. • Number of consensus building activities with traditional, religious and community leaders toward organizing a public declaration • Number of community declarations. • Evidence that there is a link between achievement of the Joint Programme results and contribution to empowerment of girls and women • Number of religious fatwas passed against FGM.	<u>*Documents*</u> • Programme reporting documents • Joint Programme country work plans • Minutes of country/regional level coordination meetings • Joint Programme communications and social norms products • Religious fatwas <u>*Interviews/Discussions*</u> • Joint Programme coordinators • National/sub-national authorities • Implementing partners (INGOs, local NGOs) • Sister UN agencies working to address FGM • Community members (women, men, youth) • Women affected by FGM <u>Online Survey</u>

Evaluation Question 3: To what extent do the Joint Programme's country, regional, and global initiatives and holistic approach create synergies that accelerate efforts to end FGM? **Criteria**: *Effectiveness, Co-ordination and Sustainability*		
Assumptions to be assessed	• **Indicators**	**Data Collection Sources and Tools**
Assumption 3.1 Management arrangements and coordination between UNFPA, UNICEF, national authorities and programme partners have facilitated both agencies to leverage their relative strengths and capacities for more effective programme implementation.	• Evidence in work plans that UNFPA/UNICEF work in geographic and technical areas appropriate to their mandate, capacities and experience. • Evidence of co-ordination and synergies across global, regional and national levels of the Joint Programme • Evidence of linkages/synergies between the Joint Programme and UNFPA/UNICEF's other areas of work/interventions. • Evidence of linkages/synergies between the Joint Programme and the work of other FGM actors.	*Documents* • Joint Programme planning documents • Programme reporting documents • Joint Programme country work plans • Minutes of country/regional level coordination meetings • UNICEF and UNFPA Country Work Plans (outside of the Joint Programme) *Interviews/Discussions* • Joint Programme coordinators • UNICEF and UNFPA COs • National/sub-national authorities • Implementing partners (INGOs, local NGOs) • Sister UN agencies working to address FGM Online Survey
Assumption 3.2 The global programme has effectively developed and leveraged partnerships and collaborations with other development actors to amplify efforts, particularly with regards to more in-depth research on social norms change and its linkages to	• Evidence of achievement and/or acceleration of positive results due to strategic partnerships (that UNFPA/UNICEF would not have achieved directly or within the same time frame). • Evidence of partnerships that have facilitated strategic or innovative guidance/support to the Joint	*Documents* • Joint Programme planning documents • Programme reporting documents • Joint Programme country work plans • Minutes of country/regional

changes in individual and collective behaviours.	Programme interventions around social norm change and its links to behaviour change • Evidence of partnerships with research and academic institutions to produce data and information on FGM. • ' Evidence that the Joint Programme is optimising its convening role (global, regional, national, sub-national) for programmatic and advocacy purposes'	level coordination meetings • Documents published by other FGM actors (i.e. the Population Council, the Girl Generation, etc.). *Interviews/Discussions* • Joint Programme coordinators • UNICEF and UNFPA COs • National/sub-national authorities • Implementing partners (INGOs, local NGOs) • Sister UN agencies working to address FGM • Other actors working on FGM (i.e. Population Council, the Girl Generation, etc.) • Research and academic institutions Online Survey
Assumption 3.3 Joint Programme acted as a catalyst for established and emerging actors to strengthen the response to end FGM, at national, regional and global levels, including e.g. other UN agencies, other programmes, new donors and funders, national governments, regional bodies, civil society and implementing partners.	• Evidence of support provided by the Joint Programme to emerging actors. • Evidence of information sharing across countries and regions and between diverse actors. •	*Documents* • Joint Programme planning documents • Programme reporting documents • Joint Programme country work plans • Minutes of country/regional level coordination meetings • Documents published by other FGM actors (i.e. the

		Population Council, the Girl Generation, etc.). *Interviews/Discussions* • Joint Programme coordinators • UNICEF and UNFPA COs • National/sub-national authorities • Implementing partners (INGOs, local NGOs) • Sister UN agencies working to address FGM • Other actors working on FGM (i.e. Population Council, the Girl Generation, etc.) • Research and academic institutions Online Survey
Assumption 3. 4 The Joint Programme has raised the profile of FGM and contributed to the acceleration of its end through establishing global normative standards among governments.	• Evidence that the Joint Programme has contributed to raising the global profile of FGM. • Evidence that programme interventions achieve strong synergies, address gaps, and avoid duplication between UNFPA and UNICEF and among other actors, especially national actors as well as UN entities and civil society.	*Documents* • Joint Programme planning documents • Programme reporting documents • Global, regional and national normative standards and commitments • Joint Programme country work plans • Minutes of country/regional level coordination meetings • Documents published by other FGM actors (i.e. the

		Population Council, the Girl Generation, etc.). *Interviews/Discussions* • Joint Programme coordinators • UNICEF and UNFPA COs • National/sub-national authorities • Implementing partners (INGOs, local NGOs) • Sister UN agencies working to address FGM • Other actors working on FGM (i.e. Population Council, the Girl Generation, etc.); Online Survey
Evaluation Question 4: To what extent does the Joint Programme draw on the relative strengths of each organisation, promote efficient programme implementation to amplify the programme's contribution? **Criteria:** *Efficiency/ Co-ordination*		
Assumptions to be assessed	• **Indicators**	**Data Collection Sources and Methods**
Assumption 4.1 Joint Programme financial systems and structures enable the efficient and timely flow of resources to support implementation and achieve planned results.	• Trends in funds mobilized by Joint Programme over time. • Expenditure rates at global, regional and national level. • Identified funding gaps and time lags. • Achievements of outputs vis-à-vis funds available and spent.	*Documents* • FGM Joint Programme financial data: general ledger reports, Atlas/GPS reports • Joint Programme Annual Reports • Minutes of Steering Committee meetings *Interviews/Discussions* • Joint Programme coordinators • UNFPA/UNICEF management teams (ROs/COs)

		• UNFPA/UNICEF programme staff (ROs/COs) • Implementing partners (INGOs, local NGOs) Online Survey
Assumption 4.2 Oversight by the Joint Programme Steering Committee to the Joint Programme has contributed to efficient implementation	• Clear guidance (technical and administrative) provided by the Joint Programme Steering Committee to the programme • Clear expectations among the Joint Programme Steering Committee members about the pooled fund and Joint Programme approach	*Documents* • Minutes of Steering Committee meetings • Minutes of country/regional level coordination meetings *Interviews/Discussions* • Joint Programme coordinators • UNFPA/UNICEF management teams (ROs/COs) • Steering Committee members • National/sub-national authorities Online Survey
Assumption 4.3 Monitoring, reporting and evidence-gathering systems are in place and are compatible across both agencies, and are adequate to measure progress towards expected results and promote learning at all levels.	• Evidence of availability of trained personnel managing such systems in each programme country. • Evidence of systematic monitoring, combining and reporting of results across programme countries. • Evidence of participation of national staff and in-country implementing partners in the design of such systems as well as in the collection and analysis of the data, and the dissemination of the results. • Evidence that results were utilized to inform strategic programme decisions and steer programme implementation. • Systems for learning and evidence-based programming are in place, managed by trained staff and learning is integrated into implementation at all levels. • Degree to which information is collected, shared, and analysed using compatible	*Documents* • *Results frameworks* • *Country work plans* • *Minutes of coordination meetings* • *Minutes of Steering Committee meetings* • *Annual reports and other reports* • *M&E documentation* *Interviews/Discussions* • *Joint Programme coordinators* • *UNFPA/UNICEF management teams (ROs/COs)*

	data collection and analysis methods across agencies.	• *UNFPA/UNICEF programme/M&E staff (ROs/COs)* • *Implementing partners (INGOs, local NGOs); Online Survey*
Evaluation Question 5: To what extent does Joint Programme programming lead to sustainable change for the eradication of FGM? **Criteria:** *Sustainability*		
Assumptions to be assessed	• **Indicators**	**Data Collection Sources and Methods**
Assumption 5.1 The Joint Programme supports national ownership of efforts to eradicate FGM by building institutional capacity and by integrating programming into established national systems and processes.	• Evidence that Joint Programme programming is designed in consultation with national stakeholders, including government ministries. • Evidence that Joint Programme initiatives are integrated into national systems and processes rather than as stand-alone interventions. • Number and types of capacity development initiatives supported by the Joint Programme. • Evidence that the Joint Programme promotes government ministries to integrate FGM data into their national data collection systems. • Evidence that the Joint Programme promotes dedicated FGM budget lines within national and sub-national budgets.	*Documents* • *Results frameworks* • *Country work plans* • *Annual reports and other reports* *Interviews/Discussions* • *Joint Programme coordinators* • *UNFPA/UNICEF management teams (ROs/COs)* • *UNFPA/UNICEF programme/M&E staff (ROs/COs)* • *Implementing partners (INGOs, local NGOs); Government partners*
Assumption 5.2 The Joint Programme promotes changes in social norms at the community level that are sustained over time and that lead to improvements in gender equality dynamics between men and women.	• Number of communities that continue to promote the eradication of FGM after making public declarations to that effect. • Evidence that FGM initiatives have opened dialogue or led to concrete changes around gender equality at the community level. • Changes in attitudes and beliefs about FGM between different generations of community members (i.e. changes in perceptions among youth versus older members of the community).	*Documents* • *Results frameworks* • *Country work plans* • *Annual reports and other reports* • *Community FGM declarations* *Interviews/Discussions* • *Joint Programme coordinators*

		• *Implementing partners (INGOs, local NGOs)* • *Government partners* • *Community and religious leaders* • *Community members (women, men, youth)* *Online Survey*
Assumption 5.3 Interest around FGM generated by the Joint Programme at the global level leads to more sustainable donor funding and long-term efforts to eradicate it.	• Evidence of increased funding for FGM initiatives (including those outside of the Joint Programme) over the course of the Joint Programme. • Number and type of multi-phase global FGM initiatives.	*<u>Documents</u>* • *Donor reports* • *Programme documents from non-Joint Programme interventions* • *Joint Programme budgets* *<u>Interviews/Discussions</u>* • *Joint Programme coordinators* • *Implementing partners (INGOs, local NGOs)* • *Government partners* • *International donors* • *Other UN agencies* • *Online Survey*

Annex 1.2 Structure for the evaluation report

I. Final report

Number of pages: 70-80 pages without the annexes

Table of Contents; List of Acronyms; List of Tables (*); List of Figures

Executive Summary: 7- 8 pages**:** objectives, short summary of the methodology and key conclusions and recommendations

1 Introduction

Should include: purpose of the evaluation; mandate and strategy of UNFPA/UNICEF support elimination of FGM

2 Methodology

Should include: overview of the evaluation process; methods and tools used in evaluation design; analysis of UNFPA/UNICEF strategic framework; evaluation questions and assumptions to be assessed; methods and tools used for data collection; desk review; survey; case studies; limitations to data collection; methods and tools used for data analysis; methods of judgment; the approach to triangulation and validation

3 Main findings and analysis

Should include for each response to evaluation question: evaluation criteria covered; summary of the response; detailed response

4 Conclusions

Should include for each conclusion: summary; origin (which evaluation question(s) the conclusion is based on); detailed conclusion

5 Recommendations

Should include for each recommendation: summary; priority level (very high/high/medium); target (business unit(s) to which the recommendation is addressed); origin (which conclusion(s) the recommendation is based on); operational implications. Recommendations must be: linked to the conclusions; clustered, prioritized; accompanied by timing for implementation; useful and operational

Annexes shall be confined to a separate volume

Should include: evaluation matrix; ex-post theory of change; portfolio of interventions; methodological instruments used (survey, focus groups, interviews etc.); bibliography; list of people interviewed; terms of reference; minutes of the ERG meetings.

(*) *Tables, Graphs, diagrams, maps etc. presented in the final evaluation report must also be provided to the Evaluation Office in their original version (in Excel, PowerPoint or word files, etc.).*

The final version of the evaluation report shall be presented in a way that enables publication (professionally designed and copy edited) without need for any further editing (see section below). Please note that, for the final report, the company should share the files in Adobe Indesign CC software, with text presented in two columns with no hyphenation. Further details on design will be provided by UNFPA/UNICEF Evaluation Office in due course.

Annex 1.3: Editing guidelines

Evaluation reports formal documents. Therefore, they shall be drafted in a language and style which is appropriate and consistent and which follows UN editing rules:

Acronyms: In each section of the report, words shall be spelt out followed by the corresponding acronym between parentheses. Acronyms should be used only when mentioned repeatedly throughout the text. The authors must refrain from using too many acronyms. In tables and figures, acronyms should be spelt out in a note below the table/figure.

Capitalization: Capitalize high ranking officials' titles even when not followed by a name of a specific individual. Capitalize national, political, social, civil etc. groups – e.g. Conference for Gender Equity, Committee on HIV/AIDS, Commission on Regional Development, Government of South Africa.

- Capitalize common nouns when they are used as a shortened title, for example, the 'Conference' (referring to the Conference on Gender Equity) or the 'Committee' (referring to the Committee on HIV/AIDS). However, do not capitalize when used as common nouns – e.g. 'there were several regional conferences.'
- Some titles corresponding to acronyms are *not capitalized* – e.g. human development index (HDI), country office (CO).
- Use lower case for: UNFPA headquarters; country office; country programme; country programme evaluation; regional office, country programme document; results framework; evaluation system.

Numbers: Spell out single-digit whole numbers. Use numerals for numbers greater than *nine. Always spell out simple fractions and use hyphens with them (e.g. one-half of…, a two-thirds majority).* Hyphenate all compound numbers from *twenty-one* through *ninety-nine*. Write out a number if it begins a sentence. Use % symbol in tables and "per cent" in the text

Terminology: Use "UN organizations" not "sister agencies." Do *not* use possessive for innate objects (UNFPA's, the Government's, the country's, etc.). Instead, use: the UNFPA programme, the government programme, the UNFPA intervention, etc.

Bibliography

Author (last name first), *Title of the book*, City: Publisher, Date of publication.

Author (last name first), "Article title," Name of magazine (type of medium). Volume number, (Date): page numbers, date of issue.

URL (Uniform Resource Locator or WWW address), author (or item's name, if mentioned), date.

List of people consulted

- should include the full name and title of people interviewed as well as the organization should be organized in alphabetical order (English version) with last name first
- should be structured by type of organization

See United Nations Editorial Manual Online at: http://dd.dgacm.org/editorialmanual/

Annex 1.4: Code of conduct and norms for evaluation in the UN system

Evaluations of UNFPA-supported activities need to be independent, impartial and rigorous and evaluators must demonstrate personal and professional integrity. In particular:

1. To avoid **conflict of interest** and undue pressure, evaluators need to be **independent.** The members of the evaluation team must not have been directly responsible for the policy/programming-setting, design, or overall management of the subject under evaluation, nor should they expect to be in the near future. Evaluators must have no vested interest and should have the full freedom to conduct impartially their evaluative work, without potential negative effects on their career development. They must be able to express their opinion in a free manner.
2. The evaluators should protect the anonymity and **confidentiality of individual informants**. They should provide maximum notice, minimize demands on time, and respect people's right not to engage. Evaluators must respect people's right to provide information in confidence, and must ensure that sensitive information cannot be traced to its source. Evaluators are **not expected to evaluate individuals**, and must balance an evaluation of management functions with this general principle.
3. At times, evaluations uncover **evidence of wrongdoing**. Such cases must be reported discreetly to the appropriate investigative body.
4. Evaluators should be **sensitive to beliefs, manners and customs** and act with integrity and honesty in their relations with all stakeholders. In line with the UN Universal Declaration of Human Rights, evaluators must be sensitive to, and **address issues of discrimination and gender equality**. They should avoid offending the dignity and self-respect of those persons with whom they come in contact in the course of the evaluation. Knowing that evaluation might negatively affect the interests of some stakeholders, evaluators should conduct the evaluation and communicate its purpose and results in a way that clearly respects the dignity and self-worth of all stakeholders.
5. Evaluators are responsible for the **clear, accurate and fair** written and/or oral presentation of study limitations, evidence based findings, conclusions and recommendations.

A **declaration of absence of conflict of interest must be signed by each member of the team and shall be annexed to the offer.** No team member should have participated in the preparation, programming or implementation of UNFPA /UNICEF interventions on FGM during the period under evaluation.

Annex 1.5: Country evidence table

COUNTRY NAME

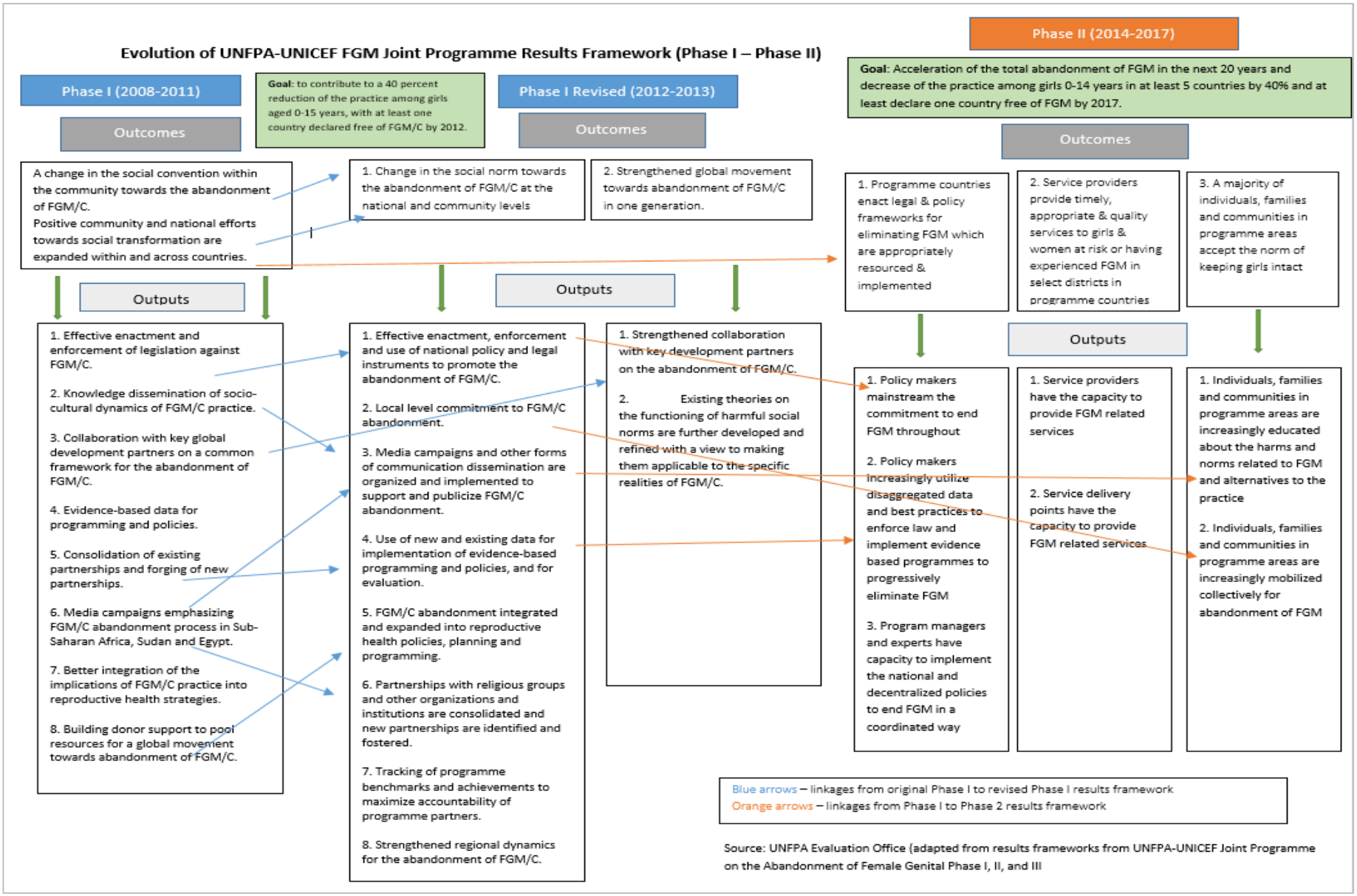
Context	Document	Evidence	Interviews Evidence
Interventions			
Expenditure			
Implementing partners delivering			
EQ 1 –	**Document**	**Evidence**	**Interview Evidence**
Assumption 1			
…			
EQ 2 –	**Document**	**Evidence**	**Interview Evidence**
….			
Important issues not included in the Assumptions			
1	**.**		
2			
3			
…			

CONSIDERATIONS FOR THE OVERARCHING GLOBAL THEMATIC LEVEL

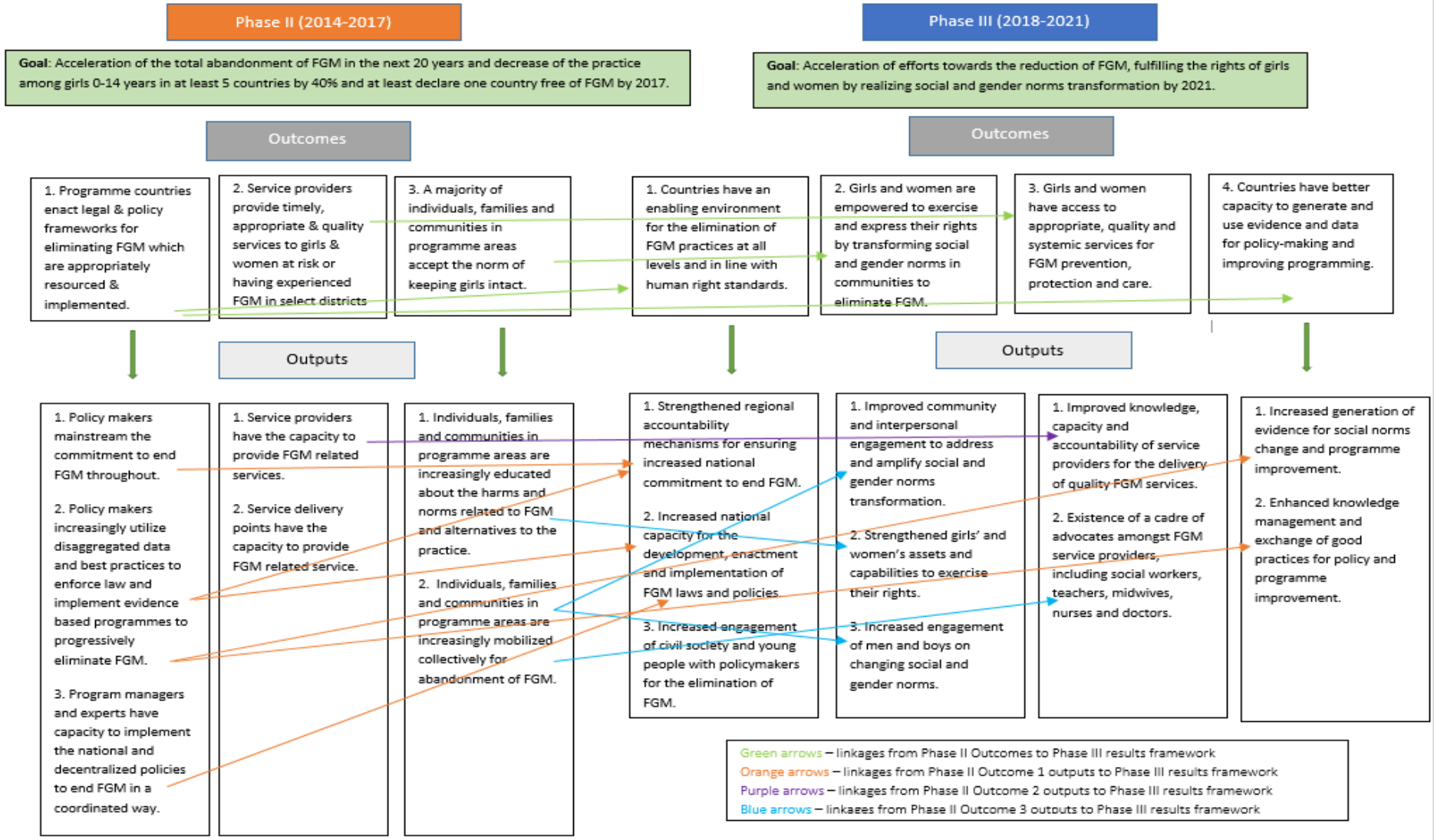
Consideration 1.
Consideration 2.
…

Interview respondents / documentation reviewed	
1	**.**
2	

Annex 1.6: Evolution of the results frameworks



Evolution of UNFPA-UNICEF FGM Joint Programme Results Framework (Phase II – Phase III)



Source: UNFPA Evaluation Office (adapted from results frameworks from UNFPA-UNICEF Joint Programme on the Abandonment of Female Genital Phase I, II, and III

Annex 1.7: Examples of Phase II Joint Programme Interventions

Level of Engagement	Component	Selected Interventions
Global	Strengthened Coordination	• Increase engagement of the regional institutions and networks specifically the African Union • Support the engagement and mobilization of midwives and medical professional associations
	Technical Assistance	• Roll-out of several tools to strengthen country capacities, such as manual on social norms, medical guidelines for management of health complications • Provide technical assistance to the 17 countries in support to the regional offices particularly for scaling up sound interventions and to the strengthening of M&E systems.
	Advocacy	• Increase visibility on FGM through global advocacy, and participation in global initiatives such as: International Day of Zero Tolerance of FGM; CSW; UNGA; International Day of the Girl Child, Conferences, among others.
Regional / Sub-regional	Strengthened Coordination	• Strengthen South-South collaboration, provide support for cross-border initiatives and organize regional consultations and technical reviews on FGM
	Technical Assistance	• Technical support to country offices in the Joint Programme on FGM/C in programme management, data collection and reporting, and knowledge sharing • Contribute to knowledge development on: FGM, legal frameworks assessments, men and boys engagement, and evidence for programming
	Advocacy	• Develop regional advocacy materials on FGM (de-medicalization, data, etc.) to influence and engage with regional institutions and networks • Support CSOs, regional media and countries reporting and investigation on human rights and other harmful practices, and application of the laws
	Policy and Legislation	• Policy dialogue, consultative forums and support of national/dec. coordination mechanisms. • Building capacity of parliamentarians, judges, medical staff and law enforcement to ensure knowledge on the link between FGM, HR and development. • Develop & sustain local surveillance systems to avoid the occurrence of FGM.
National	Service Delivery	• Strengthen the capacity of service providers to deliver prevention services, protection interventions and care services. • Strengthen Service Delivery points for prevention, protection and provision of care: Assessments, reorganization of services, marketing of services, records, and referral. • Support anti-medicalization of FGM strategies.
	Community (targeted) work	• Support education and empowerment, through dialogue, social mobilization, inter-community meetings, and public declaration activities. • Involving national and local media (e.g. community radio, print media, billboards) to spread info regarding FGM abandonment. • Involving religious leaders and networks to secure abandonment of FGM and to inform people that it is not a religious obligation.

Source: UNFPA/UNICEF Annual Work Plans and Annual Reports (2008-2017)

Annex 2: Minutes of the Evaluation Reference Group meetings

First Meeting - 4 December 2018 (9:35 AM – 12:20 PM)
Minutes

In attendance:	Evaluation Management Group (EMG) Alexandra Chambel, UNFPA Evaluation Office (Chair of EMG) Mathew Varghese, UNICEF Evaluation Office Karen Cadondon, UNFA Evalution Office (minutes taker) Laurence Reichel, UNICEF Evaluation Office External Evaluation Team Susanne Turrall, Team leader Corinne Whitaker, FGM thematic expert Evaluation Reference Group Members Nafissatou Diop, UNFPA FGM Joint Programme Coordinator Berhanu Legesse, UNFPA FGM Joint Programme Coordination Team Thierno Diouf, UNFPA FGM Joint Programme Coordination Team Harriet Akuluu, UNICEF, FGM Joint Programme Coordination Team Joseph Mabrizi, UNICEF FGM Joint Programme Coordination Team Mar Jubero, UNCIEF FGM Joint Programme Coordination Team Charlotte Lapsansky, UNICEF Communication for Development Specialist Claudia Cappa , UNICEF Data and Analytics Charles Kantende, UNFPA Chief, Strategic Information & Knowledge Management Branch Aynabat Annamuhamedova, UNFPA Policy and Strategy Ingrid Hordvei, Norway MFA Anja Sletten, Senior Adviser, Norway, NORAD Loredana Magni, Italy MFA Jo Feather, Individual consultant undertaking review of DFID end of FGM programme (observer) Patrick Duerst, UNFPA Evaluation Office

I. Opening/Introduction and PowerPoint Presented

The meeting opened with a welcome and brief introduction of the evaluation from Alexandra Chambel, Chair of the Evaluation Reference Group.

Alexandra noted that the Evaluation Reference Group meeting would focus primarily on the preliminary findings from data collection to date. These findings include insights from the 4 in-country case studies – Ethiopia; Kenya, Senegal; Egypt; the 12 extended desk country case studies and the regional component of the evaluation.

A survey to the Joint Programme implementing partners is currently ongoing; the deadline is December 7.

Alexandra briefly presented the methodological approach of the evaluation and status to date, **Susanne** Turrall, co-team leader and **Corinne** Whitaker, thematic expert, presented the preliminary findings.

II. Key Discussion Points

Pushback on Joint Programme

Nafy: Need more clarification on the issue of push back in Burkina Faso.

> Evaluation Team: The evaluation used Burkina Faso to illustrate the context to which the programme was working where there was already social change/tensions that were not necessarily related to FGM. The point being that in Burkina Faso they have done so much excellent work, but the Joint Programme still faces this challenge of push back.

'Jointness' of the Joint Programme

Thierno: On measuring effectiveness of the joint work of UNFPA/UNICEF, the evaluation seems to question the fact that the agencies are not working in same area. Is there evidence of effectiveness of working in same areas as well as working on different areas based on country context?

> Evaluation Team: Burkina Faso is a good example of where the two agencies work together in the same geographic region by design. In Burkina Faso, it was designed to ensure a full package of services and that synergies were made where both agencies are working in a small area together. There was also a joint effort to position this work next to different regions where it could affect change (adoption/diffusion Tostan approach). There's a lot of learning on this approach - while limited in scope, it perhaps has had a more powerful impact. The evaluation recognizes that there are two ways for 'jointness' – a more structured coordination and intentional planning as in Burkina Faso and coordination based on capacity and geographic area of respective agencies. The point is taken and will be further elaborated in the report.

Nafy: On the jointness of programme, beyond the fighting and personalities, we would like to hear more about what did you learn and what are you learning on working together? Also, what is the added value of working together at all levels?

> Mathew: Agreed. In the context of Spotlight, there is a lot to learn from the Joint Programme and Spotlight needs this learning because the issues we are talking about, and how to work together, these issues have not come through. And I hope that some of the learning on this from the evaluation goes into Spotlight and we have the greatest potential for working together.
>
> Alexandra: Noted. Point well taken. The elevation team has collected data in this regard and can speak to this and further elaborate in the report.

Refugee and displacement populations

Nafy: Need more information on the refugee and displacement population and how the next survey (census or DHS, etc.) may influence the measurement that we already have in those areas.

> Evaluation Team: The reference was made to Ethiopia in particular. In the Ethiopia example, the Ethiopian DHS is based on census where IDPs are not captured, only established refugee camps. The evaluation highlights that there is a need to be conscious of these groups (that are not accounted for) as they also have an influence

on surrounding communities. The point is taken and will be further clarified in the report.

Implementation of the law

Mar: On implementation of the law, elaborate on the point that it is not clear if this a positive thing or not.

Evaluation Team: There is no question that the law is important, but the evaluation found that it becomes an obstacle when it comes to reporting. Not unique to FGM, any practice subject to legal restriction goes underground and this is what the evaluation saw with FGM (changes of practice, which hides the practice). In this view, the evaluation has noted that efforts funded by Joint Programme have supported ways of responding to this challenge; e.g. In Kenya, there were FGM watch groups established (CHWs, parents, kids, actors) which helped in monitoring and reporting of the practice. The challenge here is such actors have to rely on judicial and security sectors that are not very strong and UNFPA/UNICEF don't have comparative advantage in this area.

Linkages between measurement and behavior change

Joseph: Clarification on social change measurement, in particular the statement that there is no link between measurement and behavior change.

Evaluation Team: The evaluation has highlighted the challenges in measurement of social change, both broadly and specific to this exercise. A key challenge is demonstrating how changes in social norm result in changes in behavior. There is also the problem of self-reporting. The evaluation team are currently following up with stakeholders working on Drexel tool and Columbia who will be able to provide more insight. It is a work in progress.

Monitoring of Joint Programme

Harriet: Clarify point on how country offices prioritize their work and the view that supporting Joint Programme activities are additional role to offices – how much evidence or weight of evidence did you find around this?

Evaluation Team: The evaluation can provide more precise numbers, but as an estimate, over half of COs found monitoring burdensome for the size of the funds that were provided. Tier 3 COs particularly pointed this out. Further, the reporting focused on output level versus orienting to outcome level monitoring which would be more useful for reflecting and learning. There was a sense that repointing was for reporting sake rather informing how the Joint Programme is progressing and moving forward.

Thierno: To follow up on the issue of analysis of indicators and burden of reporting – this is a question results framework globally and the approach of the programme. Looking at the number of indicators, it was intended that the countries be allowed to select relevant outputs and indicators as appropriate based on their context, i.e. countries do not need to report on all indicators.

Evaluation Team: There seems to be mixed messages coming through on this point. From the Joint Programme coordination team, there is a view of contextualization. But

from the country level, we have not hear this, rather we have heard their request to contextualize the results framework. This is not unique to phase 1 and 2, but also applies to phase 3 (data for all). The issue of communication and the need for clarification on this point between the Joint Programme coordination team and the country offices is evident.

Cross-border efforts

Berhanu: We are interested to hear more on the country perspective, particularly on the seriousness of this issue.

> Evaluation Team: The reference made to cross border work was specific to east Africa, which may have a regional cross border sensitivity more so than perhaps other parts of the continent. In Kenya for example, there is a very conscious effort to work with council of elders on Tanzania border. Resistance in that region has something to do with identities across the border. There has been innovative work is a vernacular radio station that can reach across a border. The evaluation also found that cross border issues is not just about cutting girls across border, but also the influence of other communities in these areas (e.g. Djibouti radio station reaching beyond its borders). The point is taken and will be further elaborated in the report.

Public declarations:

Italy: Welcome clarification on lacks strategies and tools to support continued behavior change after Public Declaration in villages.

> Evaluation Team: Public declarations are not the final goal and there is an effort from to sustaining the change. The follow-up mechanism is a work in progress. The challenge was setting up of monitoring system within community context; still communities would still fall back on judicial and security systems, which in most cases are not strong. There is a need for specific guidance on what should be done post declaration and the Joint Programme Joint Programme has in place steps to do research on what happens afterwards (e.g. work in Eritrea on readiness).
>
> Alexandra: I have noted some progress from phase I (Evaluation of phase I) to phase II on the follow up to public declarations. The Joint Programme and partners (e.g. Tostan in Senegal) acknowledging a need to go beyond public declarations and putting mechanisms in place to do so. Ethiopia is another example, where the Joint Programme is working with exiting systems and national and sub-national levels (e.g. women development committees).

Nafy: Public declarations is more complex, more complicated and needs to be contextualized because public declarations in one community may be different in another. So there is a need to clear on ethnic and cultural aspect in these communities because public declarations may play out differently in terms of structure and compliance (e.g. public declaration can be the start or end deepening on ethnic groups; compliance may vary depending on the leader or ethnic group). That said, we would like to see the evaluation provide different examples of post PD system, highlighting what is working and what is not working (e.g. Senegal model – is it working, are they able to use it all the new communities? Similarly, in Burkina Faso, which has different models – why is it reportedly struggling?)

Charlotte: Interesting to look at this - if this is endpoint, milestone or beginning - in social norms framework and where it lands on the curves of diffusion of new practice/curve of social norm change. From UNCIEF standpoint, it is at the tipping point – could the evaluation unpack that more?

> Alexandra: The contextualization of the value/meaning of public declarations and the sustaining benefits for public declaration are key elements to consider. These comments are noted and will be further elaborated in the report, paying attention to this language and terminology.
>
> Evaluation Team: Agreed. These comments are noted.

Saleema Best Practice

Nafy: On Saleema, need more clarification on why it is a best practice. What are the elements and evidence that this model that works better than some other model? What data analysis basing this conclusion that Saleema is best practice that needs to be replicated?

> Evaluation Team: The point is taken and will be further elaborated in the report. The presentation highlights that any findings done on Saleema need to be considered when the Joint Programme wants to adapt core elements of the approach to a specific context. The only way to understand how a mechanism works is to test it in a different context and attune to factors of change.

Feasibility of funding beyond one-year cycle

Nafy/Berhanu: The evaluation of phase I highlights clearly the need to have longer planning process. The Joint Programme tried to implement this by having multi-year commitment from donors. This is key because if the Joint Programme does not have this, then is not able to plan for 2-year cycle. At the moment, there are 3 donors (EU DFID and Norway) who pledge for multi-year commitment. This is useful for planning because we know exactly when and how much will be allocated; and you see this predictability in the formulation of bi-annual work plans starting in 2014 for some and 2017 for other countries. This is also the case for Italy, while they do not provide a formal multi-year commitment, they have been consistent since 2008 in the available of funds so we are able to anticipate the allocation based on previous years and plan accordingly (planning for an ambitious work plan and an non-ambitious one should funding not be available). The other challenge for us in internal organizational structures that do not allow for this (e.g. compliance to Non Core Funding Unit processes). As such, even though we have a 2-year work plan in place, the Joint Programme cannot transfer 100% of the funds in the beginning only 50%.

> Alexandra: The point is taken on these challenges: predictability of funds which requires donors to provide multi-year commitment; differences between UNICEF /UNFPA on internal policies for the management of non-core funds (e.g. UNICEF is able to keep funds and roll over – pending implementation rate; UNFPA this is not the case); the actual disbursement to COs. While having a workplan for two years is an improvement for longer term, planning funds are only available for the first year. Thus, predictability of funds is still an issue for COs and implementing partners. The availability of funding is one challenge, and institutional mechanism is another.
>
> Mathew: Can further reflect on if the Joint Programme can be functional even with these constraints and if these institutional processes be adapted to this programme.

Global issues – addressing non-programme countries with high prevalence rates

Nafy: Main contribution of Joint Programme so far in including Indonesia is through advocacy level and data analysis and dissemination of good practice.

Mar: There is a community of practice that is used as a knowledge-sharing platform. Moreover, the Spotlight Initiative will receive funds from EU on this regional aspect (in Africa), where both Joint Programme countries and countries outside of programme will benefit from

Links with immigrant communities – diaspora in Europe

Nafy: Since 2 -3 years, we have been work with and implementing partner on this; however, we are quite limited to what we can do at that level as we are not in position to provide funds to NGOs working in European countries. We only have one partner working in both Africa and European countries. We will continue to look at that component. We have also funded the European and FGM network conference last week and have supported the community of practice COP on FGM (knowledge management platform funded 100% by the Joint

Programme). There are limited funds committed to this intuitive so need to explore more ways on how at the EU level, they can coordinate their approaches for this effort.

Mathew: FGM is a complex subject and it is important to get the analysis right in terms of mainstreaming and how we can get it into the systems.

A few points that have come up include: Is the programme relevant? It is a grave violation and something needs to be done about it. Another key issue is that there are things happening in the country irrespective of UNFPA and UNICEF and how can we attribute our work or not. What is the UN value added – its presence, its knowledge, its coordination? There is a lot of synergies between child marriage programme and FGM and these synergies can be better exploited. The the value of the Joint Programme should not be lost. There are various actions taking place and better scope for integration of that; that needs to be clearly placed.

The evaluation report should be both country specific and bring out the value of a global programme in the coordination and the elements of a global programme that can actually bring about.

Next steps:

Alexandra: Outlined the timeline of the reporting stage of the evaluation:

- Zero draft: before the end of the year. The zero drat will include preliminary findings only. If there is agreement on the findings, then can move to conclusions and recommendations.
- Internal workshop with evaluation team and the evaluation management group: beginning 2019. Drawing on the findings, the workshop will discuss and formulate the conclusions and recommendations
- Meeting on recommendations with the Evaluation Reference Group: February 2019. The meeting will serve to ensure the recommendations are useful, well framed within the current implementation of Phase 3. Although the evaluation is retrospective, looking at 2008-2017 it is also forward looking given that recommendations have to be well positioned within the current phase so that recommendations are useful and operational for the Joint Programme but also strategic for the work on FGM of both agencies beyond the Joint Programme and within the agenda 2030.
- Final version of evaluation report: March 2019
- Presentation to the Steering Committee: March or April 2019

Meeting closed

JOINT EVALUATION OF THE UNFPA-UNICEF JOINT PROGRAMME ON THE ABANDONMENT OF FEMALE GENITAL MUTILATION: ACCELERATING CHANGE Phase I and II (2008–2017)

Work session with the Joint Programme team: on preliminary conclusions and recommendations

27 Febraury (2.30 PM – 19.00 PM)
Minutes

In attendance:	Evaluation Management Group (EMG) Alexandra Chambel, UNFPA Evaluation Office (Chair of EMG) Laurence Reichel, UNICEF Evaluation Office External Evaluation Team (ImpactReady) Susanne Turrall, Report lead, Evaluation Specialist Corinne Whitaker, Gender and harmful practices expert Rafael Eguigurrem, Evaluation lead, in-country case studies Katherine Garven, Evaluation Specialist Maria Borisova, Quality manager (minutes taker) Joint Programme team Nafissatou Diop, UNFPA FGM Joint Programme Coordinator Nankali Maksud, UNICEF FGM Joint Programme Co - Coordinator Berhanu Legesse, UNFPA FGM Joint Programme Coordination Team Thierno Diouf, UNFPA FGM Joint Programme Coordination Team Mar Jubero, UNCIEF FGM Joint Programme Coordination Team Harriet Akullu, UNICEF, FGM Joint Programme Coordination Team Joseph Mabrizi, UNICEF FGM Joint Programme Coordination Team

I. Opening/Introduction

The meeting opened with a welcome from **Alexandra Chambel**, Chair of the Evaluation Reference Group and was followed by a brief discussion on the current status of the Evaluation Report and the process for next steps.

Alexandra: first draft received with the findings; ERG comments have been consolidated and shared with the Evaluation team. Due to a large number of comments, the second draft was not finalised in time for the Conclusions and Recommendations workshop, however findings have been revised (Findings table enclosed). All the comments on the Findings have been taken into consideration – can discuss pending issues at the end e.g.: Finding 21, positive deviance.

Objectives of the meeting:
Alexandra: The objective of the meeting is to discuss conclusions and preliminary recommendations – working session. Test the conclusions together with the Joint Programme, work on getting them right and come up with operational and feasible recommendations. The revised version of the evaluation report will include the findings (revised), conclusions and recommendations along with the audit trail, i.e. responses to the comments.

Action: End of March to have a strong evaluation report; Joint Programme Steering Committee on April 9 - present the report

Nafi: shared the concern of the Joint Programme that it would be helpful for the Joint Programme to be able to clarify few things before the report goes to the donors. EMG should not share the report with donors before consulting with Joint Programme in order to give them a chance to clarify and react to certain issues.

Alexandra: Well noted. As you know there was certain push from the donors – DFID and Norway to have access to the draft as soon as possible. The Action Brief that had preliminary findings was originally shared only with Joint Programme but due to the tight timeline, this was not possible with the draft evaluation report.

Action: Second draft of the report to be shared with Joint Programme for the first round of comments.

II. Presentation of the preliminary conclusions and recommendations

Conclusion 1. Contribution of the Joint Programme

Nafi: what does it mean ''meaningful proportion''?

Evaluation Team: Less achievements due to the funding cycle. Phase II had bi-annual planning but there are still planning issues in the year 2. It I important to raise this issue for the credibility of the evaluation. Intention to be generic.

Action for Evaluation Team: Need to analyse the achievements within the political agenda. Important to be very careful with wording. Need to re-word the conclusion

Conclusion 2. Design, Timeline and expectations

Joint Programme: we need clear programmatic recommendation that can tell us where we have achieved progress and where we have gaps. We have some intermediary markers – we need detailed discussion on it (Act framework.)

Nankali: **increase communication and visibility of partial achievements**? We are already feeding a lot of information to the donors. **Nafi** also expresses a concern as the statement can be interpreted differently by the Joint Programme and the Donors. It could be a negative interpretation for donors as it might be interpreted that vis a vis SDG's we are very far from achieving and it is still a long way to go. Should not forget that we are navigating within the political agenda, it's not only technical. **Nafi**: once again wording of statements is crucial.

Evaluation Team: Using the right language in communicating with decision makers, who don't have field experience and organising collaborative workshops with donors where realistic indicators can be identified.

Nafi: do you have evidence that we don't do it? We are already doing it. We have 2 steering committees, technical meeting in London, etc

Alexandra responding: clarifying that the problem is not necessarily with the process, but with the quality of indicators. There is demand for more indicators as Public Declarations is not the most efficient of the indicators but is being used a lot.

> **Action for Evaluation Team:** rework the wording of the PARTIAL ACHIEVEMENT; provide examples of intermediary Progress markers, examples of indicators;

Conclusion 3: Collective Action and Strategic Choices

Joint Programme: Very broad; Collective action: not clear whether this is positive or negative: would like more specific direction on what should be done:

Evaluation Team responding: Joint Programme is drawing on its comparative strength to play a convening role. Need to connect the catalytic role and strategic choices. Therefore, important to be strategic. Is investing in care strategic? What about geographic scope? Perhaps reviews investment in the current countries? To which extend it is a global programme and thinking through cross border element? Joint Programme is mostly working on the African continent. Should Joint Programme have country presence outside of Africa? Spreading too thin or intensity of investment? Could be a strategic decision? What are the implications for the region, for example if one of the countries in the regions is not covered by Joint Programme, ex Somalia? Joint Programme should stick to making strategic choices – what are the areas that can be done by other actors? Like post FGM survivors support? Not do provision of post FGM care?

Alexandra responding: Joint Programme started in 2008 with Phase 1 (it was catalytical and holistic), it was supposed to identify the leverage point. We are talking about Country level, Joint Programme support existing structures and it's great at engaging different stakeholders and bringing different actors. In Phase II – we have new actors coming in, and now it requires collective action to achieve SDG indicators on FGM beyond the scope of the phase II. Joint Programme is an important actor in the collective action to achieve full abandonment. Joint Programme needs to be strategic to identify areas where it has comparative strength, and its strength is in playing a convening role. The questions is given the limited resources and looking ahead where it should be investing? For example, is it strategic to continue supporting interventions on post-FGM care?

Nafi: we are doing our convening role sometimes too much, more advocacy we do, less time we have for other things. Important to remember that our convening strength comes from all other things that the Joint Programme was good at from the beginning. Regarding Investing in supporting survivors of FGM, maybe we should have assessment how much is going to this area? There are a lot of places where without Joint Programme nothing would have been done on FGM. Would be important to look at that and give recommendations to the countries.

Joint Programme: Countries consider services differently, limited cases where Joint Programme funds the services.

Mar: Care is always left behind – important to address the needs who have been cut, maybe making partnerships with other players?

Berhanu: Convening role differs in different countries, might need more investment in some countries and not much in others. Context of the country is very important

Nankali: not convinced that Collective action and Strategic Choices should be together. **Alexandra responding**: Joint Programme is not acting on its own; to achieve SDG – collective action needed; and Joint Programme has limited resources, therefore collection action is very strategic

Joint Programme: From Advocacy perspective we are global, convening role we are global, but we can't support CSOs.

Joint Programme: the discussion about choosing countries was already done, lots of political tensions about clustering countries. We want to work in Indonesia but the country offices of UNFPA and UNICEF don't want to work on FGM because it is politically sensitive. That's why we do only advocacy there

Action for Evaluation Team:

- Recommendations should not be descriptive (what should and should not be dropped)
- Need more specificity around the gaps around convening. Why should they convene more? (i.e. convening Islamic leaders). The Joint Programme team don't just want to run around holding meetings.
- Team to acknowledge the grassroots elements that give Joint Programme the credibility to convene.
- Is there a way to pull out of the convening role once the country has some convening capacity?
- Supporting survivors and providing health care services post FGM (can we identify how much money is going into this area?)
- If the Joint Programme doesn't provide services, nothing will happen at the country level (what are the risks of removing services from the Joint Programme portfolio?)
- Mention the potential for partnerships.

Conclusion 4 – Evidence Gaps/capitalization on existing knowledge, big gaps in research

Recommendation: research creative solutions, implementation knowledge, need to harness the lessons from the field. There is no systematic way of sharing information from the subnational level to the country and regional. Learning from the field.

Joint Programme: not possible to implement all that with the limited resources:

Laurence: Can HQ have a role in knowledge management; so for the next evaluation we already have that information?

Action for Evaluation Team:

- What needs to be prioritized, where we should focus on in addition to our convening role?
- Can HQ have a role in knowledge management?

Conclusion 5. Challenges around Shifting Practices

Joint Programme: the issues are there: when the social norm has changed – it is very a big thing. Public declaration is an indicator of the social norm change

The Evaluation Team: When a change in paradigm occurs, a change of strategy is required. Distinction between social norm and individual behaviour. When people collectively change their thinking that is the change of the social norm. We need to unpack social norms (change in opinion doesn't result in change of behaviour.) Some of the elements are evolving we can't equate one element to social norm change.

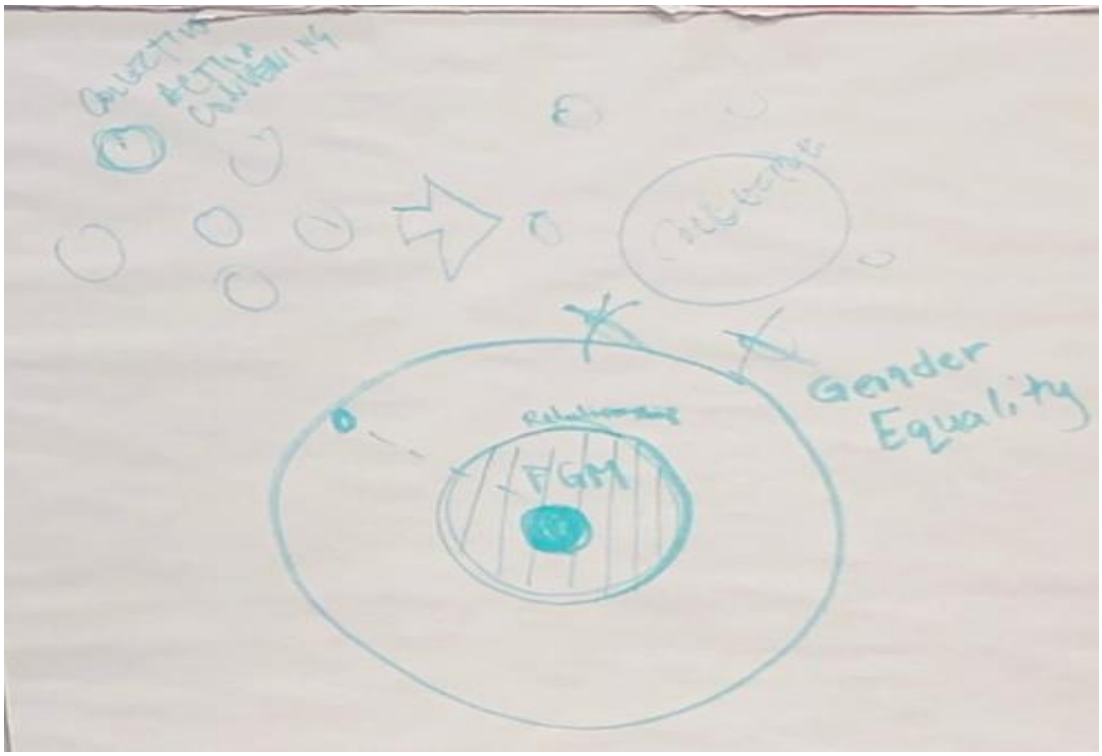
Nafi: evidence here is lacking, what is the percentage crossing border, not comfortable with this conclusion and recommendation…. We don't have evidence whether its major or minor issue to change the strategy. We need to call for more evidence and understand this area better and then to develop the recommendation.

Action for Evaluation Team:

- Clarify that social norms change does not equal passing community declarations. "indications that social norms have changed or are changing".
- Evidence is lacking for these emerging issues.
- Provide evidence whether these shifts are major or minor
- Provide evidence on cross border

Conclusion 6. Gender Transformation

Evaluation Team Diagram:



Berhanu – where do you position the case countries within this diagram? In terms of working on relationships between men and women using community dialogue?

Evaluation Team: good solution as UNFPA can't talk about sexuality, good to remember that often FGM has economic reasons behind.

Nafi: where is the work on girls and women empowerment within this diagram?

Alexandra: girls empowerment is not yet reflected in the recommendations

Evaluation Team: lots of work around FGM with girls was around the integrity of their bodies**.**

Joint Programme: the way this recommendation is written – it puts enormous pressure and responsibility on Joint Programme which will inevitably fail due to such a big and important task that can't be achieved by purely Joint Programme. Need rewording. Should not limit the problem to just the relationships between men and women. We have strong history in changing the social norms and educating men, including the religious leaders.

Joint Programme (Harriet): research came back (Data Analytics) and usually mothers are more in favour of FGM than fathers.

Evaluation Team: for gender transformation men should be engaged in the dialogue, not only at the community level.

Joint Programme: be careful with language, disagree with the title of the conclusion. (change to gender transformative agenda rather than gender equality framework) When writing new Phase we need to market it. We want to make the information on girl empowerment visible as it has always been there – perhaps give more emphasis to it now.

Action for Evaluation Team:

- What about girls' empowerment? Team not to lose this element. They can't only talk about relationships between women and men but also women's empowerment (personal confidence building)
- Acknowledge the power imbalances between women and men and the role of powerful men who want to make all of the decisions.
- The Joint Programme could never fully achieve gender transformation. So, team should be clear that it is a "contribution" towards gender transformation.
- In many cases, women are the ones making decisions on FGM. This should be acknowledged and taken into consideration.
- "within the gender transformative agenda".
- Change the wording to "Emphasis and making it explicit, more visible, etc." (or something like that) – rather than "shifted its focus."

Conclusion 7: Media Messaging

Evaluation Team: Important to select positive and actionable messages in the communications strategies. Important to test C4D strategies before implementing.

Joint Programme: Change the conclusion to Communication and Messaging instead of Media and Messages

Joint Programme: Amplification through media – Joint Programme done a lot of that, but not C4D.

Evaluation Team. Strengthen the capacity of Joint Programme in c4D as it is very useful and helpful practice.

Joint Programme: We already do a lot of C4D at community level; Public advocacy and mass media communication; Donor communication – 3 levels of communication. The Joint Programme should further harness the C4D potential**. Alexandra:** conclusion should also include the strategies for 3 levels of communications

Action for Evaluation Team: Communications and Messaging

- amplification of media and messages is also needed.
- C4D is appropriate only for changing behaviour among target audience.
- need to differentiate between different forms of messages and communication (at the community level, public advocacy and communication (national ratio and TV), and donor)
- should include advocacy under this conclusion and recommendation (how to improve advocacy)

Conclusion 8. Co-ordination and Jointness

Joint Programme: responsibility and roles of who? UNICEF, UNFPA? Or also with other partners? Careful with the partnership – its good but more than 2 partners could be too much from coordination perspective

Alexandra: makes sense to include governance here and steering committee. What is the value of having a Joint Programme on FGM with UNICEF and UNFPA? Why these agencies? Expand more on that.

Joint Programme. It is very good if the importance of regional level will come up in conclusion and evaluation in general.

Joint Programme: Regional is the bridge between country and HQ level, but are not performing well and they get upset if they get passed. So, which areas should regional office lead?

Action for Evaluation Team.

- Suggest a review of different roles and responsibilities at different levels. (**Ask for standard operating procedure to be sent to us from Joint Programme).**
- Added value on working through a Joint Programme on FGM should be highlighted.
- Explain where jointness is not working and why.
- We need to identify which areas are the particular strengths of the ROs.

Conclusion 9/ Rec 9: Synergies across levels (global, regional, country)

Joint Programme: need to review these recommendations. Nafi not convinced. Regional offices should take more leadership in work with CSOs. Need to further elaborate. Coordination might be difficult in simultaneous work with several offices. Leverage INGO's The RO really doesn't have the capacity to approach the African Union. The capacity is really at HQ. The RO could work with civil society networks.

Action for Evaluation Team: Review and elaborate further on this recommendation

Conclusion 10: Moving forward: sustainability:

Evaluation Team: Joint Programme need sufficient plan for post Phase III.

Joint Programme: happy with this recommendation

- Some donors are pushing back on these sustainability issues, so it's important to communicate the importance of these elements clearly in the conclusions.
- They have also invested in the capacity of NGOs (to develop a stronger civil society).

Alexandra: to include how RB framework is designed; part of the sustainability to have strong civil society empowered.

III. Next Steps

Alexandra outlined the timeline of the reporting stage of the evaluation:

- the draft report including conclusions and recommendations will be shared with the Joint Programme team shortly.
- The next ERG meeting will take place in April (date tbd).
- The results of the evaluation will be presented to the Joint Programme steering committee on April 9.

Meeting closed

Annex 3: List of documents reviewed

Joint Programme Documents Annual Global Reports

UNFPA-UNICEF Joint Programme on FGM/C, Annual Report, 2008, 2009, 2010, 2011, 2012.

UNFPA-UNICEF. "Metrics of Progress, Moments of Change. UNFPA-UNICEF Joint Programme on Female Genital Mutilation/Cutting: Accelerating Change, Annual Report," New York, 2015

UNFPA-UNICEF. "By the numbers: accelerating change. Annual Report of the UNFPA–UNICEF Joint Programme on Female Genital Mutilation/Cutting: Accelerating Change," New York, 2016

UNFPA-UNICEF. "Performance Analysis for Phase II. UNFPA-UNICEF Joint Programme on Female Genital Mutilation: Accelerating Change," New York, 2018

Annual Country Reports

UNFPA-UNICEF Joint Programme on FGM/C. Annual Report, Burkina Faso, 2009, 2010, 2011, 2014, 2015, 2016.

UNFPA-UNICEF Joint Programme on FGM/C, Annual Report, Djibouti, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017.

UNFPA-UNICEF Joint Programme on FGM/C, Annual Report, Egypt, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017.

UNFPA-UNICEF Joint Programme on FGM/C, Annual Report, Ethiopia, 2008, 2009, 2010, 2011, 2013, 2014, 2015, 2016, 2017.

UNFPA-UNICEF Joint Programme on FGM/C, Annual Report, Eritrea, 2011, 2012, 2013, 2014, 2015, 2016, 2017

UNFPA-UNICEF Joint Programme on FGM/C, Annual Report, Gambia 2009, 2010, 2011, 2014, 2015, 2016.

UNFPA-UNICEF Joint Programme on FGM/C, Annual Report, Guinea 2008, 2009, 2010, 2011, 2014, 2015, 2016.

UNFPA-UNICEF Joint Programme on FGM/C, Annual Report, Guinea Bissau 2008, 2009, 2010, 2011, 2014, 2015, 2016, 2017.

UNFPA-UNICEF Joint Programme on FGM/C. Annual Report, Kenya 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017.

UNFPA-UNICEF Joint Programme on FGM/C. Annual Report, Mali, 2011, 2014, 2016.

UNFPA-UNICEF Joint Programme on FGM/C. Annual Report, Mauritania, 2011, 2012, 2013, 2014, 2015, 2016, 2017.

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UNFPA-UNICEF Joint Programme on FGM/C, Annual Report, Somalia, 2009, 2010, 2011, 2014, 2015, 2016, 2017.

UNFPA-UNICEF Joint Programme on FGM/C, Annual Report, Sudan, 2008, 2009, 2010, 2011, 2014, 2015, 2016.

UNFPA-UNICEF Joint Programme on FGM/C, Annual Report, Uganda, 2009, 2010, 2011, 2014, 2015, 2016.

UNFPA-UNICEF Joint Programme on FGM/C, Annual Report, Yemen, 2014.

Annual Work Plans

UNFPA/UNICEF Joint Programme on FGM/C, Annual Workplans, 2009-2012

UNFPA-UNICEF Joint Programme on FGM/C. Annual Work Plan, Burkina Faso, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017.

UNFPA-UNICEF Joint Programme on FGM/C, Annual Work Plan, Djibouti, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018.

UNFPA-UNICEF Joint Programme on FGM/C, Annual Work Plan, Egypt, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018.

UNFPA-UNICEF Joint Programme on FGM/C, Annual Work Plan, Ethiopia, 2008, 2009, 2010, 2011, 2012, 2013, 2014-15, 2016, 2017, 2018.

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UNFPA-UNICEF Joint Programme on FGM/C, Annual Work Plan, Senegal, 2008, 2009, 2011, 2012, 2013, 2014, 2015, 2016, 2017.

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Annex 4: List of consulted stakeholders

Joint Programme agencies (UNFPA and UNICEF)

Name	Title (if known)	Institution	Sex	Country
Dekha David	Child Protection Specialist	UNICEF	F	Djibouti
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El Sallab May	Program Officer	UNFPA-CO	F	Egypt
Elsherbini Reem	Child Protection Officer	UNICEF-CO	F	Egypt
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Dr Luay Shabaneh	UNFPA RD	UNFPA	M	Egypt
El Sayed Gehad	Y-PEER coordinator	UNFPA	F	Egypt
Enshrah Ahmed	Gender Advisor	UNFPA ASRO	F	Egypt
Haque Fazlul,	Deputy to Representative	UNICEF	M	Egypt
Line Baago Rasmussen	Programme Specialist	UNICEF MENARO	F	Egypt
Saji Thomas	Chief of Child Protection	UNICEF	M	Egypt
Abdel Maha	Reproductive Health Programme Analyst	UNFPA	F	Egypt
Bayoumi Dalia	Monitoring and Evaluation Specialist	UNICEF	F	Egypt
Darwish Khaled	Child Protection Specialist	UNICEF CO	M	Egypt
Dictus Richard	UN Representative	UNICEF	M	Egypt
Dr. Aleksandar *Sasha* Bodiroza	UNFPA Representative	UNFPA	M	Egypt
Haddad Germaine	Assistant Representative	UNFPA	F	Egypt
Maes Bruno	UNICEF Representative	UNICEF	M	Egypt
Said Nihil	Adolescent and youth programme analyst	UNFPA	F	Egypt
Strigelli Gaia Chiti	Chief , Communication for Development	UNICEF	F	Egypt
Alem Ellen	Social Policy Section, knowledge management	UNICEF-CO	F	Ethiopia
Anemu Ashi Nafi	CP Officer	UNICEF-Afar	M	Ethiopia
Ashanafi	Regional Coordinator-	UNICEF-Afar	M	Ethiopia
Belay Ephrem	Former Coordinator	UNICEF, Afar	M	Ethiopia
Gachiri Joyce	Region Chief	UNICEF, SNNPR	F	Ethiopia
Gette Tsehaye	Program Officer	UNFPA-CO	F	Ethiopia
Heissler Karin	PO CP	UNICEF-CO	F	Ethiopia
Hussein [*]	Regional Coordinator	UNFPA-Afar	M	Ethiopia
Kibur Martha	Knowledge Management, M and E	UNICEF-CO	F	Ethiopia
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Negesse Ayele	Monitoring and Evaluation staff	UNFPA-CO	M	Ethiopia
Sakato Tarekegn	PC	UNFPA-SNNPR	M	Ethiopia
Shekur Zemzem	Social mobilization and development specialist	UNICEF-CO	F	Ethiopia
Tadesse Hailemariam	PO	UNFPA-SNNPR	M	Ethiopia
Ahmed Enshrah	Regional advisor Gender, Culture Human Rts	UNFPA Arab States Regional Office	F	Global
Akuluu Harriet	UNICEF, FGM Joint Programme Coordination Team	UNICEF	F	Global
Annamuhamedova Aynabat	UNFPA Policy and Strategy	UNFPA	F	Global
Cappa Claudia	UNICEF Data and Analytics	UNICEF	F	Global
Charlotte Lapsansky	UNICEF Communication for Development Specialist	UNICEF	F	Global
Delsol Christian	Media and Communications Branch,	UNFPA HQ	M	Global
Diallo Amira	Consultant, FGM and GBV	UNFPA ESARO	F	Global
Diop Nafissatou	UNFPA FGM Joint Programme Coordinator	UNFPA	F	Global
Diouf Thierno	FGM M&E Specialist,	UNFPA HQ	M	Global

Dr. Luay Shabaneh	Regional Director	UNFPA Arab States Regional Office	M	Global
Duerst Patrick	UNFPA Evaluation Office		M	Global
Gharzeddine Omar	Media and Communications Branch,	UNFPA HQ	F	Global
Gotham Jennifer	REGA	UNFPA ESARO	F	Global
Ihalainen Mira	Resource Mobilization Specialist , Communications and Strategic Partnerships	UNFPA HQ	F	Global
Jubero Mar	Associate Director, Child protection	UNICEF, HQ	M	Global
Kantende Charles	UNFPA Chief, Strategic Information & Knowledge Management Branch	UNFPA	M	Global
Karlssen Jonna	Child Protection Specialist	UNICEF ESARO	F	Global
Kasenene Robert		UNFPA Liaison Office to African Union	M	Global
Kullu Harriet	Joint Programme Team,	Joint Programme Team available	F	Global
Legesse Berhanu	Technical Specialist , Gender, Human Rights, and Culture Branch	UNFPA, HQ	M	Global
Mabrizi Joseph	UNICEF FGM Joint Programme Coordination Team	UNICEF	M	Global
Macdonald Anthony	Regional Senior Child Protection Specialist	MENA UNICEF	M	Global
Maksud Nankali	Coordinator, UNFPA/UNICEF Global Programme to Accelerate Action to End Child Marriage and FGM	UNICEF, HQ	F	Global
Mora Luis	Head, G/HR/Culture Branch, Tech	UNFPA Gender, Human Rights, and Culture Branch	M	Global
Mosoti John	Chief, Multilateral / inter-governmental work,	UNFPA, HQ	M	Global
Rasmussen Line Baago	Child Protection Specialist	UNICEF MENA	M	Global
Snow Rachel	UNFPA Population and Development Branch, ,	UNFPA, HQ	F	Global
Toure Ramatou	Senior Child Protection Specialist	WCARO UNICEF	F	Global
Upala Devi	GBV Specialist, Gender, Human Rights, and Culture Branch	UNFPA Gender, Human Rights, and Culture Branch	F	Global
Wassihun Hilina		UNFPA Liaison Office to African Union	F	Global
Williams Cornelius	Associate Director, Head Child Protection	UNICEF, HQ	M	Global
Ingabire Anita	FGM Focal Point	UNICEF	F	Guinea
Wang Fanta	FGM Focal Point	UNFPA	F	Guinea
Blute Ednilson	FGM Focal Point	UNFPA	M	Guinea Bissau
Makelele Jean Pierre	FGM Focal Point	UNFPA	M	Guinea Bissau
Polonio Sonia	FGM Focal Point	UNICEF	F	Guinea Bissau
Abdullahi Mohamed	Chief, Field Office	UNICEF	M	Kenya
Abdulradir Maryam s.	VAC Spec	UNICEF	F	Kenya
Ahmed Zeinab A.	Child Protection Specialist	UNICEF	F	Kenya
Dr. Ademola Olajide	Country rep	UNFPA	M	Kenya
Dr. Dan Okoro	Program Spec SRHR/Mat Hlt	UNFPA	M	Kenya
Gachanja Florence	CP Specialist		F	
Mugor Caroline	NPPP	UNFPA	F	Kenya
Mutai Rael	Program Coor	UNFPA	F	Kenya
Mutemi Rseolyn	C4D Spec	UNICEF	F	Kenya
Mutungi Antony	ME Specialist		M	
N.Wawla Rose	HIV Specialist	UNICEF	F	Kenya
Ngure Ezekiel	Population Data Specialist	UNFPA	M	Kenya
Onyando Jackson	HIV/AIDS Officer OIC	UNICEF	M	Kenya
Schultink Werner, PhD	Country rep	UNICEF	M	Kenya

Somo Haithar	CP Spec	UNICEF	M	Kenya
Faye Nana	FGM Focal Point	UNFPA	F	Mali
Renault Mathilde	Child Protection Specialist	UNICEF	F	Mali
Sangare Aminata Dicko	Child Protection Specialist	UNICEF	F	Mali
Cheikh Kadijetou	Focal Point	UNFPA	F	Mauritania
Fatma Soueid Ahmed	Focal Point	UNICEF	F	Mauritania
Kidane Milen	Focal Point	UNICEF	F	Nigeria
Odebode Olasunbo	Focal Point	UNICEF	F	Nigeria
Tabara Deborah	Focal Point	UNFPA	F	Nigeria
Camara Diatta	Chargé Suivi & Evaluation	UNFPA Country Office	M	Senegal
Gueye Babacar	Chargé programme Jeunes	UNFPA Country Office	M	Senegal
Tine Yakar	Child protection Specialist	UNICEF country office	F	Senegal
Botev Nikolai	Rep for Somalia in Kenya	UNFPA	M	Somalia
Kigen Elizabeth	FGM Focal Point for Somalia in Kenya – Programme Officer	UNFPA	F	Somalia
Ross Brendan	FGM Focal Point in Somalia	UNICEF	M	Somalia
Germain Maxime	Child Protection Specialist	UNICEF	M	Gambia
Leighton Rupert	Deputy Representative in The Gambia	UNICEF	M	Gambia
Mme Fatou Kinteh	FGM Focal Point	UNFPA	F	Gambia
Cherop Esther	Program Analyst	UNFPA-Uganda	F	Uganda
Subtotal			59 F 44 M	

Other United Nations agencies

Name	Title (if known)	Institution	Sex	Country
Korayem Rana	Program Associate	UN Women	F	Egypt
Wafaa Heba	Gender Team Leader	UNDP	F	Egypt
Berhanu Gezu	Program Officer-Population and Development	UNFPA	F	Ethiopia
Fekadu Afework	Program Officer, Joint Gender Programme	UNDP	M	Ethiopia
Melesse Dr. Fikir	NPO-Programme Management	WHO Ethiopia	F	Ethiopia
Zenebe Luam	Program Officer	UN Women	F	Ethiopia
Castano Juncal Plazaola	Data Specialist Eliminating Violence Against Women Programme (EVAW), Policy Division	UN Women HQ	F	Global
Christina Catherine PALLITTO	Dept. of Reproductive Health and Research,	WHO	F	Global
Kalliopi Mingeirou	Acting Chief EVAW; Spotlight ,	UN Women HQ	F	Global
Kenny Erin		EU Spotlight	F	Global
Meenagh Caroline	Policy Specialist, Policy Division	UN Women HQ	F	Global
Grace Wangechi	Program Analyst	UN Women	F	Kenya
Lavussa Joyce	National Professional officer	WHO-Kenya	F	Kenya
Mathenge Martha	Programme Officer	UNDP-Kenya	F	Kenya
Subtotal			13 F 1 M	

Development Partners

Name	Title (if known)	Institution	Sex	Country
Dr. Gamal Serour	Head of Islamic Research Center	Al Azhar University	M	Egypt
Name withheld		Al Azhar University	4M, 1 F	Egypt
Ahmed Neveen	Gender Focal Point	EU Delegation	F	Egypt
Dr Omaima El Gebali	Prof. Public Health & Community Medicine	Assiut University	F	Egypt
Drøyer Elisabeth	Counselor	Embassy of Norway	F	Egypt
Fatma El Zanaty + one researcher	Researcher / Prof. Cairo Univ/ President, El Zanaty and Associates.	El-Zanaty &Associates	2F	Egypt
Hunskaar Maria	First Secretary	Embassy of Norway	F	Egypt

Mergia Woiz Mieraf	Deputy Team Leader-Human Development/Social Development Advisor	DFID	F	Ethiopia
Janson Landin Susanna	Embassy of Sweden Lusaka	SIDA, Swedish MOFA	F	Global
Daublain Maxence	FGM	European Commision - DEVCO	M	Global
Feather Jo	Individual consultant	DFID	F	Global
Hodvei-Dana Ingrid	Ministry of Foreign Affairs, Norway	Norway	F	Global
Jessica Cuperllini	MFA, Italy	Italy	F	Global
Magni Loredana		Italy MFA	F	Global
Scott Beth		United Kingdom (DFID)	F	Global
Sletten Anja		Senior Adviser, Norway, NORAD	F	Global
Rocha Graça	Gabinete de Planeamento, Programação e Estatística	Portuguese Cooperation	F	Guinea Bissau
Dr. Samuel Kimani,	Associate Investigator Senior Lecturer	ACCAF African coordination center for abandonment of FGM	M	Kenya
Name withheld	Gender Technical Working Group (observer)		20 F 2 M	Kenya
Hill Jenny	Counsellor, Development and Head of Cooperation	Government of Canada	F	Kenya
Kimani Samuel	Research Specialist Coordinator	Africa Coordinating Center for the Abandonment of FGM/C (ACCAF)	M	Kenya
Prof Guyo W. Jaldesa	Assc Prof, consultant O/G Founder	Nairobi Hospital, ACCAF	M	Kenya
Subtotal			37 F 11 M	

Civil Society

Name	Title (if known)	Institution	Sex	Country
Dakrouny Fatma	Managing Director	YPeer	F	Egypt
Dr. Abdel Hamid Attia	Chairperson	Doctors Against FGM	M	Egypt
Israa Ibrahim Manal Fawzi	Programme Unit Manager	PLAN International	2 F	Egypt
Sheikh Ahmed Abdel Gawad Hassan	Preacher	Dairout, Al Azhar	M	Egypt
Name withheld	YPeer Educators	YPeer, Assuit	3M 8F	Egypt
Abdelhameed, Dalia	Researcher	ex EIPR	F	Egypt
Afaf	Coordinator	ACDA	F	Egypt
Alaaedin Ead Ali	Coordinator		M	Egypt
Dr Ayman Sadek		Plan International	M	Egypt
Faisal Fadwa	Admin. Assistant		F	Egypt
Father Ruweis and two more priests	Coptic Orthodox Clerics	BLESS	3 M	Egypt
Fawzi Manal		Plan	F	Egypt
Hamdawy Ahmed	Project Manager		M	Egypt
Israa Ibrahim , Prog. Unit Manager		Plan	2F	Egypt
Kamal Ayat	Coordinator		F	Egypt
Kamal Saad Morcos	Priest		M	Egypt
Kareem Samar Abdel	Data Entry		F	Egypt
Mahmoud Sabrine	Field Coordinator	YPeer	F	Egypt
Monica	Data Entry		F	Egypt
Name witheld	Manager	Manshayat Nasser Centre	F	Egypt
R.H.	Priest, El Qoseya		M	Egypt
Sallam Mamdouh		Plan Qena	M	Egypt
Sawsan	(Financial Manager		F	Egypt
Shaker Antonios	Priest		M	Egypt
Shaker Ereen	Accountant		F	Egypt

Talaat Nahed		BLESS	F	Egypt
Name withheld	YPeer Educators	YPeer. Luxor	1M 1F	Egypt
Name withheld	YPEER educators	Caritas. Qena	11F 6M	Egypt
Name withheld	3 midwives in clinical services	Catholic Church of Ethiopia-SNNPR	3 F	Ethiopia
Abdeuemuslim Shehissen	Muslim Religious Leader	Inter-Religious Council	M	Ethiopia
Ahmed, Ali	Administrator	Mille Hospital	M	Ethiopia
Asmelash Ato	Director	Rohi Weddu	M	Ethiopia
Befikadu Addisalem	Senior Program coordinator	Norwegian Church Aid	F	Ethiopia
Belayneh Kidist	Head of Programs	Norwegian Church Aid	F	Ethiopia
Bizubyehu Andarssa	Executive Director	ODAWACE	M	Ethiopia
Bouha Hassan	Religious Leader	NA	M	Ethiopia
Cababush	nurse	NCA-supported Catholic Church maternity ward and hospital	F	Ethiopia
Dabit	Representative Vicarate SNNPR	Catholic Church of Ethiopia	M	Ethiopia
Dinkele	clinical nurse	NCA-supported Catholic Church maternity ward and hospital	M	Ethiopia
Dr. Omar	doctor	Mille Hospital	M	Ethiopia
Gebr Dr Bogalech	Director	KMZ	F	Ethiopia
Hail Melake	Elder Ethiopian Orthodox Church	Inter-Religious Council	M	Ethiopia
Madina	Coordinator	APDA	F	Ethiopia
Martha Yigezu	Child Fund Secretariat Manager	Plan International Ethiopia	F	Ethiopia
Shuma Yohannes	Program Coordinator	Inter-Religious Council	M	Ethiopia
Tadele Feleke	President (Principle Investigator, FGM Research)	Ethiopian Society of Sociologists, Social Workers, and Anthropologists	4M	Ethiopia
Tespas	Midwife	NCA-supported Catholic Church maternity ward and hospital	F	Ethiopia
Weldesilassie Hulluf	Deputy Secretary General	Inter-Religious Council	M	Ethiopia
Woldemariam Asemeslash	Executive Director	Rohi Wodu	M	Ethiopia
Wubetu Kinfe	Senior Programme Manager, Child Protection	Save the Children, Ethiopia	M	Ethiopia
Michau Lori	Author SASA	Raising Voices	F	Global
Kamano Fara Djiba	Director	l'ONG AFASCO	F	Guinea
Mady Kaba Bintou	Executive Secretary	l'Association des Amis de la Solidarité Sociale et du Développement (ASD).	F	Guinea
Oularé Mouctar		Tostan	M	Guinea
Djalo Mamadu Saido		NGO Protégé	M	Guinea Bissau
Malam Camará	Project Manager	ADPP	M	Guinea Bissau
Nyrup Asger	National Director	ADPP	M	Guinea Bissau
Semedo Odete	Coordinator of the Socio Anthropologic Study on FGM	National Institute for Studies and Research (INEP)	F	Guinea Bissau
Abdullahi Mohamed Sheikh	Community Mobilizer	WOKIKE	M	Kenya
Chege Mercy	Head of Unit	Plan International	F	Kenya
Dr. Francis Kuria	Executive Director	Inter-Religious Council of Kenya	M	Kenya
Florence Robi	COA	Civil Society East Africa Child Rights Network (EACR)	F	Kenya
Name withheld	Program Manager – Narok South	AfyaAfrika, COVAW, NASCNET, Gender Officer	3M 3F	Kenya
Getende Maria Joseph	Pastor	Maranatha Church	M	Kenya
Name withheld	Womenkind, WV, ADRA	Womankind, WV, ADRA	2F	Kenya

			1 M	
Hussein Sheikh	Scholar	Supreme Council of Kenya Muslims (SUPKEM)	M	Kenya
Irhad	PO	Sisters Maternity Hospital (SIMAHO)	M	Kenya
Keter Emily	Program Officer	Tasaru Ntomonok Initiative (TNI) / Rescue Center	F	Kenya
Name witheld	Excutive Director and 3 Other staff	Pastoralist Girls Initiative	4F	Kenya
Maina Anthony	Organizational Development Manager	Womankind(WOKIKE)	M	Kenya
Maranga Alice	Programme Officer	Federation of Women Lawyers Kenya (FIDA)	F	Kenya
Maryan	Member	Silver Lining	F	Kenya
Muktar	Chair	Garissa Paralegal	M	Kenya
Muteshi Jacinta	ED	Population Council Nairobi Office, Evidence to End FGM (DFID)	F	Kenya
Mwangi-Powell Faith	Global Director	The Girl Generation	F	Kenya
Mwangovya Flavia	Lead	Ending Harmful Practices, Africa, Equality Now	F	Kenya
Ndirangu Meshack	Country Director, Kenya	AMREF	M	Kenya
Omar Esmael	PO	TGG	M	Kenya
Orongo Jeremiah	Program Manager – Narok South	World Vision	M	Kenya
Qamar	Secretary	Garissa Paralegal	F	Kenya
Qamar	Secretary	Inua Girls	F	Kenya
Rodha	Counsellor	Refugee Council of Kenya	F	Kenya
Salat Ahmed	Project officer	WOKIKE	M	Kenya
Samuel Maria Sagirai	Pastor	Maranatha Faith Assemblies	M	Kenya
Seleyian Agnes Partoip	Founder/Director	Murua Girl Child education program	F	Kenya
Sheikh Abdi	Imam	SUPKEM	M	Kenya
Sheikh Abdi Latif Shaban	Director General	SUPKEM	M	Kenya
Waichinga Anne	Associate Director Education and Child Protection	World Vision	F	Kenya
Walgwe Ester,	Operations Program Officer	Population Council Nairobi Office	F	Kenya
Wangoi Njau Phyllis	Gender and Reproductive Health Specialist	Indpendent	F	Kenya
Name withheld	women paralegals	CoE -ADRA	F	Kenya
Ballo Bréhima	Director	Programme Association Malienne pour le Suivi et l'Orientation des Pratiques Traditionnelles (AMSOPT)	M	Mali
Traoré Siaka	President	Sini Sanuman Sotuba Logements Sociaux	M	Mali
BA BEKAYE	Responsible tehnique et financier	Cellule MGF	M	Mauritania
El Mamy Ould Elkheir	President	COAN	M	Mauritania
Malal Samba Guissé	Coordinateur	ONG SIFAA	M	Mauritania
Yacouba Diagana	Président ONG ACTION	ONG ACTION	M	Mauritania
Adebisi Ademola		Social Media Aadvocate OSUN	F	Nigeria
Ndouloumadji Dembé	Membres	Association des ex-exciseuses	F	Senegal
Aziz Sy Abdoul	Chargé de programme	Tostan Thiès	M	Senegal
Coulibaly Mamadou	Coordonnateur de Zone	Grand Mother Project/Vélingara	M	Senegal
Diack Abou	Coordonateur zone de Tostan Matam	Tostan Matam	M	Senegal
Fall Moustapha	Coordonateur régional GEEP	Groupe pour l'Etude et l'Enseignement de la Population	M	Senegal
Gaye Mohamed	Représentant régional RADDHO	Rencontre Africaine Des Droits de l'Homme-RADDHO/Matam	M	Senegal

Kane Seydou	Coordonateur	Forum pour le Développement Durable Endogène-FODDE	M	Senegal
Mané Ansou	Coordonateur régional AEMO/Ministère de la Justice	Action Educative en Milieu Ouvert -AEMO	M	Senegal
Mme Sabaly	Coordinatrice EDUCO	EDUCO	F	Senegal
Moussé Fall Mame	Coordonateur RIP	Réseau Islam et Population	M	Senegal
Mr Ibrahima Aly Sow	Coordonnateur régional/ Représentant de WHEPSA	Women Health Education Prevention and Strategy Alliance- WHEPSA	M	Senegal
Samsedine Sané	Point focal CDPE/Sédhiou	CDPE Sédhiou	H	Senegal
Ahmed Hassan Mustafe	Programme Coordinator	Nagaad Network	M	Somalia
Nunow Abdikadir Abdirahman	Protection Manager	INTERSOS	M	Somalia
Tayasir Ahmed Omar	Executive Director	IRADA	M	Somalia
Bakoto Musu		Think Young Women – (TYW	F	Gambia
Ceesay Omar		Health Promotion and Development Organization (HePDO)	M	Gambia
Jallow Musa	Director	GAMCOTRAP	M	Gambia
Mendy Francois S	Director	Nova Scotia Gambia Association	M	Gambia
Oumie Sissoho	Coordinator	The Girls' Agenda	F	Gambia
Twongyeirwe Hilda	ED	Uganda Women Writers Association - FEMRITE	F	Uganda
Weswala Umar	Founder and Managing Editor	The Community Agenda	M	Uganda
Survey			35 F 36 M 6 O	
Subtotal			**116 F** **134 M** **6 O**	

Central Government

Name	Title (if known)	Institution	Sex	Country
Ashmawy Azza	Sec. Gen.	NCCM	F	Egypt
Morsy Maya	Secretary General	National Council for Women	F	Egypt
Amin Mona		Ex-NPC	F	Egypt
Dr A.Kram Elzayat	Programme Manager	NCCM	M	Egypt
Dr Gamal El-Khatib	Consultant	NCCM	M	Egypt
Dr Khaled El Oteify,	UnderSec, Primary Health Care	Health Ministry	M	Egypt
El khayat Fatma	Undersec of social ministry	Social Ministry	F	Egypt
Fouad Vivian		Ex-NPC	F	Egypt
Nahla Abdel Tawab	Director	NPC	F	Egypt
Zak Amal	Ministry of Health (ex), now Consultant	National Council for Childhood and Motherhood	F	Egypt
Asnake Inku	Deputy of Women and Children Coordination Office	Federal Attorney General's Office	F	Ethiopia
Tadesse Ato Seleshi -	Director, women mobilization and participation enhancement Directorate	MoWCA	M	Ethiopia
Tsehay Mzirak	Coordinator	National Alliance to End Child Marriage and FGM	F	Ethiopia
Camara Souleymane	FGM Focal Point	Ministère de l'Action Sociale	M	Guinea
Nabe Aboubacar Sidiki	FGM Focal Point	Secrétariat aux Affaires Religieuses	M	Guinea
Birat Lilian	Education Officer	MOE	F	Kenya

Dr. Joel Gondi	Head RMHMSU	Ministry of Health (MoH)	M	Kenya
Jalenga Stephen	Head	MOE-Youth and Gender Mainstreaming	M	Kenya
Karimi Caroline	Head Children, Victims and Witnesses Support Division	ODPP	F	Kenya
Loloju Bernadette	Chief Executive Officer	Anti-FGM Board	F	Kenya
Mawangi Alice	Head SRH	FMOH	F	Kenya
Onyango Protus	Director – Gender mainstreaming	State Department of Gender Affairs (SDGA)	M	Kenya
Name withheld	Jeunes relais	Ministère de la Jeunesse/Centre Conseil Adolescents	M F	Senegal
Baisecka Fanta	Director	Women's Bureau	F	Gambia
Candiru Jocelyn	FGM focal point	Ministry of Gender, Labour and Social Development	F	Uganda
Survey			18 F 14 M 1 O	
Subtotal			**35 F** **4 M** **1 O**	

Local Government

Name	Title (if known)	Institution	Sex	Country
Gamal Akmal	Ex Project Manager, Luxor	Ex National Population Council ,	M	Egypt
Dr Ibsam Fathalla	Head of Health Education	Ministry of Health, Luxor	F	Egypt
Abdelah Ali	NCCM		m	Egypt
Jamal Nour El Din	Assist Governor		M	Egypt
Name withheld	Governorate Staff		13 2 F	Egypt
Fathy Sherif	Assistant, City Council		M	Egypt
Hegazy Osama	Health Directorate		M	Egypt
Lotfy Ashraf	Department of Education		M	Egypt
Omran Mohamed			M	Egypt
Shehata	City Council		M	Egypt
Abdu [*]	Regional Staff	BOWCA, Afar	M	Ethiopia
Alemayo Masfin		BOWCA, Afar	M	Ethiopia
Ali Mahammed haji Ali	Vice President	Woreda Sharia Court-Afar	M	Ethiopia
Ayza Atsfe	Head	BOWCA, SNNPR	F	Ethiopia
Burk Katamo	Region Deputy Head of Bureau	BOJ, SNNPR	M	Ethiopia
Name withheld	Coordination Mechanism for Angecha Woreda for KMG program	Angecha Woreda BOWCA, BOH, BOJ, BOC	7 M 6 F	Ethiopia
Cummad Qali Gifti Zahra	Bureau Head	Bureau of women and Children Affairs, Afar	F	Ethiopia
Demissie Afework	Prosecutor	BOJ, SNNPR	M	Ethiopia
Fatuma [*]	Chief	BOWCA-Afar	F	Ethiopia
Gezahan Geleye	Legal Translator	BOJ, SNNPR	M	Ethiopia
Hussein Adnan	Focal Point, Gender	BOWCA-Afar	M	Ethiopia
Name withheld	Justice Coalition members (prosecutor, BOWCA, police)	BOWCA -Afar	2 F 5 M	Ethiopia
Name withheld	Justice Coalition members (prosecutor, police, sharia)	BOWCA -Afar	3 F 6 M	Ethiopia
Macamma Fatuma	Vice Bureau Head	Regional BOJ-Afar	F	Ethiopia
Mamo Tesfaye	Joint Programme Focal Point	BOWCA, SNNPR	M	Ethiopia
Mathewos Nega	TA for FGM (UNICEF supplied)	BOWCA, SNNPR	M	Ethiopia
Sheik Mohammed Darasa	Head	Bureau of Sharia/Supreme Sharia Court -Afar	M	Ethiopia
J.K Chepchieng	County Commissioner	National Government Garissa	M	Kenya
Abdi Hussein Mohamed	Coordinator	County Children office	M	Kenya

Billy Adera	Children's Officer	National Government/Narok Country	M	Kenya
Buro Golicha Guyo	Manager	Garissa Children Rescue Centre	M	Kenya
Name withheld	Senior Chief, Asst Chiefs (2)	National Government	3M	Kenya
Kawanu Kiungo Salome	SCO	MOJ	F	Kenya
Khaemba Pilot	Sub county Children's Office (Narok North and East)	National Government/Narok County	M	Kenya
Kivonira Susan	Assistant Country Commissioner	National Government/Narok County	F	Kenya
Name withheld	Local Government Actors (9)	Sankuri Garissa	8M	Kenya
Mondi James O	SCCO	DCS	M	Kenya
Muhia Peter	Gender Officer	National Government/Gender	M	Kenya
Nyokabi Mercy	ODPP Narok	ODPP Narok	F	Kenya
Obinya John	Sub County Coordinator	Children's Services,	M	Kenya
Onyango Pamela	Management Assistant	National Government/Narok County	F	Kenya
Paul Rotech	EO	MOJ	M	Kenya
Ronald	Deputy County Commissioner	National Government/Narok County	M	Kenya
Samburu Miriam	Nursing Officer	MOH, Level 4	F	Kenya
Senior Chief	chief	Bukira clan -ADRA	M	Kenya
Sun-Country Coordinator	Sub County Coordinator	Sub County Coordinator, Children's Services, Migori	F	Kenya
Topisia Phanice	Public Health Nurse	National Government/Narok South Sub county	F	Kenya
Name withheld			F	Kenya
Egwu Flora	Chairperson	Child Protection Network, Ebonyi State	F	Nigeria
Famosaya Dayo		National Orientation Agency (NOA) Ekiti State	M	Nigeria
Olawoyin Balikis Kemi		Ministry of Health, Oyo State	M	Nigeria
Toyin Adelowokan		Primary Health Care Development Board, Osun State	F	Nigeria
Doulo Birane Sow	Point focal service régional de l'Action Sociale	CDPE-Matam	M	Senegal
Faye Alassane	Préfet département Matam	CDPE-Matam	M	Senegal
Mbengue Andala	Point focal service régional Développement communautaire	CDPE-Matam	M	Senegal
Mme Lô Aissatou Diouf	Coordinatrice SR district de Kolda	Région Médical de Kolda/district sanitaire de Kolda	F	Senegal
Freda Emuron	District Community Development Officer	Amudat District, Uganda	M	Uganda
Survey			2F	
Subtotal			**31 F 76 M**	

Communities

Name	Title (if known)	Institution	Sex	Country
Name withheld	Programme participants from PLAN projects		14F	Egypt

Name withheld	Programme participants involved with Caritas, Dandara village		14F	Egypt
Name withheld	Programme participants at Manshayat Nasser Centre, Cairo		20F	Egypt
Name withheld	School pupils, Damietta		13F	Egypt
Name withheld	Community members, Damietta		8M	Egypt
Name withheld	Programme participants from Resala		4F	Egypt
Name withheld	Community members	Youth Center, Damietta	8M	Egypt
Name withheld	Damietta school students		13 F	Egypt
Name withheld	Implementing partners		1F 3 M	Egypt
Name withheld	Programme participants in undisclosed location		26 F 35 M	Egypt
Name withheld	Programme participants involved with Caritas, Dandara village		14 F	Egypt
Name withheld	Programme participants at Manshayat Nasser Centre, Cairo		20 F	Egypt
Name withheld	10 male missionaries for Catholic Church	Catholic Church	10 M	Ethiopia
Name withheld	2 female role models; group of 10 girls		12 F	Ethiopia
Name withheld	30 Girls ages 10-14 in catholic schools and in anti HTP clubs in group	Various Catholic schools	30 F	Ethiopia
Name withheld	30 Schoolgirls, 2 officers of BOWCA		32F	Ethiopia
Name withheld	Abahina Ali, Aminaa Jagob, Kanawe Mohammad Ex-circumcisers		F	Ethiopia
Name withheld	Elders, Male representatives		16 M	Ethiopia
Name withheld	Elders, Male representatives		16 M	Ethiopia
Name withheld	Essaye-Role Model Fatima		F	Ethiopia
Name withheld	Ex-circumcisers		4 F	Ethiopia
Name withheld	Gezzima Group (Standing Together Group) Members; KMG	Gezzima Group of KMG	6 F 6 M	Ethiopia
Name withheld	Gezzima Group (Standing Together Group) Members; KMG	Gezzima Group of KMG	6 F	Ethiopia
Name withheld	Girls Club Members	Girls Club	18 F	Ethiopia
Name withheld	Group of 21 women; group of 16 male elders; 2 health extension workers; group of 5 girls		28 F 16 M	Ethiopia
Name withheld	Leaders(5) Members (4)		9F	Ethiopia
Name withheld	Mixed group of community level actors from 2 kibeles in Dara Woreda, Sidama Zone (religious leaders, kebele leaders, facilitators)		8 M	Ethiopia
Name withheld	Surveillance Group Members (11) Village, youth and women leaders		9 M 2 F	Ethiopia
Name withheld	Teacher and Student	Private School, Wasara Kebele	2 F	Ethiopia
Name withheld	Uncut girls		24F	Ethiopia
Name withheld	Uncut Girls Group; KMG 1 chairperson 1 secretary 3 facilitators 8 members	Uncut Girls Group of KMG	13 F	Ethiopia
Name withheld	Women (14) ages 30-50; 2 <20; 2>60		14F	Ethiopia
Name withheld	Women's Group	Women's group	22 F	Ethiopia
Name withheld	Women's Group		22 F	Ethiopia
Name withheld	Group members		6M	Ethiopia
Name withheld	Members	COE-ADRA	3M	Kenya
Name withheld	Group members	community savings group ADRA	2M 3F	Kenya
Name withheld	Girls	ARP of ADRA	7F	Kenya
Name withheld	Boys group	Boys group	18M	Kenya
Name withheld	Boys Group –non ARP	Boys Group	9M	Kenya
Name withheld	Champions for Change Group	ADRA through Maranatha Church	9F 1M	Kenya
Name withheld	Champions for Change with CHW	ADRA supported	3F	Kenya

			2 M	
Name withheld	Change champions Hawa, Maryan, Halima, Hibo, Fatuma	Umulkheir	5F	Kenya
Name withheld	Community Champions		6M 3F	Kenya
Name withheld	Community members	Sankur	57M 48F	Kenya
Name withheld	Coordinator Council of Elders	Kuria -ADRA	M	Kenya
Name withheld	Girls	Girls group (ARP)	5F	Kenya
Name withheld	Girls group	Women's group	18F	Kenya
Name withheld	Girls Group –non ARP	Girls Group –non ARP	9F	Kenya
Name withheld	Male Champions	UmulKheir Centre	3M	Kenya
Name withheld	Men's Group	Men's group	11M	Kenya
Nakola Daniel Ole	programme participants	Regional Council of Elders	2M	Kenya
Nayianoi, Iren	Traditional Birth Attendants	TBA	2F	Kenya
Pastor David				Kenya
Purity Oyie	programme participants	Role Model	F	Kenya
Name withheld	Reformed Circumcisers	UmulKheir Centre	5F	Kenya
Name withheld	Rescued Girls Group ARP	Maranatha Church ADRA	F7	Kenya
Name withheld	rotating savings group, parents of uncut girls ADRA	ADRA	3M 3F	Kenya
Name withheld	school girls in health club program ; boy supports	ADRA supported	30 F 10 M	Kenya
Silvia	programme participants	Reformed Cutter/School Cook	F	Kenya
Name withheld	Women's Group	Women's Group	20F	Kenya
Name withheld	Relais communautaires	Membres de la communauté	M	Senegal
Name withheld	Membres de la communauté d'ASNE BALLA	Membres de la communauté	M F	Senegal
Name withheld	Membres de la communauté de Coulandiala	Membres de la communauté	M F	Senegal
Name withheld	Membres de la communauté de Hamady Ounaré	Membres de la communauté	M F	Senegal
Name withheld	Membres de la communauté de Mamboukou	Membres de la communauté	M F	Senegal
Name withheld	Membres de la communauté de Taliyel	Membres de la communauté	M F	Senegal
Name withheld	Membres de la communauté de Talto Diega	Membres de la communauté	M F	Senegal
Subtotal			**570 F 276 M**	

Annex 5: Stakeholder map

The stakeholder map includes stakeholders at the global, national, subnational and community levels; and considers their role in relation to human rights approaches.

Table 1: Stakeholder analysis based on human rights based approaches

Type of Stakeholder	Stakeholders	Human rights roles[12]
Global Level		
UN Joint programme programme staff, coordinators and Steering Committee members	Joint programme FGM Leadership; agency liaisons; steering committee UNFPA Headquarters (executive board, leadership, management, technical advisers) UNICEF Headquarters (executive board, leadership, management, technical advisers)	Tertiary duty bearer
UN Other (Global)	UN System Agencies: UN Women, WHO, UNAIDS, UNDP, ILO, IOM, WFP, UNHCR Coordination: RC / HC, OHCHR, UNCTs, GTGs Supervisory Bodies CEDAW, CRC, ICPD, GREVIO/COP, CSW Global Joint Programming mechanisms: Global Programme on Child Marriage; Spotlight; Secretariat/SG International Initiatives (PMNCH)	Tertiary duty bearer
Donors (Global)	Donors Bilateral: United Kingdom, Austria, Iceland, Ireland, Italy, Luxembourg, Switzerland, Norway, Sweden, European Union, Finland, Germany Multilateral: EC, OECD	Tertiary duty bearer
Civil Society (Global)	Civil society organisations e.g. Women's Refugee Commission, Population Council, International Center for Research on Women, EndFGM, AIDOS Building Bridges, Orchid Project, 28 is too many, Girl Generation, youthSave, Equality Now, CRR, Human Rights Watch, Amnesty International, Centre for Reproductive Rights, Plan International (and affiliated groups e.g. Girls Count), World Vision, Save the Children, International Planned Parenthood Federation, IPAS, EngenderHealth, Safe Cities initiatives (UN Habitat, UN Women, UNICEF, Microsoft), BRAC (selected countries), Promundo, MenEngage	Tertiary duty bearer

[12] Ljungman, Cecilia M., COWI. Applying a Rights-Based Approach to Development: Concepts and Principles, Conference Paper: The Winners and Losers from Rights-Based Approaches to Development. P. 6. November 2004.

	HERA, DAWN, Women's Global Network for Reproductive Rights	
Regional Level		
UN Other (Regional)	UNFPA and UNICEF Regional Offices (leadership, management, technical advisers, coordinating mechanisms)	Tertiary duty bearer
Regional Organisations	African Union, Pan African Parliament Economic Commission for Africa, InterAfrican Committee	Tertiary duty bearer
Country Level		
National Authorities	Central government – Ministries/ Departments (and/ or Regulatory Oversight for) Health, Gender, Youth, Education, Public Works , Water, Sanitation and Hygiene Community development, Labour, Justice, Disaster Management, emergency response, Statistics. Parliamentarians Security forces-local	Tertiary Duty Bearer
Civil Society (National Level)	Civil Society Advisory Groups-Country Level (communities of practice; technical committees) National CSOs: National Human Rights Commission, Women's groups	Tertiary Duty Bearer
Sub-national level		
Sub-national level	Representatives of Ministries e.g. Local Representative of Women's Affairs and Ministry of Health. Elected representatives including mayors and councils, Appointed leaders, Administrators Service providers Medical and Health Providers -Media (all types) -Security (Police, military, local "militia" "watch committees") -Judiciary (lawyers, judges, court structures)	Secondary Duty Bearer
Implementing Partners	As advised by Country Office for each Country Case Study	Secondary Duty Bearer
Community Level		
Community Structures	Community structures (other than governmental structures including community level militia) - Religious and Traditional leaders --Traditional institutions (traditional court systems, Sharia courts, Rotating Savings and Credit Associations, cultural leaders, local councils)	Primary Duty Bearer (as agents of change, as heads of households and assumed/traditional decision-makers)

	-Traditional birth attendants and healers -Cutters and ceremonial participants -Village level “enforcement” committees for follow up post declaration to abandon -CBOs (associations, chapter organizations, clubs) -youth groups and leadership/theatre or arts groups/role models	
Community Members	Women – across the life cycle e.g. young women (20-30), adolescent girls (15-20), young adolescent girls (10-15), older women, married, unmarried Men-across the life cycle - young men, adolescent boys, young adolescent boys, older men, married, unmarried	Rights Holders

For each country case study, a context-specific stakeholder mapping exercise was conducted that also included information on the relationship between stakeholders, how they were involved in FGM, and how they were involved in the joint programme.

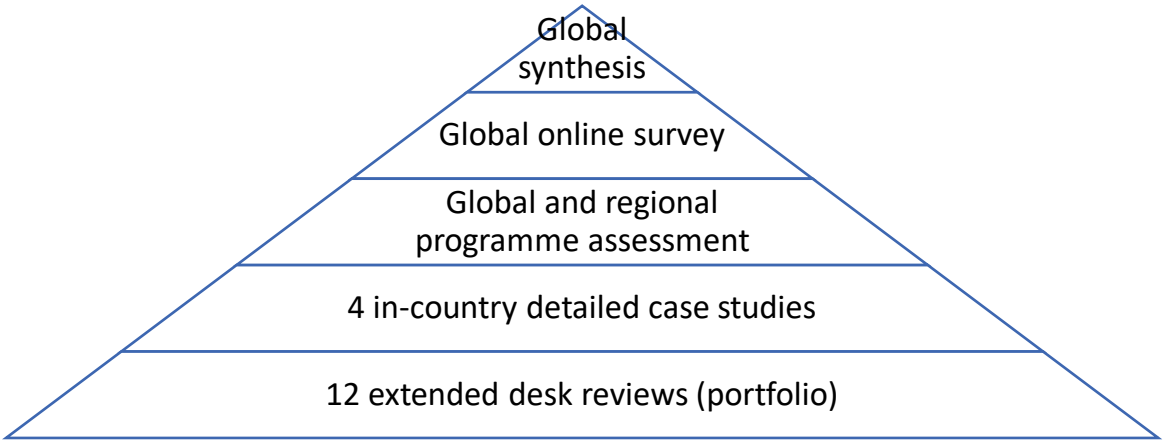
Annex 6: Detailed Methodology

The evaluation is a theory-based evaluation, drawing on the intervention logic behind Phases I and II of the Joint Programme, as represented in the programme's evolving results frameworks (see the terms of reference within Annex 1). A theory-based evaluation attempts to understand an intervention's contribution to observed results through a process interpretation of causation. This is appropriate to the evaluation given that it makes sense to examine the programme and especially its contribution to results at a theoretical level, guided by the Programme Logic Model.

The evaluation takes a utilisation approach so that it maximises utility to the end users; and a learning approach to identify lessons to inform the implementation and evolution of the joint programme. The intention is to enhance use of evaluation findings and lessons learned to facilitate decision-making by intended users.

As per the terms of reference, the evaluation comprises of four components:

Figure 1: Evaluation lines and levels of evidence



Evaluation components

This section describes each of the four evaluation components in more detail.

Country case studies

Four country case studies were conducted in Ethiopia, Kenya, Senegal, and Egypt. (The sampling strategy and reason for selection of the countries is shared in annex 1.9). Case studies added in-depth insights and realism to an evaluation. They were used cumulatively and synthesized to draw patterns, themes and divergences across the different cases.

Each case study involved preparatory desk review and a three-week country visit[13] by a team of evaluators to capital and subnational levels to conduct in-person key informant interviews, focus group discussions, group discussions, observations, and review of primary documentation. This enabled a strong focus on understanding the country and sub-national context to support understanding of institutional, political, social and normative contexts, and how the Joint Programme has responded.

[13] Approximately 3 weeks, to be slightly adjusted depending on the specific circumstances and needs.

A visit to Ethiopia as a field pilot was carried out (June 20th – July 11th) and enabled testing of the overall approach and data collection and analysis methods. Overall it was found that the approach was sound. Nonetheless, some modifications and improvements were introduced in the tools and approach, such as a refined evaluation matrix and country table; the inclusion of guidelines to work with interpreters, with local consultants and with country offices; interview protocols and guidelines for interview protocols at community level. In terms of the approach, a better understanding of team organization (in particular splitting teams) was incorporated for subsequent field missions. In addition, a more holistic conception of the connection between the Country case studies and the remote interviews was developed to ensure consistency and complementarity.

Each country visit commenced with a briefing to and from the national Evaluation Reference Group. Interviews with key informants (relevant UN agencies, government stakeholders, implementing partners) were held remotely prior to field visits.

Some stakeholders prioritized in these first days in the capital were:

1. Country Office managers and staff for the Joint Programme, both in UNICEF and UNFPA.
2. Key UNICEF and UNFPA staff from other portfolios of relevance (women's, girls, adolescents, education, sexuality education, SRH services).
3. Main Civil Society Organisations (CSOs) involved in FGM.
4. Main donors involved in FGM.
5. Research groups, academic groups, donor groups which are focused on in-depth research and analysis of FGM drivers anywhere in country
6. Statistical office and medical association/regulatory bodies
7. Any capital offices of the Implementing Partners that were to be visited in the field to get an overview of their programs before field visit

Two different field sites – defined in very broad terms - were visited in the country for approximately a week, each by a different team (for criteria see Section 3.3). The field visits included both local government and community visits in which focus group discussions and individual interviews were held. The teams ensured that the voices of both women and men were included through disaggregated FGDs, with specific attention to characteristics such as their age, married/non-married status, cut/not-cut, rural/urban, etc. Some groups more influential in social norm change or with specific knowledge on the FGM phenomenon were given particular attention such as ex-circumcisers, birth attendants, traditional leaders, religious leaders, surveillance committees, etc. Also, service providers of different extractions, such as medical, educational or juridical. The same level of disaggregation was pursued with local government and local civil society.

The field visits were followed by a period in the capital to carry out further key informant interviews to verify emergent findings, and for analysis. The visits were concluded with a debriefing to the ERG on emerging findings and lessons, as well as in-depth discussions with the country office team addressing FGM to validate findings and lessons and draw out new insights.

The broad outline of the visits is shared below, with further detail within section 6.

Table 4. Field Visit Preparation, Data Gathering and Analysis

Stage	Focus	Activity
Prior to Visit	Preparation	Desk review (country information, project documentation) Prepare stakeholder map Identify potential sub-national sites (selection criteria provided by local consultant and case study team) Skype meeting between Country Office and team to agree sub-national sites, agenda, logistical assistance
Visit	Data gathering	Internal evaluation team meeting Briefing meeting with ERG Interviews with key stakeholders in capital (UNFP/ UNICEF staff, UN System entities, national government entities, academia/ research entities, civil society/ advocates, development partners/ donors) Interviews where appropriate with regional stakeholders and cross-border stakeholders Community level focus group discussions Community level interviews Community level key informant interviews (traditional leaders, religious leaders, health and service providers)
	Data analysis and reporting	Record and store data (Evernote) using tagging system Analyze and generate findings and develop Country Table Analyze evidence against the evaluation matrix Submission of evidence table

The country visits were led by a team of 1 or 2 ImpactReady evaluators, 1 local consultant and 1 staff member from UNFPA and/or UNICEF Evaluation Offices (details are provided in Annex 4). The Country Office also nominated a focal point to coordinate the field visits. The CO focal point assisted the local consultant and the evaluation team in identifying and accessing relevant stakeholders based upon the criteria prioritized by the evaluation; and in light of their local expertise and on-the-ground knowledge; and providing inputs to the mission agenda in consultation with the local evaluation team consultant.

The local consultant worked with the Country Office to expedite data collection and access to information and key informants; participated in interviews and group discussions; reviewed and provided comments to the evaluation deliverables; and facilitated the dissemination of the results of the evaluation at country level (see Annex 5). The consultant led on the production of a country brief and complete the document portion of the country table.

A country field mission planning tool was devised to assist in the organization of the missions, as well as ethical and consent protocols (Annex 8) and interview guides for all types of stakeholders (Annex 9);

Observation was used as a tool to facilitate the gathering of observational data, efforts were made to interact with key informants in situ during field visits, so that it was possible to see such things as sites where services were delivered, potential challenges for programme participants in attending service delivery sites, and other types of contextual factors that

might have been impacting upon service delivery and thus programme results whether negatively or positively.

All data that was gathered has been stored within Evernote which is a software tool for note-taking and organizing data. Template logbooks for recording interviews have been developed (see Annex 10) which were structured around Evaluation Questions and assumptions. A tagging system was devised to tag the interviews according to the Evaluation Matrix, mainly by Evaluation Question and Assumption, so that data could be categorised and searched for accordingly. Other categories, such as level (global, regional, country, community), stakeholder type, sex and case study are addressed in a combination of tagging and folder distribution (see Annex 10). The data was then synthesized and added to a Country Table, which is structured around the evaluation questions and assumptions.

Extended desk review of country documents

The evaluation team conducted extended desk reviews of country documentation for the remaining 12 countries where the programme operates, complemented by a limited number of remote interviews with key respondents. The data was compiled and analyzed using the same country evidence tables as the country case studies to facilitate the synthesis for the final report.

Global and regional interviews

A number of interviews were conducted with technical advisors, experts, and advocates working at the global level, as well as at the Africa and Middle Eastern regional and sub regional levels. This included key informants within the UN agency and Joint Programme structures; principal investigators and academics in dedicated evaluation, research and documentation initiatives; major donors; leadership of collaborating regional entities such as the African Union, ECOWAS, The Economic Commission for Africa; global and regional chapters of medical and health associations and regulatory mechanisms; and global and regional advocates and relevant movements for women, girls, health and rights.

This component examined the contributions, effectiveness, and efficiency at each level in the areas of:

1. **Oversight and management mechanisms.**
2. **Technical assistance.**
3. **Strategic synergies.**
4. **Research, advocacy and communities of practice.**

These were all reviewed in terms of the interactions between levels, for example how technical assistance, communications and advocacy work shapes the work at the national level.

Survey

The purpose of the survey was to gather data to respond to Evaluation Questions (from the Evaluation Matrix), to supplement the field data and secondary data collected. The target audience were the Implementing Partners that the Joint Programme was working with at the time (and have worked with during Phase I and II). They were at the forefront of implementation and are also able to provide perspectives about the management of the Joint Programme (as discussed further below).

In particular, there was focus on Evaluation Questions for which: (i) data could be collected more efficiently within a survey; (ii) it was useful to have a significant number of respondents answering the same questions provides data to make comparisons and meaningful findings; (iii) we could fill gaps in data collection that were found to be more difficult (or less useful) to collect in face-face interviews during field work, as discovered within the Ethiopian pilot.

The questions focus on all of the evaluation questions, but with more emphasis upon effectiveness, efficiency and co-ordination and sustainability. The table below shows the particular parts of the Evaluation Matrix that the survey responded to.

Table 5. The Evaluation Questions and Assumptions that the Survey Responds to

Evaluation Question and Criteria	Assumption Number	Assumption Topic
EQ 1. (Relevance)	1.3	Evidence base
EQ2. (Effectiveness)	2.1	Implementation of legal frameworks
	2.2	Health services
	2.3	Changing Social Norms
EQ3. (Efficiency)	3.1	Leveraging agency strengths
	3.2	Partnerships
EQ4. (Co-ordination)	4.1	Flow of resources
	4.3	Monitoring
EQ5. (Sustainability)	5.1	National ownership
	5.2	Sustained social norm change

The Survey can be seen in Annex 11. It comprises: a series of statements to be ranked (from 1-5); prioritization of responses to specific questions; and, one open-ended question.

As mentioned, there were several clear advantages of focusing upon implementing partners: To start, the Implementing Partners are at the "front line" working on the ground directly with programme participants, and thus were well placed to provide insight about the effects of the programme on the programme participants and communities with whom they interact, for example on social norm change. This was particularly important given that the evaluation fieldwork to date reveals that there is a gap in the systematic monitoring data of the Joint Programme at the country level in this area; therefore, the survey data helped to address that gap.

Secondly, the Implementing Partners were in a position to provide viewpoints about the management of the Joint Programme at the country level. In particular, they were able to respond to questions about efficiency and coordination, which were issues that were particularly difficult to investigate during the pilot visit in Ethiopia. In this view, a follow-up survey was a useful additional data set to supplement the information collected in case studies. Moreover, there were also a sufficient number of Implementing Partners (16 countries with for example 3-4 current implementing partners each) to ensure that numerical generalisations could be made. There were fewer Implementing Partners at the Regional Level, but it was felt useful to include them as another data set to draw upon.

The survey also included questions regarding the survey participant including (i) country/ region, (ii) gender; (iii) type of implementing partners (; (iv) level of work (regional, national, sub-national, village); and, (iv) focus of FGM work, so that any patterns / themes could be drawn from the data set.

The evaluation questions were developed internally by the team, and shared with the evaluation management team. The survey was prepared in French and English. Implementing partners accessed the survey through a link which was sent out by the Country Offices and Regional Offices in each country. This ensured that the coordination was being carried out at the country level, who were better placed to liaise and coordinate with the implementing partners than the evaluation team.

Data Recording

All interview notes (key informant interviews and group discussions from the field to global levels) were recorded by the team using interview templates on Evernote Premium as stated. This enabled tagging, for example by assumption and stakeholder type, so that data could be categorised and searched for accordingly (the tagging system used is shared in Annex 10).

A Google Drive was established during the scoping and preparatory phase by the UNFPA Evaluation Office in order to provide a shared portal for all relevant documentation. ImpactReady was responsible for managing the Google drive and the Evernote platforms. Photos and videos were uploaded to Google drive under deliverables/country name. All of these tools were only accessible on password-protected devices.

Methods for data collection

Considering the scope, size, complexity and sensitive nature of the information collected for this evaluation, the following data tools were selected. They were chosen because they fit with the evaluation approach. The tools were primarily qualitative with a quantitative element; theory based and used case studies to provide in-depth insight.

Table 6: Evaluation data collection methods

Method	Use	Tools	Storage
Literature review (structured, extended desk)	16 Joint Programme-FGM countries, regional, and global	Evernote Premium (tagging, search, semantic coding) Excel (stored Dropbox)	On password-protected devices, sync to cloud
Roundtable & group facilitated discussions (reference groups, (de)briefs, group interviews)	Global level and in four country case studies, including two regional offices	Evernote Premium (allows note taking and audio recording)	On password-protected devices, sync to cloud
Key informant interviews (semi-structured, Skype)	Country, regional and global level	Evernote Premium Skype	On password-protected devices, Evernote sync to cloud
Observation (field visits)	Four country case studies	Evernote Premium (notes) Dropbox (photos)	On password-protected devices, sync to cloud
Survey and remote interviews (computer-moderated structured questionnaire)	16 country and regional level, including countries outside of the Joint Programme-FGM	A minimum of 16 Skype interviews with key stakeholders. SurveyMonkey	Cloud

Sampling strategy

Purposive sampling strategy for in-country case studies: the selection was guided by a set of sampling criteria which emerged from consultations with key stakeholders, including Joint Programme staff. The sampling criteria looks at particular characteristics of the programme countries to help identify which would be the most information rich and yield the most opportunities for an in-depth investigation of the key evaluation questions.

Sampling criteria for country case study selection:

- **Phase I Evaluation:** In the evaluation for Phase I of the Joint Programme, country case studies were conducted in four countries. These countries can provide a baseline for comparison as well as leverage the learning from Phase I of the evaluation. Moreover, these countries may be able to demonstrate results, or insights, into how the programme has contributed to medium term to longer term.
    - For the purposes of selection, the countries were scored as follows:
        - Yes, was a previous case study = 1, No, was not a previous case study = 0
- **The Joint Programme Phase II Cluster classification:** This criterion is based on the Joint Programme's classification of countries by cluster, where Cluster 1 – "Acceleration" countries (higher investment), Cluster 2 – "Emergent" countries, and Cluster 3 – "New" countries (refer to section 2.3 for more details). The countries were classified based on their ability to create an enabling environment, their demonstrated political and financial commitment, the strength of civil society, and the extent of community ownership. These clusters also have incidence on funding, where programme countries in the first cluster ("Acceleration" countries) have the most investment followed by those in the second cluster (Emergent" countries).
    - For the purposes of selection, the countries were scored as follows:
        - Acceleration = 2, Emergent = 1, New = 0
- **Expenditures by country:** This criterion looks at the total expenditures by country for phase I and II of the Joint Programme (as seen in the annex).
    - For the purposes of selection, the countries were scored as follows:
        - High (expenditures above USD 5 million) = 3, Medium (expenditures between USD 3 to USD 5 million), Low (expenditures below USD 3 million) = 1
- **Countries with new research programs and/or strong Joint Programme supported research efforts:** Several countries in the Joint Programme have existing or potential collaborative work with ongoing, future or recently completed rigorous research programs**.** The research was focused on testing assumptions regarding drivers of norms, practice and change; developing more effective tools to measure key intermediate and long-term outcomes; or mapping the change processes and/or networks/communications patterns which contribute to changes in norms and practice. [14]

[14] The resulting scoring of countries is based on the Scoping exercise of this evaluation. The exercise reviewed the presence of initiatives in each country, including Population Council field studies; planned joint Population Council and Joint

- For the purposes of selection, the potential for linkages to research was scored as follows:

  High potential = 3, Medium potential = 2, Low potential = 1

Other criteria[15]**:**

- **Regional distribution:** This criterion serves to ensure the sample was illustrative of the geographic coverage of the programme, so that countries from all regions in which the programme operates were included in the sample.
- **Security concerns**: If the evaluation team was not able to travel to the location due to security concerns, the country was not considered for selection.

Table 3: Sample frame for country case study selection

Region	Country	Phase I Evaluation (Y=1, N=0)	Cluster Group (A=3, E=2, N=1)	Total Expenditures (H=3, M=2, L=1)	Research (H=3, M=2, L=1)	TOTAL
West and Central Africa	Burkina Faso	1	2	2	2	**7**
	Gambia	0	1	1	1	3
	Guinea	0	1	1	2	4
	Guinea Bissau	0	1	1	1	3
	Mali	0	1	1	1	3
	Mauritania	0	1	1	1	3
	Nigeria	0	0	1	2	3
	Senegal	1	2	3	3	**9**
Arab States	Djibouti	0	1	2	1	4
	Egypt	0	2	2	3	**7**
	Somalia					
	Sudan	1	2	3	2	**8**
	Yemen					
East and Southern Africa	Eritrea					
	Ethiopia	0	2	2	3	**7**
	Kenya	1	2	3	3	**9**
	Uganda	0	2	2	1	5

RED Security/Travel issues

Based on the scoring in the sample frame, the sampled in-country case studies were:

Country Case Studies included in Phase I Joint evaluation (*both countries were case studies, and thus can serve as a basis for comparison):*

- **Senegal**: was an "acceleration" country in the programme, possessing higher levels of expenditure ($6,708,542) to address FGM in the Western and Central African region. The profile of interventions reflected a holistic approach to end FGM

Programme studies; Drexel tool testing; independent Joint Programme studies; planned multivariate analysis of DHS data.

[15] These criteria were included in the scoring of the sample, but act as another filters for final selection.

- **Kenya:** was an "acceleration" country in Eastern and Southern Africa, marked by the second highest level of expenditure ($6,134,488) in the Joint Programme. Kenya was identified as a programme country with the greatest variation in approaches to addressing FGM (including a strong history of work with alternative rites approaches).

Country Case Studies (not included in Phase I Joint evaluation)

- **Egypt:** as an "Emergent" country, Egypt experienced a higher level of expenditure ($4,123,159). The country worked across many sectors to change attitudes and social norms regarding FGM because laws alone are not sufficient to change deeply entrenched cultural practices. Egypt was a good case to also look at the issue of medicalization of the practice of FGM as overwhelming majority of cases are done by medical providers.
- **Ethiopia:** an "Emergent" country also in Eastern and Southern Africa, which possessed a substantial amount of expenditures ($3,683,540). Unlike Kenya, it was not included as a case study in the joint evaluation of the first phase of the Joint Programme, and thus provided a basis of comparison for change that has occurred, particularly compared to other countries in the region as well as among other "Emergent" countries.

* All selected countries joined the programme in 2008 thus these case studies provided an opportunity to capture medium and long term change.

Within each case study visit, stakeholders were purposefully sampled to provide a diversity of voices ranging from government officials to community members. Each sampling strategy selection of field visit sites set out below) was different in order to take into consideration differing national and sub-national contexts. The sampling strategy for each case study was developed in collaboration between the evaluation team, the lead evaluation manager, and the UNFPA and UNICEF field offices prior to visits.

The criteria for choosing field visit sites within the case study country was largely based on the following considerations:

1. Prevalence of FGM in the area;
2. Presence of UNICEF/UNFPA programme. If there were places with implementation of Phase I and II and others with only one phase, it was interesting to see both and to compare;
3. The relevance and effectiveness of Joint Programme constituted a main priority. Having said this, if there were areas of the country with no programme presence but a distinct set of social norms affecting FGM, they were considered for a potential field visit.

The evaluation also included virtual global and regional key informant interviews with stakeholders who had in-depth knowledge and understanding about the programme or the context in which FGM advocacy was taking place.

Collection and analysis of disaggregated data

As part of a gender and equity sensitive evaluation process, the upmost importance was placed on collecting equity and sex disaggregated data wherever possible. In practical terms, this meant asking questions about the different experiences of girls, boys, age groups, ethnic groups, and any other identified equity groups. Where possible, focus group discussions were divided by sex (i.e. separate groups of women/girls and men/boys) in order to identify qualitative sex disaggregated information.

The survey included a profile section that allowed the evaluation team to disaggregate responses based on sex and location. When purposively selecting stakeholder participants, the evaluation team made efforts to ensure that both women and men's voices were

adequately represented, and data was analysed in a gender disaggregated way, with priority given to assessing the differential experiences of men and women based on data gathered.

The qualitative analysis at the evaluation synthesis stage applied an intersectional lens to the available data to examine where different identities (gender, ethnicity, location, etc.) may have shaped and vary experience as well as access to resources and rights, if data collection allowed. This was carried out by choosing the programme results and compared based on a variable of interest (e.g. country, ethnicity, gender, age). An indicator for each of the categories of importance was devised based upon the data that was available. This allowed for a more nuanced analysis of what mix of intervention was effective in specific contexts, which was particularly useful in communities that consisted of diverse ethnic groups.

Methods for data analysis

In this section, we set out the data analysis approach and techniques. This includes the guiding framework and methods that were used for data processing, synthesis and assessing the programme contribution to results.

The guiding framework for the evaluation was the Evaluation Matrix (see Annex 1.1) which was used to structure the analysis of the data and formulate findings. This comprised three layers of information:

- Indicators which provided relevant specific, time-bound evidence
- Assumptions that aggregate data from relevant indicators to test each assumption
- Evaluation Questions which aggregate information from the respective assumptions

Data Processing and Synthesis

The data collected (from global and regional desk review and remote interviews, in-person country case studies, virtual case studies and the global online survey) was carefully processed and synthesised to allow us to develop findings and conclusions for each of the key evaluation questions.

There were three key data products or 'building blocks' for the data analysis. Before we explain the different analytical methods in more detail, the three key levels and lines of evidence are described here:

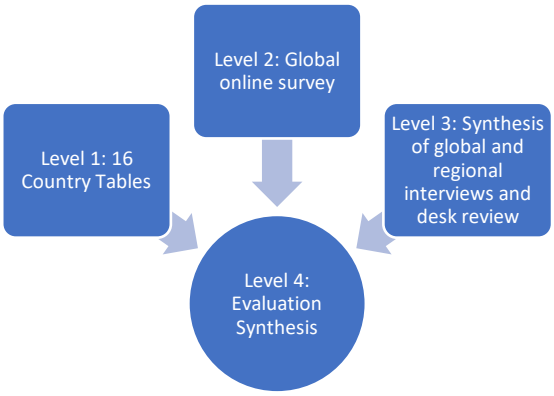
Level 1 – 16 Country Tables: structured around the evaluation questions and assumptions. They included key evidence, sources (including documentary sources and interviews) and findings and considerations for the evaluation report. They comprised the primary source of data at the country level for analysis and represented the key relevant data from interviews and documentary evidence (as well as observation and discussion groups from the four in-person country visits). This served to synthesise data to conduct the analysis more efficiently (rather than trawling through copious interviews from across the 16 countries).

Level 2 – Online survey: survey results from the structured questionnaire were generated to produce quantitative and qualitative data that helped to inform findings at the country levels regarding efficiency and co-ordination, by implementing partners. Quantitative information

generated by the survey was used to triangulate and further substantiate qualitative data including for non-field sites.

Level 3 – Global and Regional Qualitative synthesis: interview notes (for the interview logbook template, please see annex 10) from key informant interviews with global and regional key stakeholders and documentary evidence from a desk research were reviewed and collated. This synthesis was developed using Content Analysis to pull out key themes, trends and patterns for each relevant key evaluation questions (including indicators and assumptions). It was also used to identify any divergent views. The synthesis was drawn from key informant (semi-structured) interviews and a review of global and regional documentation. The advantage of the approach of developing a synthesis was that of guiding the integration of data and insights gathered by different methods of the evaluation team so that there was coherence of analysis across a multi-member, multi-country team conducting a complex evaluation.

Figure 3. Data sources for the Analyses



These elements of the evaluation process were developed using a range of data analysis techniques to triangulate qualitative and quantitative analysis in parallel (to verify/validate findings) and in series (to deepen/explore findings). Level 1, 2 and 3 was used to test and triangulate the assumptions in the evaluation matrix. Level 4 was used to combine these sources to answer the evaluation questions by developing major findings and conclusions. The data analytical tools include:

Level 1 – Country cases:

- [QUAL] Descriptive Analysis to understand the country contexts in which the Joint Programme operates and describe the types of interventions that operate within them.
- [QUAL] Content Analysis[16] was used to analyse data that emerged from documentary reviews, country level case studies and global and regional interviews. As a tool it enabled identifications of themes, patterns, trends and divergent views.
- [QUANT] financial data analysis in Excel using sum, average and trend analysis to analyse financial flows and efficiency.
- [QUAL/QUANT] Comparative Analysis[17] was used to review the country tables to examine findings on specific issues or themes across different countries. Where

[16] Busch C, De Maret P S, Flynn T, Kellum R, Le, Brad Meyers S, Saunders M, White R, and Palmquist M. (2005). *Content Analysis*. Writing@CSU. Colorado State University Department of English. Retrieved from http://writing.colostate.edu/guides/research/content/

[17] Baptist, C., and Befani, B. (2015). *Qualitative Comparative Analysis – A Rigorous Qualitative Method for Assessing Impact,* Coffey. Retrieved from: http://www.coffey.com/assets/Ingenuity/Qualitative-Comparative-Analysis-June-2015.pdf

appropriate it also assisted in identifying best practices, innovative approaches and lessons learned. Comparative data was gathered so as to facilitate later qualitative comparative analysis (data related to the conditions surrounding each case of an observed outcome).

The country table template is available in Annex 11.

Level 2 – Online survey:

- [QUANT] Frequency analysis was used to analyse findings from the online survey, using Survey Monkey. Survey questions were directly linked to assumptions and indicators. As the survey purpose and structure were like that of the evaluation from Phase I, a baseline comparison was also conducted. This was triangulated with qualitative data to further develop insights.
- [QUAL] Content Analysis was used to analyse long-form text data based on the assumptions in the evaluation matrix.

Level 3 – Regional and global:

- [QUAL] Timeline Analysis[18] was used to develop a timeline of key events at the global level for the Joint Programme
- [QUAL] Qualitative Synthesis (including content analysis) of the desk reviews and interviews at the regional and global level was carried out in order pull out key trends, issues and patterns across the different evaluation assumptions. Comparisons were also made between contexts to consider differences (cultural, economic, political, social).
- [QUANT] financial data analysis in Excel using sum, average and trend analysis to analyse financial flows and expenditure for the Joint Programme as a whole.

Level 4 – Synthesis and triangulation:

- [QUAL] Qualitative Synthesis of levels 1, 2 and 3 in order pull out key trends, issues and patterns across the different evaluation questions.
- [QUANT] Quantitative synthesis using crisp-set (binary) qualitative comparative analysis in EvalC3 software based on an assessment of whether each of the evaluation assumptions is mostly present or mostly absent from the 16 country cases.

Human rights and gender equality

There was a strong focus on gender and human rights throughout the analytical process. This was not only related to specific relevant questions within the Evaluation Matrix but was integral to the process:

- Human rights analysis at multiple levels: (1) the alignment of programming at country and global level with intergovernmental norms and standards, and with national human rights instruments, (2) the adherence of programme design, processes and implementing practices with human rights principles, (3) the extent to which programme activities identify and address root causes of gender discrimination and inequity, (4) the extent to which programme activities empower duty bearers to recognize, protect, and fulfil the realization of human rights, (5) the extent to which

[18] Samkian, A. and Greene, J. (2013, October 17). *Visualizing Process: How to Create a Stakeholder-friendly Graphic Timeline of Process Data*. Presented at the American Evaluation Society Evaluation 2013 Conference, Washington.

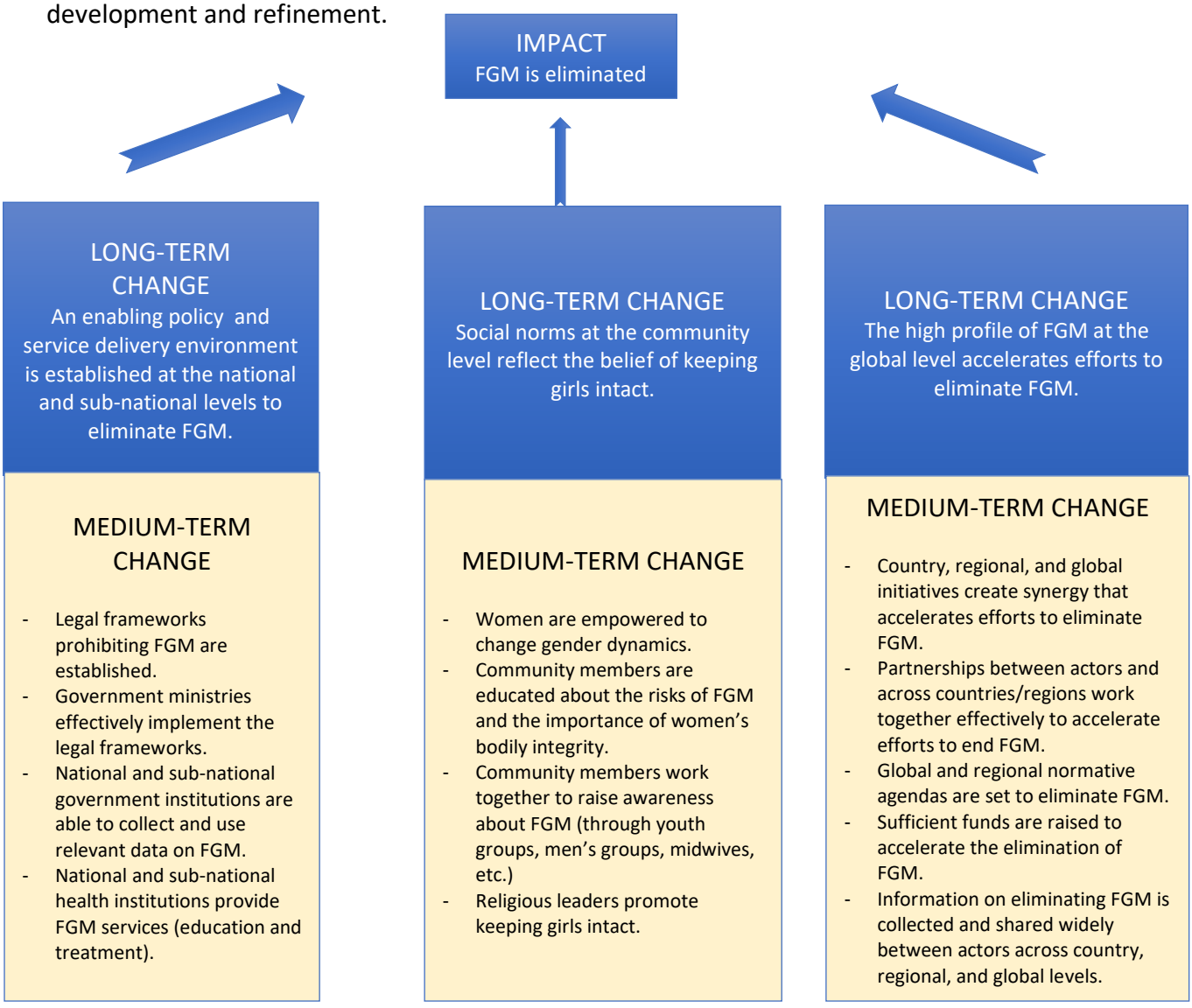
programme activities empower rights holders to understand and demand their rights, and (6) the conditions that the programme maintains to ensure that 1-5 are achieved while doing no harm.

- Gender analyses applied the Social Relations Approach to gender and development developed by Naila Kabeer, which was intended as a method of analysing existing gender inequalities in the distribution of resources, responsibilities, and power, and for designing policies and programmes which enabled women to be agents of their own development. The framework concentrates on the relationships between people, and their relationship to resources and activities - and how these were re-worked through 'institutions', including traditions and state systems. Where the information allowed, an intersectional lens was applied to assess configurations of identities that may shape or influence access and distribution of power.

Annex 7: Programme Logic Model

The programme logic model (presented below) illustrates the basis for the assessment of the contribution analysis (see Annex 17). A preliminary draft programme logic model was developed by the Evaluation Team based on documentation reviewed and interviews conducted during the Evaluation Inception Phase. It reflected the evaluation team's initial understanding of the outcome-level results sought through the Joint Programme from 2008 – present (covering all three programming phases). It took into consideration the outcome statements from each phase's results framework as well as the Theory of Change presented as part of the Phase I Evaluation.

The logic model was intended to be an internal document that could be used by the evaluation team to refine the Evaluation Matrix and to assist with data analysis. Throughout the course of the evaluation, it was being expanded and further developed to include activities and outputs, key programming assumptions, as well as contextual factors and risks. A final version of the logic model was presented as part of the draft evaluation report after stakeholders had had an opportunity to provide feedback and to contribute to its continued development and refinement.



Annex 8: Ethics and consent protocols

The evaluation will be conducted in accordance with the UNFPA and UNICEF Evaluation Policies, United Nations Evaluation Group Ethical Guidelines, Code of Conduct for Evaluation in the UN System[19], and the United Nations norms and standards for evaluation in the UN System.[20]

The most recognised standards for ethical conduct are derived from bioethics. These were codified in the Belmont Report (1979), which provides the principles of: i) maximising good and minimising risk, ii) respect for participant's autonomy, and iii) justice, or fair distribution of risks and benefits.

The Belmont principles are derived from a utilitarian philosophy, which privileges individual autonomy. The practice of an individual giving their consent through a social contract is grounded in this worldview, along with the political-economic assumption that an individual will always act in their best interest. John Rawls' *maximin* principle proposes that if it is to be considered morally fair, this social contract must maximise the position of the people who are least well-off. This is not easy to achieve, however, as the consideration of what is fair will always reflect the principles of justice that are imbued in culture of the person who has the power to take the decision.

As a result, the notion of Free, Prior and Informed Consent to take part in a preconceived project is liable to collapse a complex issue into a political technology that simply requires an optimal answer. Indeed, the very act of gaining written consent can compound power imbalances by projecting the legitimacy of a study and transferring the power of interpretation to the researcher. Privileging documentation can also undermine the traditional process for gaining trust in oral societies.

By contrast, Feminist and Afrocentric (decolonised) ethics emphasise our relationship with the Other and our relationship with society. These worldviews acknowledge human interdependency and the cogeneration of knowledge. In advocating for social justice, they highlight the need for fairer power relations.

Evaluators are "knowledge brokers, people who have the power to construct legitimating arguments for or against ideas, theories or practices." (Cram et al 2004). The legitimising power of evaluators is derived from the application of scientific standards, which under the dominant western paradigm are considered fair (and thus ethical) because of their objectivity. Hence the importance placed on independence and economic language in evaluation quality standards.

Such standards preclude a relationship between the evaluator and the evaluated – heightening the risk of misrepresenting the Other. This has important consequences for how the legitimising criteria for success (effectiveness, efficiency, relevance) are defined. In reality,

[19] United Nations Evaluation Group, UNEG Ethical Guidelines, accessible at: http://www.uneval.org/papersandpubs/documentdetail.jsp?doc_id=102 and UNEG Code of Conduct for Evaluation in the UN system, accessible at: http://www.uneval.org/papersandpubs/documentdetail.jsp?doc_id=100

[20] United Nations Evaluation Group, *Norms and Standards for evaluation in the UN System*, accessible at: http://www.uneval.org/normsandstandards/index.jsp?doc_cat_source_id=4; *Integrating Human Rights and Gender Equality in Evaluation - Towards UNEG Guidance*, accessible at: http://www.uneval.org/papersandpubs/documentdetail.jsp?doc_id=1401

the meaning and value of these measures is contested between stakeholders, and is a negotiated outcome of a social process (Hedgecoe, 2004).

Mary Brydon-Miller (2009) proposes that a feminist approach to ethics should more appropriately be covenantal (grounded in trust) rather than contractual (grounded in mistrust). She also argues that participation of the least powerful in evaluations without compensation is a form of 'scientific colonialism' – extracting, exporting and commercialising a population's data.

An ethical approach to this evaluation therefore considered the different identities and roles of the evaluators and UN staff as hosts. In addition to ensuring that instruments were culturally appropriate and compensation (including in kind) was appropriate, the evaluation differentiated between the worldviews of people from different backgrounds and offered preferential options for the marginalised that could overcome the power difference between evaluator and evaluated.

The evaluation, therefore, was conducted using the following principles and approaches:

1. The data given to the evaluation team remained the property of the person giving it.
2. No primary data was collected from children under 16.
3. All evaluation participants were provided with contact details so that they could request:
    a. Access to their data
    b. Correction of their data
    c. Deletion of their data
    d. To be forgotten (i.e. no record of their identity) as being involved in the evaluation.
4. Whilst in safekeeping, all data was held on password protected computers that were only accessible to the evaluation team; and was uploaded to service providers (Evernote and Microsoft Office365) with secure servers.
5. The power of interpretation of individual stories remained with the person who provided the story. Evaluators asked contributors why they felt the story was important to them;
6. Before collecting any data, an explanation of the purpose and the intention of the evaluation team was given and explicit oral consent was sought. People who chose to participate were provided with two cards.
    a. One card had the contact details of the evaluation team with a short explanation of the proposed use of data in a clear and unambiguous language.
    b. The other card had a smiley face.
7. At the end of the data collection, participants were invited to actively submit the card with the smiley face to one of the evaluators to explicitly signal her or his consent for the data to be included in the evaluation.

UNEG Ethics Standards

In accordance with UNEG Norms and Standards for Evaluation in the UN System and the UN Ethical Guidelines and Code of Conduct, the evaluation implemented the following practices.

Independence and Impartiality.
Clear reasons for evaluative judgments, and the acceptance or rejection of comments on evaluation products were given. Evaluation team members were required to report any real or perceived Conflicts of Interest. These were assessed by the team leaders and Independent Evaluation Office, and addressed appropriately and transparently.

Credibility and Accountability.
The evaluation team sought to implement the methods agreed in the Inception Report to the best of their abilities at all times. The Co-Team Leaders coordinated all activities to ensure that commitments were met in the timeframes specified, or that UNFPA evaluation office was advised ahead of time so that mitigating action could be taken.

Rights to self-determination, fair representation, protection and redress
All case studies included a process of ensuring that all contributors and participants gave genuinely free, prior and informed consent. Contributors were given multiple opportunities to refuse, grant or withdraw their consent based upon clear understandings of the persons/institutions involved, the intention of the process, and possible risks or outcomes.

Confidentiality
All data was held on secure databases, with ImpactReady as the Data Controller. All information was used and represented only to the extent agreed to by its contributor. When information was presented in reports accepted ethnographic norms were applied. Where information was made available as open data, it was stripped of identifiable information.

Avoidance of Harm
The evaluation team worked with local UNFPA and UNICEF offices to identify vulnerable groups prior to field visits, and to ensure that any participatory processes and evaluation questions were responsive to their needs.

Accuracy, completeness and reliability
The evaluation ensured that evidence was tracked from its source to its use and interpretation. All evaluation questions were answered through triangulation of quantitative and qualitative data from multiple sources and processed using multiple analytical tools. A comprehensive evaluation matrix linked each evaluation tool, stakeholder and question.

Transparency
All data collection and analysis tools and processes were included in an annex to the final report.

Reporting
The outcome of the evaluation was communicated through a participatory validation process and multiple accessible evaluation products.

Acknowledgement
If any incidences of ethical wrongdoing were encountered during the evaluation, these were to be reported to ImpactReady Senior Partner, Maria Borisova, who was responsible for investigating and informing the relevant parties in UNFPA Evaluation Office to be addressed in accordance with the code of conduct and norms and standards for evaluation in the UN system

Annex 9: Interview Guides

This section includes:

1. A detailed guide, instructions and tips for interviewers to be used with communities, as this is the stakeholder that needs more specialized knowledge as how to conduct interviews and FGDs in a sensitive and effective manner.
2. General interview guides for each group of stakeholders

It should be noted that the guides were not supposed to be directly used in the field in a mechanical way but were just guidelines to be studied previously by the experts to obtain a general degree of standardization in the interview goals and sequence. Whereas the main goals of the interview guides should be respected, the specific sub-questions were meant to provide guide and a "menu" of ideas to the interviewers so that they choose the most relevant ones. The time and dynamics of interviews did not allow or make advisable the inclusion of the full list of sub-questions in most cases. These guides, once internalized by the interviewers, were adapted in the field by each interviewer, so as to match the natural flow of the conversations and the capacity and will to share information of the interviewees.

Generic interview opening protocol

Acronyms used: FQ – Follow up question

A. Approach asking the questions. We are interested in **collective behaviour.** This gives us two key advantages in a sensitive topic that is even illegal in some cases. It is easier for people to speak about the experience of others in the community than about their own specific experience. In the end they will tell us both, but feeling safe. Therefore:

(a) We should not ask about the experiences of the persons we are talking with, but we are explicit in each question that we want to understand what happens "**in general in the community**" or "in some cases in the community" (as opposed to asking "Do **you** bla bla?").

(b) **Men/women:** The protocol is designed so that we can ask the same questions both to men and women and persons in different age groups. Take into account that as we care about collective behaviour, often the same question does not need reformulation as it is **always asked about others**. **For example**, if after asking "2.2 **For whom** is most important to **keep FGM**?" they tell us "for men". Our next follow up question can be formulated as "Why is it more important for men than for women?" regardless of gender of our interviewees and regardless of their age (still we will keep in our logbook who said what -women/men, age, etc- which will give us useful elements for analysis. But that affects the analysis, not how we ask the question). Also consider that a group of women might be able to give us much more detail about a specific aspect than a group of men, and vice versa, but does not affect the way we ask, only their answers and our will to pursue deeper detail on an aspect they know well, or drop it if they know little. Remember that the fact that a specific group knows nothing or little about something (for example men showing that they ignore the difference between FGM Type III and Type I, with whatever name they give it) is in itself a finding that should not be taken for granted.

- Follow up questions are marked [FQ] for two reasons, firstly because they might be unnecessary if the interviewees have already explained that aspect (so you can skip them), but if they not, they are there as reminders that you need to get more detail. Secondly because [FQ] indicates you an opportunity to continue the flow of the conversation asking them in a "natural follow up manner" and not as a new question.

- The **bold** helps you to visually see the essential aspect of any question without spending time reading, so that you can keep your attention on the interviewees.

B. Content.

- There are only **7 essential topics** we need to cover with as much detail as possible. Each topic is inside a square like this **2 Importance of FGM** .

- Below each of the 7 topics, there are **specific sub-topics/questions** that anticipate some of the important detail we need. These subtopics are designated with double numbers such as 2.1, 2.2, etc. Whereas **we must cover the 7 essential topics**, these sub-topic/questions are more flexible. If you feel during your interview that you need to add, adapt, shorten them, etc, it is fine. However, please consider that the sub-topics constitute analytical aspects of interest and the more we keep them as they are, the easier will it be later on to structure and analyse the detailed subtopics in the evidence table and report.

Two Pilot requirements in Ethiopia only:

1. If you see that some sequence or subtopic can be improved, or added or eliminated, please act accordingly, but remember to make a note for our discussion when we come back to Addis. One of the purposes of the Pilot mission is to have a tested protocol.

2. If you see some new tag needed or that is not efficient, please take note and communicate immediately with the rest of the team. (see below **E. Notes, Logbook, Tags and Evidence Table preparation**.).

C. Sequence. The interview/FGD with communities divides the 7 essential points in four main blocks:
(1) **Opening questions**: Traditional Practices/customs 1 and follow up.
(2) **FGM and change**: 2, 3 and 4
(3) **Joint Programme:** 5 and 6
(4) **Closing**: 7

D. Rationale of the sequence: We start asking about traditional practices in general and move little by little to FGM. The rationale of this sequence is based on four main assumptions:
(i) It is natural when you meet somebody for the first time to start with a more general question than to focus on something as specific as FGM. This slow-start approach helps them to warm up to the conversation, observe you and decide how much they want to share with you in a natural way. By the time you ask the key evaluation questions 5 minutes later, they are used to us and we also have the chance to learnt their dynamics and how to speak to them. You will judge how fast you want to move on to the substantial questions, depending on the situation.
(ii) Our approach should be genuine interest and curiosity about their reality and opinions, *whatever they are*. We are as interested in why some *abandon* FGM as in why some *support* FGM. Both visions and their specific details are of immense value to try to find practical solutions and recommendations. But few people share an opinion when they feel they will be judged for it, they need to feel safe. For that reason, we should not start with leading questions (e.g. focusing on abandonment), but with open ones without showing a preference. Otherwise feelings of "shame/discomfort" or conversely "wanting to please" will likely dominate and distort the whole discussion.
(iii) Starting directly talking about FGM or the Joint Programme gives often the feeling that "this is what we want". And in many communities, the way the understand hospitality or

gratefulness is definitely not to criticize it, even constructively, but to tell us that the program is wonderful.
(iv) Starting with practices in general gives us the important chance of seeing how they see FGM in the wider context of other traditional practices, in particular its relative weight (it is not the same if they mention it as a secondary thing among 20 or as a key one) and its connection with other cultural aspects (depending on how they freely formulate their opinions on the practices).

E. Notes, Logbook, Tags and Evidence Table preparation.
After finishing taking the notes, we should prepare the logbook and upload it for easy analysis later on. That requires mainly ensuring clarity on the linkage between the answers and the evidence table references. Most of the answers at community level will fall under four specific assumptions in the Evidence Table, to which I add here a new fifth aspect: "sustainability". Sustainability should be referenced adding a 3rd number to whatever category that sustainability affects. For example, if we are saying that awareness (4.1) is sustainable, then we will reference it as "(4.1.S)".
Most likely linkages to the Evidence Table

Awareness (4.1)
Social norms (4.2)
Service use (5.1)
Service delivery (5.2)
Sustainability (X.X.S)

Please ensure you follow always these 3 steps

1. **Include within the notes numeric references** linking to an assumption for each finding. Most will belong to the ones above, but there might be others you identify.
2. Save the logbook in the **folder** "Ethiopia", under subfolder Afar, SNNPR or Addis.
3. **Tag** the document title with the following tags in this order:
   -Whatever assumptions are referred to within the notes.
   - Male or female if people from the community
   -Religious leader, clan leader or community leader
   -"Hospital" if the interview is in a hospital or health center.

0. Before the interview & note taking

0.1 Decide previously **who** will take notes.

0.2 Decide previously **folder** where immediate notes be stored in Evernote.

0.3 Decide **tag policy** for notes.

0.4 Prepare your **interpreter** (see "working with interpreters – guidelines).

1. Essential data for logbook heading

1.1 Collect Name, Age, Gender, Position (if relevant). Pass sheet of paper to the interpreter with these four categories to fill in.

1.2 Include date, location (community, district and region)

2. Introduction and consent (adapt for group meetings)

2.1 **Thank you**, thank you, thank you. We know you are busy and still meeting us.

2.2 **Introduction** – Independent team to learn and give advice about 1. FGM and 2. Programs related to FGM, especially UN.

Value very much learning from you and hearing your experience, opinions.

2.3 Conversation is **confidential**. We will write a report explaining the situation in many countries in Africa, without names of people.

2.4 **We would like to ask you some questions**: if you don't understand me, please tell me and I will repeat with pleasure; if you prefer not to answer some, please tell me.

2.5 Do I have your permission to ask you questions?

****

Community rights-holders (programme participants) Focus Group Protocol

Stakeholder Specific Questions: Community

1 Opening 1.1 We would like to **understand the most important traditional practices/customs in the village with women/girls** related to marriage and maturity. Could you **explain** them to us? [Open question, stressing it is our first time in the community] [Ask as FQ] 1.2 **Why** is *that* important? [*that* is whatever they mentioned in their opening answer]

2 Importance of FGM

2.1 [Ask as FQ] …And is **FGM important** in the village? [Now we ask directly, changing formulation depending on their previous opinions] → [FQ] **Why?**

2.2 [FQ] **For whom** is most important to **keep FGM**? [if not clear, ask more concretely: men, women, grandmothers, grandfathers?] → [FQ] Why?

2.2 [FQ] **For whom** is most important to **abandon FGM**? [if not clear, ask more concretely: men, women, grandmothers, grandfathers?] → [FQ] Why?

3 Changes in FGM

3.1 **Changes in the last 10 years** → [FQ] Why/why not → [FQ] Key factors

3.2 **Present attitude** of **men** towards FGM / **Present attitude** of **women**

3.3 **Transition from Type III** *infibulation* [check with interpreter beforehand common word used] and Type I [*sunna* in Ethiopia, check with interpreter].

3.4 [FQ] **Transition from Type I** to abandonment. [FQ] Ask if what has been explained is general or exceptional) → [FQ] How happens → [FQ] Why some do the transition and others don't, main factors → [FQ] **What would be needed to support abandonment.**

4 What happens after declaration of abandonment

4.1 **Open question**: please explain **what happens in reality after** declaration of abandonment. → [FQ] How many abandon/continue → [FQ] Why

4.2 Explore **relapse** and main factors

5 Joint Programme Description

5.1 **When** did the Joint Programme start working in the community? [check beforehand with local staff how they refer to Joint Programme": e.g. is it for them "the sister", or the name of a particular person that they recognize as the Joint Programme]

5.2 → [FQ] **What** have they done in the community these years (description in their own words)

6 Joint Programme Effectiveness/Relevance

6.1 → [FQ] Of those actions, which ones have been **useful** → [FQ] **Why**/why not

6.2 → [FQ] Which ones have been **not useful** → [FQ] **Why** & why not

6.3 → Can you give me **examples** of what has changed thanks to the Joint Programme?

6.4 → Do you think that **change will last**? (sustainability)

6.5 → **What do you think the Joint Programme should be doing** from now on to support FGM eradication in Ethiopia? → [FQ] **Why**

7 Closing

7.1 **Anything else** we have not asked that you would like to share with us?

7.2 **Thank you** & 7.3 Remind them on **confidentiality.**

****

Religious leaders Interview/ Focus Group Protocol

Stakeholder Specific Questions: Religious leaders

1 Understanding FGM from religious perspective

1.1 We would like to **understand FGM from a religious perspective** (as we know there are many different interpretations). Could you please let us know what is **your interpretation** on the position of the sacred texts in relation with FGM.

1.2 [Ask as FQ] What is the **general consensus among religious leaders** on FGM? [FQ] What are the main points debated? [FQ] Has there been any change in that consensus? [FQ] Why?

1.3 What are the main paths to **spread a change of attitude among religious leaders** in relation with FGM? [FQ] Main challenges? [FQ] How could this be done more successfully in your opinion?

1.4 What are the main paths to **spread a change of attitude among communities** in relation with FGM? [FQ] Main challenges? [FQ] How could this be done more successfully in your opinion?

1.5 Have there been changes of attitude in the community regarding FGM and/or its relation with religion? [FQ] What do you think has been the main reason for these changes_

2 About the Joint Programme

2.1 Do you have **a relation with the Joint Programme** (or know about the Joint Programme?) **If yes, pass to 2.2**,

If not ask his/her **opinion on international efforts to change attitudes on FGM** and **how this should be done** in his/her opinion.

2.2 What is your opinion on the Joint Programme?

2.3 Main positive aspects and why

2.4 Main negative aspects and why

2.5 What could the Joint Programme do differently to be more helpful in the future?

3 Closing

3.1 **Anything else** we have not asked that you would like to share with us?

3.2 **Thank you** & 3.3 Remind them on **confidentiality** and we don't share individual information.

****

Traditional leaders Interview/ Focus Group Protocol

Stakeholder Specific Questions: Traditional Leaders

1 Opening 1.1 We would like to **understand the most important traditional practices/customs in the village with women/girls** related to birth, marriage, growing up, maturity… Could you **explain** them to us? [Open question, stressing it is our first time in the community] [Ask as FQ] 1.2 **Why** is *that* important? (try to move into FGM if they give you the chance, if not, continue using Traditional Practices until you can).

2 Importance of FGM

2.1 [Ask as FQ] …And is **FGM important** in the village? [Now we ask directly, changing formulation depending on their previous opinions] → [FQ] **Why?**

2.2 [FQ] **For whom** is most important to **keep FGM**? [if not clear, ask more concretely: men, women, grandmothers, grandfathers?] → [FQ] Why?

2.3 [FQ] **For whom** is most important to **abandon FGM**? [if not clear, ask more concretely: men, women, grandmothers, grandfathers?] → [FQ] Why?

3 Changes in FGM

3.1 **Present attitude** of **men/boys** towards FGM / **Present attitude** of **women/girls**

3.2 **Changes in the last 10 years** → [FQ] Why/why not → [FQ] Key factors

[FQ] Changes in prevalence (proportion of cut: more, less, same)

[FQ] In attitude (approve it or not)

[FQ] In practice (different age, different cut, going to other community to cut, to health provider).

Note for interviewer. IF they have said that there is change in practice in cut" then, explore 3.3 and 3.4 below

3.3 **Transition from Type III** *infibulation* and Type I [*sunna* in Ethiopia].

3.4 [FQ] **Transition to full abandonment**. [FQ] Ask if what has been explained is general or exceptional) → [FQ] How happens → [FQ] Why some do the transition and others don't, main factors → [FQ] **What would be needed to support abandonment.**

4 What happens after declaration of abandonment

4.0 Check if they understand what a declaration of abandonment means and if they have heard of it in the community.

4.1 **Open question**: please explain **what happens in reality after** declaration of abandonment. → [FQ] How many abandon/continue → [FQ] Why

4.2 Explore **if people who changed, then went back to old practices** and main factors (relapse).

4.3 Is there a **difference between uncut/cut girls for marriage** opportunities/rite of passage? Explain

5 Role of Traditional leaders and FGM

5.1 What is the role of traditional leaders regarding changes in FGM

5.2 The main challenges?

6 Joint Programme Description

6.1 **When** did the Joint Programme start working in the community? [check beforehand with local staff how they refer to Joint Programme": e.g. is it for them "the sister", or the name of a particular person that they recognize as the Joint Programme]

6.2 → [FQ] **What** has the Joint Programme done in the community these years (description in their own words)

7 Joint Programme Contribution: Effectiveness/Relevance

7.1 → [FQ] Of those actions, which ones have been **useful to change FGM practice/abandonment** → [FQ] **Why**/why not

7.2 → [FQ] Which ones have been **not useful** → [FQ] **Why** & why not

7.3 → Can you give me **examples** of what has changed thanks to the Joint Programme?

7.4 → Do you think that **change will last**?

7.5 → **What do you think should be done** from now on to support FGM eradication in Ethiopia? → [FQ] **Why**

8 Closing

8.1 **Anything else** we have not asked that you would like to share with us?

8.2 **Thank you** & 8.3 Remind them on **confidentiality** and we don't share info.

****

Joint Programme focal points UNFPA / UNICEF Interview Protocol

Stakeholder Specific Questions: Joint Programme focal points UNFPA / UNICEF

1 Opening: Open questions on FGM

1.1 Description of **evolution of FGM** in the last years.

1.2 Main **factors for FGM change / lack of change** in the country

1.3 What specific **evidence** of change exists [FQ] **Explore gaps in data, evidence**, information systems, new research available, research gaps.

2 Open questions on FGM

2.1 **Description of Joint Programme** over the last 10 years.

2.2 **Main changes in the approach of the Joint Programme** over time. [FQ] Do you think this evolution is **appropriate?**

2.3 **Main successes** of the Joint Programme in your opinion

2.4 **Main remaining challenges** for the Joint Programme in your opinion

2.5 Looking at the future, **what would improve the Joint Programme** in your opinion?

3 Specific questions on Joint Programme (if not answered before)

3.1 Description of comparative strengths of Joint Programme vs. other programmes [FQ] Examples

3.2 Description of comparative strengths of UNFPA & UNICEF within Joint Programme vs. separated work. [FQ] Examples.

3.3 Analysis of work with **other UN** agencies. [FQ] Work with other main donors.

3.4 Analysis on **partnerships** with different IPs [FQ] Analysis of work with government vs CSOs, etc.

3.5 Role of **Global and Regional** Joint Programme from their perspective. Description, positive added value, aspects to improve.

3.6 **Cross border** factors and Joint Programme response, if any

3.7 **Lessons learned** in the implementation of the Joint Programme, looking at the future.

3.8 [FQ] **Specific analysis** on the interface between social norm approach, legal approach, medicalization, etc.

4 Closing

4.1 **Anything else** we have not asked that you would like to share with us? (check also additional suggestions of people to meet, etc)

4.2 **Thank you** & 3.3 Remind them on **confidentiality** and we don't share individual information.

****

National Government Interview Protocol

Stakeholder Specific Questions: National Government

1 Opening: Open questions on FGM

1.1 Description of **evolution of FGM** in the last years.

1.2 Main **factors for FGM change / lack of change** in the country

1.3 What specific **evidence** of change exists [FQ] **Explore gaps in data, evidence**, information systems, new research available, research gaps.

2 Role of National Government in FGM

2.1 Explore specific role of government on FGM

2.2 Main progress milestones on FGM

2.3 Main challenges the government faces in relation to FGM [FQ on the Joint Programme in next section]

3 Specific question on the Joint Programme

3.1 Opinion on **how the Joint Programme is responding** to FGM challenges in the country

3.2 Comparative advantage / added value vs. other international agencies

3.3 Main **positive points** of Joint Programme support. Examples.

3.4 Main **limitations** of the Joint Programme. Examples.

3.5 Looking at the future, **what would improve the Joint Programme** in your opinion?

4 Closing

4.1 **Anything else** we have not asked that you would like to share with us? (check also additional suggestions of people to meet, etc)

4.2 **Thank you** & 3.3 Remind them on **confidentiality** and we don't share individual information.

****

Implementing Partners Interview Protocol

Stakeholder Specific Questions: Implementing Partners

1 Opening: Open questions on FGM

1.1 Description of **evolution of FGM** in the last years.

1.2 Main **factors for FGM change / lack of change** in the country

1.3 What specific **evidence** of change exists [FQ] **Explore gaps in data, evidence**, information systems, new research available, research gaps.

2 Role of Implementing Partner in FGM

2.1 Explore specific role of Implementing Partner on FGM

2.2 Main progress milestones on FGM

2.3 Main challenges the Implementing Partner faces in relation to FGM [FQ on the Joint Programme in next section]

3 Specific question on the Joint Programme

3.1 Opinion on **how the Joint Programme is responding** to FGM challenges in the country

3.2 Comparative advantage / added value vs. other international agencies

3.3 Main **positive points** of Joint Programme support. Examples.

3.4 Main **limitations** of the Joint Programme. Examples.

3.5 Specific question on **efficiency** of Joint Programme regarding fund transfers, common work, etc.

3.6 Looking at the future, **what would improve the Joint Programme** in your opinion?

4 Closing

4.1 **Anything else** we have not asked that you would like to share with us? (check also additional suggestions of people to meet, etc)

4.2 **Thank you** & 3.3 Remind them on **confidentiality** and we don't share individual information.

****

Academia / researchers, CSOs working on FGM (not IPs) Interview Protocol

Stakeholder Specific Questions: Academia/researchers, CSOs working on FGM (not IPs)

1 Opening: Intro questions on role of institution interviewed

1.1 Explore history, characteristics and present role of the organization in general.

1.2 Explore role regarding FGM

2 Open and specific questions on FGM

2.1 Description of **FGM phenomenon in the country**

2.2 Description of **evolution of FGM** in the last years.

2.3 Main **factors for FGM change / lack of change** in the country

2.4 What specific **evidence** of change exists [FQ]

2.5 **Explore gaps in data, evidence**, information systems, new research available, research gaps.

2.6 **What elements of research** that are not addressed would be more crucial in the understanding of FGM.

3 About the Joint Programme

3.1 Do you have **a relation with the Joint Programme** (or **know** about the Joint Programme?) **If yes, pass to 3.2**,

If not ask his/her **opinion on international efforts to change attitudes on FGM** and **how this should be done** in his/her opinion.

3.2 What is your opinion on the Joint Programme?

3.3 Main positive aspects and why

3.4 Main negative aspects and why

3.5 What could the Joint Programme do differently to be more helpful in the future?

4 Closing

4.1 **Anything else** we have not asked that you would like to share with us? (check also additional suggestions of people to meet, etc)

4.2 **Thank you** & 3.3 Remind them on **confidentiality** and we don't share individual information.

****

Interview Questions at Community Level, translated into French

Questions pour les interprètes

Introduction

Nous vous rapellons que votre participation à cette entretien est volontaire et que toutes les informations que vous nous fournirez resterons confidentielles. Pouvons nous avoir votre consentement à cette discussion?

1. Quel es la valeur social de l'excision dans votre communauté?
2. Est-ce que l'excision est pratiqué dans votre communauté? Si oui, quelles forms/types d'excision son pratiqués?
3. Pensez vous qu'il y a des conséquences de cette pratique sur l'enfant et sur la femme? Quels types de conséquences? Comment avez vous été informé sur les consequences de cette pratique? Comment cette information a eu une influence sur l'excision (leur opinion et les opinions de ceux qui sont proches)?
4. Que faites-vous dans votre communauté pour informer les membres sur l'excision et changer leur comportement?
5. Quelles types de formations ou d'appuis avez vous reçus pour aider à cela? Par qui?
6. Les femmes reçoivent t'elles de l'information sur l'excision au niveau des structures sanitaires? Où est-ce qu'elles reçoivent cette information?
7. Quelle est l'opinon des jeunes sur l'excision? Quelle est l'opinion des ainés sur l'excision? Y-a-t'il une différence d'opinion entre les jeunes et les ainés? Comment addressez vous ces divergances d'opinion?
8. Etes-vous au courant de l'existance de la loi interdisant la pratique de l'excision? Que pensez-vous de cette loi? Quelle est votre position concernant cette loi? Etes-vous d'accord ou non et pourquoi?

9. Selon vous, y-a-t'il eu des changements dans la pratique de l'excision au courant des 5 dernières années?
10. Qu'est-ce qui a expliqué ces changements? Y-a t'il eu des acteurs externes qui ont contribué à ces changements? Dans quelle mesure les hommes on été impliqué dans ce changement?
11. Y-a-t'il eu des résistances au sein de votre communauté? Si oui, pourquoi?
12. Quelles sont les meilleures façons pour faciliter le changement de comportement?
13. Y-a t'il eu des déclarations d'abandon de l'excision dans votre communauté? Suite à ces déclarations, est-ce qu'il y a des gens qui continuent à faire cette pratique? Si oui, pourquoi? Que faites vous pour que l'abandon de la pratique soit effective?

Annex 10. Interview logbook template

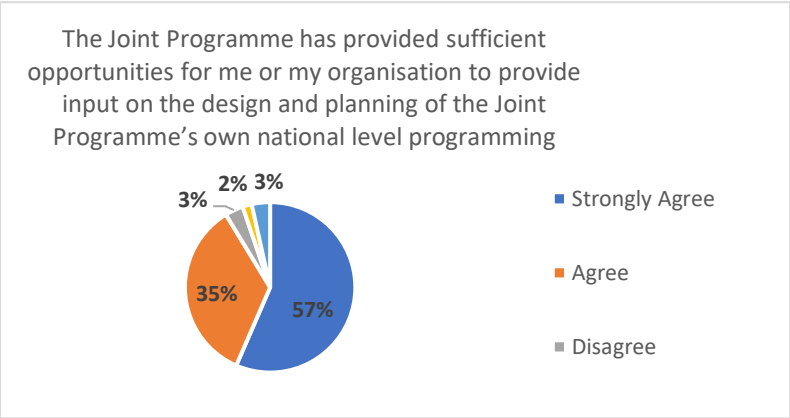
Interviewer:		Interview Code:	
Location:		Date:	
Stakeholder type:			
Name(s) of the interviewee(s):	Institutional affiliation	Position	Gender

1. Points discussed (use stakeholder-specific questionnaire where available)
2. Main outcomes of the discussion (2 or 3 points max)
3. Areas that require follow up (documentation; additional interviews)

Annex 11. Online Survey – results and analysis

Survey Question 1

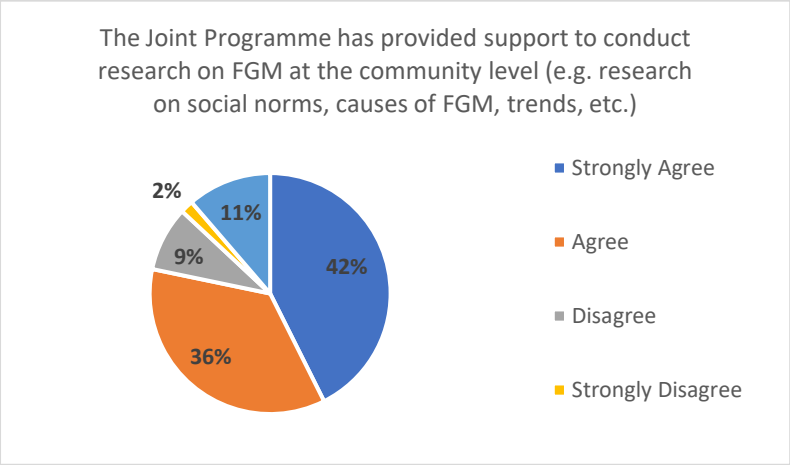
The Joint Programme has provided sufficient opportunities for me or my organisation to provide input on the design and planning of the Joint Programme's own national level programming.



Relevant Assumptions

Assumption 1.1 The Joint Programme design (including approach, strategies and interventions) is aligned with global, national and sub-national priorities and is flexible enough to be responsive to different local contexts and to changing realities and priorities.

Survey Question 2



The Joint Programme has provided support to conduct research on FGM at the community level (e.g. research on social norms, causes of FGM, trends, etc.).

Relevant Assumptions

Assumption 1.3 Joint Programme interventions at the global, regional, national and sub-national levels are based on a comprehensive analysis of all available evidence (e.g. situation analysis, needs assessments, gender assessments, identification of drivers of change, stakeholder mapping) of the populations of interest in programme countries and of the factors that create barriers and promote drivers of change to end FGM.

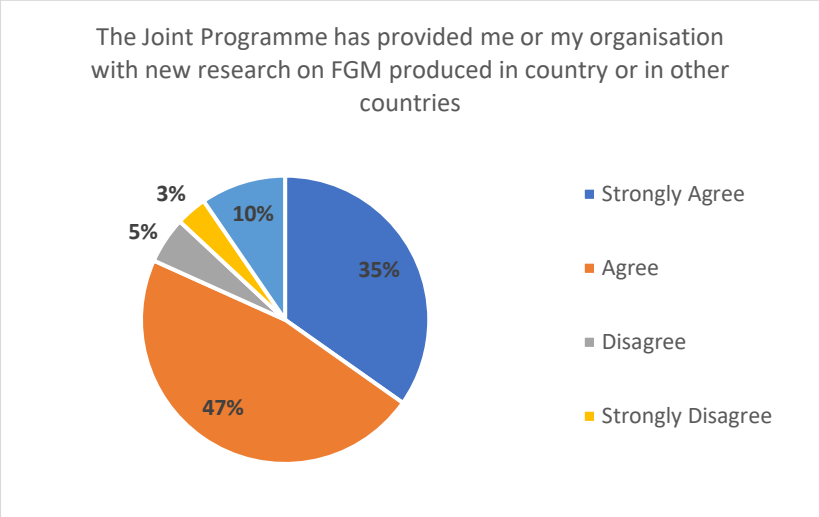
Assumption 3.2 The global programme has effectively developed and leveraged partnerships and collaborations with other development actors to amplify efforts, particularly with regards to more in-depth research on social norms change and its linkages to changes in individual and collective behaviours.

Recommendations

3.3% of recommendations received from partners were research-related.

Survey Question 3

The Joint Programme has provided me or my organisation with new research on FGM produced in country or in other countries.



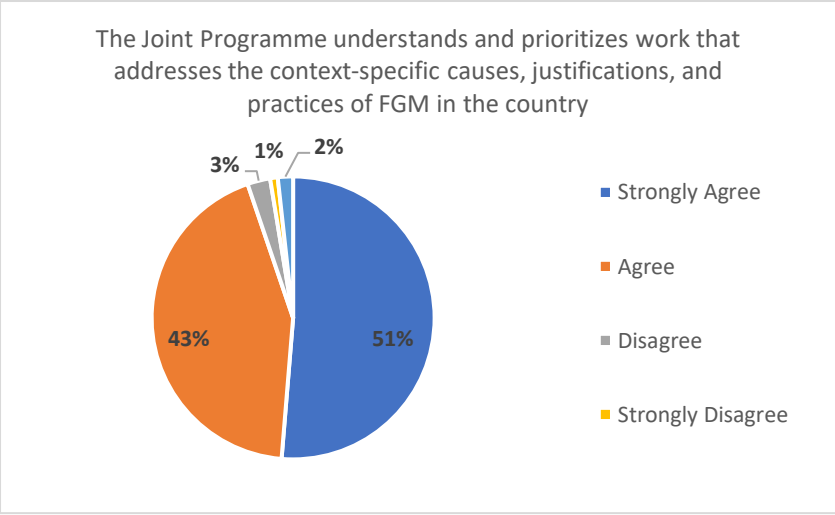
Relevant Assumptions

Assumption 3.2 The global programme has effectively developed and leveraged partnerships and collaborations with other development actors to amplify efforts, particularly with regards to more in-depth research on social norms change and its linkages to changes in individual and collective behaviours.

Recommendations

3.3% of recommendations received from partners were research related.

Survey Question 4



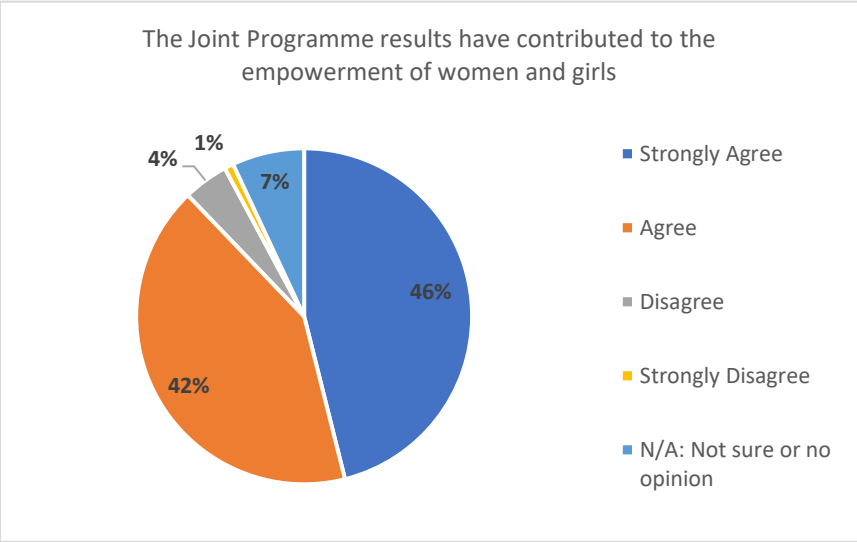
The Joint Programme understands and prioritizes work that addresses the context-specific causes, justifications, and practices of FGM in the country.

Relevant Assumptions

Assumption 1.1 The Joint Programme design (including approach, strategies and interventions) is aligned with global, national and sub-national priorities and is flexible enough to be responsive to different local contexts and to changing realities and priorities.

Survey Question 5

1. The Joint Programme results have contributed to the empowerment of women and girls.



Relevant Assumptions

Assumption 2.3 A majority of individuals, families and communities in programme areas accept the norm of keeping girls intact

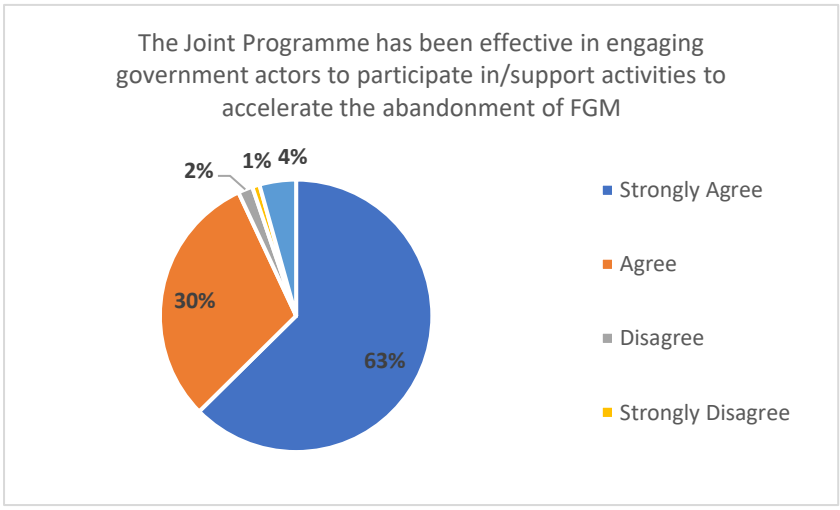
Assumption 5.2 The Joint Programme promotes changes in social norms at the community level that are sustained over time and that lead to improvements in gender equality dynamics between men and women.

Recommendations

6.3% of recommendations mentioned more resources for women and girls. Of those recommendations, 61.9% were related to empowering girls and women, 14.3% were related to establishing scholarships for girls, 19% were establishing community networks, 9.5% were supporting women's working groups.

Survey Question 6

The Joint Programme has been effective in engaging government actors to participate in/support activities to accelerate the abandonment of FGM.



Relevant Assumptions

Assumption 1.2 The Joint Programme approach is based on its comparative strengths, taking into consideration the roles and comparative strengths of other actors working in this field.

Assumption 5.1 The Joint Programme supports national ownership of efforts to eradicate FGM by building institutional capacity and by integrating programming into established national systems and processes.

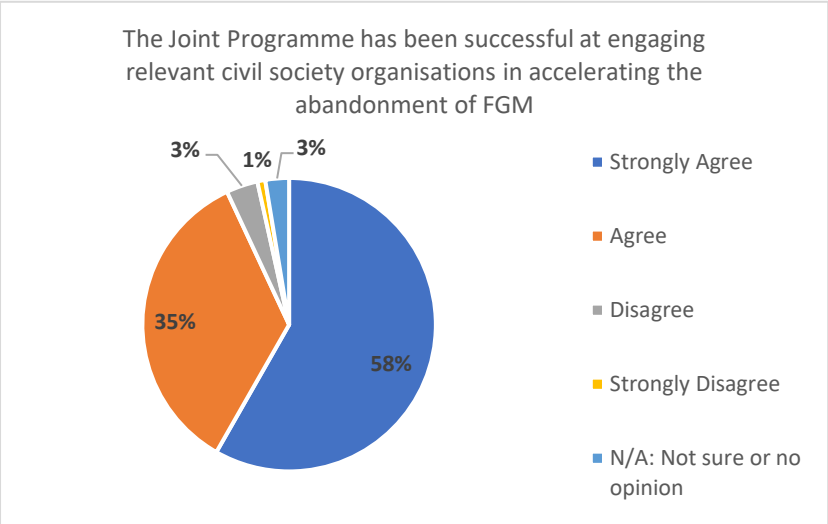
Assumption 2.1 Programme countries enact legal and policy frameworks for eliminating FGM which are appropriately resourced and implemented (in line with AU and UN Resolutions);

Recommendations

5.7% of the recommendations related to further engagement of the government. Of those, 53.3% were related to capacity building or further engagement of the government, and 13.3% were related to having a dedicated budget line for FGM programming. 33.3% were related to ensuring program sustainability.

Survey Question 7

The Joint Programme has been successful at engaging relevant civil society organisations in accelerating the abandonment of FGM.



Relevant Assumptions

Assumption 3.2 The global programme has effectively developed and leveraged partnerships and collaborations with other development actors to amplify efforts, particularly with regards to more in-depth research on social norms change and its linkages to changes in individual and collective behaviours.

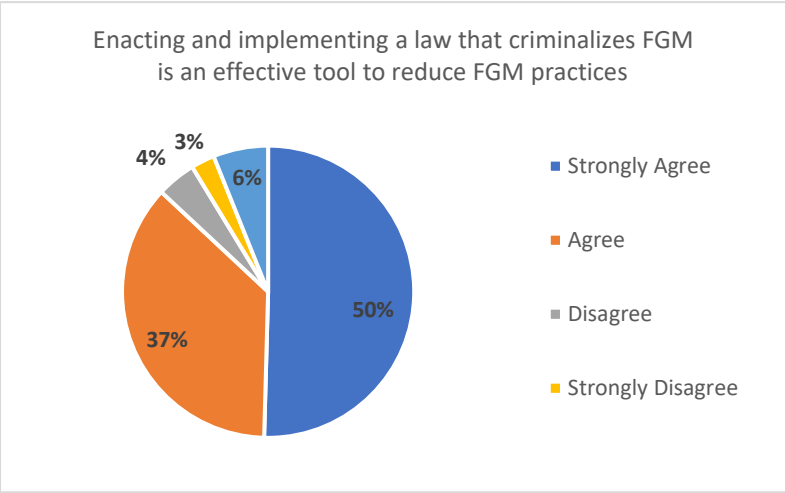
Assumption 3.3. Joint Programme acted as a catalyst for established and emerging actors to strengthen the response to end FGM, at national, regional and global levels, including e.g. other UN agencies, other programmes, new donors and funders, national governments, regional bodies, civil society and implementing partners

Recommendations

7.9% of recommendations were related to further supporting CSOs. Of those, 45.8% were related to increased funding, 29.2% were related to capacity building of CSOs, 25% were related to logistical support and 12.5% were related to general support.

Survey Question 8

Enacting and implementing a law that criminalizes FGM is an effective tool to reduce FGM practices.



Relevant Assumptions

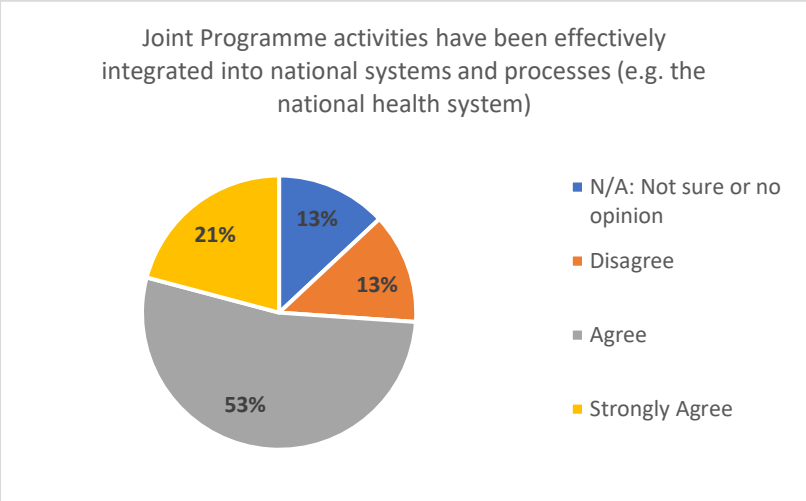
Assumption 2.1 Programme countries enact legal and policy frameworks for eliminating FGM which are appropriately resourced and implemented (in line with AU and UN Resolutions);

Recommendations

9.7% of recommendations were related to increasing advocacy and laws.

Survey Question 9

Joint Programme activities have been effectively integrated into national systems and processes (e.g. the national health system).



Relevant Assumptions

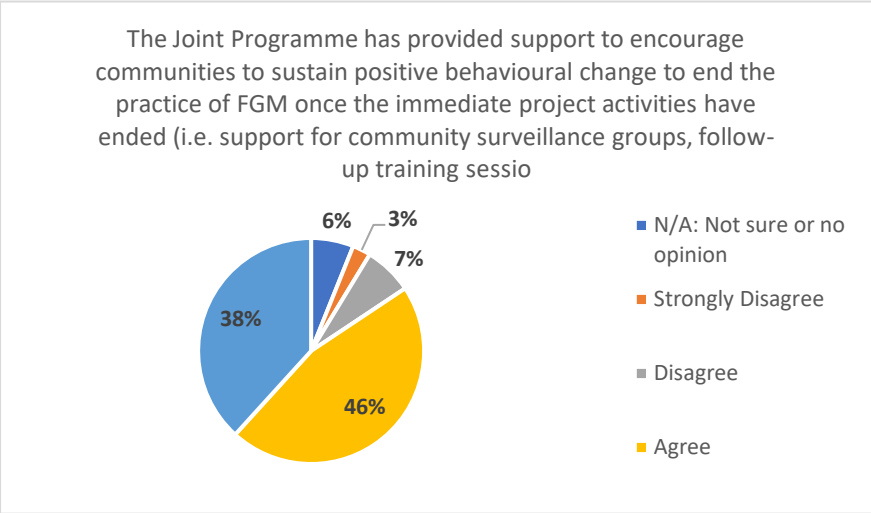
Assumption 5.1 The Joint Programme supports national ownership of efforts to eradicate FGM by building institutional capacity and by integrating programming into established national systems and processes.

Recommendations

5.7% of the recommendations related to further engagement of the government. Of those, 53.3% were related to capacity building or further engagement of the government, and 13.3% were related to having a dedicated budget line for FGM programming.

Survey Question 10

The Joint Programme has provided support to encourage communities to sustain positive behavioural change to end the practice of FGM once the immediate project activities have ended (i.e. support for community surveillance groups, follow-up training sessions, etc.)



Relevant Assumptions

Assumption 2.3 A majority of individuals, families and communities in programme areas accept the norm of keeping girls intact

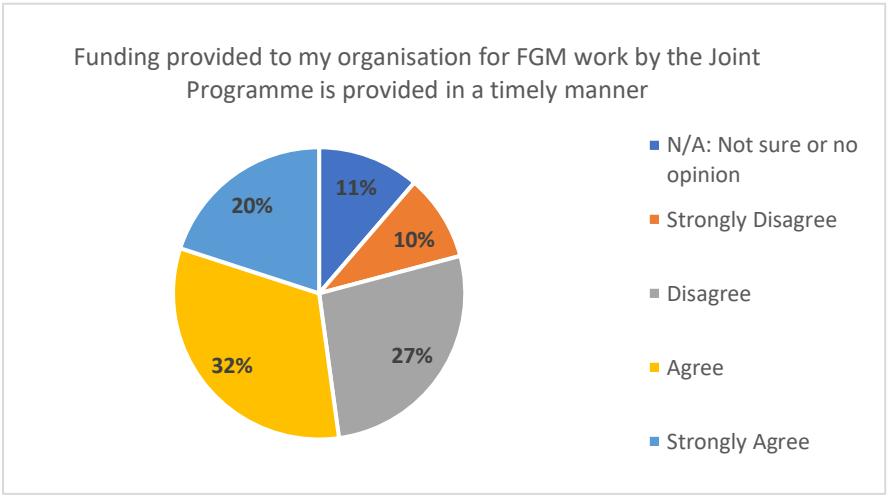
Assumption 5.2 The Joint Programme promotes changes in social norms at the community level that are sustained over time and that lead to improvements in gender equality dynamics between men and women.

Recommendations

5.7% of the recommendations related to further engagement of the government. Of those, 33.3% were related to ensuring program sustainability.

Survey Question 11

Funding provided to my organisation for FGM work by the Joint Programme is provided in a timely manner.



Relevant Assumptions

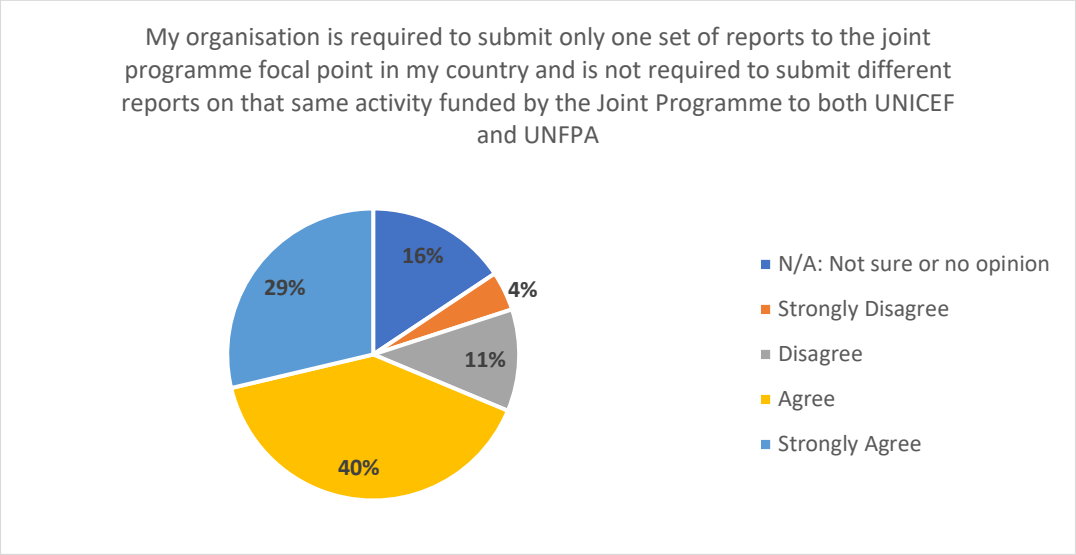
Assumption 4.1 Joint programme financial systems and structures enable the efficient and timely flow of resources to support implementation and achieve planned results.

Recommendations

6.6% of recommendations were related to program funding. Of those, 54.5% wanted timelier payments, 18.2% wanted continuous funding, 18.2% wanted increased funding, and 9.1% wanted longer funding cycles.

Survey Question 12

My organization is required to submit only one set of reports to the joint programme focal point in my country and is not required to submit different reports on that same activity funded by the Joint Programme to both UNICEF and UNFPA.



Relevant Assumptions

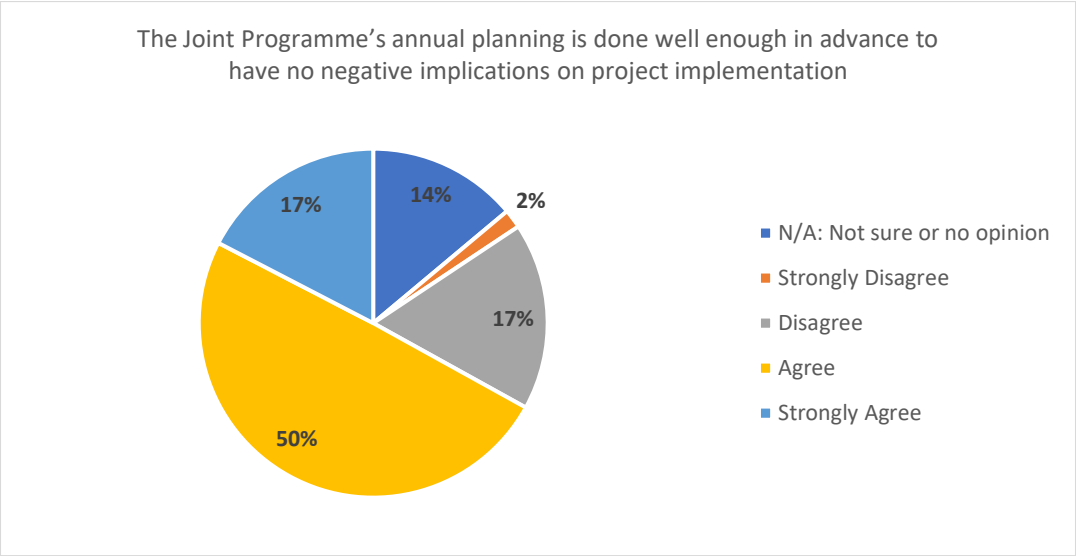
Assumption 3.1 Management arrangements and coordination between UNFPA, UNICEF, national authorities and programme partners have facilitated both agencies to leverage their relative strengths and capacities for more effective programme implementation.

Recommendations

6.9% of recommendations mentioned program planning, data collection, monitoring and evaluation or reporting. Of those, 10% mentioned reporting as an area to improve upon.

Survey Question 13

The Joint Programme's annual planning is done well enough in advance to have no negative implications on project implementation.



Relevant Assumptions

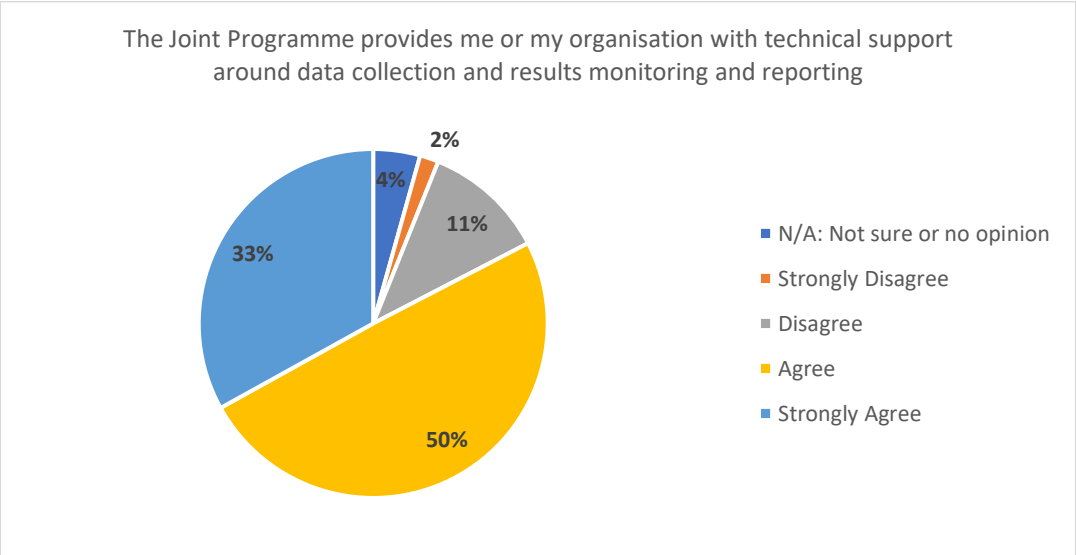
Assumption 4.1 Joint programme financial systems and structures enable the efficient and timely flow of resources to support implementation and achieve planned results.

Recommendations

6.9% of recommendations mentioned program planning, data collection, monitoring and evaluation or reporting. Of those, 30% mentioned planning as an area to improve upon.

Survey Question 14

The Joint Programme provides me or my organisation with technical support around data collection and results monitoring and reporting.



Relevant Assumptions

Assumption 4.3 Monitoring, reporting and evidence-gathering systems are in place and are compatible across both agencies, and are adequate to measure progress towards expected results and promote learning at all levels.

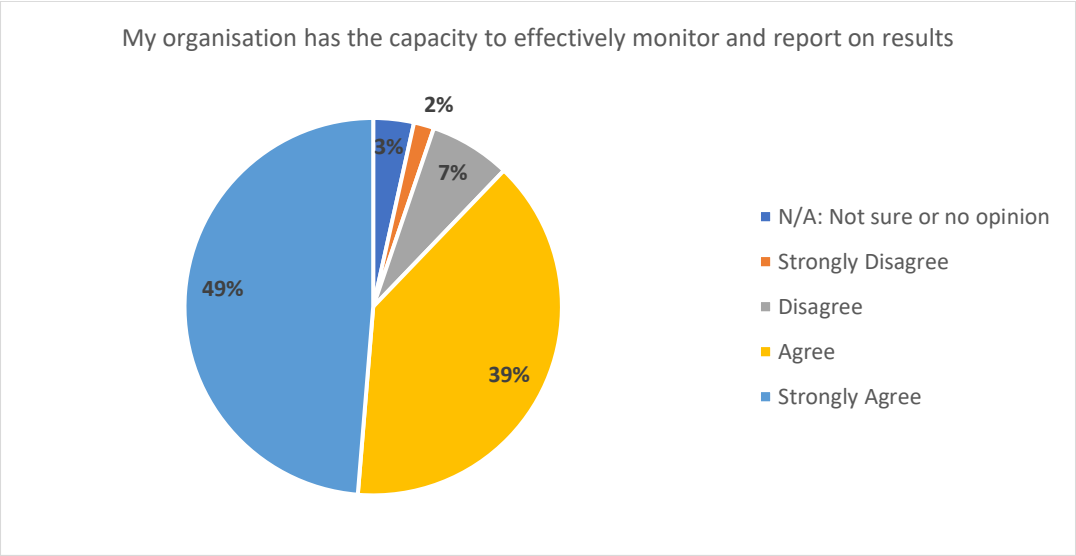
Recommendations

6.9% of recommendations mentioned program planning, data collection, monitoring and evaluation or reporting. Of those, 15% mentioned data collection as an area to improve upon, 60% mentioned M&E and 10% mentioned reporting.

7.9% of recommendations mentioned increased support for CSOs. Of those, 29.2% mentioned capacity building and 25% mentioned logistical support.

Survey Question 15

My organisation has the capacity to effectively monitor and report on results.



Relevant Assumptions

Assumption 4.3 Monitoring, reporting and evidence-gathering systems are in place and are compatible across both agencies, and are adequate to measure progress towards expected results and promote learning at all levels.

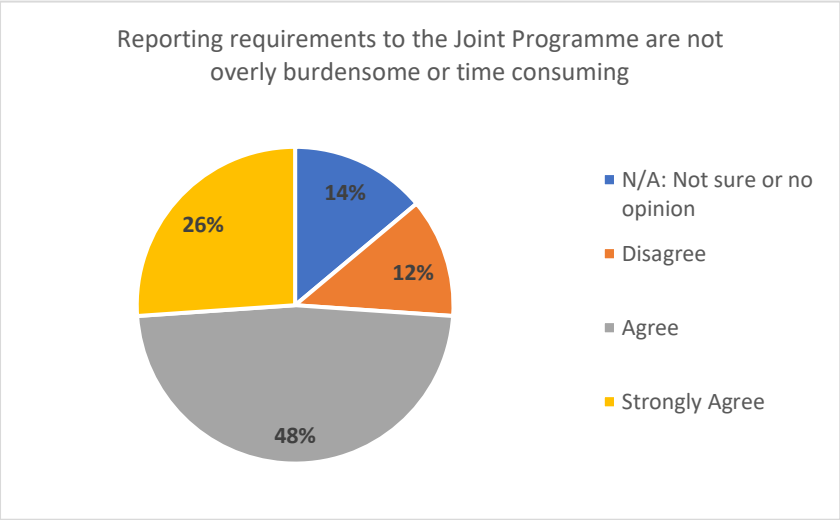
Recommendations

6.9% of recommendations mentioned program planning, data collection, monitoring and evaluation or reporting. Of those, 60% mentioned M&E as an area to improve upon and 10% mentioned reporting.

7.9% of recommendations mentioned increased support for CSOs. Of those, 29.2% mentioned capacity building.

Survey Question 16

2. Reporting requirements to the Joint Programme are not overly burdensome or time consuming.



Relevant Assumptions

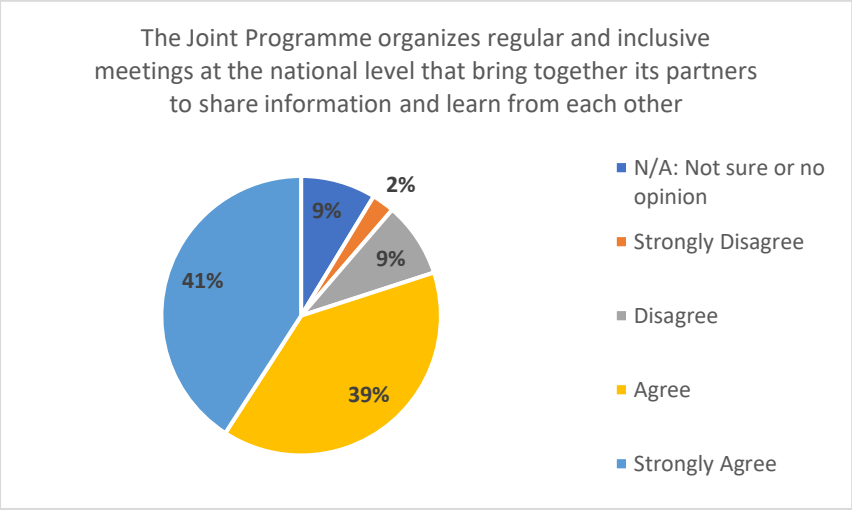
Assumption 4.3 Monitoring, reporting and evidence-gathering systems are in place and are compatible across both agencies, and are adequate to measure progress towards expected results and promote learning at all levels.

Recommendations

6.9% of recommendations mentioned program planning, data collection, monitoring and evaluation or reporting. Of those, 10% mentioned reporting as an area to improve upon.

Survey Question 17

The Joint Programme organizes regular and inclusive meetings at the **national** level that bring together its partners to share information and learn from each other.



Relevant Assumptions

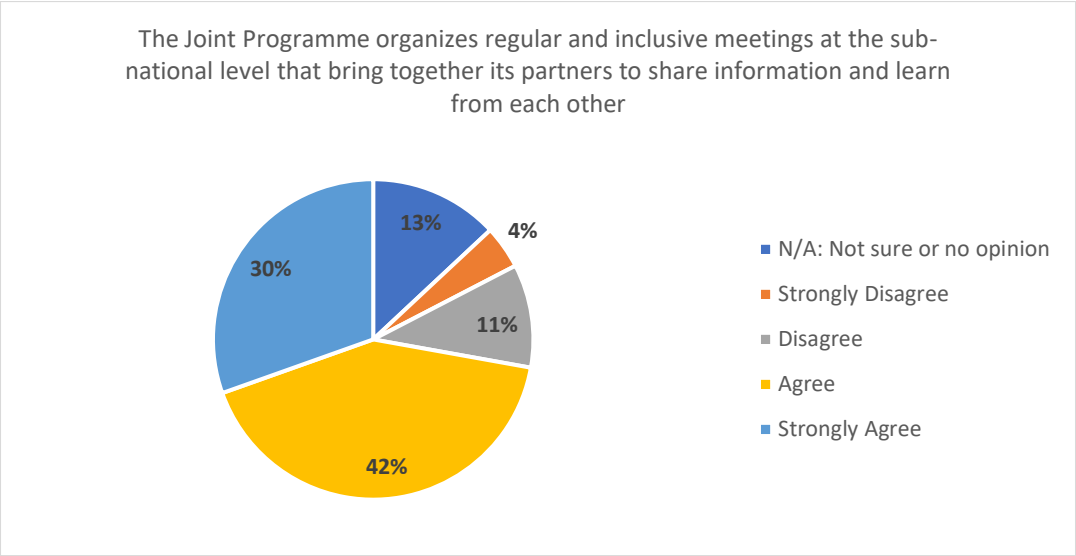
Assumption 1.2 The Joint Programme approach is based on its comparative strengths, taking into consideration the roles and comparative strengths of other actors working in this field.

Recommendations

6% of recommendations mentioned meetings as an area to improve upon. Of those, 43.8% were related to national and subnational meetings

Survey Question 18

The Joint Programme organizes regular and inclusive meetings at the **sub-national** level that bring together its partners to share information and learn from each other.



Relevant Assumptions

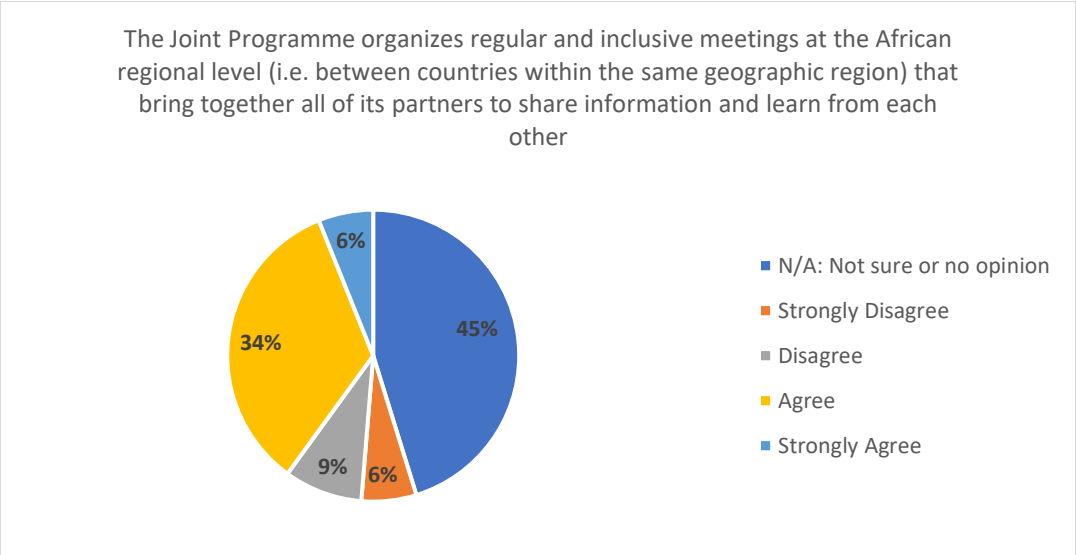
Assumption 1.2 The Joint Programme approach is based on its comparative strengths, taking into consideration the roles and comparative strengths of other actors working in this field.

Recommendations

6% of recommendations mentioned meetings as an area to improve upon. Of those, 43.8% were related to national and subnational meetings

Survey Question 19

The Joint Programme organizes regular and inclusive meetings at the **African regional** level (i.e. between countries within the same geographic region) that bring together all of its partners to share information and learn from each other.



Relevant Assumptions

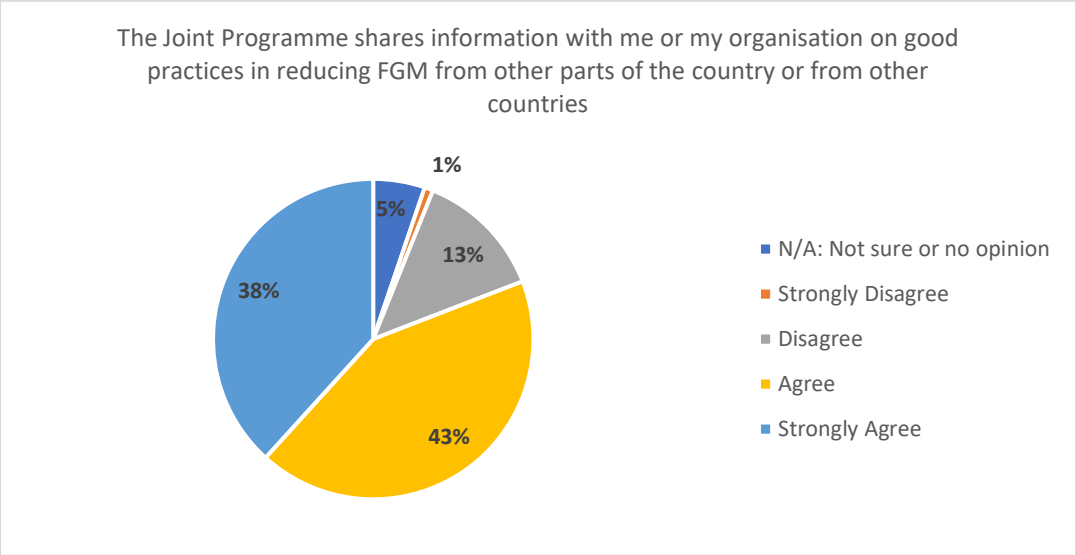
Assumption 1.2 The Joint Programme approach is based on its comparative strengths, taking into consideration the roles and comparative strengths of other actors working in this field.

Recommendations

6% of recommendations mentioned meetings as an area to improve upon. Of those, 37.5% were related exchanges with other actors and 31.3% were related to exchanges with other countries.

Survey Question 20

The Joint Programme shares information with me or my organisation on good practices in reducing FGM from other parts of the country or from other countries.



Relevant Assumptions

Assumption 3.2 The global programme has effectively developed and leveraged partnerships and collaborations with other development actors to amplify efforts, particularly with regards to more in-depth research on social norms change and its linkages to changes in individual and collective behaviours.

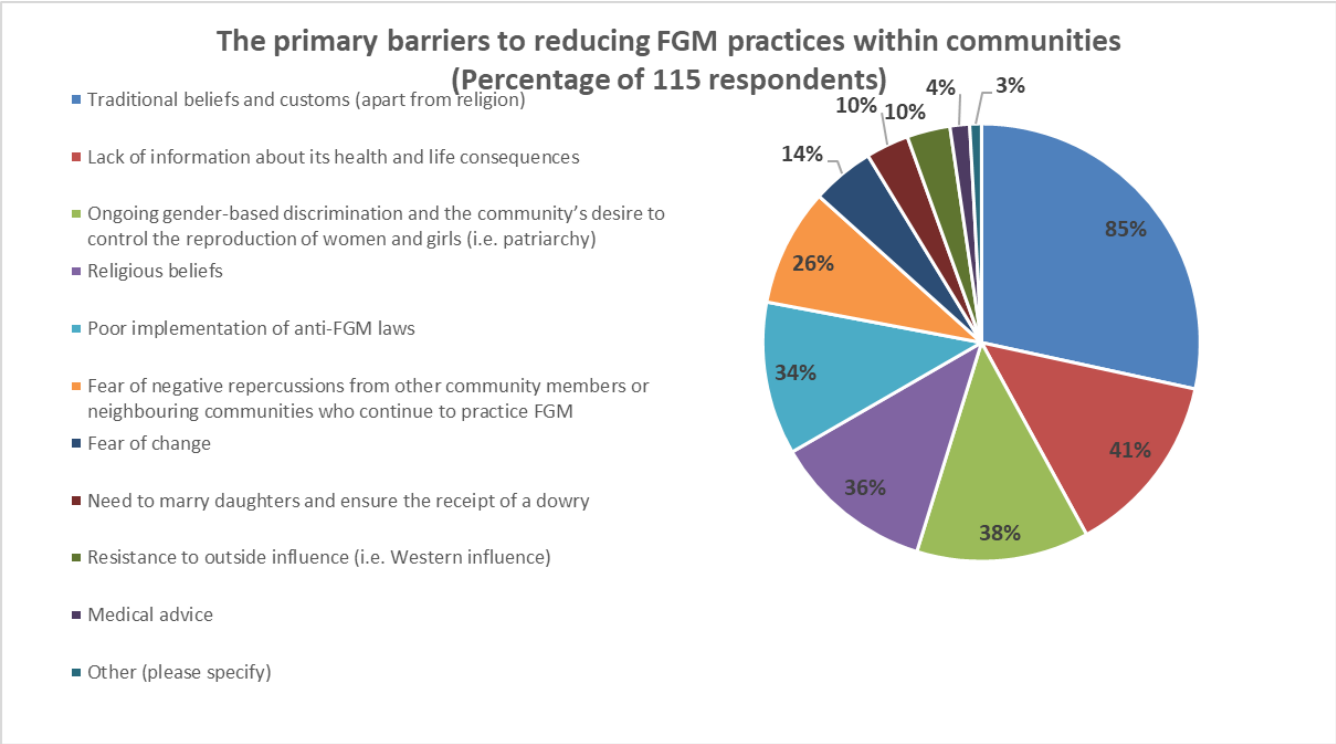
Assumption 1.3 Joint Programme interventions at the global, regional, national and sub-national levels are based on a comprehensive analysis of all available evidence (e.g. situation analysis, needs assessments, gender assessments, identification of drivers of change, stakeholder mapping) of the populations of interest in programme countries and of the factors that create barriers and promote drivers of change to end FGM.

Recommendations

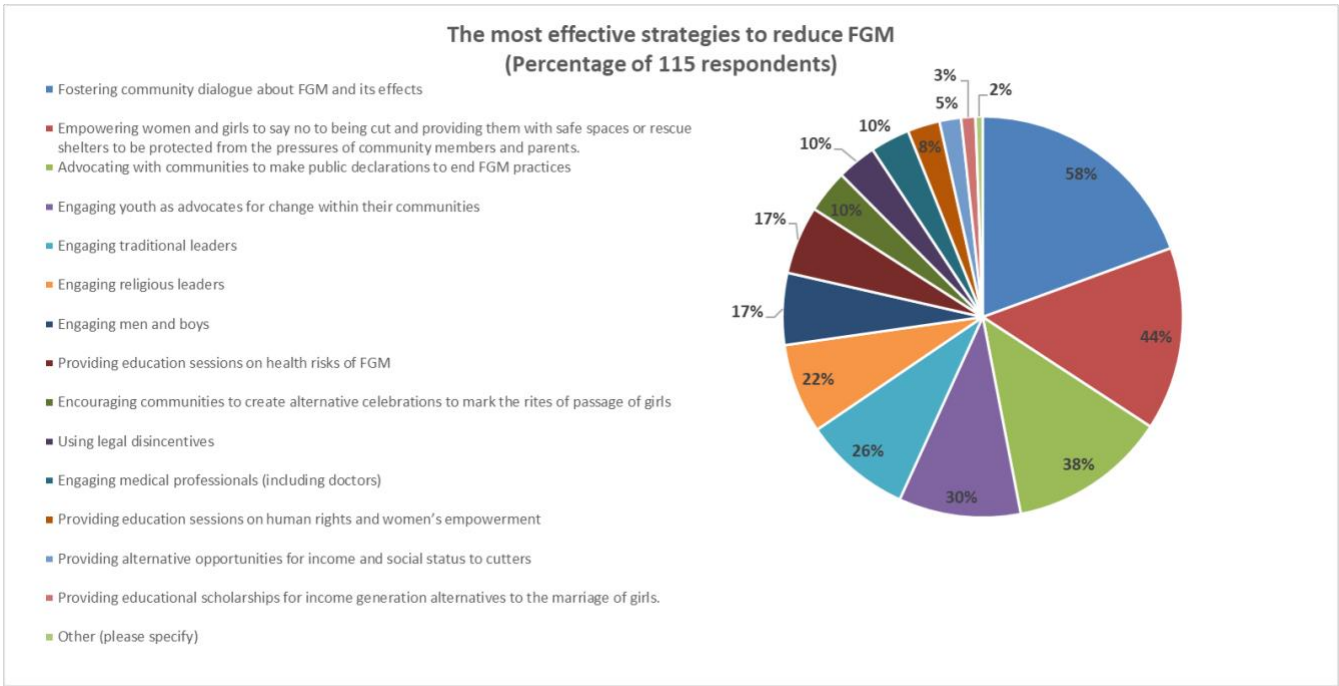
6% of recommendations mentioned meetings as an area to improve upon. Of those, 37.5% were related exchanges with other actors and 31.3% were related to exchanges with other countries.

Survey Questions with multiple categories

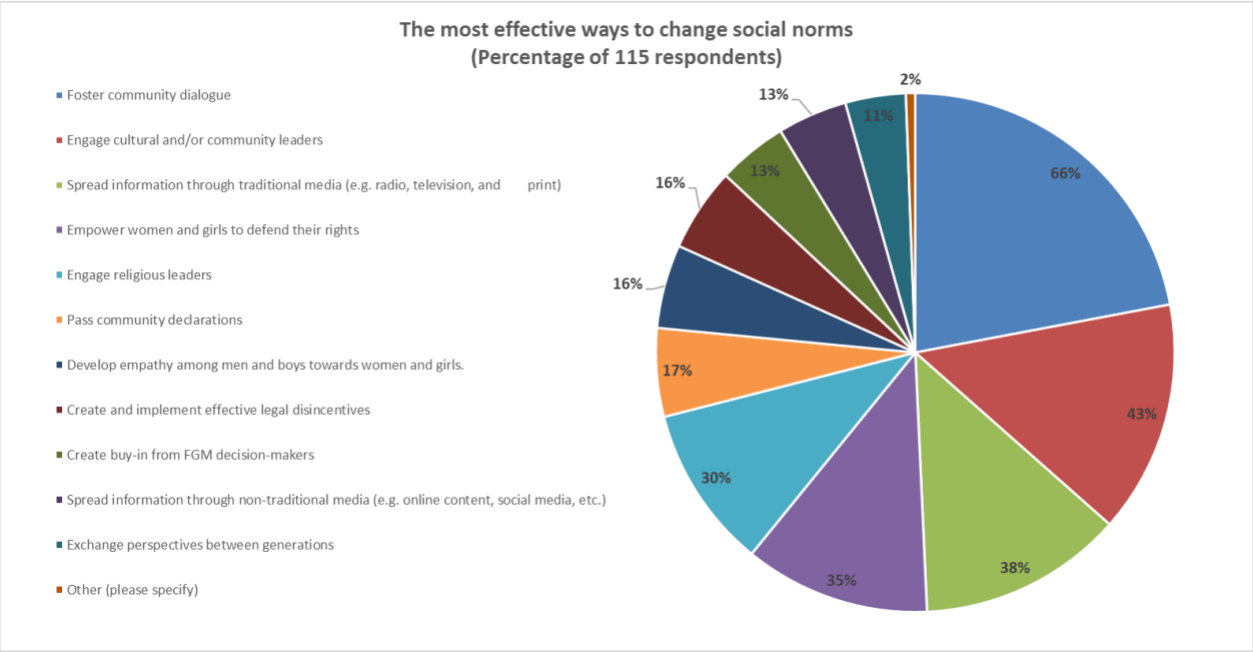
The primary barriers to reducing FGM practices within communities are (select 3 responses)



The most effective strategies to reduce FGM are (select 3 responses)



The most effective ways to change social norms are to (select 3 responses)



Relevant assumptions

Assumption 2.3 A majority of individuals, families and communities in programme areas accept the norm of keeping girls intact

Recommendations

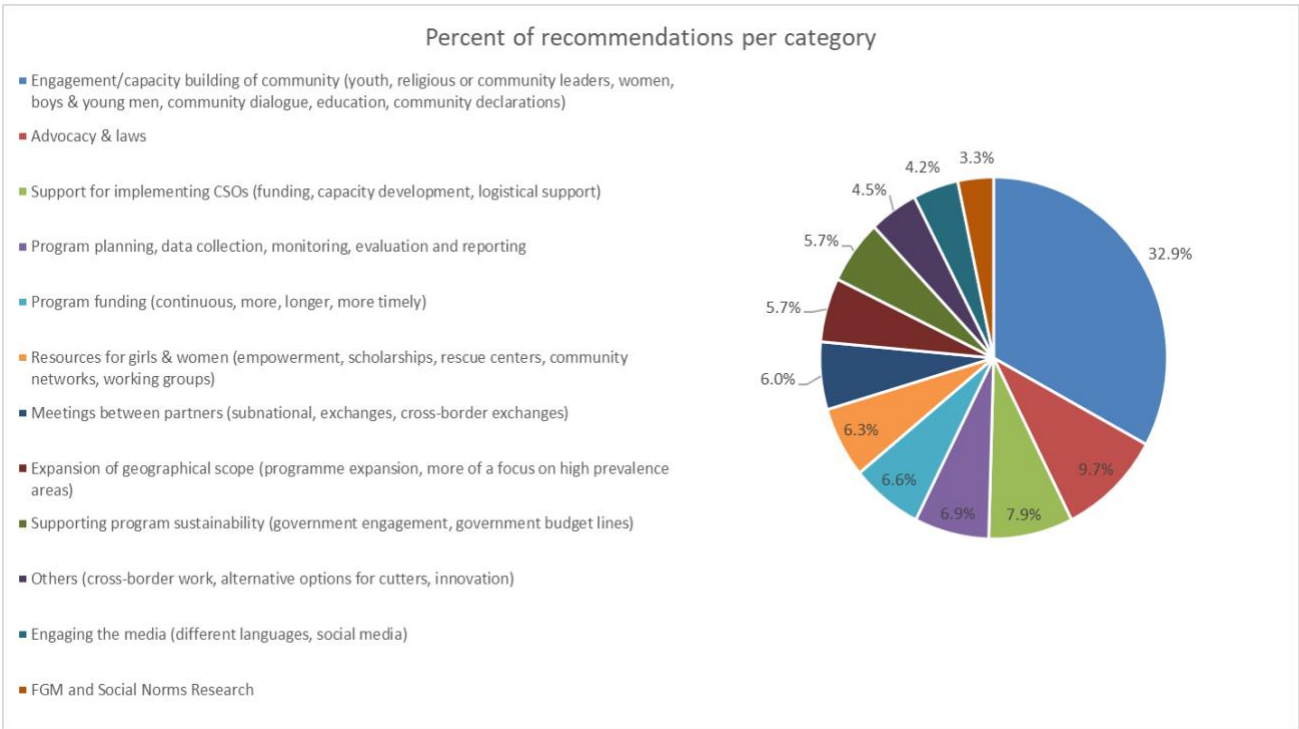
32.9% of recommendations were related to engagement/capacity building of community. Of those, 12% were related to engagement of youth, 6.5% were related to engagement of males, 16.7% were related to engagement of religious leaders, 16.7% related to engagement of traditional leaders, 20.4 % were related to community dialogue, 7.4 % were related to education, 3.7% were related to public declarations, and 31.5% were related to further community engagement/capacity building

5.7% of recommendations were related to the geographical scope of the Joint Programme. Of those, 84.2% recommended geographical expansion while 15.8% recommended focusing on high prevalence areas.

4.2% of recommendations were related to engaging the media

Summary of recommendations

What top 3 recommendations would you provide to the Joint Programme to strengthen its work to accelerate the reduction of FGM?



Other recommendations

4.2% of recommendations fell into the Others category. Of those, 14.3% related to cross-border work, 28.6% related to alternative options for cutters, 21.4% highlighted innovation, and 28.6% fell into 'others'.

Annex 12: The global and regional context of FGM abandonment

It is estimated that 200 million girls and women have undergone female genital mutilation. UNFPA estimate more than 3 million girls are at risk of undergoing female genital mutilation every year[21]. The practice of FGM has been documented in at least 30 countries, mainly in Africa, the Middle East and Asia. The practice is also found in pockets of Europe and in Australia and North America which, for the last several decades, have been destinations for migrants from countries where the practice still occurs. More than half of the 200 million girls and women subjected to FGM live in just three countries: Egypt, Ethiopia and Indonesia [22].

Rates vary widely within countries reflecting influences including ethnic identity, religious identity, and secular influences such as urbanization or changes in women's status. A UNICEF study in 2016 using specialized population-based data derived from surveys found that there has been an overall decline in the prevalence of FGM over the last three decades (in those countries with data). However, not all countries have made progress and the pace of decline has been uneven. Displacements of large populations due to conflict and climate stress complicate estimates. Critically, current progress is insufficient to keep up with increasing population growth. If trends continue, the number of girls and women undergoing FGM will rise significantly over the next 15 years[23].

Social justifications for FGM

The justifications for the practice of FGM are numerous, evolving and not necessarily consistent within a particular practicing "group", however they typically revolve around preventing undesirable pregnancy (which might result from rape or intercourse outside of a marriage or kinship contract) through reducing sexual desire or making intercourse difficult; preserving standards of purity (related to the latter), beauty, cleanliness, aesthetic attraction, or male sexual satisfaction; or preserving the desirable status of an unmarried female (reflected in differences in bride-price), assuring her social acceptance and that of her family including as part of establishing identification with an ethnic or religious group. The most common concern expressed by parents is assuring that their daughter is acceptable and accepted by the larger community and, often, that she, too, benefits from the experience her mother had. Much is invested in explaining or justifying the practice or even the type of practice.[24]

[21] The age at which FGM is performed varies: the most typical age is 7 to 10 years of age, however it may be carried out during infancy, at the time of marriage, during a woman's first pregnancy or after the birth of her first child. The majority of girls are cut before they turn 15 years old[21]. How much of a girl's genitalia is damaged or cut and how it is cut varies however all forms of practice have multiple harmful effects even when performed by "medical" personnel rather than traditional practitioners. These include short term and life-long injury: bleeding, infection, scarring, loss of sensitivity and sensation, acute and chronic pain, lifelong psychological consequences including anxiety and depression[21], slowing of birth process resulting in associated complications. For those experiencing the most severe forms involving reducing the size of the vaginal opening through binding during healing or sewing, implications include difficulty in passing or retention of urine or menstrual fluid and resulting infection with possible result of infertility; pain and tearing during sexual intercourse (whether forced or not); pain, tearing, and internal fistula during childbirth including risk of death for both the mother and the infant. (UNICEF, Female Genital Mutilation/Cutting: A global concern. New York: UNICEF, 2016. Available at http://www.unicef.org/media/media_90033.html)

[22] UNICEF Female Genital Mutilation/Cutting: A Global Concern. New York, UNICEF. 2016.

[23] UNICEF Female Genital Mutilation/Cutting: A Global Concern. New York, UNICEF. 2016.

[24]For example, there has been a rigorous debate within the Islamic community regarding whether the prophet and texts allow for the "less harmful" procedure of cutting or removing the clitoris which reducing sexual sensation and can involve scarring etc. but does not involve closing the vaginal opening),

A landmark resolution in 2012 by the UN General Assembly called for the need to intensify global efforts for the elimination of FGM and referred to FGM as 'a harmful practice, a form of violence against women and girls , and that it is inherently linked to deep-rooted negative norms, stereotypes, perceptions and customs that negatively impacts women and girls' human rights, along with their physical, mental, sexual and reproductive health'[25]. The resolution, co-sponsored by two thirds of the General Assembly, including the entire African Group, and adopted by consensus by all UN members, helped set aside the debates regarding ethnically-based practice, religious injunction, or standards of beauty to focus attention on the need to address the root cause behind the practice.

Global Framework

Female genital mutilation is internationally recognized as a harmful practice, and a violation of the rights of women and girls to bodily integrity and freedom from injury and coercion. The 2030 Sustainable Development Goals' Goal Number 5 addressing gender equality includes targets for progress on the elimination of harmful practices including FGM (target 5.3) and the elimination of all forms of violence against women and girls (target 5.2)—making elimination of the practice integral to achieving any one of the SDGs which are designed to be interdependent.

Global and Africa Regional Normative Frameworks Addressing FGM (those highlighted are in Africa)
Convention on the Elimination of All Forms of Discrimination Against Women (1979), 1990, 1992, 2010, 2014 (Joint with Committee on the Rights of the Child)
UN General Assembly Convention on the Rights of the Child (1989) The Committee on the Rights of the Child, 2011
The African Charter on the Rights and Welfare of the Child (1989)
Declaration on the Elimination of Violence against Women (1993) and all subsequent recommendations[26]
World Conference on Human Rights, Vienna (1993), UN Human Rights Council, Report of the UNHCHR, 2015.
International Conference on Population and Development (1994) and all subsequent recommendations
United Nations Commission on the Status of Women Beijing Platform for Action (1995), resolutions on ending FGM/C (2007, 2008 and 2010).
WHO/ UNICEF/UNFPA Joint Agency Statement (1997).
UN General Assembly Resolutions 2002, 2006 (seminal resolution on ending VAW), 2012, 2013, 2014, 2016, 2017
The African Union Solemn Declaration on Gender Equality in Africa (references harmful practices only) (2004)
The Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (adopted 2003, enforced 2005)
Africa Youth Charter (2006)
World Health Assembly #61 Statement on FGM (2008)
Eliminating female genital mutilation: an interagency statement UNAIDS, UNDP, UNECA, UNESCO, UNFPA, UNHCHR, UNHCR, UNICEF, UNIFEM, WHO (2008).
The African Union 66th Session Declaration for adoption of resolution banning FGM worldwide (Malabo, Equatorial Guinea) (2011)
Caucus of Women Parliamentarians Executive Committee of the Inter-Parliamentarian Union of the Intergovernmental Authority for Development (UIP-IGAD), Declaration (2012)
The European Parliament Resolution 'Towards the elimination of female genital mutilation (2014)
United Nations General Assembly, Resolution 70/1 on Transforming our World: the 2030 Agenda for Sustainable Development, A/RES/70/1, (2015)
United Nations Human Rights Council. Resolution 32/21 (2016)

FGM initially appeared on the international agenda in 1979 at a World Health Organisation (WHO) meeting on traditional practices held in Khartoum, Sudan. WHO was soon joined by

[25] UN Report of the Secretary General: Intensifying Global Efforts for the Elimination of Female Genital Mutilation. New York: UN, 2018.

[26] As of 1 January 2008, responsibility for servicing the Committee on the Elimination of Discrimination against Women transferred to the Office of the High Commissioner for Human Rights in Geneva.

other international agencies, the UN General Assembly, and African regional entities in focusing attention on harmful traditional practices and FGM in particular.

FGM became established in key broad-based conventions/agreements addressing gender equality and the rights of women, girls and children grounded FGM within international policy. The first was the 1979 Convention on the Elimination of All Forms of Discrimination Against Women, which states that violence against women is discriminatory and thus falls within the parameters of the convention, and set the foundation for a human-rights-based approach to FGM. Ten years later, the UN General Assembly Convention on the Rights of the Child (1989) addressed harmful practices impacting children. This was followed by the 1993 Declaration on the Elimination of Violence against Women which explicitly addresses violence and other harmful practices against women, with specific reference to female genital mutilation and other harmful practices.

In 1994, the International Conference on Population and Development specifically addressed the importance of FGM and urged governments and communities to take steps to eliminate 'the practice of female genital mutilation and protect women and girls from all similar unnecessary and dangerous practices.[27]. In 1995 the Beijing Platform for Action raised the issue of violence against women to one of its 12 critical areas of concern and focused on concrete action to address impunity and the need for accountability (calling on States to "*adopt and implement legislation, policies and measures that prevent, punish and eradicate gender-based violence within and outside the family, as well as in conflict and post-conflict situations*").[28] In 1997 the leading health agencies-WHO, UNFPA and UNICEF—joined in a common statement on the implications of the practice for public health as well as for human rights, declaring support for the abandonment of FGM as a practice.

The Africa region has been at the forefront of the global normative efforts reflected in the 2003 signature by most of the countries in the African Union of the Maputo Protocol, or 'The Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa'. The Protocol addresses a number of rights for women, including the right to social and political equality with men as well as control over reproductive health and an end to FGM. The Maputo Protocol has not yet been ratified by all the countries concerned and without ratification by all African States the protocol's pledges cannot be fully achieved. Nonetheless, the Africa Group within the UN General Assembly has continued to show leadership.

From 2006, several resolutions were passed by UN entities. In 2006, the General Assembly adopted a seminal resolution, calling on states to condemn all forms of violence against women, stressing the importance of intensifying global efforts for the elimination of female genital mutilations. In 2008, the World Health Organisation (WHO) established an interagency statement on eliminating FGM. This statement calls for member states, international and national organizations, civil society and communities to develop, strengthen, and support specific actions to eliminate FGM[29].

[27] Report of the International Conference on Population and Development. New York: UNFPA, 1994.

[28] Centre for Reproductive Rights, UNFPA, ICPD and Human Rights: 20 Years of Advancing Reproductive Rights through UN Treaty Bodies and Legal Reform. New York: UNFPA, 2013.

[29] WHO, Eliminating Female Genital Mutilation: An interagency statement - OHCHR, UNAIDS, UNDP, UNECA, UNESCO, UNFPA, UNHCR, UNICEF, UNIFEM, WHO, 2008

In 2012, the United Nations General Assembly adopted a Resolution to ban female genital mutilation worldwide. The Resolution [A/RES/67/146] was co-sponsored by two thirds of the General Assembly, including the entire African Group, and was adopted by consensus by all UN members. In 2014, the United Nations General Assembly adopted another Resolution on the elimination of female genital mutilation. The Resolution [A/69/150], was co-sponsored by the Group of African States and an additional 71 Member States, and was adopted by consensus by all UN members.[30] In 2016, the General Assembly adopted by consensus the [A/C.3/71/L.15] Resolution on intensifying global efforts for the elimination of female genital mutilation sponsored by the African Group[31] .

The intensity of focus is testament to the level of international consensus on the necessity to eliminate FGM and the challenges of addressing both the intractable root causes of gender-based discrimination as well as the enduring, evolving, multi-layered justifications for the practice as well as the surface drivers including efforts to reassert control in the face of social, economic, or political change or unpredictability. This intensity has helped to drive the development of major new international advocacy efforts leading to the declaration of international days of observance to end FGM (International Day of Zero Tolerance launched in 2003) and the decision and declaration by The African Committee of Experts on the Rights and Welfare of the Child in 2013 that the annual Day of the African Child would be dedicated to the the 'Eliminating Harmful Social and Cultural Practices Affecting Children: Our Collective Responsibility.' It has also led to an exponential increase in new research, technical reports, international convening meetings and platforms, adaptation of new media and communication technologies and critically important adaptations of strategy to include youth and men and boys as well as religious leadership and key implementing agencies.

Normative frameworks for FGM/C

Framework	Inclusion of FGM/C
Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) (1979),	Lay the foundation for a human-rights-based approach to addressing violence against women. Though the Convention does not mention GBV in particular, general recommendations 12 and 19 on VAW specify that the Convention includes VAW.[32]
UN General Assembly Convention on the Rights of the Child (1989) (CRC)	Includes provisions to protect children against harmful practices.
The African Charter on the Rights and Welfare of the Child (1989)	Adopted by the Organization of African Unity (now the African Union) It calls upon States to take appropriate measures to eliminate harmful social and cultural practices. The charter only enters into force in 1999.
Declaration on the Elimination of Violence against Women (1993)	The first international instrument explicitly addressing violence and other harmful practices against women, includes female genital mutilation and other traditional practices.[33]

[30] UN General Assembly, Intensifying global efforts for the elimination of female genital mutilations, (A/69/150), 2014
[31] UN General Assembly, Intensifying global efforts for the elimination of female genital mutilation [A/C.3/71/L.15], 2017
[32] See: http://www.ohchr.org/EN/HRBodies/CEDAW/Pages/Recommendations.aspx and http://www.unwomen.org/en/what-we-do/ending-violence-against-women/global-norms-and-standards#sthash.MzBb0hqS.dpuf.
[33] Declaration on the Elimination of Violence against Women 1994. See at Declaration on the Elimination of Violence against Women 1994

World Conference on Human Rights, Vienna (1993)	FGM/C is recognized by the global community as a human rights violation
International Conference on Population and Development (ICPD) (1994)	specifically addressed the importance of FGM and urged governments and communities to take steps to eliminate 'the practice of female genital mutilation and protect women and girls from all similar unnecessary and dangerous practices.' [34]
Beijing Platform for Action (POA) (1995)	Raised the issue of violence against women to one of its 12 critical areas of concern, specifically addressed the additional measures needed to address GBV in humanitarian and displacement settings, and intentionally expanded the focus on a comprehensive, cross-sectoral approach to GBV embedded in national policy and programmes.
WHO, UNICEF and UNFPA Joint statement against FGM/C (1997)	The document described the implications of the practice for public health as well as for human rights and declared support for the abandonment of FGM/C as a practice.
UN General Assembly Resolution on Traditional or Customary practices affecting the health of women and girls (2002)	The resolution calls upon all States to adopt national measures to prohibit practices such as FGM/C.
The Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa takes effect (2005)	Better known as the Maputo Protocol, enters into effect. It calls upon States to take measures to eliminate FGM/C and other traditional practices that are harmful to women.
2006 UN General Assembly Resolution 61/143	A seminal resolution calling on States to intensify efforts to eliminate all forms of violence against women. This resolution was concurrent with a major highly technical and programme-oriented report released by the UN Secretary General. The resolution highlighted violence justified based on culture or religion but did not mention FGM specifically: the SG's report did both.
United Nations Commission on the Status of Women resolutions on ending FGM/C (2007, 2008 and 2010).	These resolutions were concurrent with the meeting of the Commission in New York.
Eliminating female genital mutilation: an interagency statement UNAIDS, UNDP, UNECA, UNESCO, UNFPA,	In 2008, the World Health Organization released an interagency statement calling on States, international and national organizations, civil society and communities to develop, strengthen, and support specific actions to eliminate FGM. The document

[34] Available at Report of the ICPD (A/CONF.171/13), paragraph 7.40.

UNHCHR, UNHCR, UNICEF, UNIFEM, WHO (2008).	addressed the health and human rights impacts of the practice, provided data on its prevalence, cited new research which explored why the practice continued—emphasizing the normative dimension—and focused attention on both the need to end the practice and to support those who have been subject to it.
The Committee on the Rights of the Child, 2011	In the Committee's general comment No. 13, it states that children should be free from harmful practices, including FGM/C.
December 2012 Resolution to ban female genital mutilation worldwide [A/RES/67/146] December 2014, Resolution on the elimination of female genital mutilation. [A/69/150] November, 2016 [Resolution on intensifying global efforts for the elimination of female genital mutilation A/C.3/71/L.15]	Beginning in 2012, the United Nations General Assembly adopted a series of resolutions which directly addressed the need to end FGM/C. In December 2012, the Resolution [A/RES/67/146] was cosponsored by two thirds of the General Assembly, including the entire African Group, and was adopted by consensus by all UN members. In December 2014, an additional Resolution [A/69/150], was cosponsored by the Group of African States and an additional 71 Member States, and was adopted by consensus by all UN members[35]. In November 2016, the General Assembly adopted by consensus a Resolution on intensifying global efforts for the elimination of female genital mutilation, again sponsored by the African Group [A/C.3/71/L.15]. .[36]

FGM research projects and potential synergies with the Joint Programme

Project	Author	Synergies	Timeline
Evidence to end FGM/C: Research to Help Girls and Women Thrive to significantly expand the rigorous evidence base on the most effective and cost-effective approaches to ending FGM/C	Population Council/Nairobi Donor: DFID	Technical inputs: Review of research to date; technical guidance on use of population-based data; initial multivariate analysis of DHS to assess drivers underway; exploratory research begun in multiple sites; formal collaborations with Joint Programme proposed in Senegal, Sudan, Kenya, Egypt and possibly Somalia; capacity building of UNFPA/UNICEF staff in Somalia	Phase 1 2016-2017 12 studies in 7 countries delayed; start to report results in 2018; DHS multivariate Kenya (2016); Senegal, Egypt in process; Sudan, Somalia, Ethiopia, Nigeria, Burkina Faso proposed or 2017 start
Development of a macro-level M&E framework on Changing Social Norms Associated with Harmful Practices	Drexel University, School of Public Health	Project coordinated by C4D UNICEF with intended use being Joint Programme program and significant consultation with Joint Programme HQ team; literature review on social	Consultations with field staff and field testing to create a viable tool for use in M&E by non-specialist programme staff

[35] Available at Intensifying global efforts for the elimination of female genital mutilations, (A/69/150)
[36] Available at Intensifying global efforts for the elimination of female genital mutilation [A/C.3/71/L.15]

		norms change brings up to date and highlights variations in approaches; currently soliciting input from programme staff in field and planning field testing; helps clarify approaches of norm abandonment vs. norm replacement and links change to larger normative context	with limited time; field testing shifted to Sept 2017 ; potential sites for testing include Joint Programme countries
Mapping of Social Norm Change Guidelines and Tools in UNICEF	C4D team, UNICEF	Some challenges developing viable measures and tools arise from differences in theory behind various approaches to social norms work; acknowledgment by UNICEF that field level needs clear picture of range of tools and when and where to use them; as Joint Programme staff were also trained by UNICEF experts, useful to include in efforts to clarify	Mapping exercise to begin 4th quarter 2017 (?) could inform desk review of evaluation with tools specific to institutional context of the Joint Programme
"Measuring Child Protection Outcomes in Senegal: a Population-based Survey in Pikine and Kolda Departments",	Columbia University Group for Children in Adversity, UNICEF WCARO and UNICEF Senegal	Piloted a statistically representative methodology to measure shifts in social norms including on FGM/C; established a baseline on norms in selected districts in Senegal; uses indicators of prevalence which are sensitive to short term change; includes adolescents within families in sample to track intergenerational change within households	The pilot of the tool completed, seeking additional support to undertake a multivariate analysis; tool being considered for adaptation by UNICEF Arab States Regional Office at present
External Assessment of Value for Money and Strengthening Results Measurement of DFID's funding to the Joint Programme on FGM/C	ITAD Donor: DFID	Rigorous Analysis of both costing and value and use of measurement tools and results framework provide content and a baseline for comparison including at mid-point of phase 3; potential to draw on recommendations on measurement tools to inform both evaluation tools and recommendations	Completed 2017 3rd quarter
The Girl Generation social change communication programme	Options Donor: DFID	Provides a mechanism for sharing lessons learned from the evaluation with a broad audience open to change; part of the consortium with	Ongoing

		Joint Programme and Population Council	
Empowering Community to Selectively Abandon FGM/C in Somaliland; a baseline	The Orchid Project, ActionAid Somaliland	A rigorous and in-depth qualitative and quantitative survey on diversity of FGM/C practices in selected regions of Somalia tied with the ActionAid intervention; includes significant data on types of cutting based on regularly updated hospital database which is based on physical examination of patients; also explores changes in practice in face of Zero Tolerance law	Baseline completed in May 2016 and references earlier studies including 2015 supported by UNFPA and UNICEF; follow up TBD
Country Profiles on FGM/C and interventions to address FGM/C from multiple actors in community	28 Too Many Norwegian Church Aid UNJoint Programme Annual Report 2016	These studies provide more detailed information about practices and patterns in selected Joint Programme countries as well as broader lessons learned on drivers of change;	Completed studies; some of ongoing projects
Reviews of selected strategies impact on FGM/C beyond social norm change	ICRW Joint Programme WCARO	These reviews provide a baseline for particular elements of work on FGM which complement Joint Programme focus	Completed
Analytical Summary: Evaluation of UNFPA Support to the Prevention, Response to and Elimination of Gender-based Violence and Harmful Practices 2012-2017	UNFPA IEO	Ongoing evaluation of UNFPA's contributions on addressing GBV and HPs includes country case studies in Joint Programme countries and sets the work in the broader context of gender based violence including mapping the various actors supporting this work	Ongoing
Contributing to the Abandonment of Social Norms Harmful to Girls and Women: A Matter of Gender Equality	UNICEF Final Progress and Utilization Report to the European Commission GENRE/2007/142-353	Reflects recent learning on a social norms approach for broader gender equality issues	Completed

Annex 13: Feminist Evaluation

The characteristics of a feminist evaluation approach

1) Feminist evaluation has as a central focus the gender inequities that lead to social injustice.
2) Discrimination or inequality based on gender is systemic and structural.
3) Evaluation is a political activity; the contexts in which evaluation operates are politicized; and the personal experiences, perspectives, and characteristics evaluators bring to evaluations (and with which we interact) lead to a particular political stance. A feminist evaluation encourages an evaluator to view her- or himself as an activist.
4) Knowledge is a powerful resource that serves an explicit or implicit purpose.
5) Knowledge should be a resource of and for the people who create, hold, and share it. Consequently, the evaluation or research process can lead to significant negative or positive effects on the people involved in the evaluation/research. Knowledge and values are culturally, socially, and temporally contingent. Knowledge is also filtered through the knower.
6) There are multiple ways of knowing; some ways are privileged over others.

While acknowledging that some gender approaches do incorporate one or more feminist elements, key differences between feminist evaluation and gender approaches may be summed up as follows (source: betterevaluation.org):

Gender Approaches	Feminist Approaches
Identify the differences between women and men in different ways.	Explore why differences between women and men exist.
Do not challenge women's position in society, but rather map it, document and record it.	Challenge women's subordinate position; empirical results aim to strategically affect women's lives, as well as the lives of marginalized persons.
View women as a homogenous group, without distinguishing other factors such as race, income level, marriage status, or other factors that make a difference.	Acknowledge and value differences; do not consider women as a homogenous category.
Assume that equality of women and men is the end goal and design and value evaluations with this understanding.	Acknowledge that women may not want the same things as men and design and value evaluations accordingly.
Do not encourage an evaluator to reflect on her/his values or how their vision of the world influences their design and its findings	Emphasize that an evaluator needs to be reflexive and open, and recognize overtly that evaluations are not value free.
Interpret gender as "men" and "women".	Recognise other gender identities in addition to male and female
Collect gender-sensitive data	When collecting data, value different ways of knowing, seek to hear and represent different voices and provides a space for women or disempowered groups within the same contexts to be heard.

Annex 14: Recommendations from the Evaluation of Phase I and their uptake

Recommendations Evaluation Phase I	Implemented / Not implemented - with evaluators comment
Recommendation 1.UNFPA and UNICEF should pursue a second phase of the joint programme to sustain the existing positive momentum for change towards FGM/C abandonment. This second phase should entail a set of realistic overall objectives, outcomes and outputs.	**Yes**. A second and a third phase were pursued, capitalizing upon the momentum created by Phase I. Objectives were much more realistic than in Phase I, which was a considerable improvement. Still, given the resources of the programme in comparison with the intractability and magnitude of the practice, some goals can still be considered more aspirational than realistic.
Recommendation 2. UNFPA and UNICEF, in collaboration with their partners, should build on, and help to further strengthen existing government commitment and leadership, as well as central and decentralised government systems for FGM/C abandonment. They should maintain efforts to foster commitment within practicing communities by supporting the involvement of non-governmental change agents and opinion leaders at all levels.	**Partially**. The Joint Programme has strived to further strengthen existing government commitment, as reflected by the continuity of partnerships and selection of countries for Phase II and III. Also, the Joint Programme has been successful in engaging other change agents different from government, such as religious leaders, traditional leaders, communities or research institutions. However, other aspects remain a challenge. The support to decentralized government (resources to staff and system) has been limited in correspondence with the limitation of the resources of the Joint Programme and the impossibility to prioritize too many things within a limited budget. Mobilization of funds of others have also been limited in the direction of decentralized government. For similar reasons, the suggested support to actors in conducting evidence-based advocacy has been also limited. The sharing of relevant lessons learned from other countries continues to be limited and a challenge for the Joint Programme (a typical flaw for most programmes working at global and regional levels). Finally, the specific operational recommendation of assisting national partners to provide longer-term follow-up to promising achievements such as public declarations on FGM/C abandonment has not been fulfilled. The analysis contained in the present evaluation assesses in detail flaws regarding the conceptualization of said declarations themselves and other elements lacking around the milestone of public declarations, also giving a more relative value to their consideration as a success.
Recommendation 3. A second phase should maintain the catalytic nature of the joint programme. In selecting implementing partners, UNFPA and UNICEF should balance the benefits of working with established and larger organizations with the potential for innovation and diversification inherent in engaging with emerging or smaller actors.	**Partially**. The Joint Programme does maintain its catalytic nature, as recommended, even if there is ample room and need for a more concerted focus on its catalytic role ,given the magnitude of the challenge of eradication of FGM, which requires a significant collective effort. As for the selection of implementing partners, the Joint Programme is not closed to engaging emerging actors, but most partners tend to be well-established ones, something that s understandable given the limitation of resources, which leave little room for additional diversification.
Recommendation 4. UNFPA and UNICEF, in collaboration with national and regional level partners, should ensure operationalization and testing of all key aspects of the theory of change guiding their work on FGM/C, including assumptions on the role of cross-community and cross-border dynamics	**Marginally**. Even if the recommendation seems general on Theory of Change, in reality it focuses on cross-community and cross-border dynamics, as clarified through its operational development. These two aspects continue to be a pending challenge of the Joint Programme, being treated only at marginal level. The Joint Programme has not developed explicit and appropriately resourced strategies for operationalising cross-community and/or regional dimensions, as suggested by the Evaluation of Phase I.
Recommendation 5. UNFPA and UNICEF, in consultation with national	**Yes**. The joint programme has been successful both in reflecting and contributing to creating a global

governments in programme countries, should ensure that the holistic approach adopted by the joint programme is taken up and reflected by the FGM/C-related components in country programmes.	consensus on the need to use a holistic and culturally sensitive approach based on an understanding of the FGM/C practice as rooted in social norms. Also the design of Phase III is laying the foundations for a wider gender equity approach. The notion of a holistic approach also implies the need for simultaneous efforts for FGM/C abandonment at different levels, from multiple angles, and through multiple channels. UNICEF and UNFPA, in consultation with the respective national government, have ensured as much as possible that this consensus is integrated in, and reflected by the FGM/C related work of their country programmes in countries where FGM/C is being practiced, as recommended by the Evaluation of Phase I. In addition, UNFPA and UNICEF have continued –as recommended- to support national actors in creating and/or sustaining formal as well as informal mechanisms for coordinating their FGM/C-related work.
Recommendation 6. UNFPA and UNICEF should lobby existing or potential donors interested in contributing to FGM/C-abandonment work to commit to predictable, longer-term financing.	**Partially.** Whereas the Joint Programmes has lobbied for predictable long-term financing, the success has been limited. The negative effects of the annual budgeting cycle identified by Evaluation of Phase I, continues to be a challenge in the assessment of Phase II.
Recommendation 7. UNFPA and UNICEF should integrate the lessons learned from the first phase of the joint programme in relation to monitoring and reporting into the design and management of a potential second phase of the joint programme, and/or into FGM/C-related programmatic interventions within the work of each agency. This should include the development and consistent use of a limited set of clear, relevant, and specific indicators to measure and report on progress towards results.	**Partially**. The Evaluation of Phase I noted several areas for improvement in the systems and tools, capacities, and resources available for monitoring and reporting on progress towards results, as well as for capturing emerging lessons learned within and across countries. Despite efforts to improve said systems, the Joint Programme does not show a systematic follow up of results-based indicators – and the appropriateness and validity of indicators requires review. Lessons learned are in general not efficiently captured so as to be actionable across countries. There have been some specific efforts in some countries/regions of countries to include baselines, but these are not general.
Recommendation 8. UNFPA and UNICEF should further improve their coordination efforts as regards their work on FGM/C at global, regional and country levels.	**Partially**. As one of the pioneers of collaborative programming across UN agencies, the Joint Programme has made important progress in operationalizing "jointness" and has acquired valuable insight on the opportunities and challenges of various aspects of working together within the UN system and in the field. Still, there are important challenges that have not been overcome. At the global level, co-ordination between UNFPA and UNICEF is thematically strong, but the team is small relative to the management requirements of the expanded programme in Phase II. At the national level, coordination of the design and planning of country programmes varied by country and over time (see dedicated finding and table on this aspect in the present evaluation). Finally, in many countries, there is ambiguity around the roles and responsibilities between each agency at the regional and country level, with potential to hinder synergies.
Recommendation 9. UNFPA and UNICEF, in collaboration with other development partners, should engage and invest in more in-depth research on social norms change and its linkages to changes in individual and collective behaviours.	**Partially**. Despite some specific efforts in research, there are still considerable evidence gaps. In this context, the engagement with research partnerships and academia is insufficiently capitalized. The untapped collaboration with the Population Council can be notably improved.

Annex 15: Degrees of Co-ordination and the "Jointness" spectrum

The evaluation places 'jointness' at the right-hand side of the spectrum as a desirable goal.

	Co-operative	**Collaborative**	**Convergence**
Planning	Based on independent review of the progress of the implementing partners for each agency and overarching strategic priorities, each agency focal point develops plans which fit within agency priorities; these are shared and reviewed to assure there is not overlap or even contradictions in allocation of resources by geography and by implementing partner	Based on each agencies assessment of progress towards the Joint Programme objectives among their implementing partners and within their sectors of strength, a joint planning process identifies gaps and potential for added impact in their work with respective ministries and in assigned geographical areas which inform development of a shared plan which is then aligned with the resources and priorities of the two agencies.	Based on an iterative joint review and assessment process which considers the contributions of entities not directly funded by the Joint Programme, representatives of the key implementing partners, agency focal points for FGM and potential other relevant portfolios jointly identify gaps, existing and potential synergies, and existing strengths and investments of each agency to develop a cohesive plan including clear mechanisms to continue joint review and assessment.
Implementation	At the field level, parallel efforts with as-needed or midterm consultations on issues and gaps in implementation and guidance on outreach to national level entities. When sharing the same geographic area, consultations may be more frequent and may include topic specific inquires with implementing partners. At the policy level, support for advocacy and capacity building with their respective mainline ministries which reference to Joint Programme activities of relevance to that ministry. Reliance on ministries to communicate needs and plans	At the field level, established guidelines and processes to allow for regular consultation on shared partnerships and thematic areas as well as joint capacity building and monitoring efforts which emphasize the linkages among different intervention components and reinforce roadmaps for response and standards of practice whether or not working in the same geographic area. At the policy level, shared advocacy with all relevant ministries and support for integrated capacity building efforts to foster the operational elements of an intersectoral approach.	At the field level working in same geographical area, in a structured approach linking neighbouring areas; or in a planned campaign engaging subnational and national levels to coordinate service delivery with dedicated attention to linkages which foster synergies and supporting formal referral mechanisms and cross-learning among implementing partners of both agencies. This can also involve joint capacity building efforts by the regional offices of both agencies. At the policy level, leveraging capacity building efforts and support for development of policy documents and guidelines for practice to build relationships and operational linkages among both agencies, the Joint Programme focal points, all relevant implementing partners (national and subnational levels where possible), and regional technical supports.
Monitoring	Each agency is responsible for monitoring and evaluating the performance of their respective	Separate monitoring by each agency of progress of individual implementing partners and	Joint monitoring including joint visits or joint planning and follow up for agency-specific

	implementing partners based on the criteria and evaluation tools of their agency. A joint review process identifies the importance of the individual implementing partners work to the overall Joint Programme objectives and this is combined into a joint report which can inform future planning process.	towards the common framework using a shared evaluation tool and measurements. This can then inform the subsequent planning process.	visits (given logistics) based on shared tool developed with implementing partners, with clear guidance on how to integrate the results within the systems of each of the two agencies.
Roles and responsibilities	The roles, responsibility and reporting of key focal points, country representatives, management and technical staff within implementing partners, and other stakeholders reflect the needs of their agency. Coordination is carried out thru reporting systems.	The responsibility of focal points, country representatives, implementing partner staff and other agency staff responsible for e.g. disbursement or procurement including indication of their role and percent time dedicated to the Joint Programme and related work and capacity to manage shared monitoring systems is spread across all actors	The roles, responsibilities, expected capacities, and criteria for performance as linked to the Joint Programme are clear in institutional plans and monitoring systems as well as job descriptions. The value added and overall performance of individuals as it relates to the Joint Programme outcomes is publicly accessible.

Annex 16: Improved awareness at community level

Improved awareness at the community level predominantly relates to three critical aspects that are, in turn, associated with behaviour change: a) awareness of the causality link between the FGM practice and the frequent medical complications including deaths, b) awareness of the fact that religious texts do not approve FGM, and c) awareness that the laws punish FGM in those countries where the legal framework exists. However, the level of awareness and the weight of each of these factors in relation to behaviour change varies from community to community and also within communities.

a) In Egypt, for example, the evaluation finds a practically universal consensus[37] on general awareness on FGM harmful health consequences and on lack of religious prescription of FGM.
b) In Kenya, the evaluation confirms that there is no question that 'breaking the silence', de-mystification, use of scientifically correct and concrete vocabulary, demonstration of clear links to sequelae have acquired a level of momentum such that they cannot 'turn back the clock'. Even the strong resistance with which security forces met in early efforts to enforce the law (in Narok and Garissa) has not reoccurred as the programme has supported alternative sources of influence and monitoring (teacher, health workers).
c) In Senegal[38], progress has been made in raising awareness among communities about the health risks and consequences of FGM.
d) In Sudan, consulted stakeholders inside and outside of the Government of Sudan widely agree that collaboration and partnerships among key actors in the country have been strengthened and overall awareness of and efforts to mainstream FGM/C abandonment work across government agencies have increased.
e) In Ethiopia[39], awareness of FGM has increased at community level in Join Programme intervention areas. The consultations made with different kinds of stakeholders both in Afar and SNNPR indicate strong and general awareness at community level in the Joint Programme areas about the harmful effects of FGM. This is a significant achievement given the very low baseline in many communities, where even traditional birth attendants (TBAs) in constant contact with the girls, would not make the causal connection between FGM and medical complications, not to speak about men, for whom in many cases FGM was just a name that they could not connect with a practice they would not be able to visualize in realistic terms even if it happens in their own communities for time immemorial.

[37] All interviewed programme participants of the Joint Program interviewed and triangulation with NGOs working in the field.

[38] Interviews with community members who have abandoned FGM and who participated in FGDs could easily identify the health risks and consequences of FGM triangulated with document review, e.g. EDS data shows that the vast majority of men (80.3%) and women (78%) in Senegal agree that FGM practices should be abandoned. (2016 Annual Report: p.12) or information related to TV media campaigns.

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

Annex 17: Performance matrix, contribution analysis, and qualitative comparative analysis

Result Progress Tracker to synthesise progress in each country to the Joint Programme Key Performance Indicators (Source: Joint Programme monitoring data)

Result area	Level of progress for each country case study (units defined by row)																
	Bur	Dji	Egy	Eri	Eth	Gam	Gui	Gui-B	Ken	Mali	Mau	Nig	Sen	Som	Sud	Uga	Yem
Number of communities in programme areas having made public declarations of abandonment of FGM[40]	1,326	102	30	291	851	242	2,093	149	31	353	345	1,103	723	890	329	105	
Number of girls and women receiving services related to FGM/C prevention or response[41]	580,886	67,478	113,828	193,325	771,253	2,351	437,150	12,498	5,074	711,942	197,89	150,807	126,640	5,687	71,466	2,868	1,426
Number of countries with a budget line to implement legislation and policies to eliminate FGM[42]	1	1	1	1	1	0	1	0	1	1	1	1	1	0	1	1	0
Number of countries implementing a comprehensive legal and policy framework to address FGM[43]	1	1	1	1	1	1	1	1	1	0	1	1	1	0	0	1	0
Number of arrests[44]	178	2	1	278	280	5	34	16	33	0	0	0	3	0	1	10	
Number of cases brought to court	151	2	7	176	77	2	29	7	174	0	1	0	3	0	0	10	

[40] Outcome 3, indicator 1
[41] Outcome 2, indicator 1
[42] Outcome 1, indicator 2
[43] Outcome 1, indicator 1
[44] Outcome 1, Output 1.2 indicator subgroup b (number of arrests, number of cases brought to court, number of convictions and sanctions, convictions/ arrests, convictions/ cases)

Number of convictions and sanctions	109	2	8	58	2	2	24	0	90	0	0	0	3	0	0	3	
Convictions/arrests	61%	100 %	800 %	21%	1%	40%	71%	0%	273 %				100 %		0%	30%	
Convictions/cases	72%	100 %	114 %	33%	3%	100 %	83%	0%	52%		0%		100 %			30%	
Estimated affected population by % – girls and women cut[45]	76%	93%	87%	83%	65%	75%	97%	45%	21%	83%	67%	18%	23%	98%	87%	0%	19%
Estimated affected population – girls at risk (million)[46]	957		7,143		6286	319	1,749	162	813	3,857	632	14,808	699	2,174	4,474		1,897
Proportion of Joint Programme budget (%)	8%	5%	7%	5%	6%	4%	5%	4%	11%	4%	4%	5%	11%	7%	8%	6%	1%

[45] FGM prevalence among girls and women aged 15 to 49 years, https://data.unicef.org/resources/dataset/fgm/

[46] Data provided by UNFPA based on estimates for girls at risk in 2030

Qualitative comparative analysis (crisp set – binary predictive analysis)

A qualitative comparative analysis was undertaken to assess the attributes, or configurations of attributes, most associated with outcomes across all of the country cases.

Outcomes were defined in terms of a substantive reduction in prevalence of FGM among the age 15-19 cohort (more than 5 percentage points), estimated from the Phase II performance analysis. Countries without outcome data (Djibouti, Somalia, Yemen) were therefore excluded from the analysis.

The attributes taken into account were:

- Number of community declarations
- Number women and girls accessing services
- Presence of FGM budget line
- Presence of FGM policy
- Number of arrests
- Number of cases brought
- Number of convictions
- Arrest-conviction ratio
- Case-conviction ration
- Percentage of women and girls cut
- Size of population at risk
- Programme budget per girl at risk

Performance matrix converted to crisp-set QCA

Threshold for positive[47]	300	10000	Yes	Yes	100	50	10	50%	50%	50%	Above mean	Above 5 percentage points reduction	Above mean per girl
	Community declarations	Women Services	Budget line	Policy	Arrests	Cases	Convictions	Convictions /arrests	Convictions /cases	Women cut	Girls at risk	Change prevalence15-19	Prog Budget
Bur	1	1	1	1	1	1	1	1	1	1	0	1	1
Dji	0	1	1	1	0	0	0	1	1	1			
Egy	0	1	1	1	0	0	0	1	1	1	1	1	0
Eri	0	1	1	1	1	1	1	0	0	1		1	
Eth	1	1	1	1	1	1	0	0	0	1	1	1	0
Gam	0	0	0	1	0	0	0	0	1	1	0	0	1
Gui	1	1	1	1	0	0	1	1	1	1	0	0	1
Gui-B	0	1	0	1	0	0	0	0	0	0	0	0	1
Ken	0	0	1	1	0	1	1	1	1	0	0	0	1
Mali	1	1	1	0	0	0	0			1	1	0	0
Mau	1	1	1	1	0	0	0		0	1	0	0	1
Nig	1	1	1	1	0	0	0			0	1	0	0
Sen	1	1	1	1	0	0	0	1	1	0	0	0	1
Som	1	0	0	0	0	0	0			1	0		1
Sud	1	1	1	0	0	0	0	0		1	1	0	0
Uga	0	0	1	1	0	0	0	0	0	0	0	1	
Yem	0	0	0	0	0	0	0	0	0	0			0

[47] Each attribute had a threshold set to establish a binary set of presence or absence of that attribute

QCA Analysis Table - confidence that assumptions hold true in each case study?

Assumption	Eth	Ken	Sen	Egy	Gui	GuB	Sud	Bur	Gam	Uga	Som	Eri	Mal	Mau	Nig	Dji
1.1 Alignment with global, national, subnational priorities	H	H	H	H	H	H	H	H	H	H	H	M	H	H	H	H
1.2 Approach based on comparative advantage	M	H	H	M	H	H	H	H	H	H	H	M	H	H	H	H
1.3 Programme design is evidence-based	M	H	H	M	H	M	H	H	H	H	H	M	H	H	H	M
2.1 Policy and legal framework for FGM appropriately resourced and limited	M	H	H	H	H	H	H	H	H	H	H	H	H	M	M	M
2.2 Service delivery in FGM timely and well resourced	M	M	H	M	H	M	M	M	M	M	M	M	M	M	M	M
2.3 Community norm change	M	M	H	M	M	M	M	H	L	M	M	M	M	M	M	M
3.1 Management arrangements effective	M	H	H	M	H	H	H	H	H	M	M	H	H	M	H	H
3.2 Partnerships leveraged	M	H	H	M	H	M	H	H	H	M	M	M	M	M	M	M
3.3 Catalyst for emerging actors	H	M	M	M	M	L	H	M	M	M	L	L	L	M	M	M
3.4 FGM Profile raised	H	H	M	H	M	M	H	H	L	H	M	M	L	L	L	L
4.1 Financial systems and structures efficient	H	M	H	M	M	M	M	M	M	M	L		L	L	L	L
4.2 Oversight provides effective implementation	M	H	N/A	M	N/A	N/A	N/A	H	N/A	H	N/A	M	N/A	N/A	N/A	N/A
4.3 M&E is adequate	M	M	L	M	L	L	L	M	L	M	L	L	L	L	L	L
5.1 National ownership and institutional capacity	H	H	H	L	H	H	M	H	H	H	M	H	M	M	M	M
5.2 Community norms sustained	M	M	M	M	L	L	L	H	L	M	L	M	L	L	L	L
5.3 Global profile and donor funding	H	H	M	M	L	L	M	H	L	M	L	L	L	L	L	L

Analysis

The QCA tested for necessary and sufficient attributes and configurations of attributes. It found no necessary attributes – i.e. things that must be either present or absent for outcomes to be achieved.

It did find sufficient attributes – i.e. things associated with outcomes being achieved. The best predictor of outcomes being achieved is a high number of arrests relating to FGM. The second-best predictor is the combination of a high number of arrests and the presence of an FGM policy. The third-best predictor is the combination of arrests, policy, and the presence of a dedicated budget line for FGM. All of these configurations had an overall accuracy of 88 per cent (ration of true and false positives and negatives), and covered the majority of cases (60 per cent) with overall consistency of 100 percent (i.e. accurately predicting positives and negatives in all cases covered). The presence of a budget line or a policy may also be sufficient but not necessary without having arrests, but there was much lower accuracy with these predictors.

The size of the Joint Programme budget per girl at risk was found to be a less accurate predictor of outcomes than simple chance. This suggests that the level of investment of the programme per girl child at risk is not a factor in achieving outcomes (i.e. the strategy of creating an enabling environment is the main contributing factor). This may be because higher levels of budget are associated with services. High numbers of women and girls access services was not necessary nor sufficient to explain outcomes; but was a better predictor than pure chance (albeit with low levels of accuracy). This suggests that the effectiveness of services is influenced by the context of individual cases. Configurations of policy, national budget-line, and services (i.e. without arrests) were not necessary nor sufficient. However, they did represent an accuracy of 65 per cent covering 80 per cent of cases: a better predictor than chance alone.

Importantly for the theory of change of the programme, a high number of community declarations of abandonment was a less accurate predictor of outcomes than pure chance. Overall, high numbers of community declarations were associated with reduced levels of accuracy and coverage of other configurations of attributes that were sufficient to explain outcomes. This analysis suggests that community declarations are an inaccurate proxy indicator for outcomes – although a limitation of this analysis is that the assessment does not take into account whether cases are at different stages in the process of elimination. The most accurate proxy for outcomes is thus the number of arrests: which was a much stronger predictor than even the ratio of arrests to convictions or cases to convictions. A qualitative explanation of this is that arrests may be representative of policing of FGM laws – indicating applied social rejection of the practice and the threat of consequences – whilst convictions may be affected by poor capacity of the legal system.

A further crisp set QCA was undertaken based on the case study and extended desk reviews testing of each assumption in the evaluation matrix. Two versions of the of the QCA were run with different sensitivities: one based on high levels of evidence being found to support the assumption, the second based on medium levels of evidence being found to support the assumption. With a high threshold of evidence, the assumption most strongly correlated with achieving outcomes is the presence of national ownership (assumption 5.1). Beyond this

attribute, the cases found a configuration of high numbers of women and girls accessing services combined with low quality of services (assumption 2.2) was associated with strong outcomes. A further associated attribute, although in fewer cases, was the observed absence of sustained change in community norms.

Beyond these configurations, there were found to be a number of attributes with mild positive associations with outcomes. These included programme alignment with global and national priorities (assumption 1.1), a resourced policy and legal framework (assumption 2.1), effective programme management (assumption 3.1), and enhanced profile of FGM as an issue both nationally and internationally (assumptions 3.4 and 5.3). There were also found to be attributes that where absence was associated with strong outcomes. These nearly all relate to the programme, including adequate M&E (assumption 4.3), an approach based on comparative advantage (assumption 1.2), design based on evidence (assumption 1.3), community norm change (assumption 2.3), partnerships (assumption 3.2), oversight (assumption 4.3), catalysing actors (assumption 3.3), and operational effectiveness (assumption 4.1).

Adjusting the QCA to a medium threshold for evidence finds that these negative associations disappear, and the best predictor of outcomes becomes effective programme oversight (assumption 4.3) – being present in 83 per cent of cases with 94 per cent accuracy. At this threshold, the second best predictor is the improved profile of FGM as an issue at country level (assumption 3.4), with third-level predictors being any of: programme alignment with global and national priorities (assumption 1.1), an approach based on comparative advantage (assumption 1.2), design based on evidence (assumption 1.3), a resourced policy and legal framework (assumption 2.1), timely service delivery (assumption 2.2), community norm changes (assumption 2.3), and effective programme management (assumption 3.1). In combination, these analyses suggest that achieving medium levels of progress along the programme theories of change can be effectively driven by programme oversight and management; but achieving high levels of progress along outcome pathways is primarily dependent on the wider context.

In summary: enforcement of the law is the best predictor of outcomes, policies and budget are universally important contributions to outcomes, services seem to depend on the context of each case, community declarations are a worse proxy for outcomes than pure chance, and programme strategy is more important than budget invested per girl at risk. The programme theories of change relating to programme oversight, management and design are associated to an intermediate degree with achieving outcomes; while wider contextual drivers – especially national ownership – are strongly associated with outcomes.

Annex 18: Continuum of Gender Responsive Approaches in Programming to End FGM[48]

Gender responsive programs raise awareness and focus attention on gender inequalities and the impact which they have on the outcomes of interest: they appreciate that the problem they are addressing is caused by and is a contextually specific manifestation of overall gender-based discrimination. They recognize that these broader gender inequalities and associated patterns of discrimination and even violence will make it very difficult to address the problem effectively—either to foster real change (as opposed to the problem being hidden by changing slightly the nature of or renaming the discriminatory or harmful behavior or practice) or to sustain change (i.e. avoiding a relapse of the problem resulting from resistance or pushback against change which can also cause even greater harm).

Gender responsive programs articulate the ways in which the problem and overall gender-based discrimination and resulting inequalities are integrally connected and mutually reinforcing. The programs are purposefully designed to simultaneously address the problem and change the overarching patterns and practices of gender-based discrimination and violence which created and sustain it. Most importantly they actively involve girls and women in identifying and addressing both the problem and the underlying and related discrimination to strengthen their agency and empower them to take action.

This is reflected in the assessment process (i.e. asking questions revealing the linkages between the problem and broader gender-based discrimination); the design and selection of intervention areas (i.e. reaching those in greatest need and those with greatest influence to change patterns of gender-based discrimination as well as address the problem of concern); and monitoring and evaluation (i.e. tracking process and impact to measure changes in both the problem and broader patterns of gender-based discrimination – also anticipating unintended effects of intervention—both helpful and hurtful thus increasing inequalities).

The table below outlines a continuum of gender responsiveness in programming ranging from gender-negative interventions which may not solve the problem and will worsen inequalities to gender transformative which explicitly addresses fundamental gender inequalities as both means to an end (solving the problem). Any level of the spectrum may describe a program or the whole continuum may describe a program's progress as it works to become more gender responsive (including fundamental shifts in approach and intentional efforts to mitigate the negative impact of earlier non-responsive approaches).

The table offers examples to illustrate how each level might be manifest in FGM programming. It also offers suggestions for how the Joint Programme can increase its own gender responsiveness (and that of its IPs).

[48] Adapted from GENDER RESPONSIVE COMMUNICATION FOR DEVELOPMENT: GUIDANCE, TOOLS AND RESOURCES, UNICEF Regional Office for South Asia, May 2018. Additional Resources include Gender Mainstreaming Manual for Health Managers: A Practical Approach, (2011). World Health Organization: Geneva.
Integrating Gender into HIV/AIDS Programmes in the Health Sector: Tool to Improve Responsiveness to Women's Needs (2009). World Health Organization: Geneva.

These are predicated on the assumption that the current limitations on technical and financial gender-relevant remain in Phase 3. Given such limitations, the Joint Programme's gender responsive work should prioritize.

1. eliminating or fundamentally altering programming producing gender negative impact including mitigation of problems created or worsened by past programming
2. identifying and articulating the "gender relevant" pathways in the Joint Programme TOC and strategic frameworks to counteract the effects of "gender blindness" in interventions informed by rigorous gender assessments and analysis
3. raising the gender awareness of all staff, IPs and technical advisors through compulsory and iterative capacity building for staff and IPs, explicit selection and evaluation criteria for IPs and selection and performance criteria for staff)
4. strengthening capacity and providing adequate support for rigorous gender assessments and analysis to inform design and evaluation including as an example the evaluation of Phase 2s nascent gender responsive programming initiatives
5. in partnership with the full range of current global efforts and sharing their unique depth and breadth of expertise on FGM, helping to foster and support a global "reality check' and re-envisioning of the most effective strategies for addressing FGM and other harmful practices, which re-articulate identified "drivers" of practice and of change based on an understanding of gender-based discrimination, inequality, and patriarchy and championing the power and sustainability of a gender transformative approach.

Level of Gender Responsiveness	How the level addresses gender in the design, structure, selection of intervention areas and population, communications and messaging, and monitoring and evaluation of impact	Illustrative examples from programming to address FGM which reflect this level of gender responsiveness and effect of this approach whether intentional or due to lack of attention to impact	Considerations for Joint Programme programming to mitigate, reverse, or enhance Joint Programme contributions towards a more gender transformative approach (illustrative examples only).
Gender Negative	• Perpetuates gender inequality by reinforcing unbalanced norms, roles and relations • Privileges men over women (or vice versa) • Often leads to one sex enjoying more rights or opportunities than the other	Boys and men are "engaged" to address FGM through protecting girls at risk of FGM by serving as guards or chaperones which accompany girls at all times; assuring that girls are kept indoors and safe at all times ie not working in fields or getting water and not attending school or public functions. This may keep girls from being cut but does not involve them in the solution, severely restricts their agency, and actually takes away freedoms which they had previously enjoyed.	The Joint Programme has demonstrated the power of working with religious authorities to end the practice of FGM leveraging authorities' concern with protecting girls and women from harm. This work has not prioritized messaging on gender and agency and has relied heavily on work with existing power structures in key religious communities which are almost entirely men—including men who lack the practical and life experiences which would enable them to understand the centrality of gender and sexuality as drivers of FGM. The Joint Programme needs

			to carefully reassess how gender-relevant messages are developed, monitored and held to account as they filter through these structures and to build on internally and externally initiated efforts to strengthen a gender responsive, critical thinking, and broader participatory approach within these structures (e.g. the Ethiopian Orthodox Church Development Bible, the work of the Norwegian Church in several countries) in the interest of addressing FGM.
Gender Blind	• Ignores gender norms, roles and relations • Very often reinforces gender-based discrimination • Ignores differences in opportunities and resource allocations for women and men • Often constructed based on the principle of being "fair" by treating everyone the same	School-based programs in which boys and girls learn together about FGM (negative impacts on health, who does it, the need to "stop" it) and then develop a joint advocacy plan to go together to the community to educate household heads. This engages girls and boys equally but fails to recognize that girls will be "viewed" differently than boys in the campaign and may be challenged or at risk of violence for resisting unless additional support is provided.	The Joint Programme has advanced significantly in its work with girls and with youth overall: this includes support for existing programming with very strong gender and rights messaging (see KMG in SNNPR Ethiopia) and inclusion of boys as supporting members in what has been girls clubs (see also SNNPR Ethiopia). Leveraging the technical strengths of the two coordinating agencies, these FGM-focused efforts could be contextualized in broader gender and sexuality education programs which help girls and boys to appreciate the strengths and agency of each while acknowledging the difference in each of their life experiences and how the community may view their efforts to foster change. (reference Its All One Curriculum)
Gender Sensitive	• Considers gender norms, roles and relations • Does not address inequality generated by unequal norms, roles or relations • Indicates gender awareness, although often no remedial action is developed	Community dialogues and education campaigns focus on the central role of older women and/or women's traditional care providers (midwives) in the actual cutting and identify mother's as the decision-makers for cutting within the family, and engage the community in trying to hold both accountable for breaking the law and not adhering to the	The Joint Programme concern with strengthening the enforcement of laws prohibiting FGM at the community level has not given sufficient consideration to the unintended effects of a largely punitive approach implemented by a weak security and judicial sector with limited understanding of the operational aspects of "human rights" underpinning

		new norm. This approach does consider the differential role of women but fails to address how and why men have fostered and sustained the practice, how it has and continues to serve their self-defined interests (in managing female sexual activity and fertility or changing women's bodies to meet their sexual preferences) and how women cutters and mothers are not just responding to social norms but unable to identify or assert their own interests and choices due to gender norms. This approach shifts all blame and responsibility to women, allows men to avoid being held accountable for the active role of their gender (if not as an individual), fails the address the fundamental reasons which continue to sustain the practice, and harms women.	the global and national level policy decrees on FGM. With laws in place in nearly every country within the Joint Programme and national coordination mechanisms in place in the majority, resources should be invested not in "getting one more country" but rather capacity building on human rights and the FGM law at ALL levels of the system, through key entry points (eg academies, professional evaluations and certifications), and in a sustained manner that provides clear human-rights-based guidance on handling the multiplicity of examples of hard choices, lack of accountability, blame and impunity which characterize much of the "resistance" to implementation of the law. This includes blaming cutters (including the implicit blame of prioritizing alternative income sources for them), placing responsibility for the "practice" on women ("the blame game" is how government and INGO IPs described it in Kenya), and holding accountable the individual parents, families and even girls being cut for the decision to do so. It also involves engagement with human rights mechanisms such as ombudsmen and HRCs to strengthen the linkages between law and policy.
Gender Specific	• Considers gender norms, roles and relations for women and men and how they affect access to and control over resources • Considers women's and men's specific needs • Intentionally targets and benefits a specific group of women or men to achieve certain policy or	On the basis of a deep gender analysis in the programme and planning phase, an advocacy program for youth involvement makes accommodations to be sure that girls are able to participate equally, effectively and safely. As girls may not have equal access to communications media the program adapts to improve girls' access, provide common media centers where girls can safely and confidentially listen	The Joint Programme has implicitly and explicitly supported "rescue" efforts in which girls at risk are encouraged to leave the family and even community threatening to have them cut. This approach has been the focus of significant debate between those working within a child protection approach (which cautions against removing children from their families) and the "agency" advocates who

	programme goals or meet certain needs • Makes it easier for women and men to fulfil duties that are ascribed to them based on their gender roles	to or view media messages and provide feedback through text messages or email. This could mean free text messages to girls or a dedicated call in line for girls with a female responder. This approach compensates for girls' greater needs and restrictions, but it does so in a way which strengthens girls agency, access and opportunities rather than limits their participation in an effort to "protect" them.	encourage girls to take action themselves. In Kenya, the evaluation heard first hand from many girls, about the truly painful implications of making a choice to leave family and community and the despair arising when this choice resulted in their exclusion from school (based either on parents punishment or on lack of sources of support to continue their education). Education was clearly the only viable "pathway out" of their predicament, key to maintaining their conviction to remain uncut (some girls agreed to be cut in order to regain access to schooling). For a limited period of time the Swedish government funded scholarships to help girls make these choices but that had ended. As the Joint Programme works to "empower girls to make their own choices" it is accountability to being sure they can make those choices without additional harm and thus programs like scholarship efforts need to be restarted.
Gender Transformative	• Considers gender norms, roles and relations for women and men and that these affect access to and control over resources • Considers women's and men's specific needs • Addresses the causes of gender-based health [and other] inequities • Includes ways to transform harmful gender norms, roles and relations • The objective is often to promote gender equality • Includes strategies to foster progressive changes in power	A school-based programme which engages young people and their parents and educates on the harm of the practice, unpacks and challenges the justifications for the practice including local contextual differences, considers the experience and special concerns of girls within this dialogue and combines this with critical thinking skills to help student recognize the explicit and implicit manifestations of gender discrimination; builds capacity among adolescent girls and boys to develop self -efficacy, decision-making, and negotiating and communication skills; and provides guidance and identifies safe powerbrokers to whom they can report on	The coordinating agencies of the Joint Programme offer substantial experience on working across sectors to address both the surface manifestations and the fundamental gender-power drivers of FGM: this is part of UNICEF's VAC work and UNFPA's Essential Services and GBV work. Although the financial resources to sustain this are limited, the inclusion of the Joint Programme in the Spotlight initiative provides an opportunity to test the "holistic response" approach. Given longstanding concern with avoiding overlap among programming countries, there is risk that the Joint Programme's involvement in Spotlight will not be leveraged for important

	relationships between men and women	the practice and other discrimination (including “pushback”) when it occurs. Such an effort, engages girls, boys, women and men to address the problem, its root causes, their role in perpetuating it and strengthens agency, practical skills to address power structures and negotiate within relationships fostering profound, organic, and sustainable change.	change in approach. The Joint Programme at Headquarters level needs to be assertive and transparent in sharing with all levels of the programme the opportunities which this partnership represents for a gender transformative approach.

Annex 19: Public declarations and social norms

Background

The Joint Programme has undoubtedly made important progress since Phase I in understanding the central role of social norms related to public declarations. The text below[49] is intended to provide further precisions about the understanding of their complexity and of their interaction with private behaviour and strategic implications.

It is important to clarify that *public social change* and *private/individual change* are two aspects that are related –a public/social change opens the possibility for a private change and sometimes a private change generates what becomes a public/social change– but are not the same thing. In this context, these public declarations do not necessarily mean an automatic abandonment of the FGM/C practice in *private* (see below), even if they are extremely important, first of all, in their own capacity as both manifestations and creators of a change of paradigm in the *public social norm* or, in other words: they show that what is *sociably* acceptable in a community has changed or is changing.

In addition, the gradual change of the social norm from "general appreciation of FGM/C" to "general condemnation of FGM/C" has important implications at *private* level. Two of the most important implications affecting the *private level* are the *change in the social norm paradigm* and, accordingly, the *needed change in strategic focus*:

The change in the social norm paradigm

After general awareness is achieved in a community and a social norm condemning FGM/C by the majority is accepted, a new and different social norm paradigm starts in that community –regardless of the precise number of *private* abandonments of FGM/C. This change of paradigm is characterized by substantial changes both in *empirical expectations* and in *normative expectations*. Empirical expectations can be defined as expectations on how other people will behave in a specific situation, whereas normative expectations are those related to what other people think one should do in a specific situation[50]. In this context, some of the main changes in private behaviour are[51]:

(a) A part of the community continues FGM/C practice despite being aware of the disadvantages of FGM/C, which makes an awareness focus no longer a priority or an insufficient strategy for this sub-group. If this sub-group constitutes a minority[52], they can also be presumed to be, by definition, different from the majority and with specific characteristics that need to be considered in any effective strategy. To effectively challenge behaviours that are against the new social norm of the community, two specific elements need to be

[49] For further information, please contact Rafael Eguigueron

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

[51] Observed through abundant interviews in different intervention areas in Ethiopia and Egypt, the two most populated countries in the Joint Programme, both with very high prevalence. This is probably also true in the rest of intervention areas where this specific question was not asked.

[52] Practically all interviewees in intervention areas in Egypt and Ethiopia declare that the persons that continue to practice FGM/C despite a Public Declaration constitute a minority.

understood: (i) the specific reasons that drive that behaviour in those specific individuals, who assess reality in ways that are different from the rest of the community, and (ii) the social profile of that group as to understand the most effective way of exerting either influence or pressure given that specific profile.

(b) The practice of FGM/C shifts from being visible and public to being underground and invisible, which constitutes a radical change of paradigm both from a social point of view (a phenomenon that is not easily observable and is banned is socially transmitted in a different way) and from a strategic point of view (see below). This characteristic has also implications in higher difficulties for monitoring.

(c) The profile of the target groups to be addressed after the change is extremely heterogeneous. Whereas a general level of heterogeneity of FGM/C is already widely known among FGM/C experts, for example distinguishing the diversity of practice in different countries and even in different regions within the same country, there is an additional level of heterogeneity that is still underestimated, with communities that are separated by only a few kilometres presenting different profiles and requiring differentiated strategies so as to achieve effective results and even different sub-groups within the same community presenting different profiles (see more specifically about heterogeneity under Finding 16: "The extreme heterogeneity of FGM demands a more precise and specific understanding of the FGM causality model, focusing on mechanisms and contexts than the Joint Programme currently promotes").

(d) The change of paradigm, sometimes combined with a strengthening in the enforcement of the legal framework, may cause in turn **additional social changes which further compound the levels of heterogeneity**. Some significant examples are:

(i) Change of age to undergo FGM/C. This kind of change is also heterogeneous in its grade and form, even within the same country, so it needs to be the object of research to be precisely understood. In the absence of dedicated research covering the different countries, it has been observed by the evaluation[53] that the prosecution of FGM/C also implies incentives to carry out FGM/C at earlier ages e.g. immediately after birth or seven days after birth[54], which makes the practice more discreet and difficult to detect, given that older girls could protest, report the illegal practice or be missed during the period of recovery raising suspicion and unwanted questions. In other occasions[55] the FGM/C is performed two days after the wedding so that the husband can have direct control on the process.

(ii) Change of status in circumcisers. In some communities circumcisers did not receive direct payment at the time when the practice was common. However, with the change of social norm and associated prosecution, they get substantial payments, as the practice implies important punishments.

(iii) Change of protection needs for girls. The creation of a law environment that encourages reporting of FGM/C cases opens new possibilities for the girls

[53] Observed through abundant interviews in different intervention areas in Ethiopia and Egypt, the two most populated countries in the Joint Programme, both with very high prevalence. In the absence of hard research on the subject covering the different countries, nd based on the logic of the new incentives, it would be fair to assume a similar pattern in most intervention areas where Public Declarations and higher law enforcement have taken place.

[54] Specific ages coming from interviews and medical records in Afar, Ethiopia. General pattern observed also in Egypt.

[55] Specific ages coming from interviews in SNNPR, Ethiopia. General pattern observed also in Egypt.

that are not necessarily accompanied by parallel protection measures for those girls who decide to report.

Addressing this level of heterogeneity and behaviour changes requires disentangling the personal, social, economic, and cultural factors that support them and assessing their relative weights in sustaining these practices[56].

The needed change in strategic focus

In this new situation and paradigm, strategic interventions to encourage private/individual abandonment so as to achieve full eradication, should not be focused any more on awareness, but on more specific and nuanced strategies beyond awareness, which need to also take into account that the public social norm has changed. At the present moment there is an absence of sufficiently detailed data and evidence so as to be able to work effectively in the last phases of FGM/C full eradication in each community (see further development under Sustainability, Finding 47. "Despite strong engagement from community follow-up committees, the Joint Programme lacks strategies and tools to support continued behaviour change once communities pass public declarations".)

[56] Bicchieri, Cristina. The grammar of society: the nature and dynamics of social norms. Cambridge University Press. 2006.

Annex 20: Data limitations and implications

Data limitations and implications for this evaluation, the work of the Joint Programme, and accelerating efforts to end FGM

The evidence needed to accurately assess progress on ending FGM at national and subnational levels and, specifically, the contributions of the Joint Programme and its partners to such progress ending FGM, is hampered by multiple challenges. These include:

1) empirical issues intrinsic to "measuring" the procedures, outcomes, and impact of FGM—a practice involving areas of the body often shrouded in shame and secrecy

2) statistical limitations of current data sources – primarily population-based surveys – which cannot be disaggregated to a subnational level to demonstrate association, much less causality, with programme interventions

3) lack of historical and current intervention-linked data which can distinguish between changes in practice resulting from secular trends and those attributable to the intentional interventions of Joint Programme partners to foster normative change resulting in a shift in practice

4) insufficient investment in rigorous and systematic data collection, analysis, and application using appropriate, demonstrably reliable and valid methods and tools in intervention-based and operational research which would tie outcomes and impact to programme investment as discussed further in finding 5

5) limited focus given to establishing common standards/guidelines and extracting, aggregating and analysing the substantial existing or common knowledge of Joint Programme partners, participants and beneficiaries

6) the need to strengthen the ability of all stakeholders to leverage the findings and expertise of past and current global and local research efforts.