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The Norwegian International Effort Against Female Genital Mutilation



Norad

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List of Abbreviations

ACTION PLAN	The Norwegian Government's International Action Plan for Combating Female Genital Mutilation
ADAA	African Development Aid Association
APDA	Afar Pastoralist Development Association
CCT	Church Council of Tanzania
COVAW	Coalition on Violence Against Women
DHS	Demographic Health Survey
EECMY	Ethiopian Evangelical Church Mekane Yesus
EGLDAM	Ye Ethiopia Goji Limadawi Dirgitoch Aswogaj Mahiber
EOC/DICAC	Ethiopian Orthodox Church Development Association and Interchurch Aid Commission
ErOC	Eritrean Orthodox Church
EWLA	Ethiopian Women Lawyers Association
FemAct	Feminist Activist Coalition
FGM	Female genital mutilation
FOKUS	Forum for Women and Development
GBS	General Budget Support
GDP	Gross Domestic Product
GECPD	Galkayo Education Center for Peace and Development
HANAQAAD	Hanaqaad Women's Umbrella Association
HDI	Human Development Index
HTP	Harmful traditional practices
IAC	Inter-African Committee
INGO	International non-governmental organisation
KMG	Kembatta Women Self Help Centre
LHRC	Legal and Human Rights Centre
MED	Maasai Education Discovery
MFA	Norwegian Ministry of Foreign Affairs
MICS	Multiple indicator cluster surveys
MoH	Ministry of Health
MOWA	Ministry of Women's Affairs
NCA	Norwegian Church Aid
NPA	Norwegian People's Aid
NCTPE	National Committee on Traditional Practices of Ethiopia
NGO	Non-governmental organisation
NMS	Norwegian Missionary Society
NLM	Norwegian Lutheran Mission
Norad	The Norwegian Agency for Development Cooperation
NUEW	National Union of Eritrean Women
OWDA	Ogaden Welfare Development Association
PMC	Population Media Centre
PADET	Professional Alliance for Development in Ethiopia
SCN	Save the Children Norway
SCN-E	Save the Children Norway - Ethiopia
SNCTP	Sudan National Committee on Traditional Practices
TAMWA	Tanzania Media Women's Association
TBA	Traditional birth attendant
UN	United Nations
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
WAGE	Women and Girls Empowerment
WHO	World Health Organization
WLAC	Women Legal Aid Centre
WSO	Women Support Organization
WRDP	Women Resource Development Project

Executive Summary

The Norwegian Government's International Action Plan for Combating Female Genital Mutilation (FGM) was launched in 2003 and an evaluation of the efforts has been included in Norad's Evaluation Programme for the period 2006-2008. To prepare the ground for the evaluation, an overview report was commissioned, to gather baseline information to be used as reference points.

The Terms of Reference for the study were comprehensive and the report contains a wide range of topics. These span from country-specific socioeconomic and FGM prevalence information, an overview of relevant interventions and the extent of FGM mainstreaming, to a presentation of organisational and administrative arrangements, as well as an evaluability assessment. The geographical scope of the study covers Kenya, Eritrea, Ethiopia, Tanzania, Sudan and Somalia. Country visits were done in Ethiopia, Kenya and Tanzania and information gathered through interviews with partners. For the other countries, information had to be extracted from available documents, e-mail correspondence and Internet research. This has resulted in slightly less information coverage for these countries.

The low socioeconomic development, including the deficient provision of health services, of the countries covered by the study, contribute to aggravate the adverse health effects of FGM. The FGM prevalence, type of circumcision and cultural rationalities for performing it varies considerably within the region, with a noticeably higher prevalence rate and a more religiously founded rationality in the northernmost countries. FGM is still widespread in most of the places where it traditionally was practiced, but it has declined in younger age groups and in certain urban areas. At the same time, a medicalisation of the practice is observed as well as a lowering of circumcision age and a transition from more severe to milder forms of FGM. In a few areas, observations indicate that the practice of FGM may even spread to new groups.

The report gives an overview of projects and relevant interventions against FGM supported by the Norwegian Government. This overview shows that Norway is engaged in a great variety of projects implemented by several different partners. These include multilateral organisations and NGOs, the latter constituting a substantial part of the project portfolio. Ethiopia, which is a pilot country for the implementation of the Action Plan, boasts the highest number of FGM projects funded by Norway. The intervention efforts focus particularly on FGM prevention, advocacy and services. The target groups are typically women in various capacities, but also men, children and religious leaders are targeted.

Acknowledging that FGM is a sensitive social issue, the interventions are often community-based and apply dialogic methods in interaction with target groups. The embeddedness in political economies, unequal gender relations and cultural preferences presents a considerable challenge in the effort to combat FGM. Many projects are designed to cater for these larger social structures in their interventions, for instance by targeting influential community groups.

It is noted in the report that the integration and mainstreaming of FGM in documents and strategies is sporadic and not systematically incorporated, but the general impression is that in strategy documents where children and young people are the focus, FGM has been integrated as an issue.

The team found that the organisational and administrative arrangements guiding the FGM effort are intricate and sometimes difficult for partners to fully grasp, particularly with regard to the channelling of funds and follow-up. Information of recent restructuring and division of labour between the Ministry of Foreign Affairs and Norad as well as appropriate channels of funding is not sufficiently disseminated to partners. The complexity of the system is augmented by the country-specific arrangements pertaining to political context and financial support practices between the different countries.

The report shows that FGM is a multifaceted issue posing serious challenges when it comes to evaluating project impact in terms of change in FGM prevalence, the ultimate aim of the interventions. Much of the prevalence data is based upon self-reporting by informants and for several reasons, which are mentioned in the report, such data tend to be skewed. It is also difficult to reduce change in prevalence to a single factor explanation ('a project'), as sustainable change often is a result of several factors coinciding simultaneously. The complexity of the topic requires a set of interrelated indicators, where prevalence in different age cohorts and opposition to versus support of FGM constitute critical factors.

Lessons learned and best practices from the FGM interventions strongly indicate and underline the composite nature of the issue. Information presented in the report indicates that FGM projects have the best chances of success if they are community-based and founded on a culturally informed dialogue with the communities concerned. Therefore, the entry points of FGM projects must struggle to be holistic and based on long-term engagement.

Both Norwegian and local partners need knowledge on FGM in general and UNICEF in particular emphasises the importance of country-specific knowledge of the social dynamics of FGM. Generally partners required more knowledge sharing, and local partners in particular pointed to the need for a fuller understanding of best practices.

Both Norwegian and local partners reported resource constraints in their efforts to eliminate FGM. Norwegian partners seemed relatively content as to the human resource situation, while local implementing partners often suffered from high turnover of staff or a lack of personnel.

The report concludes that the abandonment of FGM within a short period of time will require substantial resources and interventions on several levels.

1. Introduction: The Assignment

This report presents an overview of the Norwegian Government's efforts to support the abandonment of female genital mutilation (FGM) in six partner countries. The study gives an overview of means and ways of support, important actors and activities, lessons learned and knowledge gaps. It also points to future directions for Norwegian support in this field.

The Norwegian Government's International Action Plan for Combating Female Genital Mutilation (Action Plan) was launched in 2003. According to the Action Plan the Norwegian Government will intensify its efforts by emphasising FGM in the political dialogue with partner countries, and increase its allocations to NGOs and international organisations. Ethiopia is the pilot country for the Action Plan. In March 2007 the Norwegian Government also launched the Action Plan for Women's Rights and Equality in Development Cooperation (2007-2009). This plan complements the existing FGM Action Plan with a more concerted focus on sexual and reproductive rights, and on gender discrimination and oppression, including violence against women. Norway has committed itself to the UN millennium development goal of abandoning FGM by 2010 (some UN organisations have extended the goal to 2015). This commitment will demand large-scale efforts both on micro- and macro level.

1.1 Terms of Reference

The Terms of Reference (ToR) for the study are comprehensive and cover a wide range of topics related both to background and baseline information as well as to existing knowledge. The topics range from country-specific FGM information, organisational and administrative arrangements pertaining to channelling funds and project implementation, to monitoring and evaluability assessments.¹ The consultants should suggest indicators to assess whether the objectives and targets of the Action Plan were met. The geographical scope covers six countries: Kenya, Eritrea, Ethiopia, Tanzania, Somalia and Sudan. These are all countries where the Norwegian Government supports efforts to combat FGM.

1.2 Team and Mission

The team consisted of Tonje Bentzen, anthropologist and consultant and Professor Aud Talle, University of Oslo. Bentzen was engaged for 13 weeks and Talle for 3 weeks. The mission involved collection and review of documents and relevant literature (cf. References), Internet research and interviews and discussions with actors in Norway as well as in partner countries. In total, 50 institutions and 80 persons from various organisations were consulted, in addition to discussions held with local men, women and religious leaders.

Tonje Bentzen made a three-week visit to Kenya, Ethiopia and Tanzania, conducting meetings and discussions with Norwegian embassies, Norwegian and local partners and other relevant institutions. While in Kenya she made two field visits, to the Dadaab refugee camp and the Maasai Education Discovery project in Narok respectively. In Dadaab she interviewed CARE employees and held meetings with religious leaders as well as with refugees involved in anti-FGM work. In Narok she visited Iltumtum village where the Maasai project operates and met with children and women who work against FGM.

The team met with a number of challenges in the collection of information during its mission: some local partners were not available for meetings, some Norwegian partners did not reply to questions asked, some information on projects was conveyed at too late a date for meetings to be held and finally, searching the Internet for multilateral organisations' involvements against FGM, for instance in Sudan, turned out to be difficult. Such constraining factors influence the breadth of information presented, resulting in uneven coverage for projects and activities.

¹ See Appendix I for Terms of Reference.

1.3 The Report

The report begins with a general overview of FGM prevalence, changes and legislation against the practice, followed by a descriptive chapter of country-specific data on socioeconomic variables, FGM information and interventions and actors. The number of projects and interventions is sizeable. A summary of the interventions is given at the end of the chapter and in matrix form in Appendix II. The next chapter, on administrative and organisational arrangements, deals with levels of mainstreaming of FGM, project organisation at the country level and the availability of resources. Norwegian strategy documents are listed in Appendix III and relevant evaluations and reviews in Appendix IV. The last three chapters discuss impact indicators with suggested possible indicators in Appendix V, monitoring and evaluating capacity among partner organisations, and lessons learned and knowledge gaps.

2. Female Genital Mutilation: Practices and Prevalence

2.1 General Background

Within the six partner countries included in this report, FGM is a widespread social practice, but with great variation both in terms of prevalence, type of mutilation performed,² age at performance and cultural explanations and rationalisations for performing it. The context of FGM performance as well as its cultural meaning are flexible parameters, and may change rapidly in response to political, economic and social circumstances.

FGM prevalence is highest in the northernmost countries – the Sudan,³ Ethiopia, Eritrea and Somalia all have a prevalence of 74 percent or higher.⁴ In Kenya and Tanzania on the other hand the prevalence is much lower, 32 and 15 percent respectively for the two countries. FGM is a social practice that primarily correlates with ethnic affiliation and cultural traditions, and not with political boundaries.⁵ This means that in many of the countries where FGM is practiced, circumcising groups live in close proximity to non-circumcising groups.

Type of procedure varies greatly among the different FGM practicing groups; within these areas the most common types are clitoridectomy and infibulation (Type II and III according to WHO's classification cf. footnote 1). It is important to emphasise that infibulation, which is reckoned to be the most severe form of FGM in terms of surgical intervention is widely practiced within the areas concerned, particularly in the Sudan, Somalia and Eritrea (and among ethnic Somalis in other parts of east Africa). In fact, this particular part of Africa is a core area of infibulation.⁶

The age at which the procedure is performed also varies considerably from operation on baby girls of 7-10 days old (or slightly older) among the Amharic and Tigray populations in Ethiopia and Eritrea, to 6-10 years in Somalia and the Sudan and 14-16 years in southern Ethiopia, Kenya and Tanzania. In general, the operation is performed before puberty and marriage. Within the study area individual cases of performance at a later age is reported.

Across the six countries, cultural explanations and rationalities for performing and continuing FGM vary, but the construction of female moral prudence (often religiously defined) and prospective marriage chances are major reasons for adhering to the practice. In some areas of Kenya, Tanzania and Southern Ethiopia, circumcision has historically been closely linked to puberty initiation rites. The reasons given for the practice can be grouped under the following headings: *religious* (it is proscribed by religion), *health* (preventing and curing genital diseases in women, children or men), *social* (to be able to marry their daughters off, to engage in unions with groups who practice FGM, to become integrated in the larger society if one belongs to a non-cutting ethnic group, as a rite of passage, as a symbolic marker of group inclusion, to please the ancestors), *sexual* (it is more pleasing to men, clitoris interferes with intercourse, clitoris grows to the size of the man's penis, one becomes sterile without circumcision), *moral* (ensuring virginity and female modesty, non-cut girls become promiscuous, prostitutes), *hygienic* (cutting prevents bad odour and is cleaner), and *aesthetics* (a cut genitalia has a nicer appearance). Infibulation is also said to be a protection against rape.

2 The World Health Organisation (WHO) has classified FGM into four different types, I-IV. Type I is excision of the prepuce, with or without excision of part or all of the clitoris; Type II is excision of clitoris with partial or total excision of the labia minora; and Type III is excision of part or all of the external genitalia and stitching/narrowing of the vaginal opening (infibulation). Type IV is pricking, piercing or incising the clitoris and/or labia. This type also includes several manipulations of the female genitalia: stretching the clitoris and/or labia, cauterization by burning of the clitoris and the surrounding tissue, scarping of tissue surrounding the vaginal orifice or cutting of the vagina, and introduction of corrosive substances or herbs into the vagina to cause bleeding or for the purpose of tightening or narrowing it. Furthermore, Type IV includes 'any other procedure that fall under the above definition' (WHO).

3 FGM (and circumcision of men) are mainly concentrated to northern Sudan. In the southern parts of the country these practices are traditionally not performed.

4 Demographic Health Surveys.

5 UNICEF 2006.

6 UNICEF 2006. Infibulation is also called Pharaonic circumcision, alluding to the great antiquity of the practice.

Depending upon type of FGM procedure and the circumstances of operation performance, health consequences for the women vary. Particularly girls who undergo infibulation are reported to suffer severe pain and often experience the most adverse health effects.⁷ These include both immediate effects such as haemorrhage, shock and infection, even death, as well as long-term effects: keloid scarring, urine retention, menstrual disorders, obstructed labour and fistula. Many informants understood there to be an interconnection between fistula and FGM, either directly or indirectly from the linkage between FGM and early marriages. While extensive statistical data on health consequences are rather scarce, an interrelationship between infibulation and prolonged labour and perinatal mortality is relatively well documented.⁸

2.2 Changes Observed

There are some general changes observed which will be briefly mentioned initially and then more fully explored in connection with the country descriptions. Four of the countries (Eritrea, Ethiopia, Kenya and Tanzania) demonstrate a marked decrease in prevalence in younger age groups, while the Sudan remain roughly the same.⁹ Survey data from Somalia on prevalence and change, indicate that performance and support of the practice prevail at a high level.¹⁰

A general trend, except for in the Sudan, is that FGM is less prevalent in urban than rural areas. The urban-rural difference is most pronounced in Kenya and Tanzania. It is not unlikely that in these two countries, FGM has another cultural rationality; it is more closely associated with backwardness and traditionalism and less with religion and female modesty (virginity). The historical depth of the practice is proven to be less in these two countries.

There is also a tendency in all countries, except Ethiopia and Eritrea, to 'modernise' the circumcision procedure, which implies that operations are performed by medically trained personnel. Traditionally, FGM is performed by local practitioners, often older women within the communities who operate without any form of antiseptic or anaesthetic means. In contrast, modern practitioners use surgical instruments and apply medication in order to lessen the pain of the operation and to avoid fatalities due to excessive bleeding and tetanus infection. The medicalisation of FGM is particularly common in towns, where such medical services are available. These interventions, however, have proven to have additional adverse effects on the girls. While the painless and sterile operation definitely may be beneficial to the girl at the point of intervention, there are indications at least in Somalia in the 1980's¹¹ that the modern operators tended to cut more deeply and stitch more tightly (because the girl felt no pain and did not struggle to get loose). An additional effect of the medicalisation is that girls are operated upon at a lower age.

Underreporting of operations performed is observed to be increasing. Several African governments are passing laws and establishing institutions to abandon FGM, and all countries in the area, except Somalia, have imposed laws against the practice (see section 2.3 for an overview). The fact that the performance of FGM has become a criminal act and that it, at least in some countries, is strongly associated with backward traditions and in conflict with human rights, makes people unwilling to raise their views publicly or disclose operations done in their family or community.

Another general trend, particularly in areas where infibulation is the norm, is a shift to so-called *sunna*¹² operations, which are perceived as less harmful. The term *sunna* is applied to a variety of operations, which range from pricking of the clitoral hood, to partial or total removal of the clitoris and labia and suturing of two-thirds of the vulva.¹³ In reality it ranges from Type I to III in the WHO classification.

7 In a recently published book, a Somali refugee midwife who during the civil war took shelter in a rural area for about two years (1991-93) gives an account of her experiences as a birth attendant. She kept a record of the cases she attended to and within one year these amounted to 250 women. Fifty per cent of these delivering women died, and she relates the high number of fatalities to a combination of factors: infibulation, the war, poverty and lack of medical resources (Gardener and El Bushra 2004:135).

8 The Lancet 2006.

9 UNICEF 2005a.

10 World Bank/UNFPA 2004.

11 Talle 2003.

12 The word *sunna* is Arabic and means in the 'way of the Prophet'. It is not an obligatory religious act, but one that is perceived as morally good, thus linking *sunna*-operations semantically to religion.

13 World Bank/UNFPA 2004.

In summary, the changes in practice observed include medicalisation of the practice, lower age at the time of operation, transition from severe to what is perceived as less severe types of FGM, and widespread underreporting.

2.3 Legislation against FGM

In view of the above description, FGM stands forth both as a physical procedure with severe health consequences in young and adult life as well as a serious abuse of women and children's rights. Human rights organisations both within and outside Africa have lobbied against FGM for a long time and have put pressure on governments to use the law as an instrument to abandon the practice.

To date, of the 28 African countries in which FGM is practiced, 16 have passed laws against it. Five of the six countries covered by this report are included amongst these 16 and three of the countries receiving Norwegian support have national action plans for FGM abandonment.

Table I

Eritrea	<ul style="list-style-type: none"> • The Female Circumcision Abolition Proclamation No.158/2007
Ethiopia	<ul style="list-style-type: none"> • Revised Penal Code of 2005 • National Action Plan for Gender Equality (NAP-GE)
Sudan	<ul style="list-style-type: none"> • A law prohibiting infibulation was passed in 1946 but not implemented. • A proposal has been submitted to Department of Justice on new legislation
Somalia	<ul style="list-style-type: none"> • No legislation currently introduced
Kenya	<ul style="list-style-type: none"> • Children's Act of 2001 • National Plan of Action for the Elimination of FGM
Tanzania	<ul style="list-style-type: none"> • Sexual Offences Special Provisions Act 1998 • National Plan of Action 2001-2015 (2003)
Tanzania cont.	<ul style="list-style-type: none"> • National Plan of Action for the prevention and eradication of violence against women and children (2003)

In spite of the present legislation against FGM, as many informants noted, the bottleneck is the implementation of the laws. According to the Population Council in Kenya¹⁴ for instance, the lack of clarity within the law as to who is responsible for the implementation, whether it is the police or local administrative leaders, remains.

One example illustrates the point above. The Ethiopian NGOs Legal and Human Right Centre and Women Legal Aid Centre went to court with a case concerning a father who had had his three daughters circumcised, but lost the case. Representatives of the Centre, however, focus on raising the awareness of the law, and less on the need to incarcerate the parents. FGM cases may be difficult to pursue legally, because children will not testify against their parents, and because it is a sensitive issue to examine. In addition, according to Tanzania Media Women's Association (TAMWA), court personnel are at times bribed to direct the outcome.

With regard to effective interventions, one should also be aware that there appears to be a lacking political will to make the abandonment of FGM a major issue; many politicians fear losing re-elections if they dedicate themselves to the cause. In addition, the relevant Ministries in Ethiopia, Kenya and Tanzania¹⁵ have wide-reaching mandates resulting in lacking capacity and resources to advance the issue effectively.

The law may be an important preventive instrument, but challenges with regard to implementation of the law within the particular social and political environment in which most of the circumcised women live, should be acknowledged.

¹⁴ Personal communication with Director Ian Askew, March 21st 2007.

¹⁵ Ethiopia: Ministry of Woman's Affairs, Tanzania: Ministry of Community Development, Gender and Children, Kenya: Ministry of Gender, Sports, Culture and Social Services.

3. Country Profiles: Background Information, FGM Prevalence and Interventions

The present part of the report presents country-specific information on FGM prevalence and practices, and interventions against FGM supported with Norwegian development funding, but implemented by local partners. Information on the interventions has been gathered through a combination of oral and written information from local partners, Norwegian NGOs, embassies and Internet research.¹⁶ The focus is on present and planned project activities at the expense of past activities. Included in the introductory part is an overview of socioeconomic data (Table II). The larger part of the chapter is descriptive, but is followed by a summary, emphasising the major characteristics of the projects. A matrix of interventions and their main features, target groups and donors is presented in Appendix II. NGO activities, which are not funded directly by the embassies, are for the most part based on agreements with Norad. The countries are presented alphabetically.

3.1 Socioeconomic Background Information

Taking into consideration the poverty of these countries, that women and children often constitute the poorest groups, and that health facilities are generally deficient, the severity of the performance of FGM for women's health and lives is exacerbated. Perinatal mortality is observed to rise by one to two percent as a consequence of FGM.¹⁷ As will become evident below, poverty in various ways appears to be a factor that greatly influences the sustainability of FGM projects. The socioeconomic variables in Table II are taken to be relevant in order to contextualise FGM and advance intervention efficacy.

Table II Socioeconomic variables by country

	Eritrea	Ethiopia	Sudan	Somalia	Kenya	Tanzania
Total population (1.000)	4.401	77.432	36.232	8.228	34.256	38.329
Life expectancy Male/female	52,3/56,1	46,8/48,8	55,1/58,0	45,8/48,2	48,5/46,5	45,6/46,2
Crude birth rate /1000	39	40	32	44	39	37
Crude death rate /1000	11	16	11	17	15	17
Under 1 mortality /1000	50	109	62	133	79	76
Under 5 mortality /1000	78	164	90	225	120	122
Total fertility	5.3	5.7	4.2	6.2	5.0	4.8
Primary school enrol- ment male/female	50/42	58/55	47/39	-/-	76/77	92/91
Primary school atten- dance male/female	69/64	33/28	60/57	13/11	79/79	71/75
Secondary school en- rolment male/female	31/20	34/22	-/-	-/-	40/40	-/-

¹⁶ In many instances, the various sources provided contradictory information, something which presented a challenge with regard to concluding about actual activity.

¹⁷ The Lancet 2006.

	Eritrea	Ethiopia	Sudan	Somalia	Kenya	Tanzania
Antenatal care coverage %	70	28	60	32	88	78
Skilled attendance during delivery %	28	6	87	25	42	43
Maternity mortality ratio reported per 100 000 live births	1000	870	550	-	410	580
GDP per capita (US\$)	219	114	594	-	481	288
Urban/rural %	20/80	15,7/84,3	38,9/61,1	34,9/65,1	39,3/60,7	35,4/64,6

Sources: UNICEF *State of the World's Children 2007*, *Human Development Report 2006*, *Human Development Index 2004*¹⁸

Although all the countries are poor in a global perspective, there are still huge differences between the countries on many variables. For instance regarding education, Tanzanian has a primary school attendance of over 70 percent, while Ethiopia has an attendance ratio of 30 percent.

Ethiopia also stands out along with Somalia in terms of a combination of low life expectancy, high mortality rates, high fertility rates, low school attendance and a more or less complete lack of health care facilities; 88,6 percent of urban and 97,2 percent of rural Ethiopian women experience great problems in accessing health care.¹⁹ 30,7 percent of urban Ethiopian women have no education compared to 72,8 percent of rural women. The figures illustrate the number of women and children who do not have access to education or health facilities, and women in rural areas are particularly vulnerable. In addition to being denied their basic human rights to health and education, schools and health facilities are institutions wherein important information (for instance on FGM) may be passed on. Consequently, this information seldom reaches marginalised women and children.

3.2 Eritrea

3.2.1 FGM Information

The estimated FGM prevalence in the country is 89 percent,²⁰ with a prevalence difference between urban and rural areas of 86 percent versus 91 percent. Reports claim a generally modest trend of declining prevalence in the country.²¹ A high discrepancy between the rate of prevalence and declared opposition to the practice (51,6 percent) has been reported, which may indicate that a critical mass of population is willing to abandon or already silently has abandoned the practise of FGM in Eritrea.²²

FGM is widespread both among Christian and Muslim populations, and while type II is the common form among Christian groups; type III is more widespread among Muslims. The Muslim groups in Eritrea are culturally related to Afar and Somali groups further south, ethnic groups that are well known for predominantly practicing infibulation (cf. below). While Christians are reported to be more receptive to abandon FGM, Muslims tend to change FGM type, from infibulation to clitoridectomy.

Among the ethnic/religious groups in Eritrea, FGM is closely associated with female morality, marriageability and conjugal fidelity. Within the Muslim communities, for instance, the 'sunna' form of circumcision is thought of as a religiously auspicious act.²³ Religious leaders at the national level have declared that FGM is a cultural and traditional practice, and not linked to religion.²⁴

¹⁸ UNDP 2006.

¹⁹ Demographic Health Survey, Central Statistical Agency Addis Ababa 2005.

²⁰ UNICEF 2005a.

²¹ Berggrav et al 2007.

²² UNICEF 2006:35.

²³ People often refer to their form of circumcision as 'sunna', but as noted on page 5 the term does not cover a uniform type of FGM.

²⁴ Berggrav et al 2007.

3.2.2 Interventions

The Norwegian Embassy has signed an agreement of NOK 3,6 million for four years with UNFPA and the local *National Union of Eritrean Women (NUEW)* as implementing partner. The project is located to the Debub zoba region. The *NUEW* project will conduct a baseline survey, train facilitators, establish anti-FGM committees, and conduct outreach activities towards many target groups (men, women, girls and boys). The project will also organise meetings in schools, health facilities and villages, and arrange workshops, bigger gatherings and mass media campaigns. The “National Strategy on Female Genital Mutilation (FGM/C) Abandonment in Eritrea”²⁵ was funded as part of the *NUEW* project and was launched in 2006. It will involve ministries, community participation, involvement of local, religious and other community leaders and men, the development of a national baseline survey and the promotion of the integration of FGM in health care. An Anti-FGM/C unit has been appointed, and a Coordinating Committee with the Ministry of Health as the coordinator.²⁶

Norwegian Church Aid (NCA) has signed a Strategic Partnership Agreement with the Norwegian Embassy to carry out projects addressing internally displaced people, gender issues and dialogue with religious leaders. Their gender programme directs attention to gender-based violence (GBV), FGM and other harmful traditional practices (HTPs), and HIV/AIDS. The organisation has now received approval from the Eritrean government on four projects, with a total budget for 2007 of NOK 1, 571 million.

One is a project with the *Eritrean Orthodox Church (ErOC)* as implementing partner, giving training to Eritrean Orthodox clergy and female Sunday school teachers. Another project is with the *National Union of Eritrean Women (NUEW)*, giving gender education in Gash Barka to educate leaders through workshops on HIV/AIDS, FGM and gender issues. The third project is also with *NUEW* as local partner; an integrated Gender Empowerment project in Shilalo sub-Zone to empower women through micro credit schemes, to educate women, girls and the community on FGM, HIV/AIDS and gender and to increase access for girls’ education. The final project has the *Ministry of Health (MoH)* as local partner, working to eliminate the practise of FGM in the Northern Red Sea Zone by addressing gender based violence through legal and political means, carrying out campaigns using religious leaders and establishing community mobilisers.

3.3 Ethiopia

3.3.1 FGM Information

Estimated FGM prevalence in Ethiopia currently stands at 74,3 percent. There has been a drop in the prevalence rate over a relatively short time from 80 percent in 2000 to 74,3 in 2005.²⁷ According to the prevalence data, the practise tends to be decreasing particularly among the younger age groups (73 percent circumcised in age group 20-24, while 80,8 percent circumcised in age-group 45-49).²⁸

Data from Ethiopia show a slightly higher prevalence in rural (75,5 percent) than urban areas (68,5 percent), but with a large variance in prevalence and type of FGM practised between ethnic groups. Among the Afar and Somali in the southeast of Ethiopia FGM prevalence is more than 90 percent (Afar 91,6 and Somali 97,6); among the largest ethnic groups in the country, the Amhara and the Oromo the prevalence is 68,5 and 87,2 respectively; and among the Tigray and Gambela the prevalence is below 30 percent in both groups. Several ethnic groups in the western and south-western parts of the country do not practice FGM at all.

Infibulation is particularly widespread among the Somali (83,8 percent) and the Afar (97,3 percent) circumcised women²⁹ while among the other groups clitoridectomy of various degrees (type I & II) is the norm. The extent and severity of the operation varies with many factors, such as the age of the girl at the time of operation, the preference of the family, and the knowledge, skills and courage of the practitioners.³⁰

25 Gebrekidan, A. and Eltanir, A. 2006.

26 The information on the *NUEW* FGM project in Eritrea is taken from the draft report by Berggrav, Strøm and Taraldsen 2007.

27 UNICEF 2005a.

28 UNICEF 2005a.

29 UNICEF 2007.

30 Alemu, S. Moland, K. M. and Talle, A. 2007.

Data demonstrate a tendency among infibulating groups to modify their operation towards 'sunna'. This trend is particularly noticeable in Harrar in southeast Ethiopia, where the girls used to be infibulated. Now, according to one report, while 85,1 percent of the women in the area are still circumcised, only 12,5 percent of them are infibulated.³¹

Among both the Muslim and Christian populations in Ethiopia female circumcision is considered a morally and aesthetically beneficial act for the woman and for the community. The removal of external genitalia controls or diminishes female sexuality and thus makes the girl a pliable and pleasing wife. Marriage and successful childbearing is strongly associated with FGM.

3.3.2 Interventions

There are many partners and activities supported by Norway in Ethiopia. This is partly related to Ethiopia's status as pilot country.

An important actor in Ethiopia is *Save the Children Norway-Ethiopia (SCN-E)*. It has been working in the North Gondar Zone in Amhara with a child-centred community development project in collaboration with the Department of Labour and Social Affairs (DOLSA). The project has a rights-based approach. SCN-E uses women radio-listening groups and change agents, conducts advocacy and networking, holds public campaigns and encourages child participation. SCN-E also introduces alternative rites of passage and involves practitioners in FGM abandonment. Moreover, SCN-E works with schools and on strengthening local structures, and integrates FGM and harmful traditional practices (HTP) in other programs. Women/girls are assisted with surgery for fistula at the Fistula Hospital in Addis Ababa.³² The activities in these woredas (Chilga and Lay-Armachiho) is funded by Norad and will end this year. The project has two new additional woredas, East and West Belessa, which is funded by the Norwegian Embassy. SCN-E extended their project in cooperation with NCA to two new woredas in the period 2005-2008. The project is a joint one, and SCN-E and NCA operate in different geographical areas. The joint amount for both SCN-E and NCA projects for 2007 is approximately NOK 1,8 million and the total project budget approximately NOK 6,7 million.

SCN-E is a strategic partner with the Norwegian Embassy, and in January 2007 SCN-E entered into partnerships with several actors: *Care Ethiopia Afar*, *Population Media Centre* and *Ye Ethiopia Goji Limadawi Dirgitoch Aswogaj Mahiber (EGLDAM)*.³³

EGLDAM runs information campaigns for leaders, circumcisers and birth attendants. It conducts activities such as training of trainers and school clubs. Furthermore, it attempts to include FGM in the school curriculum, and to influence students and parents. The organisation coordinates an FGM network and produces a newsletter that exchanges experiences on best practices, harmonises messages and gathers different perspectives in the struggle to abandon the practice. Through this strategic partnership, *EGLDAM* has been given the task of conducting a follow-up survey to their previous 1997 survey published in the book *Old Beyond Imaginings. Harmful Traditional Practices* (2003).³⁴ An updated survey will be due in 2008. The 2003 book is to be translated into Amharic. Total project budget is approximately NOK 1,7 million.

The Population Media Centre is initiating preparatory research for a nationwide project through their partnership with SCN-E, is developing a project concept paper, and making preparations for the FGM prevalence survey. The centre will use former experiences in the realisation of this new FGM project, namely research-based production of radio serial dramas. The focus is on reproductive health, FGM and HIV/AIDS. The centre will organise phone-in and panel discussions, print materials, strengthen competency and capability of producers, experts in theatrical arts, etc., and train women and youth groups. The Afar and Somali

³¹ UNICEF 2007.

³² It is not quite clear to the team whether partners regard FGM as causing fistulas, or whether they regard FGM as interconnected with early marriage (as FGM in many instances becomes a preparation for marriage) – which again causes delivery complications due to the low age at delivery. Thus the relationship between FGM and fistula in this report is based on local perceptions of interconnectedness, not necessarily substantiated by medical research findings.

³³ Previously called National Committee on Traditional Practices of Ethiopia (NCTPE).

³⁴ Published under *EGLDAM*'s previous name National Committee on Traditional Practices of Ethiopia (NCTPE).

regions will be given special attention due to the severity of circumcision in the area and its underserved communities. Total project budget is approximately NOK 13,6 million.

Care Ethiopia runs an FGM elimination project in the Afar region. The project has a community-based approach with a focus on women's rights and health. It directs attention to the dissemination of information as well as facilitation of community dialogues and capacity building. It also mobilises religious leaders, traditional birth attendants and coordinates women's groups. Furthermore, the project is active in establishing clubs and radio-listening groups. A previous assessment has pointed to some lessons learned, including the importance of strengthening partnerships with religious leaders, extending the operational area from focused community approaches to include regional-wide advocacy efforts and endorsing laws against FGM. The assessment also recommended that the project strengthens the sustainability of the community-based health system (water, education), establishes female income generating schemes and introduces community intergenerational dialogue – emphasising the importance of intergenerational exchange. The contract with the Embassy is for the period 2006-2010. Total project budget is approximately NOK 16 million.

The Ethiopian Women Lawyers Association (EWLA) is an advocacy group that focuses on research and documentation, legal aid and public education related to gender issues, FGM included. Assistance through EWLA relates to educational and awareness activities as well as counselling to girl victims of FGM. EWLA is funded by the Norwegian Embassy.

NCA is a strategic partner to the Norwegian Embassy for the period 2005-2008. *NCA* has many local partners: *Kembatta Women Self Help Centre (KMG)*, *EGLDAM*, *African Development Aid Association (ADAA)*, *Rohi Weddu Pastoral Women Development Organisation*, *Ethiopian Orthodox Church Development Association and Interchurch Aid Commission (EOC/DICAC)* and *Ogaden Welfare Development Association (OWDA)*, *Women Support Association* and *Professional Alliance for Development of Ethiopia (PADET)*. These will be mentioned briefly below.

KMG directs interventions at the community level and runs community dialogues in five districts in Southern Nations, Nationalities and Peoples (SNNP). It particularly targets children and women and works to empower them as rights holders. *KMG* has established anti-harmful practises groups and trained girls are represented in each district reporting cases of FGM. *KMG* presents alternative sources of income for practitioners and arranges an annual declaration ceremony against FGM. They plan to start a women and child protection team unit at the police station, giving legal and psychosocial assistance. Norad and Embassy funding for 2006 was approximately NOK 546 531.

EGLDAM has a project agreement with *NCA* to establish a strong National Network among organisations working on FGM and other HTPs. This network will share best practices, lessons learned and strategies and prevent duplication of efforts. Funding for 2006 from the Norwegian Embassy was approximately NOK 86 742.

ADAA is based in the Oromiya area. An important activity of the organisation is the organising of district-level workshops, targeting men, women and elders in rural areas, teachers, religious leaders and committee elders. The aim of the workshops is to create consensus and establish ownership of the cause against FGM. FGM information is linked to education, HIV/AIDS and HTPs in general. Religious and community leaders are addressed in particular. To highlight the legal aspects, *ADAA* invites law experts. *ADAA* will gradually expand to the community level to reach those not attending the central meetings. Anti-HTP associations at the local level have been established. *ADAA* works closely with the Woman Affairs Office, monitors with them and exchanges feedback. Embassy funding for 2006 constituted approximately NOK 148 800.

Rohi Weddu – Pastoral Women Development Organisation works in Afar using two approaches: regional advocacy and community interventions. The method for the latter is community dialogue based upon traditional communication practices. Many groups are targeted, but the first to be sensitised are leaders who after sensitisation may become

activists, and the Women Affairs Office. There are anti-FGM committees, and both boys and girls are included. School children are also approached with the anti-FGM message. Project staff register newborns to conduct follow-ups and approach the parents in order to convince them not to circumcise daughters. 250 girls have made public announcements against FGM. They have tried to integrate the law against FGM into customary law, for instance slaughtering a cow as a fine if one has circumcised one's daughter. Embassy funding for 2006 constituted approximately NOK 42 598.

Ethiopian Orthodox Church Development Association and Interchurch Aid Commission (EOC/DICAC) work in the northern part of the Amhara region, using religion as an entry point. It targets religious leaders, parents and practitioners. It has established anti-HTP groups in schools in order to sensitise the children, and plays and dramas are arranged. Embassy and Norad funding for 2006 was approximately NOK 262 529.

Ogaden Welfare Development Association's (OWDA) anti-FGM projects operate in Gode Zone Afar, engaging in community participation. The association organises workshops with elders, community leaders, teachers, doctors and nurses, midwives, religious scholars, youth leaders and women association leaders, and also produces brochures and dramas. The entry point is human rights and the religious aspects and HTPs. Parents who do not circumcise their daughters are given awards and supported financially. Embassy and Norad funding for 2006 constituted approximately NOK 224 578.

Women Support Organization (WSO) is an indigenous, non-governmental and humanitarian organisation, working in Ethiopia to improve the social, economic, and physical well being of poor, rural women in particular, and the community in general. WSO work with gender based violence, HTP and anti-FGM activities. WSO initially provided assistance to destitute and displaced women living in the area called Garji, located in Woreda 17 of Addis Ababa Administrative Region. After three years of such involvement in the town, the organisation has extended its interventions in the rural areas of North Shoa and Oromia Zones in the Amhara National Regional State. WSO's vision is to see the life of disadvantaged women in the target areas sustainably improved and to assist the target groups to bring about sustainable development through their active participation. Funding from Norad for 2006 constituted approximately NOK 45 225.

Professional Alliance for Development in Ethiopia (PADET) has been active in Wuchale Jida Woreda, North Shoa Zone, Oromia National Regional State in order to promote community based development programs targeting the very poor and vulnerable communities, particularly women, children and youth. PADET has contributed in North Shoa and North Wollo zones of Amhara and North Shoa Zone of Oromia National Regional States. Among the achievements is the mitigation of harmful traditional practices including FGM, and a number of under age marriages were cancelled through joint effort of PADET and law enforcing bodies in Meket, Gidan and Gubalafto Woreda of North Wollo Zone and Wuchale Jida Woreda. Norad funding for 2006 constituted approximately NOK 85 315.

The Norwegian Missionary Society (NMS) in cooperation with the Norwegian *Inner Wheel* and the local partner *Ethiopian Evangelical Church Mekane Yesus* operates a fistula project in western Ethiopia, Beghi-Gidami and Bodji, bringing fistula patients to the hospital in Addis Ababa. This is mainly funded by the Forum for Women and development (FOKUS). Funding for 2007 is approximately NOK 200 000. The remaining projects include three village-development projects in Oromiya, funded by *Norwegian Missions in Development (Norsk Misjons Bistandsnemnd)*, providing health services, infrastructure, primary education and water, where one component in the holistic approach is HTPs, gender and women's rights. For 2007, the budget for the three projects is NOK 2 million. A women's empowerment project (2006-2009) has also been instigated, into which FGM is embedded. Approximate budget is NOK 900 000. NMS report on the fistula project to FOKUS, and to Norwegian Missions in Development on the other projects.

The *Norwegian Lutheran Mission (NLM)* in Norway, has a project in Bale zone Oromiya, with *The Ethiopian Evangelical Church Mekane Yesus Wabe Batu Synod* as implementing

partner. The objectives of the interventions are to raise the awareness of the community against FGM, enhance capacity of district level stakeholders, and to strengthen women's capacity to organise, to lobby and to advocate their rights. Community mobilisation, organisation and awareness raising will be applied, while advocacy and training will be used at the government office level. So far, one workshop has been held. The NLM budget for 2007 with NLM and Norad as donor is NOK 211 000. By the end of 2006 a fistula hospital in Yirga Alem was completed.

The Development Fund (Utviklingsfondet) has started work in Afar with the local partner *Afar Pastoralist Development Association (APDA)*, by targetting religious leaders and traditional birth attendants. The budget for 2007 is NOK 366 985, with FOKUS and Norad as donors.

New Life Community has received funds from FOKUS to instigate a project on combating FGM among young women in the Akaki area outside Addis Ababa. Target groups include practitioners, local authorities and women. FOKUS funds NOK 509 686, but the team has been unable to assess the total budget.

In collaboration with the Norwegian Embassy, UNICEF and UNFPA are embarking on a rights-based approach to adolescent and youth development in a Joint Program in the Oromiya, SNNP, Amhara, Afar and Addis Ababa region, being funded 100 percent by the Norwegian Embassy (NOK 100 million over the project period 2007-2011). One component of this program includes strategies to combat FGM. They will initiate youth and community conversations, advocacy against gender-based violence and FGM and build legislative and law enforcement capacity. To reduce gender-based violence, strategies such as FGM mass abandonment, the education of youth facilitators, information material production and dissemination, media usage, training of law enforcement agents and support to youth organisations, parents and government counterparts will be applied. Part of the joint program also entails monitoring and evaluation in a more scientific manner, seeking best practices and indicators, and financial assistance for development of, for instance, Demographic Health Surveys (DHS).

3.4 Kenya

3.4.1 FGM Information

Kenya reports an overall FGM prevalence of 32 percent, with considerable variation between different parts of the country, between urban and rural areas and to a certain degree between the educated and the less educated.³⁵

The highest prevalence of circumcised women is to be found in the north-eastern parts of the country, bordering Ethiopia and Somalia and inhabited by different semi-nomadic Somali and Oromo groups. In this area, the prevalence is reported to be as high 98,8 percent. Also the pastoral Maasai straddling the border between Kenya and Tanzania, and the agricultural Abagusii in western Kenya report similarly high prevalence figures. Many ethnic groups, for example the numerous Luo in western Kenya and the Turkana in northern Kenya on the border to southern Sudan, however, do not practice FGM (nor do they circumcise males).

In Kenya, there is a considerable prevalence difference between urban and rural areas. The overall picture for the country is 23,4 percent prevalence in urban areas and 37,1 percent in rural areas. Furthermore, a substantial decline in FGM in recent years has been observed: in the age group 20-24, 25,9 percent are circumcised, while 50,3 in the age group 45-49.

There is also a radical decrease in prevalence among certain ethnic groups, especially among the modernised and highly educated Kikuyu and some Kalenjin groups. Generally, level of education does have an effect on the FGM rate: among women with no education 58,2 percent were found to be circumcised, while only 21,1 percent among those with secondary education

³⁵ Demographic Health Survey, Central Bureau of Statistics Nairobi 2003.

and above.³⁶ But there are exceptions to this trend: the Abagusii and the Kisii have a high level of education, but simultaneously a high level of FGM (over 95 percent prevalence). In the case of these groups, FGM appears to work as cultural markers.

Partners and collaborators report of changes in FGM procedures: a general trend is medicalisation, which means that the operation decreasingly is done as part of public puberty rituals of initiation and learning, and has become a single event on individual girls. The medicalisation of the practice has also brought down the circumcision age. While girls used to be circumcised in early puberty, now they are often of pre-school age. People tend to think that it is less harmful to cut girls at a young age.³⁷

3.4.2 Interventions

The number of Norwegian-funded projects in Kenya is limited and mainly concentrated to pastoral areas, which in general are economically and politically marginal areas and where FGM on the whole is most widespread.

Maasai Education Discovery (MED) works to strengthen Maasai education and rights. They have conducted surveys in three villages. MED runs an outreach program with handbooks for trainers of trainers where trainers visit villages and conduct interactive education and dialogue with different groups. MED runs an art centre, library, resource centre and internet café for the whole community, while the Cisco network academy and scholarship programme targets girls specifically for their educational programme. Girls who have completed the educational programme continue to work as mentors for other girls. MED also trains midwives and practitioners in presenting knowledge to girls as an alternative rite of passage, whereby the activity changes but the income remains the same. MED also rehabilitates FGM traumatised girls. The Embassy has provided NOK 800 000 for 2007.

ARC-aid funds an anti-FGM project in the Somali refugee camp Dadaab located on the Somali border, implemented by *Care Kenya*, with a budget of approximately NOK 550 000 for 2006 and 2007 respectively. The project sensitises the community, targets religious leaders, scholars, imams, sheiks and madrasa teachers in addition to men and women. Focus group discussions involving a small number of people are used, while larger dialogue meetings are conducted with the religious leaders present. They have established anti-FGM groups called Circle of Friends for young girls who have escaped FGM, for mothers and fathers to undergo counselling, and for men, youth and Sheiks against FGM. There are community development workers who visit families and report to the police if someone is threatened by others for not practicing circumcision, or attempt to intervene in domestic disputes. The religious committee also deals with sexual and gender-based violence, domestic conflicts and tries to reason on issues of FGM. Interest free microfinance loans are given to individuals as rewards for being against FGM. Care Kenya has started providing fistula treatment to selected women.

The Norwegian Lutheran Mission is phasing out its West Pokot development programme in 2007. The programme has worked in many fields: FGM, schools, health, agriculture and education. They have built a secondary school with boarding facilities to protect girls from being circumcised. A fund has been established for girls who run away, assuring them school attendance in a boarding school or in Kenyan foster families. The Evangelical Lutheran Church of Kenya has taken over two clinics, providing information, birth attendance and vaccinations.

NCA has two partners in their projects against FGM, and a budget of NOK 350 000. *The Coalition on Violence Against Women (COVAW)* and *Habiba*. *COVAW* works in Laikipia and Kajiado Districts targeting Maasai people and encouraging community dialogues especially wherein youth act issues out and the community discusses, and efforts to empower women, for instance, by teaching women how to write project proposals. *COVAW* uses sensitisation in schools and resource mobilisation. They use paralegals to further sensitise and to assist with domestic conflicts. They have established a refuge centre for girls in Kajiado.

³⁶ cf UNICEF 2007.

³⁷ UNICEF report 2006:35-36.

HABIBA works in Mandera, raising awareness and community sensitisation about the adverse effects of FGM. The organisation has introduced alternative income sources for ex-practitioners, and seeks to influence and inspire community leaders, politicians, youth and religious leaders to become advocates against FGM. Refuge centres and support groups have been established.

The Christian Union for Young Women (KFUK) has started a project in Meru, Kajiado and Kisii. They will use already established youth- and women's groups and make school visits. They will train change agents and organise media campaigns. The project is funded by FOKUS, with a budget of approximately NOK 990 000 for 2007.

3.5 Somalia/Somaliland

3.5.1 FGM Information

FGM is widespread, almost universal, in Somalia/Somaliland, with a prevalence of 97-98 percent frequently reported.³⁸ The practice is also very common among ethnic Somalis in other parts of east Africa.

A majority of the Somalis perform the most severe type of mutilation, that is type III of WHO's classification. The exception to this general picture of FGM in Somalia is the ancient ethnically mixed communities of the coastal towns (Mogadishu, Merka and Brava) where type I traditionally has been the common type. Some of these communities, however, had begun in the years before the civil war under the influence of the majority population ('nomadic' Somalis) to perform various forms of infibulation.

FGM is widespread both in urban and rural areas, but studies indicate that urban residents in general are more aware of adverse health consequences of FGM than rural and nomadic residents. More Somalis are also questioning the practice of FGM and increasingly linking it to tradition and not religion.³⁹

In the Somali culture, FGM is referred to as an act of purification (*halalayn* derived from Arabic). This term, which is used for all forms of circumcision, implies that the uncut girl is perceived as unclean (physically and spiritually) and needs to be purified. The cutting and the closing (*qodob*) of the vulva create a beautiful and morally upright woman, who in anticipation of marriage several years later, can represent her family respectfully.

Somalis both within and outside Somalia are increasingly performing what they call *sunna* operations instead of infibulation, perceiving the former as legitimated by religion. As noted above, in the Harrar area where inhabitants are closely related to Somali people, *sunna* has become the common circumcision type in recent years.

3.5.2 Interventions

Somalia is politically unstable, and northern Somalia or Somaliland declared itself independent from The Republic of Somalia in 1991. The declaration, however, has not been internationally recognised. These political circumstances constrain donors in committing themselves to large-scale or long-term involvements in the country.

NCA operates in the Gedo and Puntland regions, to create awareness on the health implications of FGM and with capacity building. *NCA* was initially requested by local women to assist them in their efforts against FGM. The activities target community and religious leaders, men, women and children. Through the project surveys are conducted and documentation gathered, and information is disseminated through educational material such as videos and demonstration models. The budget is NOK 400 000.

Care Norway cooperates with the *SAHAN* network, a youth NGO, and FGM is one of the components of their HIV/AIDS program. *SAHAN* runs awareness and education programme through radio and TV. *Care* also cooperates with a youth umbrella called *SONYO*, to integrate FGM in their Youth Peer Education program. Another partner is the human rights network *SHURO*, raising community awareness and education messages and preparing articles and

³⁸ World Bank/UNFPA 2004.

³⁹ World Bank/UNFPA 2004.

laws. Care cooperates with the *Ministry of Family Welfare and Social Development* which receives funds to initiate the development of FGC policy and effective coordination mechanisms, the *Ministry of Health and Labour* for training TBAs and health centre staff, the *Ministry of Education* to raise the level of education on FGM to youth groups through formal and non-formal schools; and finally the *Ministry of Religion* to sensitise religious leaders and to come up with one standpoint on FGM. Care Norway also fund a trauma clinic and counselling. The total budget is NOK 1,150 million.

The Norwegian Nurses Association has developed a project to reduce FGM in Mogadishu and surrounding areas, and to influence the government to legislate against FGM. The project is financed by FOKUS, and Mogadishu University is the local partner who involves the local nurses association *COSNO*. Activities include public meetings, women conversation groups, use of radio and TV, contact with teachers on elementary and secondary levels and contact with local leaders. The budget for 2007 is NOK 646 000.

FOKUS and Norad also funds *Somalian Women's Union* (Somalisk Kvinneforening) for a new project, but the report team has been unable to acquire knowledge on what type of project this is. The budget is NOK 286 860.

Norwegian People's Aid (NPA) has been supporting a project with *Galkayo Education Center for Peace and Development* and *Hanaqaad Women's Umbrella Association* as local implementing partners on a Somali Women's empowerment project. The goal is to strengthen the ability of organisations in combating violence against women. The target groups are women and girls. Activities include promoting education by providing scholarships and teachers' incentives, and creating awareness on FGM and HIV/AIDS. Funding to the Galkayo Education Center for Peace and Development for 2007 is NOK 203 000, and to Hanaqaad Women's Umbrella Association NOK 163 000. NPA is phasing out this project in 2007.

3.6 Sudan

3.6.1 FGM Information

Estimated prevalence in the (Northern) Sudan is 90 percent, with an urban prevalence of 92 percent and rural 88 percent. Ethnic groups in southern Sudan have traditionally not practiced circumcision on neither boys nor girls. People who have fled from the war in the South and live as internally displaced persons in camps in the North, however, are reported to have begun to practice circumcision on both boys and girls.

The Sudan is the only country where the reported prevalence is higher in urban than rural areas.⁴⁰ The most widespread type of FGM is infibulation, including several intermediate variations of this type. Type I is said to be commonly performed in towns. The British colonial administration campaigned against FGM in the Sudan and the Ministry of Health prohibited infibulation already in 1946. The effect of the law was not abandonment, but changes in practice towards what people perceived as permissible forms of circumcision. At the time clitoridectomy was not forbidden by the law.

In the Sudan, FGM is intimately associated with concepts of female virginity and morality and is in several ways, not least by language, sanctioned and legitimised by religion.⁴¹ However, a religious movement is unfolding in the Sudan to de-link FGM from Islam.⁴² Medicalisation of the practice is widespread in urban areas and in fact has been so for a long time (medicalisation of the practice is also common in Egypt further north).

3.6.2 Interventions

Despite the high prevalence and the widespread performance of infibulation, only NCA among the Norwegian NGOs are engaged in FGM related efforts in the Sudan.

NCA runs projects in a camp for internally displaced people in Khartoum, working on creating awareness among teachers, parents, midwives, students, and community leaders, among

⁴⁰ UNICEF 2007.

⁴¹ Dr. Amna Hassan SNCTP, personal communication, March 2007.

⁴² UNICEF 2006:35.

others. The projects encompass curriculum development, conducting workshops for teachers, parents, leaders and universities and organising alternative income generating activities for ex-practitioners. The budget is NOK 250 000.

The local partner is *the Sudan National Committee on Traditional Practices (SNCTP)*. SNCTP, among other activities, works with information and education campaigns on FGM and HTPs. SNCTP involves midwives in order to raise awareness amongst pregnant and lactating mothers and people within the community using the community conversations approach. SNCTP is advocating for a revitalisation of the 1946 law against circumcision and has issued a “fatwa” against FGM.

3.7 Tanzania

3.7.1 FGM Information

The reported prevalence of FGM in Tanzania is 15 percent,⁴³ and the practice is concentrated particularly in the northern and central parts of the country. FGM was never a widespread tradition in the western and southern parts. Just like in the case of Kenya, the rural-urban prevalence difference is pronounced: according to the DHS survey 7 percent in urban areas versus 18 percent in rural areas. Furthermore, the survey also shows an overwhelmingly large percentage of men and women favouring an end to the practice (89 and 91 percent respectively on national level, 97:95 in urban, and 87:86 in rural).

Among some ethnic groups such as the Maasai and the Kuria, circumcision prevalence continues to be high, 100 and 85 percent respectively. But among others, for example the Chagga in the Kilimanjaro region, prevalence has been decreasing. Even there, however, prevalence continues to show significant local differences and some report that the Chaggas are again taking up FGM due to bad harvests, believing this to be an ancestral punishment for not practicing FGM. According to informants, in the more ‘rural’ (read: unenlightened) localities, FGM is still widespread. Partners in Tanzania claim that FGM is spreading into new areas in the region.

Clitoridectomy and labia excision (Type II) is the most common type of circumcision in Tanzania, while infibulation is mainly performed among ethnic Somalis and Nubian (Sudanese) immigrants.

In interviews, partners and informants voiced a certain scepticism regarding the information from the DHS survey of a decreasing FGM prevalence rate. Representatives from the Women’s Research and Documentation Project Association (WRDP) for instance referred to a study in one area which included clinical examination, which showed that the prevalence was far higher than the 20 percent reported by DHS.⁴⁴ Furthermore, the study indicated that through intermarriage FGM is spreading to groups that traditionally did not circumcise their girls. It also showed that with higher mobility of the population, some communities have adopted more severe types of FGM. It was also reported that because of the law or for religious reasons people tend to adopt types of circumcision that require less cutting.

A general lowering of the age at which FGM is performed is observed, as well as a certain tendency to medicalise operations. One reason given for the lower age is the need to control young girls’ sexuality and morality. The law and the criminalisation of the practice has also contributed to lower the age of operation; very young girls cannot protest or tell on their parents or older relatives.

The most cited reasons for the enduring practise of FGM concern the construction of cultural and social identities. Through circumcision girls (and boys) become adult and moral persons and in that capacity they are able to marry and reproduce. Exceptions are found in the Iringa and Mtwara regions (in the southern part of the country), where hygiene and prevention of ‘modern’ diseases such as *lawalawa* are given as a major reason. The standard cure of *lawalawa* that attacks the genitalia of women (and men) by itchy, black spots, is circumcision. Thus if the *lawalawa* disease continues to spread, circumcision may also very well do so.⁴⁵

43 Demographic Health Survey, National Bureau of Statistics Tanzania 2004.

44 Personal communication with Hildegarda Kiwasila, April 5th 2007.

45 The Women Resource and Development Project (WRDP) also claims that FGM has become a ‘cure’ for several other genital diseases.

Furthermore, female body parts cut away at circumcision have entered a market of attractive magic objects, hence encouraging parents to circumcise their daughters for profit. These recent developments in Tanzania strongly indicate the dynamic character of the FGM practice. Personal communication Hildegarda Kiwasila, April 5th 2007.

3.7.2 Interventions

The Norwegian Embassy directly funds three NGOs, which work in the area of gender and women's rights.

The Legal and Human Rights Centre (LHRC) is funded through a basket fund with a common plan and budget (NOK 1,5 million for 2006). The contract with LHRC ended last year, but further support may be forthcoming through NCA as the strategic partner. The *Women and Legal Aid Centre (WLAC)* is given funds for legal aid clinics and administrative costs (NOK 1 million for 2006). Together with the *Tanzania Media Women Association (TAMWA)*, the three organisations are all part of the Coalition against FGM. Contracts with the NGOs are normally signed for a three-year period.

WLAC is the present coordinator for the FGM network. It has a rights-based approach, conducts training of paralegals, and enlightens communities and the police on the law against FGM. They have lawyers specifically trained in the area of FGM. They were the instigators of a test court case in Morogoro together with *WLAC*, where a father had circumcised his daughters. They lost the case but achieved publicity on the law against FGM. *WLAC* coordinated the Zero Tolerance Day in 2005 (the coordinating role is on a rotating basis between organisations). *WLAC* runs advocacy campaigns jointly with *LHRC*, raises awareness on FGM in the context of HIV/AIDS and how it contributes to spreading the disease, produces national and local radio programs, networks, provides publications and legal research and provides human resources in terms of attorneys in connection with court cases involving *LHRC*.

LHRC is an NGO which organises training of paralegals, enlightens communities and police on FGM, conducts advocacy campaigns and is the leading coordinator for a national anti-FGM network. *LHRC* coordinated the Zero Tolerance Day in 2007. The organisation contributed human resources in the above mentioned court case, and work to raise awareness of the effect of FGM in the context of HIV/AIDS infection. In their awareness campaigns they attempt to reach everybody, but with legal aid they target women. Continued financial support may be provided through the NCA partnership.

TAMWA attempts to raise public awareness on gender-based violence through advocacy, training and capacity-building and information dissemination. *TAMWA* employs a "Bang Style" journalism, which entails the diffusion of information to various media institutions at the same time. *TAMWA* has established a crisis centre for victims of gender-based violence. Because they generally only receive funding for small one-year projects against FGM, the organisation expresses a lack of financial resources to conduct follow-ups, to lobby politicians or to visit villages in the combat against FGM, thus limiting their FGM activities.

The Embassy has established a strategic partnership with the *Norwegian Church Aid* focusing on accountable governance and economic justice, inter-religious dialogue for peace and the end to violence. NCA will introduce "Women and Men addressing Gender Based Violence" in next year's country programme. The current contract expires in December 2007. NCA's local partners are the *Church Council of Tanzania (CCT)* and *Bakwata*.

CCT operates in Mara with trainers organising workshops, using facilitators on topics of tradition and culture, and introducing alternative rites of passage. The organisation works with local authorities and target religious leaders and all gender and age groups. Until recently these activities did not involve young men, but the organisation has been encouraged by locals to include this group as well. *CCT* also plans to conduct media campaigns and facilitate the creation of change agent groups. The budget for 2007 is NOK 200 000.

Partnership with *Bakwata*, the National Muslim Council of Tanzania, has just been initiated and their focus at this stage has been on theoretical clarification. *Bakwata* plans to initiate radio and TV projects and a suggestion has been made of a tour with interchurch dialogue. *Bakwata* is funded by the Norwegian Embassy through the strategic partnership with NCA. The budget for 2007 is NOK 65 000.

Care runs Women and Girls' Empowerment (WAGE), a country program to strengthen women and girls' rights. They organise savings and loan groups from which funds may be accessed, for instance, for school fees or health services. They also conduct information work on women's rights, reproductive and sexual health including FGM. The total budget is NOK 7 million.

The Tanzanian branch of *Inter-African Committee (IAC)* is supported by Norad and *Forum for Women and Development (FOKUS)* through the Norwegian *Women's Front*. IAC is an umbrella organisation of national committees in 28 African states. IAC works to design programmes and policy applicable to the 28 states and to introduce FGM policies to the UN agenda. The Women's Front supports two regional chapters of IAC in Tanzania; Dodoma and Singida. IAC conducts training sensitisation campaigns, carries out advocacy efforts, develops information materials, research projects and alternative rites of passage. They have opened a clinic in Moshi giving treatment for urinary tract infections contracted as a result of cleaning with sand due to lack of water. People believe these types of infections may be cured by performing FGM. Funding from the Women's Front and Norad for 2007 is NOK 135 000 to the Singida branch and NOK 129 789 to the Dodoma branch. With funding from FOKUS, the Women's Front supports IAC's work towards youth and the empowerment of women. Funding was for 2006 NOK 694 582 (international youth conference), for 2007 NOK 249 200 (empowerment courses) and for 2008 NOK 700 000 (support to another international youth conference). Moreover, the Women's Front supports the IAC network to support their planning, advocacy work and programme officers at the head quarters. Funding to the network from the Women's Front and Norad for 2007 is NOK 1,5 million.

3.8 UN Interventions

The multilateral activities related to FGM that the team has been able to ascertain are presented below. Several UN organisations are active in the work against FGM and are provided with core funding from MFA. Norwegian donor core funds allocated to UN organisations are difficult to trace to specific projects. To the team's knowledge, MFA does not provide project based or earmarked funding for FGM specifically to UN organisations. In addition to core funding, specific partnership agreements have been signed between Eritrean and Ethiopian Embassies and UN organisations for specific interventions. Multilateral activities related to FGM that the team has been able to ascertain are presented below.

3.8.1 Ethiopia

WHO is involved in advocacy to raise FGM awareness amongst health workers. The organisation gives technical support to the Ministry of Health and the Woman's Affairs departments. It cooperates with IAC on advocacy, conducts training at mid-level, and produces training manuals. WHO is particularly concerned with the high maternal mortality rates in areas where female circumcision is widespread.

UNICEF assists the Government of Ethiopia and the Women's Affairs Offices, and conducts advocacy work with a focus on HTPs. They train facilitators at the *kebele level*, teaching the facilitators basic communication skills, reproductive health education, and information about how early marriages lead to fistulas. They work to integrate HTPs and HIV/AIDS into the project. UNICEF has conducted surveys in three different ethnic groups and is planning to collaborate with Rohi Weddu and the Midwives Association.

UNFPA has a gender programme focusing on reproductive health, including FGM, and conducts programme advocacy, scientific research and small model projects. One such project is on emergency obstetric care in Axum training "barefoot-doctors" to do Caesarean sections. The need for obstetric surgery is related to adverse delivery effects of circumcision practices.

3.8.2 Kenya

UNICEF operates in the North Eastern province. The programme has a community-based approach. Together with Population Council of Kenya, UNICEF trains health service providers to increase the quality of obstetric care and promote safer maternal health, increase psychosocial support for affected women, buy supplies and train staff. Together with the Ministry of Education, UNICEF works to increase access to education, to introduce solar lighting

programs, to improve water and sanitation facilities, to organise training for dispirited, isolated teachers and to build boarding facilities for girls. All these are strategies to combat FGM. UNICEF has tried to get the Ministry of Education to add life skills to the school curriculum, and FGM is now being introduced in all schoolbooks. UNICEF has also attempted to get an inter-ministerial taskforce to work against FGM, and suggested that the Ministry of Gender, Culture, Sports and Social Services lead the work, but failed due to political obstacles. According to UNICEF, the National Focal Point against FGM is not operational. UNICEF also informed that the Central Bureau of Statistics is providing a new Multiple Indicator Cluster Survey (MICS) in one month's time.⁴⁶

UNFPA is working through the following implementing partners: SAIDIA in Samburu District, Tasaru Ntomonok Initiative in Narok District, the Catholic Diocese of Nakuru, Archdiocese of Nairobi and the Council of Imams and Preachers of Kenya. The projects focus on supporting the communities to design sustainable mechanisms for eliminating gender based violence such as FGM and early marriage, provide counselling and rehabilitation for those who have undergone FGM and sensitise and mobilise religious and community leaders, teachers and traditional circumcisers to support and advocate for the elimination of FGM. The implementing partners also promote basic reproductive health services and HIV/AIDS prevention campaigns.

3.8.3 Somalia

UNICEF implements interventions targeting young parents whose daughters are approaching the age when FGM is customarily performed, as well as opinion leaders that can influence the decisions of individual families. They use awareness-raising education and community mobilisation. The *UNICEF* programme activities have included workshops bringing together authorities, elders, religious leaders, health workers, women, youth, educators and displaced persons to debate and reach consensus within the context of Islam. It advocates total abandonment of the practice. Currently, the focus of *UNICEF* interventions is on advocacy and mobilisation of communities, engaging families with young girls, focusing on youth who will be future parents, and targeting the leaders who exert influence over community members. The *UNICEF* interventions fall into two categories: interventions aimed at behaviour change through awareness-raising and increased capacity of individuals and communities to make choices that break the current 'norm', and interventions aimed at change in the societal norms i.e. change in the status of FGM as a desirable act within the society at large.

3.8.4 Tanzania

Tanzania is a pilot country for the UN Reform. *UNFPA* in Tanzania coordinates and chairs the overall work on gender among the UN organisations in Tanzania. *UNFPA* works to ensure that the poverty reduction plan of 2006 includes measures against gender-based violence and general policy development in close cooperation with the Ministry of Community Development, Gender and Children, NGOs, religious organisations and Tanzania gender networking program to adopt a strong gender program and focus on population development and reproductive health. The organisation has established a youth advisory panel using innovative approaches on the issues of FGM which involves youth in programmes both on policy and programme levels. The new country programme launched in January by FemAct and the Ministry of Justice and Legal Affairs includes a gender-based violence campaign which includes FGM. Attempts are being made to revise the current Marriage Act which allows girls of 15 to be married with parents' consent.

3.9 Intervention Analysis

The number of Norad supported activities aimed at eliminating FGM varies between the different countries. Ethiopia in particular stands out in terms of the number of projects, while Sudan and Somalia have few. The number of projects funded by the various Norwegian embassies also varies between countries.

The Norwegian Action Plan against FGM has an annual frame of NOK 20 million. In 2005, an estimated NOK 16,8 million was channelled to projects that included FGM in their

46 Information provided in personal communication with Roger Pearson at UNICEF in Kenya on March 20th 2007. Frontiers in Reproductive Health Population Council is an NGO funded by USAID and UNFPA, and works with health care providers in the North Eastern Province, with religious leaders in Wajir, and with Care and UNICEF in developing education manuals. They have also conducted major research into FGM interventions, methodology and promising practices. Both organisations have no funding from mid-2007. Personal communication with Director Ian Askew on March 21st 2007.

focused efforts. A rough estimate based on budgets for 2007 indicate that the figure will be approximately NOK 45 million for the six countries. This figure, however, includes integrated and holistic development projects with wider targets, and includes an adolescent and youth project between UNFPA and UNICEF in Ethiopia. Interventions in other countries than the six mentioned are not included.

From the information provided above on the various projects and interventions, it is clear that the vast majority of these interventions are preventive. Rehabilitation and treatment is only exceptionally the focus of FGM projects. The chosen approaches are largely either community-based or focused on the media and advocacy. Community-based projects target a broad spectre of citizen groups, including men, women, young people and religious and other leaders. Many projects involve general community dialogue or community intergenerational dialogue. The projects may involve the employment of change agents or training of trainers, the organisation of workshops or establishment of anti-FGM groups. Many projects focus on advocacy, running media campaigns towards the general population, producing pamphlets, t-shirts, radio talk shows and radio call-ins or disseminating information to local or national authorities. Many interventions have a rights-based approach to FGM, providing education on the laws and rights of women and children. Many also have a health-oriented component, relating FGM to reproductive health, HIV/AIDS or HTPs which then serve as an entry point into the communities.

A few have a more practical approach, such as the provision of legal advice, income-generating opportunities for ex-practitioners or women, loans to women and the introduction of alternative rites of passage. Very few provide shelters or housing for run-away girls. The provision of shelters generally appears less systematic, and more on the level of individual persons housing run-away girls. There is little or no provision of protection for girls and their families; one partner had plans to start up a protection unit at the police station, another has community development workers who visit families and report to the police if someone is endangered. Shelters would give assistance to the girls, but in areas where great stigma is attached to being non-circumcised, parents and siblings also suffer immediate threats from their environment – in some cases violence. They are thus dependent on the competency, will and resources of the local police.

Quite a few of the interventions focus on the provision of information on FGM to teachers and students in schools, either to sensitise or to encourage the establishment of anti-FGM clubs. Schools are thus used as entry points to pass on information on FGM to, for example, parents. Other projects are concerned with the provision of schooling for girls, boarding facilities or funding for school attendance.

As far as health service is concerned, a relatively large number of projects are concerned with the provision of FGM information to health service providers such as doctors, nurses and midwives. Services related to treatment or rehabilitation of girls and women included psychosocial/trauma counselling or health service provision. The IAC in Moshi in Tanzania has established a clinic that provides treatment for urinary tract infections. A few have established specialised services and provision for treatment of fistula. The referral of women for fistula treatment (apart from those providing separate fistula clinics) appears to be rather unsystematic and more on an ad hoc basis. A few projects provide psychosocial/trauma counselling.

The provision of health services is a government responsibility. However, in many of the countries, and in particular in remote rural areas, health service provision is highly inadequate if not completely absent. Thus, women in these areas will not have access to health care facilities that can alleviate complications suffered from FGM. Moreover, prolonged and complicated labour is a factor contributing to mother and child mortalities, and as the table in Chapter 2 shows, maternity mortality ratios are very high in these six countries. Skilled attendance during delivery is thus an important factor. Issues related to treatment will also be examined Chapter 6.

In conclusion, FGM related cooperation with the six countries is mainly driven by geographically dispersed 'projects' rather than large-scale support to central institutions.

Although disparate, this project-based support shows many commonalities with reference to approaches and types of interventions, wherein NGOs see the importance of involving both religious leaders, men, women and children in the effort of combating FGM. FGM is related to both health and human rights, but the general impression is that the NGOs' efforts of integration into large-scale sector-based efforts such as education, health information and services and human rights are quite unsystematic. Nonetheless, exceptions do occur, for instance in the case of UNICEF Kenya, which seems to have a relatively coordinated strategy with both the educational and health sectors.

A selection of evaluations and reviews regarding projects, prevalence, approach methods and best practices are provided in Appendix IV, sorted by country.

4. Organisational and Administrative Arrangements

4.1 Integration of FGM in Norwegian Strategy Documents

As a human rights, health and gender issue FGM may be included under several general labels, for instance “reproductive health” or “gender-based violence”. However, the team has reviewed strategy documents on the basis of whether they mention FGM specifically. Generally it appears that in the case of the strategy documents where children and young people are the focus, the elimination of FGM has been integrated as a specific objective. FGM has also been included (although only with one sentence referring to the Norwegian Action plan against FGM) in the updated strategy document on fighting poverty (2003-2004), whereas it was not mentioned at all in the original document from 2002. FGM is also included in the recent strategy document on women’s rights and equality. FGM is not mentioned in the latest position paper on Norway’s HIV/AIDS policy, nor is it included in strategy documents on education, indigenous people or peace and security. FGM thus appears to be integrated in documents specifically focusing on women (although not in the strategy document on forced marriages) and children, but not in other relevant sectors such as HIV/AIDS, security or education. Appendix III presents strategy documents separated into those that mention FGM and those that do not.

4.2 General Information on Project Organisation

The reorganisation of the Norwegian Ministry of Foreign Affairs and Norad in 2004 changed their respective roles and responsibility with regard to bilateral assistance to developing countries. Until then, Norad had been responsible for this kind of assistance, but after the reorganisation the embassies’ administrative role was expanded substantially.

FGM related efforts may be funded through a wide range of budget allocations, the most common being those managed by the Norwegian embassies or Norad. Concerning the division of labour between the two institutions, Norad supports Norwegian NGOs which work in partnership with local organisations. The overall purpose of the allocations is for Norwegian NGOs to contribute to building civil society in the partner countries.

Norad gives funding on the basis of project applications for long-term agreements (*rammetilskudd*) or single agreements. Norad may give funding through Norwegian NGOs who cooperate with local NGOs, or via umbrella organisations. Local partners report to the local Norwegian NGO office or the headquarters in Norway (alternatively to the umbrella organisation), which again reports to the Department of Civil Society of Norad. Norad also administers the support to international NGOs (INGOs). Norad receives applications for single and long-term agreements from Norwegian NGOs in October each year. The respective embassies are consulted in the assessment of the applications.

Funds from the Norwegian Ministry of Foreign Affairs are channelled through various budgets, such as the regional allocation (*regionbevilgning*), gender allocation (*kvinnebevilgning*), formerly through the allocation for human rights and democracy and as multilateral assistance. The embassies, on behalf of MFA, administer the regional allocations and country allocations for MFA, while MFA administers the general multilateral support to organisations such as UNFPA or UNICEF. Political guidelines for each country are revised every year. The embassies may give financial support to Norwegian and/or international NGOs operating in the country (strategic partnerships) and local NGOs, country offices of the multilateral organisations or as bilateral support to local or national government structures such as departmental ministries. Local organisations may request the embassies for funding, or the embassies’ strategic partners.⁴⁷

⁴⁷ The three paragraphs above are based on information provided by Norad and MFA.

The reorganisation of MFA and Norad has had certain undesirable effects, although some of these may be temporary. Information about the reorganisation and its consequences has not reached all local partners and may present obstacles in their efforts to apply for funds. Another confusing issue for partners may be that allocations from Norad may be directed by other guidelines than those of the embassies. For instance, the Norwegian Embassy in Ethiopia has guidelines which emphasise good governance, natural resource conservation and human rights. This means that partners who address the Embassy with projects within the field of for instance education, cannot be supported by the Embassy since the guidelines for the bilateral cooperation exclude this sector.

The present arrangement poses challenges in terms of coordination and information-sharing, as the embassies do not always have sufficient knowledge about other Norwegian funded projects in the country. A project by Care Ethiopia in the Afar/Awash region was for instance funded by Care Norway. Care Norway, however, withdrew their funding due to head office priorities. This information only reached the Embassy by coincidence. As the Embassy regarded the projects worthy of continued support, it was decided to secure further Norwegian funding by including the project in the group of projects financed by the Embassy and managed by Save the Children Norway (Ethiopia). Thus, despite the existence of a reporting system where the embassies are informed by Norad about which Norwegian NGOs that have received funding, there is still a potential for improvement in the communication lines between the embassies and Norad/MFA as well as between the embassies and NGOs.

4.3 Country-Specific Information

Different political and economic developments and national organisational arrangements with regard to funding partly explain the differences in funding practices between the Norwegian embassies.

4.3.1 Eritrea

According to a recent report⁴⁸ and the Norwegian Embassy, the abandonment of FGM is given high priority by the Government of Eritrea, and according to the Embassy in all parts of the government structure. The Norwegian Embassy additionally pointed out that the media is active in awareness raising and sensitisation campaigns. The national strategy on FGM/C⁴⁹ abandonment aims to be a multi sectorial and integrated approach that promotes an efficient use of resources. According to the Embassy this may require increased financial support in addition to the strengthening of capabilities of advocacy work and dissemination of knowledge to the local implementing partners.

4.3.2 Ethiopia

The Embassy in Ethiopia manages approximately 40 percent of the total Norwegian assistance to Ethiopia, while the remaining 60 percent is administered by Norad and the Norwegian Ministry of Foreign Affairs, including humanitarian and multilateral assistance. Being a pilot country in the effort to eliminate FGM, the Embassy is scaling up its efforts. Based on the Norwegian Government's International Action Plan for Combating FGM, the Embassy has developed its own strategy for the work in Ethiopia. The strategy has three components: 1) preventive measures and social mobilisation against FGM, 2) treatment and rehabilitation and 3) competence building. The Embassy has a previous strategic partnership with SCN-E and NCA in the area of FGM (NOK 7,5 mill. in the period 2005-2008). In December 2006, the Embassy signed a strategic partnership agreement with SCN-E as an appendendum to the previous agreement. SCN-E will manage a total of NOK 44,5 million over four years. Through this agreement, SCN-E enters into and manages agreements with several organisations on behalf of the Embassy. The decision-making authority, however, rests with the Embassy. The aim of the additional partnership is, by close collaboration, to avoid overlapping and to improve monitoring and evaluation routines. By outsourcing the day-to-day management of agreements with local partners, the Embassy is given more capacity to increase its policy and advocacy work. SCN-E will be responsible for the administrative, professional and economic follow-up of projects.

48 Berggrav, M., Strøm, N. and Taraldsen, S. 2007: Draft report.

49 Female Genital Mutilation/Cutting, a combined term frequently encountered in the literature.

The mismatch between the *Ministry of Women's Affairs (MOWA)* broad and important mandate and its low capacity was well known to the Embassy, and was taken into account when planning the support to the MOWA. The Embassy was willing to provide sufficient human resources to design and follow up the support. However, after cuts in the Embassy's administrative budget, and consequent re-allocation of resources, it was decided that the Embassy could no longer take on this huge task in 2007. The NOK 9 million from the gender allocation set aside for this purpose were thus returned.

4.3.3 Kenya

Subsequent to the suspension of diplomatic relations between Norway and Kenya, it was only in 2004 that a new cooperation agreement was established. The only major bilateral programme is for anti-corruption. Kenya's share of the regional allocation is NOK 40 million in addition to the multilateral assistance to the UN offices. Hence, there is lesser bilateral activity and more multilateral activities, as Nairobi houses the UN headquarters and is the centre of a huge UN activity. The Embassy does fund one anti-FGM project directly under its human rights focus, that is MED mentioned above.

4.3.4 Tanzania

Norwegian funds (NOK 170 million) to Tanzania are channelled through General Budget Support (GBS), which is a general pool allocation to the government via the Ministry of Finance. This is a strategy of donor harmonisation towards the Tanzanian government's national development strategies to alleviate poverty (*MKUKUTA* and *Tanzanian Assistance Strategy JAS*). The intention is to make the Tanzanian government responsible. Other ministries apply for project-based funds from the Treasury and there is strict control that the funding is used to the designated project. This entails fierce competition between ministries. The Ministry of Community Development, Gender and Children has a separate directorate on FGM. They apply to the Ministry of Finance for project-based funds. The Ministry of Community Development, Gender and Children often lose to other ministries in the battle for funds.

The *Gender Macro Working Group* consists of foreign development partners (including the Norwegian Embassy), gender focal points (based in the different departments to ensure gender mainstreaming) and representatives from civil society. This constitutes a technical arm of the Ministry of Gender and conducts policy discussions on the Ministry's mandate to mainstream gender. The focal points, however, need to be strengthened.

The Embassy is moving away from funding small individual NGO projects. In 2005 it entered into a general strategic partnership with NCA (see 3.7.2) in order to engage more effectively with the civil society and reduce transaction costs. This partnership covers all aspects of democratisation development, and not solely FGM. The Embassy will organise a seminar in the second half of 2007 involving Norwegian NGOs and their Tanzanian partners. The seminar is scheduled to discuss and share information on gender and women's issues, including FGM.

The Embassy further channels funds (NOK 1,3 million) through the *Foundation for Civil Society*, established by likeminded donors, now a Tanzanian NGO. The purpose is to create a more harmonised and better organised support to civil society. Local NGOs apply for grants. These grants are given to all kinds of projects and not solely to FGM. The contract expires in December 2007.

4.4 Resources

With reference to the availability of human, financial and institutional resources, the Norwegian NGO partners expressed a relative contentment as to the human resource situation. Knowledge of this competence area seems slightly person-dependent; arising from the personal dedication to raise FGM within the organisations rather than from an institutionalised focus on FGM. Increasing the emphasis on FGM and gender-based violence posed internal structural difficulties for some.

Some informants expressed disappointment that the Action Plan against FGM was not followed by increased allocations of funds, which meant that the NGOs dedicated to the cause had to

reallocate from other sources. In terms of institutional adequacy there had been difficulties in finding FGM dialogue partners within the MFA, especially regarding questions of finances. Moreover, some expressed difficulties in accessing the recent gender allocations; others found a lacking systematic follow-up of the Action Plan or clarity as to departmental responsibilities.

In the partner countries, the availability of resources may depend on the location of the projects. In general, local NGO partners in urban offices reported having adequate human resources with little turnover of staff, but still in need of financial resources to properly follow up projects.⁵⁰ The partners localised outside urban areas, however, emphasised both the lack of (skilled) staff (huge areas to cover and difficulty in acquiring personnel willing to work in these remote areas, high turnover of staff), overburdened focal persons and strong financial constraints.

As the project cycle progresses, new needs arise, such as the need for scaling up to neighbouring villages, increased needs for school fees,⁵¹ land allocation to girls, support mechanisms and provision of security for those opposing FGM and refusing to undergo or have their daughters undergo the procedure.⁵² Particularly projects implemented in marginal areas are faced with these difficulties. Lack of means to follow up and take on new responsibilities may discourage local participation and endanger project sustainability.

Furthermore, some informants mentioned the police, the degree of corruption and local and national government stakeholders as representing obstacles to further progress. Political instability poses another problem in certain areas, where local authorities have mistaken huge gatherings of people for anti-FGM purposes as being anti-governmental political meetings.

In conclusion, the human resource situation seems relatively adequate at the moment for the NGOs having administrative responsibilities or those with urban offices, while local implementing partners have inadequate human resources. In terms of funding, both administrative and implementing Norwegian and local NGOs express the need for increased allocations over a sufficiently long time span.

⁵⁰ According to the Norwegian Embassy in Eritrea, however, the central offices of the local partner National Union of Eritrean Women (NUEW) do not have the necessary human resources and suffer from a high turnover of staff.

⁵¹ This was also a strong concern raised by local women against FGM in Ittuntum village who were part of the MED project in Kenya. They wished not to circumcise and send their daughters to school, but although primary school is free there were expenses such as books, and secondary school is not free. If a girl was not circumcised, the parents would need to send her to school, thus amassing additional expenses.

⁵² In the Dadaab refugee camp on the Kenyan border to Somalia, a mother who opposed FGM showed her son who had lost his eyesight following violence because his sister was not cut. Girls could not fetch water or firewood on their own, and both men and women opposing FGM felt the security issues most pressing – they all felt vulnerable and susceptible to violence.

5. Evaluation Indicators

There are various means of evaluating efforts against FGM, and on various levels. One level is the combined Norwegian efforts against FGM focusing on outputs and outcomes, while another is on actual impact or social change. Furthermore, evaluation may focus on the Norwegian efforts at country level, or at the local level. Appendix V presents a table suggesting possible indicators for evaluating the overall implementation of the Action Plan. The table suggests output and outcome indicators for policy, funding and competence building respectively.

A potential challenge with regard to the measurement of the suggested indicators, involve the assessment of whether Norway achieves the 25% budget increase suggested in the Action Plan or not. Funds are not necessarily earmarked for FGM activities, and FGM is often one among other components in integrated village development projects. These factors coupled with the fact that there is not a separate DAC sector code for FGM, makes it difficult to acquire precise figures.

The Action Plan focuses on targeting religious and other leaders. The table in Appendix V has added “appropriate groups” under output indicators although this is not mentioned in the Action Plan, seeing as the lessons learned point to the importance of involving men, young men, women, children and practitioners in the sustaining of efforts.

5.1 Reliability and Validity of Prevalence Data

Due to the sensitivity and complexity of FGM, reliable data gathering poses huge challenges, both in terms of determining prevalence and of assessing development impact. Even large scale surveys such as DHS or those undertaken by UNICEF have weaknesses in their findings. A large part of this is due to the fact that data gathering on FGM prevalence is done by self-reporting, and thus to a large extent prone to be influenced by the participants’ motivations and the mutual trust embedded in the interview situation. Moreover, in terms of type of FGM, many women and girls are not aware of which type of cutting they have undergone, reducing the validity of data. An added problem is the fact that some geographical areas are very difficult to reach and for that reason may be omitted from data gathering. Finally, the age cohorts used do not encompass the age from 0 to 15 years.

In spite of numerous challenges and uncertainties with regard to reliability and validity of data, the securing of baseline data prior to the implementation of projects is highly important. It is important in order to secure both appropriate design and sound planning of interventions (whom to address, finding appropriate entry points, the units to target, i.e. one village or several intermarrying villages) as well as for evaluating project processes and impact. There is, however, no single indicating factor that may be used to monitor and evaluate project impact at a reasonable cost.

5.2 Outcome Indicators

Measuring a community’s raised awareness level subsequent to an intervention seems relatively reliable. Many partners use this type of measurement. The questions posed may be concrete – some not very sensitive – and may therefore capture any raised awareness within the community. In particular, this may be so as the communities themselves gain something from educative and awareness-raising projects, particularly when addressing health issues. In areas where the health system is deficient, villagers depend on their own capabilities for gathering information relevant to their lives, and may be keen recipients of information on issues such as HIV/AIDS or other health matters.

Local outcome indicators of raised awareness may be knowledge as to what female genitals look like and knowledge of rights and health consequences, the extent to which girls declare

their intent not to be circumcised, and the number of boys expressing willingness to marry uncircumcised girls. Media campaigns, radio serial dramas and advocacy projects would use factors such as the amount of letters received, people visiting their sites, radio responses, parliament discussions, the activity level of the ministries and information dissemination among the target groups as indicators of outcome.

5.3 Impact Indicators

The ultimate aim of FGM intervention is social change and lowered prevalence. Identifying robust indicators to measure and monitor progress is a challenge in project management. An added difficulty arises from the fact that several factors usually *coincide* in order for changes to take place,⁵³ and single factors are generally not sufficient. Moreover, the before-and-after method applied when gathering baseline information to be used as assessment criteria presupposes that other non-registered changes do not enter into the picture. Thus, if there are several interventions directed at the same target group within the same community, it may be difficult to assess which intervention has had the larger/lesser impact; whether it be for instance local/national legislation, radio programs or directing interventions toward men, women, religious leaders or children within a community.

At the international and national levels Demographic Health Surveys (DHS) and Multiple Indicator Cluster Surveys (MICS) are important measurement tools. One possible method for gathering baseline FGM information is to use UNICEF's five standard indicators for situation analysis agreed upon by the Global Consultation.⁵⁴ These include:

- Prevalence of FGM by age cohorts 15-49
- FGM status of all daughters
- Percentage of "closed" (infibulation, sealing) FGM or "open" (excision)
- Performer of FGM
- Support of, or opposition to FGM by women and men age 15-49

The Global Consultation could not agree on the definition of younger cohorts; some suggested cohorts 0-9 and 10-14, others 0-15. The issue remains unresolved. Moreover, data on incidence cannot be provided by DHS or MICS as women, as noted above, are most often unaware of the type of circumcision they have been subjected to. An accurate picture of local level prevalence may better be provided by locally based or small-scale surveys.

FGM prevalence figures by age cohorts by five-year groups indicate the number of women and girls who have undergone circumcision. The FGM status of daughters may do the same, but may also be an indication of changes in the age at which FGM is performed. The percentage of "closed" or "open" and differentiation between various performers of FGM may provide indicators as to changes in circumcision practice, for instance as to types of cutting or extent of medicalisation. Performers of FGM indicate both the numbers of practitioners, as well as the type of practitioner; whether they are traditional circumcisers or health professionals. Expressions of support of or opposition to FGM may indicate attitudes and attitude changes, but responses may also be vulnerable to the political environment regarding FGM.

To assess the effectiveness of programs promoting the abandonment of FGM, the following three local level indicators were agreed upon by UNICEF: 1) public declarations of intent; 2) community-based monitoring mechanism to follow-up on girls at risk; and 3) drop in prevalence, which can be obtained at the local level over a minimum of five years and where a baseline survey has been conducted.

It is important to be aware that a means (raising awareness) does not constitute a final goal,⁵⁵ increased knowledge does not equal FGM abandonment. Women usually know whether they are circumcised or not and interview material may provide quite reliable data on FGM abandonment, but the only certain means of finding actual FGM prevalence is clinical examinations. Spot tests at maternity clinics or other health facilities could provide useful data for limited populations. The lack of health facilities, however, may constitute a constraint for

⁵³ As the Rattsø Committee points out in Ministry of Foreign Affairs 2006: New Roles for Non-Governmental Organisation in Development Cooperation.

⁵⁴ UNICEF 2005a.

⁵⁵ As pointed out by Rainbo in their evaluation of Norwegian Church Aid projects in Norwegian Church Aid 2005a.

this type of measurement. In Ethiopia, for instance, only six percent of women benefit from skilled attendance during delivery.

The Women Research and Development Project Association (WRDP) in Tanzania points out that sustained change can only be seen after a lengthy process involving many actors and considerable inputs at individual, institutional and community levels. One may need continuous support with funds for institutional capacity-building including facilities for treating diseases that induce people to circumcise. The most effective and practical way to monitor and evaluate progress is to link baseline socio-cultural, environmental, and economic studies related to FGM with age cohort longitudinal clinical studies for future impact assessment of effectiveness.⁵⁶

In summary, one might say that in terms of evaluating efforts against FGM, it is far less challenging to measure outputs and outcomes than factual impact in terms of lowered prevalence. Declining prevalence and changed attitudes towards the practice is the ultimate aim of FGM-related projects and interventions. This involves profound social processes that do not lend themselves easily to the establishment of straightforward causality links.

5.4 Monitoring and Evaluation Capacity

Norwegian-funded projects must be monitored according to the Development Cooperation Manual,⁵⁷ ensuring quality assurance of the progress of the project. According to Save the Children Ethiopia, there is a general lack of monitoring skills among local partners, a certain degree of subjectivity in measuring objectives, and a lack of systematised reporting. The Rainbo report⁵⁸ by NCA mentions some of the same weaknesses in monitoring and evaluation capacities and routines, and NLM Norway suggested that monitoring methods by local organisations may largely be based on counting, i.a. the number of workshops, participants etc., not necessarily very informative when it comes to measuring effect of FGM projects. Indicators for legal aid activities, however, such as the amount of women reached or the number of court cases, may be measured this way.

Some local partners monitor their projects by frequent visits every two weeks, which can be difficult when the settlements are scattered and inaccessible or without access to appropriate transportation (4WDs). MED in Kenya, for instance, described the route to one of the villages with practically no road access and river crossings. Once the project officer had been stranded in the village overnight. Maasai girls have their heads shaved upon being circumcised, thus the frequent visits. Others were given reports by facilitators and girl groups, in other cases from community leaders who would report to the government offices.

When asked whether they had systems and mechanisms for pre- and post-baseline surveys, monitoring and evaluation, some local partners in the countries visited affirmed that they did, claiming to conduct both pre- and post-surveys, while others expressed that they were not good at monitoring. Some conducted their own baselines, others hired consultants, gathered information from other NGOs, EGLDAM, Women Affairs Offices or paralegal units which possessed this kind of knowledge. Others again did not conduct baselines, but initiated projects based on a general knowledge of high prevalence.

It is often said that the less financial resources invested in baseline and monitoring, the less trustworthy the data. Donors often demand evaluations and data from partners but the recipients of the funds may not possess the financial resources to establish baselines and monitoring as desired. These procedures also collide with short-term projects, which leave little room for baseline studies. Funding must thus be sufficient to incorporate studies prior to and during the implementation process.

⁵⁶ The organisation Frontiers in Reproductive Health Population Council in Kenya enhances the importance of research-based interventions, the long-term duration of projects and the provision of sufficient funds for baseline studies. According to H. Kiwasila at Women Research and Development Project Association (WRDP) in Tanzania, evaluation of effectiveness of FGM abandonment efforts in Tanzania must be conducted by independent evaluators using rigorous multiple research methods for triangulation purposes and should be age specific (e.g. 0-5, 6-15, 16+). Clinical examination is a contested method, but should not be ruled out. Community baseline data are important and must be created at the outset of an FGM related project for future assessment of impact. FGM abandonment efforts should be supported continuously and linked to HIV related funding as some girls in Tanzania start coitus early before their initiation to FGM, there is also significant rural-rural and urban-rural migration to areas where FGM is endemic. There must be longitudinal medical study that clinically follows the same girls and women and their children for a long time (20-30 years) or follow a few girls up to the birth of their first child according to WRDP.

⁵⁷ Norwegian Ministry of Foreign Affairs 2005.

⁵⁸ Norwegian Church Aid 2005a.

6. Lessons Learned, Entry Points and Target Groups

6.1 Lessons Learned and Best Practices

Based on communication with partners and the reading of literature, research and evaluations, the team has arrived at some conclusions. The paragraphs below are thus based on a variety of sources. The team concludes that FGM is a social practice deeply embedded in power structures in the societies concerned and represents various meanings and values. The practice is resilient to change, and requires multifaceted efforts with long-term timeframes.

Awareness-raising campaigns and advocacy are generally appropriate and important methodologies in advancing knowledge, but not sufficient to ensure the abandonment of the practice. Focusing solely on the health complications associated with FGM may lead to medicalisation and changes in cutting types, for instance from infibulation to so-called 'sunna'; projects should therefore also include a rights-based focus.

The general lessons learned regarding interventions are that community-based projects, or integrated socioeconomic development approaches, are the most effective. Furthermore, all social groups, men, women, young men, young girls, health workers, religious and other leaders and local authorities, have a role to play in abandoning FGM. A holistic approach meeting other basic needs and prominent concerns, while at the same time focusing on rights and health related effects, appears to be the most viable path.

In order to ensure sustainability and effectiveness, the communities must experience ownership of the projects, and activities must be based on voluntary commitment and participation. Up-scaling to neighbouring or intermarrying villages is frequently necessary. Project duration should ideally be five or six years (or longer), and sufficient funds should be provided for baseline surveys, monitoring and evaluation.

6.2 Entry Points and Target Groups

In order to maximise project impact, the entry points into the communities appear to be of considerable importance. Some interventions may use HIV/AIDS, others reproductive health, HTPs, the rights of women and children or gender-based violence as entry points for discussions on FGM. The particular rationalities for FGM also vary and require different approaches and these should be taken seriously in the designing of efforts.

The best units to target may also change as the practice of FGM has proven to be a dynamic social practice. As stated in Chapter 2 on changes observed, there are certain general trends that may need to be taken into consideration either in the design of projects or their implementation. The increase in medicalisation entails that health workers are performing FGM previously done by local practitioners. Health workers should, therefore, be considered an important group to target. Another change is that among some groups, girls are circumcised at a younger age. In these instances, introducing alternative rites of passage may not have the desired effect as girls will already be circumcised when they reach traditional circumcision age. One should therefore reach parents and schoolteachers in primary schools or health personnel. Some groups circumcise their girls at infancy. Reaching the parents prior to delivery is then important, and health workers at antenatal care clinics, midwives or traditional birth attendants constitute important target groups. However, this approach poses challenges inasmuch as Somalia and Ethiopia in particular have low antenatal care coverage (28 and 32 percent respectively).

Furthermore, Eritrea, Ethiopia and Somalia have low levels of skilled attendance during delivery, which means that it must be important to target those women who assist during deliveries, such as female relatives or traditional birth attendants. The fact that FGM in certain areas is becoming a more private event, losing some of its public ceremonial aspects, may be

an undesired effect of legislation and other attempts at reducing prevalence. FGM practices may be more difficult to ascertain, when girls for instance are brought to neighbouring villages or further afield, to be circumcised. In such situations targeting local practitioners may be insufficient when the girls are cut by practitioners in neighbouring villages. Circumcision types are also changing in some areas from infibulation to 'sunna'. Religious leaders who have taken a stand against FGM may still support the 'sunna' variant, and there is perhaps a need to encourage the religious leaders to further debate this issue in relation to the interpretations of the Koran.

FGM is connected with marriageability. Thus, it may be important to document which villages intermarry so that interventions may target, for instance, young men in these neighbouring villages. Seeing FGM in many instances as a preparation for marriage, the consequences are often early marriages. As the socioeconomic information illustrates, school attendance is particularly low in some countries. Ensuring that girls receive an education, and through the school system receive information on FGM, may be one strategy to delay or combat FGM. It is important to ensure that the daughters' school attendance does not become a financial burden for the parents. Primary school attendance may be free in some countries but not secondary education. Secondary education may be critical as it is at this age that many girls are circumcised. Acquiring a proper education can make girls capable of becoming income-generating agents, a possible motivating factor for parents, and capable of acquiring an economical autonomy which may decrease the urgency and importance of immediate marriageability.

Schools, hospitals or health clinics are largely unavailable in many of the rural, inaccessible areas within the six countries, and many groups do not have the financial resources to access these services. Certain service provisions that may be necessary in order to ensure the sustainability of anti-FGM efforts, such as the availability of schools, teachers, boarding facilities for girls who have not been circumcised, health clinics that provide treatment for genital diseases, skilled attendance during deliveries, the access to clean water to prevent diseases, and institutional and human resources to protect and ensure the safety of the girls and families that have chosen not to practice FGM. Educating local police on FGM and relevant legislation may be important in areas where there is social stigma attached to not being circumcised. In inaccessible areas the police may be largely absent and unable to provide such protection. Other types of protection services may then be needed. Providing treatment for girls and women subjected to FGM is a provision meeting their human rights needs, but may also have an additional effect by enlightening the women on the fact that complications and pains they have endured are in fact due to FGM and not a biological fact of womanhood. This insight may again be shared with other women.

There are considerable challenges in the struggle against FGM. FGM is as noted a social practice embedded with cultural meaning, and is resilient to change. FGM is not a topic those who practice it discuss; it is an intimate and matter-of-fact feature of their everyday lives,⁵⁹ a necessary and for some unimportant issue without any urgent need for change. Getting the local population to acknowledge the importance of FGM, human rights⁶⁰ or women and girls' rights is a challenge in the implementation of projects. For many, other needs are more pressing, like the access to clean water⁶¹ or attending to cattle.⁶² Thus, for project implementers it is important to be both knowledgeable and sensitive, for instance by ensuring that meetings and activities do not conflict with the cycle of pastoralist activities, such as seasonal mobility in search of pastures or the daily attending to cattle that, for a pastoralist, will always take first priority.

59 Talle, A. 2003.

60 Norwegian Church Aid 2005a.

61 For instance mentioned by Care Awash, personal communication with Tamirat Lonseko, Care Area coordinator Awash, March 27th 2007.

62 For instance mentioned by Lilian Seeno, Project Manager, Maasai Education Discovery, personal communication March 23rd 2007.

7. Knowledge Gaps

Some local NGOs identified a gap in general FGM knowledge and a lack of available statistics. Others needed to improve their knowledge about how to systematise and document information on prevalence, on best practices and lessons learned, and on local FGM prevalence and rationality. Finally, others expressed the need for information and experience sharing, as well as more knowledge on research findings on best practices.

Norwegian NGOs mentioned a lack of knowledge on how to gain entry to communities due to the sensitive nature of FGM, how to investigate, evaluate and measure impact, and how to gather baseline data. Partners also required more knowledge on FGM rationality and prevalence, on women's situation and rationalities for instance regarding sexual practices, HIV/AIDS and HTPs in general. Partners further mentioned a lack of experience sharing between organisations and a general lack of communication between researchers in the FGM field and the implementing organisations.

Local and Norwegian NGOs mentioned a lack of cooperation due to the fact that there is a competition for funds. If projects, however, had long-term durations this sense of competition would perhaps not be so pressing, thus facilitating a more fruitful environment for experience-sharing and networking.

Both local and Norwegian partners need information on how to monitor and evaluate FGM projects. Part of the reason for this may be what UNICEF⁶³ points out, namely that there is a need to develop a set of qualitative and quantitative indicators at different stages based upon the different approaches used, such as public declaration, positive deviance approach, integrated development approach, health approach, provision of services and the human rights approach. Different types of interventions may need different types of monitoring and evaluation. Developing appropriate tools for measuring the effect of the various types of projects would perhaps meet this need. Moreover, as evaluation often involves the gathering of quantitative data that are difficult to access, another means would be to apply qualitative and more in-depth case studies as a means of capturing the social dynamics (including changing motives) of FGM processes.

Partners also needed knowledge about local rationalities of FGM, the rationalities of women and knowledge on women and girls' reproductive health. There is literature on FGM prevalence, rationalities and best practices. There are also various Internet pages that have documents on lessons learned, reviews and evaluations, such as the Population Council pages⁶⁴ where such information can be gathered. The partners, however, must be aware of the existence of these sources of information, and there is perhaps a need to make this research known to partners. Local partners may moreover be unable to access relevant information through the Internet, the countries in question may not have adequate bookstores providing relevant literature, and partners may not have the financial means to buy literature. Assisting them with acquiring relevant literature would perhaps be useful.

There is still a need for further research and knowledge on FGM. UNICEF⁶⁵ has underlined the need to undertake further studies to gain in-depth understanding of country-specific social dynamics. For instance, while in Kenya there is a need for further studies on why FGM efforts achieved better results in some areas than others, in Ethiopia research to assess best possible means of entry is needed. Moreover, according to WHO⁶⁶ thorough research is needed in order to understand the role of women in perpetuating the tradition. WHO claims that

63 UNICEF 2006.

64 popcouncil.org/rh/fgc.html

65 UNICEF 2006.

66 WHO 2006.

more women than men support the practice; while publicly opposing FGM many mothers nonetheless ensure that their own daughters are circumcised. WHO experts believe research is needed specifically to probe the complex mechanisms underlying women's attitudes and actions related to FGM, the socio-cultural beliefs and how interventions should best be designed to induce women to withdraw their support.

8. Conclusion

FGM is defined as a human rights issue with considerable adverse health effects on women and girls, irrespective of type of operation performed. The Norwegian Government and other international donors have committed themselves to abandon the practice by 2010 (2015). The Norwegian International Action Plan against FGM is part of that historical and political context. The ambitious vision of FGM abandonment within less than eight years from date would require substantial resources.

This study does demonstrate that the Norwegian Government is involved in the fight against FGM through support to NGOs and multilateral organisations. The collaboration with UN agencies, particularly with UNICEF, which is a major actor in the field, places Norwegian FGM assistance well within the global discourse on the topic.

The designation of Ethiopia as a pilot country is a methodological strategy acknowledging the huge challenge involved; experiences from the Ethiopian case are to be closely monitored and followed-up in order to learn lessons that may be transferred to the context of other countries. The idea of a pilot country is also part of an ambition to generate knowledge and advance strategic thinking in the field.

The numerous projects and actors involved in FGM elimination, which have been detailed in this report, work along similar lines in terms of approach and perspective. A community-based approach, and the involvement of a wide range of target groups (not only women) seem to be a commonality between the projects. Furthermore, prevention is the overall objective of most projects. The emphasis on rights and civil society, and not only health, has widened the scope of FGM intervention. There is still a potential for strengthening cooperation between actors within the field.

The abandonment of FGM, however, is still ahead of us, as the prevalence data of the six countries and the resilience of the practice have shown. On the other hand, there are also changes taking place, with reference to both prevalence reduction and a shift to what people consider less harmful types. The picture of social change across the countries is however not homogenous, requiring that FGM interventions are adapted to local conditions. UNICEF emphasises country-specific 'social dynamics'. Local partners request information and teaching on best practices. The levels of knowledge about FGM and FGM dynamics suggest a considerable potential for improvement.

FGM elimination concerns millions of women. To achieve this aim within a short time horizon will demand a combination of mass mobilisation, a considerable political will and an increase in resources, which should be invested on both micro as well as macro levels.

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Appendix I: Terms of Reference

State of the Art Study:

The Norwegian International Effort against Female Genital Mutilation

1. Introduction

1.1 Background

It is estimated that between two and three million girls are subjected to female genital mutilation (FGM) every year. FGM is practiced in several of Norway's partner countries in East Africa. There are significant differences regarding prevalence as well as type of FGM, both within and between countries.

The Norwegian Government's International Action Plan for Combating Female Genital Mutilation⁶⁷ was launched in 2003, as a "contribution to the efforts to promote the fundamental human rights and health of girls and women". The plan includes a number of measures to prevent female genital mutilation, treat and rehabilitate girls and women who have already undergone mutilation, as well as competence building at all levels. According to the plan the Norwegian Government will intensify its efforts by emphasising FGM in the political dialogue with partner countries, in addition to increasing its allocations to NGOs and international organisations working in this field.

The Action Plan was meant to have an annual budget of NOK 20 mill. by 2005. The launch of the plan did not introduce new earmarked financing, meaning that the effort would have to be realised within the existing budgetary framework.⁶⁸

Norwegian support should be channelled through country programmes, through sector programmes for health and education, in addition to regional organisations and institutions. The UN organisations WHO, UNFPA and UNICEF are particularly important partners in this effort. Institutions and organisations working to promote human rights in the partner countries will also receive Norwegian support, as well as non-governmental organisations working against FGM in countries where Norway is not otherwise engaged in development cooperation (particularly West Africa). Together the measures of the Action Plan constitutes Norway's contribution to the target of eliminating FGM by the year 2010.⁶⁹

1.2 Ethiopia as a pilot

In view of the high FGM prevalence, Ethiopia has been chosen as a pilot country for the Action Plan. So far the activity connected to this status as a pilot has been limited, however, during the spring of 2006 a review⁷⁰ of the Norwegian FGM work in Ethiopia was commissioned, with a view to strengthen the effort. Using the recommendations of this review as a starting point, the Norwegian Embassy in Addis Ababa has suggested ways to operationalise the status as pilot country, including an increase in number and size of supported projects and programmes, raising competence levels and support research and documentation. Furthermore, an expert group, led and coordinated by Norad will be established. Finally, a FGM programme with Save the Children Norway as a link between the Embassy and the other NGOs, will be established.

67 Henceforth referred to as the Action Plan.

68 Figures for 2005 suggest that the Norwegian FGM effort reached NOK 20 mill. Earmarked funding will not increase in the 2007 budget, but funding from the new budget line for Women and Gender Equality may be available.

69 This is the target agreed upon at the 2002 UN Children's Summit. However, this target is now widely regarded as far too optimistic, and several UN organisations and others have extended the target year to 2015, in line with the Millennium Development Goals.

70 Aud Talle, Karen Marie Moland og Sølvi Taraldsen, 2006: *Assessing Options for Increased Norwegian Support to Scale-Up Action Against Female Genital Mutilation in Ethiopia*.

1.3 Follow-up and evaluation of the effort against FGM

During the autumn of 2006 the Ministry of Foreign Affairs (MFA) is embarking upon a process aiming at putting more emphasis on and attention to the international effort against FGM. As a part of this, a strategy for the follow-up of the Action Plan is being developed.

Implementation of the plan is supposed to be evaluated every other year, however, so far a comprehensive evaluation of the plan has not been undertaken. Furthermore, there is a perceived need for updated knowledge generally, and particularly in view of the envisaged increased effort.

An evaluation in the area of FGM has been included in Norad's Evaluation Programme for the period 2006-2008. However, while in view of the announced increased effort, a major evaluation is deemed untimely at present, preparations towards a major evaluation will commence during the latter part of 2008. To prepare the ground for the evaluation, but also to provide knowledge which can be an interesting and useful contribution to the current work, the Evaluation Department is commissioning a state-of-the art study.

2. Purpose

The state-of-the-art study should be structured and presented in such a way that it can serve as an input to the forthcoming evaluation, by providing information and overviews that contribute to establishing a baseline⁷¹ for the forthcoming evaluation. The study should also present an overview of existing knowledge and perceived knowledge gaps, primarily with reference to the chosen case countries (see Chapter 3). The purpose, thus, is threefold:

- Gather and present baseline information to be used as reference points when measuring or assessing change in connection with the forthcoming evaluation. On the basis of the baseline information gathered, the study should suggest indicators that can be used to assess whether the objectives and targets of the Action Plan have been reached. The baseline information should be policy relevant, timely and comprehensible, contributing to monitoring and evaluation at a reasonable cost.
- Identify and present an overview of existing knowledge and sources of information with reference to the practice and prevention of FGM, as well as information and knowledge gaps perceived by key actors.

3. Scope and Focus

The study will in principle cover all channels and modalities, but may choose to emphasise some more than others in view of considerations regarding significance, risk, complexity or other.

In terms of geographical scope, the study should cover Ethiopia, Eritrea, Kenya, Tanzania, Sudan and Somalia. These countries are selected because a significant proportion of the Norwegian FGM effort is located here. Overviews should include measures for prevention of FGM, measures for treatment and rehabilitation, and measures for building knowledge and competence.

The study should cover – but not necessarily be limited to - the following main components and underlying issues:

3.1 Where Are We Now?: Background and Baseline Information

With reference to Norwegian interventions against FGM in the selected countries (see above), information regarding the following areas should be included:

- 3.1.1 Socio-economic information, including type (rural/urban) and size of community, GNP per capita, crude birth/death rate, and life expectancy taking into account gender differences when possible, as well as data regarding school enrolment, availability of health services including services connected to reproductive and maternal health.

⁷¹ A description of existing conditions to provide a starting point against which progress can be assessed of comparisons made.

- 3.1.2 FGM-specific information, including prevalence taking into account type of FGM practiced, the age of the girls when FGM is performed and by whom it is performed, observed health consequences
- 3.1.3 Information about local concerns, including FGM context and justification, association with transitional rites, religious and other relevant cultural context, national and local political and legal infrastructure and legislation concerning FGM.
- 3.1.4 Overview of relevant interventions, including a description of the logic and rationale behind the intervention, with a division into interventions that are primarily directed towards prevention, and those that are directed at treatment and rehabilitation of victims of FGM, and a division of those interventions that are mainly focused on men or women, adults and youth/children including an assessment of whether the majority of interventions have a rights-based or a service-oriented approach, or a combination of both. In addition to bilateral interventions and support to NGOs, include an overview of the Norwegian effort through UNICEF, UNFPA and IPPF.
- 3.1.5 An overview of efforts towards integration and mainstreaming, including an overview of to what extent FGM is integrated and reflected in key Norwegian policy and strategy documents in other relevant areas (including inter alia reproductive health and rights, HIV/Aids, education for girls), and an overview of whether Norwegian funded interventions are integrated and/or coordinated with relevant sector-based efforts (primarily health and education).
- 3.1.6 An overview of organisational and administrative arrangements, including an overview of the major channels through which funding is distributed, an overview of how the FGM work is organised, with regard to division of responsibility between MFA, Norad, the embassies and partners, an overview of the availability of adequate and sufficient human, institutional and financial resources, and how these are distributed between the different modes and channels of cooperation.
- 3.1.7 In preparation for the forthcoming evaluation, present an evaluability assessment, with particular reference to the complexity and sensitivity of the FGM field, and the availability of reliable and valid data.
- 3.1.8 An overview of a selection of evaluations and reviews with regard to results and lessons learned so far.

3.2 Knowledge and knowledge gaps

- 3.2.1 From the perspective of both Norway and partner countries, present an overview of systems and mechanisms for monitoring and evaluation, and available updated research-based knowledge.
- 3.2.2 From both a Norwegian and partner country perspective, present an overview of perceived knowledge gaps, information and data needs, as well as suggestions regarding how these needs can be met.

4. Methodology

- Desk study – review of key documents
- Field trips to Ethiopia, Eritrea, Kenya and Tanzania, meeting key personnel and partners, and gathering quantitative and qualitative, primary and secondary data.
- Structured/semi-structured interviews with key personnel at headquarters, embassies and locally.

5. Qualifications

- Documented experience with producing studies and evaluations
- Good general knowledge of current Norwegian and international development policy
- Thorough knowledge of and experience from the East African region
- Good knowledge of the area of FGM

6. Reporting

An inception report outlining the methodological approach and a detailed work plan shall be submitted to the Evaluation Department for approval within two weeks of commencing the assignment. A draft report is to be submitted to the Evaluation Department for comments. Lastly, a final report is to be handed over to the department within two weeks after receiving comments to the draft report. The report should include information about methods used,

questions asked and individuals interviewed. The final report should not exceed 30 pages, excluding necessary appendices and a two-page executive summary. The report shall be written in English.

Throughout the process, the Evaluation Department will consult with the reference group which has been established for this study.

7. Tentative time table:

- February 12, 2007: Commencement
- March 01, 2007: Inception Report
- April 16, 2007: Draft Report
- May 03, 2007: Final Report

Appendix II: Intervention Matrix

Country	Donor/ Norwegian ⁱ	Local partner	Preventive	Treatment/ rehabilitation ⁱⁱ	Rights based	Service based	Targeting men	Targeting women	Targeting youth/children
Eritrea	Norwegian Embassy/ UNFPA	NUEW	•		•	•	•	•	
	Norwegian Embassy/ NCA	ErOC	•		•		•	•	
	Norwegian Embassy/ NCA	Ministry of Health	•		•		•	•	
Ethiopia	Norad/ SCN	SCN-E	•	•	•	•		•	
	Norwegian Embassy/ SCN-E	SCN-E			•				
	Norwegian Embassy/ SCN-E	EGLDAM	•			•	•	•	
	Norwegian Embassy/ SCN-E	PMC	•		•		•	•	
	Norwegian Embassy/ SCN-E	Care Ethiopia	•		•	•	•	•	
	Norad/ Norwegian Embassy/	KMG	•		•		•	•	
	Norwegian Embassy/ NCA	EGLDAM	•			Ω			
	Norwegian Embassy/ NCA	ADAA	•		•		•	•	
	Norwegian Embassy/ NCA	Rohi Weddu	•		•		•	•	
	Norad/ Norwegian Embassy/ NCA	EOC/ DICAC	•		•	•	•		
	Norad/ Norwegian Embassy/ NCA	OWDA	•		•		•	•	

Country	Donor/ Norwegian'	Local partner	Preventive	Treatment/ rehabilitation ⁱⁱ	Rights based	Service based	Targeting men	Targeting women	Targeting youth/children
Ethiopia cont.	Norad/NCA	WSO	•		•	?	?	•	?
	Norad/NCA	PADET				?	?		
	FOKUS/ Inner Wheel/NMS	EECMY	•	•	•	•	•	•	
	Norad/ Norwegian Missions in Development/ NMS	EECMY	•		•		•	•	
	Norad/ NLM	EECMY	•	•	•	•	•	•	
	Norwegian Embassy	EWLA	•		•	•	•	•	?
	Norad/ FOKUS/ The Development Fund	APDA	•		•		•	•	
	FOKUS/ New Life Community	?	•				•	•	
		WHO			•				
		UNICEF	•		•		• *	• *	• *
		UNFPA	•		•		• *	• *	• *
Kenya	Norwegian Embassy	MED	•	•	•	•	•	•	
	Norad/ ARC-aid	Care Kenya	•	•	•	•	•	•	
	Norad/ NLM	NLM	•		•	•	?	•	
	Norad/ NCA	COVAW	•		•	•	•	•	
	Norad/ NCA	Habiba	•		•	•	•	•	
	FOKUS/ KFUK	?	•		•		?	•	
		UNICEF							

Country	Donor/ Norwegian ⁱ	Local partner	Preventive	Treatment/ rehabilitation ⁱⁱ	Rights based	Service based	Targeting men	Targeting women	Targeting youth/children
Somalia	Norad/ NCA	?	•		•	•	•	•	
	Norad/ Norwegian People's Aid	GECPD and HANAQAAD	•		•	•		•	
	Norad/ Care Norway	Sahan, Sonyo, Shuro, Ministries	•	•	•	•	•	•	•
	FOKUS/ Norwegian Nurses Association	University of Mogadishu	•		•	•		•	•
	Norad/ FOKUS/ Somalian Women's Union	?	?	?	?	?	?	?	?
		UNICEF	•		•		•	•	•
Sudan	Norad/ NCA	SNCTP	•		•		•	•	•
Tanzania	Norwegian Embassy	LHRC	•		•	•	•	•	•
	Norwegian Embassy	WLAC	•		•	•	•	•	•
	Norad/ NCA	CCT	•		•		•	•	•
	Norwegian Embassy/ NCA	Bakwata	•				•		•
	Norad/ Care	?	•		•	•	?	•	
	Norad/ FOKUS/ Women's Front	IAC	•		•	•	•	•	
		UNFPA	•		•				

* With the new Joint Program

i In those instances where Norad and the embassies are not donors, funding may have been provided for instance by umbrella organisations based on funds acquired through television fund-raising campaigns.

ii Treatment is defined as providing either physical or psychosocial assistance following FGM.

Appendix III: Integration of FGM in key Norwegian Policy and Strategy Documents

Reference to FGM is made in:

- *Government Budget Proposal No. 1 (2006-2007) for the fiscal year 2007*. Norwegian Ministry of Foreign Affairs.
- *On Norwegian activities in Annual Report. Human Rights 2004/2005. Annual Report on Norway's Efforts to Promote Human Rights*. Norwegian Ministry of Foreign Affairs 2005.
- *White Paper No. 35: Fighting poverty together. A comprehensive policy for Development (2003-2004)*.
- *Three Billion Reasons. Norway's Development Strategy for Children and Young People in the South*. Norwegian Ministry of Foreign Affairs 2005.
- *National Plan of Action. Norway's follow-up on the United Nations Special Session on Children*. Norwegian Ministry of Children and Family Affairs 2003.
- *The Rights of the Child. Norway's third report to the United Nations Committee on the Rights of the Child*. Norwegian Ministry of Children and Family Affairs and Norwegian Ministry of Foreign Affairs 2003.
- *United Nations Special Session on Children May 2002. Report to the UN on Norway's follow-up January 2007*. Norwegian Ministry of Children and Equality and Norwegian Ministry of Foreign Affairs 2007.
- *Satsing på barn og ungdom. Regjeringens mål og innsatsområder i statsbudsjettet 2007. [Targetting children and youth. The Government's goals and target areas in the Government's fiscal budget 2007]* Norwegian Ministry of Children and Equality 2007.
- *Action Plan for Women's Rights and Gender Equality in Development Cooperation 2007-2009*. Norwegian Ministry of Foreign Affairs 2007.

Reference to FGM is not made in:

- *Position paper in development cooperation. Norway's HIV and AIDS policy*. Norwegian Ministry of Foreign Affairs 2006.
- *The Norwegian Government's Action Plan for the Implementation of UN Security Council Resolution 1325 (2000) on Women, Peace and Security*. Norwegian Ministry of Foreign Affairs 2006.
- *Strategic framework. Development policy's contribution to peace building. Norway's role*. Norwegian Ministry of Foreign Affairs 2004.
- *Education – Job Number 1. Norwegian Strategy for Delivering Education for all by 2015*. Norwegian Ministry of Foreign Affairs 2003.
- *Report. Global Partnerships for Development. Millenium Development Goal No 8. Progress Report by Norway 2004*. Norwegian Ministry of Foreign Affairs.
- *Fighting Poverty. The Norwegian Government's Action Plan for Combating Poverty in the South towards 2015*. Norwegian Ministry of Foreign Affairs 2002.
- *Norway's Efforts to Strengthen Support for Indigenous Peoples in development Cooperation. A human rights-based approach*. Norwegian Ministry of Foreign Affairs.
- *Plattform for regjeringssamarbeidet mellom Arbeiderpartiet, Sosialistisk Venstreparti og Senterpartiet. 2005-09. [Political platform for a majority government. Issued by The Labour Party, The Socialist Left Party and The Centre Party 2005]*.
- *Action plan against forced marriages*. Ministry of Children and Family Affairs 2001.

Appendix IV: Overview of Relevant Evaluations and Reviews

Eritrea

- *A Study on Female Genital Mutilation in Eritrea*. W. Zerai. Norwegian Church Aid 2003.
- *A report on a baseline survey on the attitude, knowledge and prevention of female genital mutilation/cutting (FGM/C) in Zoba Debub, Eritrea*. National Union of Eritrean Women and UNFPA Country Office Asmara, Eritrea. W. Zerai. 2006.
- *Evaluation Report of NCA's FGM pilot project for MoH and NCA*. W. Zerai, 2005.
- *National Strategy. Female genital mutilation (FGM/C) Abandonment in Eritrea. A paper prepared for the first OSSREA National Workshop, Asmara*. A. Gebrekidan UNFPA and A. Eltanir UNICEF 2006.

Ethiopia

- *Community dialogue leading to abandoning of HTPs. Results of a Survey conducted in three Regions of Ethiopia*. UNICEF Ethiopia August-November 2006.
- *The Effect of Radio Serial Dramas on Reproductive Health Behavior: Key Findings from the Evaluation*. Population Media Center 2005.
- *Community Conversations on HIV/AIDS. Pilot Projects in Alaba and Yabello: Assessment of the Methodology*. A. Gebre and Y. Admissie 2005.
- *Assessing Options for Increased Norwegian Support to Scale-up Action against Female Genital Mutilation in Ethiopia*. A. Talle, K. M. Moland and S. Taraldsen 2006.
- *Awash FGC Elimination Project. Final Evaluation Report*. Care International Ethiopia 2005.
- *Evaluation Report. The Dolsa/SCNE project on FGM and other harmful traditional practices, North Gondar Zone*. Dr. S. Alemu, K. M. Moland and A. Talle March 2007.
- "Meeting the Sexual and Reproductive Health Needs and Rights of Poor People. An evaluation of the Family Guidance Association of Ethiopia (FGAE)" in *Reaching Poor People with Services in Sexual and Reproductive Health. An evaluation of the IPPF. Vol. II: Country Reports from Bangladesh, Uganda and Ethiopia*. Nilsdotter, A., Hadera, S., Lauglo, M., Taraldsen, S., Forss, K., Hailu, S., Mezgebu, F., Negash, K., Yosef, R., Girma, A. 2006.
- *January 1st – June 30th 2005. Interim Report*. Ethiopian Women Lawyers Association.

Sudan

- *SNCTP/Norwegian Church Aid: Internal evaluation report. Mayo Farm Project*. Norwegian Church Aid 2005.
- *A Study on Female Genital Mutilation in Rashad County – Nuba Mountains*. Norwegian Church Aid 2004

Somalia

- *The report of the rapid assessment of female genital mutilation activities in Gedo*. Norwegian Church Aid in Somalia. Prepared by Mohammed, F. and Ali, A.
- *Female genital mutilation/cutting in Somalia*. World Bank/UNFPA 2004.

Kenya

- *Kenya: Mobilize Health Care Providers to Advocate against FGM/C*. OR Summary no. 60. Frontiers in Reproductive Health Population Council 2007.
- *A Religious Oriented Approach to Addressing FGM/C among the Somali Community of Wajir, Kenya*. Frontiers in Reproductive Health Population Council 2007.
- *Medicalization of Female Genital Cutting Among the Abagusii in Nyanza Province, Kenya*. Frontiers in Reproductive Health Population Council 2004.
- *Kenya: Begin Community Dialogue on FGM/C by Discussing Cultural Justification*. OR Summary no. 59. Frontiers in Reproductive Health Population Council 2007.

Tanzania

- *FGM Interventions: Achievements, Challenges and Prospects in the Light of the National Plan of Action to Accelerate the Elimination of FGM and other Harmful Practices in Tanzania.* Women Resource and Development Project 2007.
- *The Legal Process, can it save girls from FGM? A case of three Maasai girls in Morogoro. A report on the enforcement of the FGM law.* LHRC 2004.
- *Legal and Human Rights Centre. Holistic Evaluation Report.* LHRC 2005.
- *Female Genital Mutilation. A Human rights abuse veiled with customs and traditions. A report on the research into the practice of FGM in Tanzania.* LHRC, Second edition 2005 (first edition 2002).
- *Inter-African Committee. Working against female mutilation. Tanzania. A qualitative evaluation.* T. H. Lie, E. A. Lothe, and C. Ali 2004.

General or several countries covered

- *Abandoning Female Genital Mutilation/Cutting. An in-depth look at promising practices.* Population Reference Bureau 2006.
- *Changing a Harmful Social Convention: Female Genital Mutilation/Cutting.* UNICEF 2005.
- *Using Operations Research to Strengthen Programmes for Encouraging Abandonment of Female Genital Cutting.* Frontiers in Reproductive Health Population Council 2002.
- *Review of FRONTIERS Program FGM/C-related Activities.* Frontiers in Reproductive Health Population Council 2007.
- *Female Genital Mutilation/Cutting. A Statistical Exploration.* UNICEF 2005.
- *Female Genital Mutilation/Cutting Technical Note. Coordinated Strategy For the Abandonment of Female Genital Mutilation/Cutting in a Single Generation.* UNICEF 2006.
- *Female Genital Mutilation (FGM) Program. Findings and recommendations of three-year (2001-4) Program evaluation.* Rainbo for Norwegian Church Aid 2005.

Appendix V: Suggested possible indicators for assessing whether the objectives and targets of the Action Plan have been reached

	Output	Outcome
Policy	<p>To what degree does Norway engage in dialogues with national and/or local authorities on the importance of FGM?</p> <p>To what degree does Norway promote rights-based development in their dialogues with authorities?</p> <p>In which fora has Norway promoted the battle against FGM in the UN, the World Bank and/or The African Development Bank Group, and when?</p>	<p>Do national, regional and local authorities have an increased openness on the subject of FGM – do they raise the issue in parliament debates, television or radio?</p> <p>To what degree is FGM integrated in national plans in the health sector?</p> <p>To what degree is the subject of FGM integrated in the training of health workers?</p> <p>To what degree is FGM integrated in schoolbooks and curriculums, life skills and teacher training?</p> <p>Do national authorities provide increased allocation of funds for efforts against FGM?</p> <p>Do national or local authorities conduct national or local surveys on FGM prevalence, or do they provide funding to organisations who do?</p> <p>Is there legislation or national action plans against FGM?</p>
Funding	<p>Does Norway provide a budget increase of 25% to interventions against FGM?</p> <p>Is funding provided for organisations which target religious leaders or other local leaders, or is funding provided for religious or other leaders who work as change agents?</p> <p>Are the appropriate groups targeted on project level?</p> <p>To what degree does Norway support organisations or government authorities in efforts to provide treatment and rehabilitation of girls and women?</p> <p>Do the embassies channel increased funds to UN organisations (WHO, UNFPA, UNICEF)?</p>	<p>Is there an increased number of Norwegian funded projects working against FGM?</p> <p>To what degree is there an increased awareness of the human rights aspects and the health complications of FGM in the areas targeted?</p> <p>Are interventions progressing according to plan, and if not how may obstacles be alleviated?</p> <p>To what degree are necessary service provisions offered to induce sustainability such as boarding school housing for girls, education, mother/child health?</p> <p>To what degree is an increasing number of women and children being provided with treatment and rehabilitation?</p> <p>To what degree does WHO, UNFPA and UNICEF engage in closer cooperation?</p>

	Output	Outcome
Competence building	<p>To what degree does Norway assist financially or with knowledge in capacity building of local and national authorities?</p> <p>To what degree is funding provided for re-search and documentation of best practices?</p>	<p>To what degree is knowledge on FGM prevalence, its social dynamic, changes and best practices disseminated to the embassies?</p> <p>Do the embassies have alert measures to assist girls and women who seek assistance?</p> <p>Do the embassies have available brochures on FGM in local languages?</p> <p>To what degree is knowledge on FGM prevalence, prevalence, its social dynamics, changes and best practices disseminated to relevant partners or government departments?</p>

Appendix VI: Organisations and Persons Consulted

Country	Organisation	Persons
Norway	Norwegian Church Aid	Thora Holter Kari Øyen
	Save the Children	Berit Knudsen
	Care	Grete Benjaminsen Moira Kristin Eknes
	Norwegian Lutheran Mission	Elin Vannes Solveig Irene Seland
	Norwegian Missionary Society	Kristin Fjelde Tjelle (by email) Ragnhild Mestad (by phone and email)
	Plan Norway	Signe-Lise Dahl (by email)
	ARC-aid	Kjellan Spinnangr (by phone)
	Norwegian Nurses Association	Michael Vitols (by email)
	Women's Front (Kvinnefronten)	Agnete Strøm (by email)
	FOKUS	Mette Moberg (by email)
	Norwegian People's Aid	Liv Bremer (by phone and email)
	Ministry of Foreign Affairs	Elin Graae Jensen (by phone and email)
Norad	Marit Berggrav (by email) Nina Strøm (by email) Gunvor Skancke (by phone) Gabriella Kossmann (by phone) Vivian Hilde Opsvik (by email and phone) Stine Thomassen (by email) Helene Christensen (by phone and email)	
USA	UNICEF	Gabriella de Vita (by phone)
Kenya	Care Kenya in Dadaab	Wilson Kisiero, Sector Coordinator Dadaab, Gender and Development
		Sheiks against FGM: Sheik Noor Aden Sheik Abdullahi Hassan Sheik Khalar Issack Sheik Abdullahi Issack Sheik Hajir Abdullahi Sheik Shamsocin Khadar
		Women against FGM: Hawo Hussein Abdi Halimo Adens Hussein Sahoro Ali Ahmed Fadumo Sheik Sharif
		Halimo Acten Mursal Adey Asdi Hakav Asho Kaanan Ahmed Fosiyo Aden Ali Rakio Omar Salat Shamso Farah Warsame

Country	Organisation	Persons
Kenya cont.		Halimo Rage Salah Zanab Iman Dubad Halimo Abukar Ali Daliyo Noor Hussein Fardun Ali Yahaye Bifo Omar Bulle Saharo Omar Othawa Halim Molied Asdullahi Men against FGM
	Norwegian Embassy	Vibeke Sørgaard Sophie Cleve
	UNICEF	Roger Pearson, Deputy Representative
	Population Council Frontiers	Ian Askew, Ph.D. Director
	Norwegian Lutheran Mission	Gerd Holmedal
	Norwegian Church Aid	Kirsten Engebak, Area Representative Agnes Leina, Programme Officer Laikipia COVAW John Mururi, Programme Coordinator Kenya/Uganda
Maasai Education Discovery	Lilian Seenoi, Project Manager Beatrice Macksallah, Director of Operations Koitamet Olekina, Executive Director Women against FGM	
Ethiopia	UNFPA	Helen Amdemikael, NPO Gender and Advocacy
	WHO	Dr. Abonesh H/Mariam
	UNICEF	Tabeyin Gedlu, Assistant Project Officer HTP, Gender and Child Protection Team
	Ministry of Women's Affairs	Desit Feyesa Million Worku Mahret Admassu
	Norwegian Embassy	Rannveig Rajendram, Councillor Gizaw Ashenafi, Programme Officer
	Care Ethiopia Afar/Awash	Tamirat Lonseko, Area Coordinator Awash Kassaye Mezmur, Project Manager Afar
	Norwegian Church Aid	Ejigayehu Teffera Dawit Kebede
	KMG	Azmeraw Belay
	ADAA	Adem Alo
	Ethiopian Orthodox Church and Inter-aid Commission	Emebet Woldeyes
	EGLDAM	Abebe Kebede, Executive Director
	Population Media Centre	Hailu Belachew, Programme Coordinator
	Save the Children Norway	Mohammed Jemal, Programme Coordinator
	Care Ethiopia	Dr. Barbara Pose, SRH Programme Coordinator
	Norwegian Missionary Society	Aud Karin Hovi
Norwegian People's Aid	Kjersti Berre, Resident Representative (by email)	

Country	Organisation	Persons
Tanzania	Legal and Human Right Centre	Helen Kijo-Bisimba, Executive Director
	Norwegian People's Aid	Svein Olsen, Director Paschal W. Chambiri, Relief and Development Project Officer
	Plan International	Aminata Nene Sow Thiam, Programme Support Manager
	Norwegian Embassy	Amina Joyce Lwasye, Programme Officer
	Women Legal Aid Centre	Scholastica Jullu, Director
	TAMWA	Ananilea Nkya, Executive Director
	UNFPA	Nicola Jones, Representative Batula H. Abdi, Programme Officer Youth Mary Akuupa, Gender Consultant
	Norwegian Church Aid	Fredrik Glad-Gjernes, Director Kari Lindemann, Programme Officer Blandina Faustin, Programme Officer Björg Sjølie
Women's Research and Documentation Project (WRDP)	Hildegarda L. Kiwasila Blandina Mapunda Pricilla Nanyaro Fabia Shundi Vivian Bashemererwa	
Eritrea	Norwegian Embassy	Aster Gebreab Weldeluul (by email)
	Norwegian Church Aid	Luz Joseph, Gender Officer (by email)
Sudan	SNCTP	Dr. Amna Hassan, Executive Director (by email)
	Norwegian Embassy	Margunn Indrebø (by email)

Appendix VII: Questions Posed to Partners

1. What are your interventions against FGM/C, and what are your starting points, approaches or point of entry? Who are your local/Norwegian partners?
2. Who are the interventions directed at?
 - a. Men - women
 - b. Children/young people– adults
 - c. Religious leaders, other leaders
 - d. Others
3. What types of interventions are they?
 - a. Prevention
 - b. Treatment, rehabilitation
4. What procedures do you have for gathering baseline information – types and forms of FGM/C, distribution?
5. Who do you receive your funding from; Ministry of Foreign Affairs, Norad, other NGO organisations – and how does the financing go about?
6. What do you regard as your responsibilities towards Norad and/or the embassies and local/Norwegian partners and whom do you report to?
7. Do you have adequate human (both in terms of knowledge and amount of persons), institutional and financial resources in the FGM/C field?
8. What challenges/limitations do you experience in your work against FGM/C?
9. Do men as easily as women become interested and involved in the issues of FGM/C, or does it remain a woman's issue?
10. Do you have written material, evaluations and reviews we may be given copies of?
11. Do you have methods for evaluating and monitoring your interventions, and if so how are these methods? How do you measure possible changes in FGM/C practice?
12. Are there areas where there is a need for more knowledge or data?

Appendix VIII: Questions Posed to Embassy Staff

1. Which interventions do you support against FGM/C? Who are your local/Norwegian partners?
2. Who are the interventions directed at?
 - e. Men - women
 - f. Children/young people – adults
 - g. Religious leaders, other leaders
 - h. Others
3. What types of interventions are they?
 - c. Preventive
 - d. Treatment, rehabilitation
4. What procedures do you have, if any, for gathering baseline information – types, forms and amount of FGM/C?
5. Do you have methods for evaluation and monitoring the interventions, and if so, how are these methods? What are your thoughts on indicators to measure possible changes in FGM/C practice?
6. Administration and organisation: What are the main channels for funding of the interventions – what departments, grants, budgets etc.?
7. How is the work organized?
8. What do you regard as the responsibilities between the embassies, Norad, MFA and partners respectively?
9. Do you have adequate human (both in terms of knowledge and available/number of personnel), institutional and financial resources in the FGM/C area?
10. Which challenges/limitations do you experience in your work against FGM/C?
11. What are your experiences in getting men interested and involved in the subject of FGM/C? Does it remain a woman's issue?
12. Do you have relevant written material – evaluations and reviews of which we may be given copies?
13. What areas do you regard as having a need for further knowledge and data?

EVALUATION REPORTS

- 3.92 De Private Organisasjonene som Kanal for Norsk Bistand, Fase I
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