TOWARDS ENDING FEMALE GENITAL MUTILATION / CUTTING IN AFRICA AND BEYOND

A programme to demonstrate effectiveness, catalyse change, build the evidence base and strengthen a global movement to end Female Genital Mutilation/Cutting

DFID
Africa Regional Department
AIDS and Reproductive Health Team, Policy Division
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### Acronyms

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<th>Acronym</th>
<th>Description</th>
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<tr>
<td>DFID</td>
<td>Department for International Development</td>
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<tr>
<td>FGM/C</td>
<td>Female Genital Mutilation/Cutting</td>
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<tr>
<td>MDG</td>
<td>Millennium Development Goal</td>
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<tr>
<td>NGO</td>
<td>Non-Governmental Organisation</td>
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<tr>
<td>UK</td>
<td>United Kingdom</td>
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<tr>
<td>UN</td>
<td>United Nations</td>
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<tr>
<td>UNFPA</td>
<td>United Nations Population Fund</td>
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<td>UNGA</td>
<td>United Nations General Assembly</td>
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<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
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<tr>
<td>UNJP</td>
<td>United Nations Joint Programme on ending FGM/C (‘Accelerating Change’)</td>
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<td>WHO</td>
<td>World Health Organisation</td>
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**Intervention Summary: Toward ending of FGM/C in Africa and Beyond**

<table>
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<tr>
<th>What support will the UK provide?</th>
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<tr>
<td>DFID will provide up to £35 million over a period of 5 years (starting March 2013) to support efforts to end Female Genital Mutilation/Cutting (FGM/C).</td>
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<th>Why is UK support required?</th>
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<td><strong>What are we trying to address?</strong></td>
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There is a window of opportunity to end female genital mutilation/cutting (FGM/C), which is one of the most extreme manifestations of the disempowerment of girls and women. FGM/C is a practice that is thousands of years old which results in physical, psychological and emotional damage. This includes excruciating pain and trauma as well as risks of haemorrhage and infection at the time it happens. This is frequently followed by years of pain and complications, including urinary and menstrual retention. There is evidence of increased risk of complications at childbirth putting mothers and new-borns at risk. FGM/C proactively reduces female sexual pleasure. It is estimated by WHO that 3 million girls a year in Africa alone are at risk of FGM/C and that 100-140 million women and girls have undergone the practice. There is no health benefit to the practice.

The practice of FGM/C varies widely, even within countries. The WHO defines it as all procedures that involve partial or total removal of the external female genitalia or other injury to the female genital organs for non-therapeutic reasons. It can involve cutting or cauterising. The most extreme form of FGM/C (which is carried out on 90% of girls in Somalia) involves cutting out all the external genitalia and sewing up the girl's vagina. Girls are cut open, usually with a razor blade, on the marriage night to enable sexual penetration. In some countries FGM/C is carried out on new-borns, and in others during adolescence.

FGM/C is a deep-rooted social practice that is carried out because, in practising communities, it is believed to be essential for marriage and ‘proper’ womanhood. It is carried out because it is believed to be in a girl’s best interests: uncut girls cannot marry and would be condemned to a life of stigma and discrimination. Interventions to end the practice need to be based on this understanding. Experience from West Africa suggests that working closely with communities to support their own collective action to abandon the practice is the most effective and sustainable approach. Banning or condemning FGM/C can have a counter-productive impact because it can easily be perceived as an attack on communities’ culture and risks sending the practice underground.

FGM/C is a highly neglected area, and progress towards ending the practice has been hindered by too little attention, evidence, commitment and resources. Few donors support efforts to end the

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1 The practice is known as Female Genital Mutilation (FGM), Female Genital Cutting (FGC) and (with decreasing usage) female ‘circumcision’. The term ‘cutting’ is used to reflect understanding that the practice is not carried out with the intention of harming girls but because in communities where it is practiced, they cannot be married – and would therefore be isolated and stigmatised - without it. This understanding is essential to designing successful interventions to end the practice. The term is not intended to question that it is an extremely harmful practice. The term ‘mutilation’ is used to describe the extreme damage done by the practice and the fact that it violates girls’ and women’s human rights and bodily integrity, and is a purposefully non-neutral term to reflect this. FGM is the term used in international negotiations. In French the practice is known as ‘excision’. In this business case we use FGM/C – which is consistent with the UN Joint Programme – to reflect our respect for both of the above positions. Practising communities all have their own words for the practice.
practice and funding is low (totalling approximately $18 million globally in 2011). DFID has had only had limited engagement in this issue so far. This is primarily an African issue, and a highly sensitive one, so without African leadership there was a risk that a UK intervention could have been construed as culturally inappropriate.

There is now strong African leadership and real momentum for change in Africa. Increasing numbers of communities, traditional and religious leaders, national policy-makers and other high-profile champions are working to end FGM/C. These efforts were given a new level of legitimacy with the passing of a UN General Assembly resolution in December 2012, led by the Africa Group, calling for a global ban to the practice. This is an important moment when UK support is needed to get behind these efforts and ensure that this opportunity is maximised and not missed. UK support alone will not be enough, but UK leadership on this issue is likely to be catalytic in leveraging further commitment and funding.

With parallels to the ending of foot-binding in China in the early twentieth century, there is a real possibility that the practice of FGM/C could end in one generation. UK support – working with other partners – will help make this happen at scale, working across Africa and beyond to other practising communities, particularly in the Middle East.

**What will we do?**

This programme will address FGM/C through four complementary approaches:

1. **Direct work with practising communities**, implemented by civil society organisations in at least 15 of the most affected countries. This will support whole communities to end the practice through a comprehensive package of support including education and awareness-raising. To be led by the existing UN Joint Programme on Ending FGM/C.

2. Efforts to ensure **legislation and policy** is in place and appropriately implemented, and support regional and cross-border agreements and approaches particularly where practising communities straddle national borders. This will also be implemented by the UN Joint Programme.

3. **Social change communications**, to galvanise a global movement to end FGM/C. This will work at the global level, to increase attention and funding toward ending FGM/C and will also work in affected countries at national and community levels. It will also work strategically with diaspora groups in the UK to leverage change in their home countries. This will be separately contracted and will encourage new players in the private sector to partner with civil society and others to develop innovative evidence-based approaches.

4. A robust **research programme** to produce a global evidence base on the most effective and cost-effective approaches to ending FGM/C in different contexts, to inform future policy and programming. This component will be separately contracted to ensure independence.

The programme will work collaboratively with DFID country office efforts to end FGM/C and support the design of country specific plans for additional DFID effort at the country level. It will also work in coordination with cross-government efforts to end FGM/C in the UK. The social change communications component will take on an overall coordinating hub function between the various parts of the programme, ensure coherence and communications between the components.
This programme will be funded jointly through DFID’s Africa Regional Department (up to £24m), Policy Division (£3m)\(^2\) and Research and Evidence Division (TBC up to £8m)\(^3\). This business case is for the first 5 years of a programme that is anticipated to be for at least 10 years.

The programme is directly in line with the UK’s commitment to put girls and women front and centre of its development policy. Work on ending FGM/C supports all four pillars of the Strategic Vision for Girls and Women, which are: delaying first pregnancy and supporting safe childbirth, getting girls through secondary school, reducing violence against women and girls and getting economic assets to women and girls. As put by Dr Nafissatou Diop of UNFPA, ‘The girl who undergoes FGM/C is the same girl who is taken out of school early to marry. And this is the same girl who dies before she reaches age 20, giving birth to her third child’.

There is a strong moral case for addressing FGM/C as a human rights issue, which violates girls and women’s bodily integrity. It is not possible, and it would be inappropriate to put a monetary value on women’s genitalia and the full benefits for a woman or girl of not being cut or otherwise damaged. The appraisal of programme options for the business case includes a cost-effectiveness assessment of delivery mechanisms to determine the most appropriate approach. As none of the options is without risk, the programme will include a robust review at the end of Year 2 of implementation to assess progress and the balance between the delivery mechanisms, with the option to alter the mechanisms and balance if needed.

### What are the expected results?

#### What will change as a result of this programme?

The **impact** will be an end to Female Genital Mutilation/Cutting in one generation.

The **outcome** will be a reduction in the incidence of FGM/C in at least 15 countries.

The specific results will be:

a. A reduction in cutting of girls by 30% in at least 10 countries in 5 years (measured by prevalence among 0-14 year olds)

b. Robust knowledge and evidence produced and made widely available to key actors, leading to more effective FGM/C policies and programmes.

c. A Global Movement to end FGM/C – to galvanise unprecedented political commitment and funding for this neglected issue.

The programme will have substantial indirect benefits as it will support transformational change in the lives of women and girls and their wider communities in FGM/C-practising societies. These will include social, economic and health benefits, directly to girls and women, and indirectly to their families and communities which in future will no longer have to bear the on-going

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\(^2\) The Policy Division contribution recognises the global nature of FGM/C, allowing the programme to extend beyond sub-Saharan Africa to the Middle East and North Africa region and beyond, and ensuring the programme is linked to the UK’s international policy engagement on this issue.

\(^3\) The research component of this programme will be developed in collaboration with DFID’s Research and Evidence Division. It will be developed over a longer timeframe, and this business case will be updated to reflect the full research component by the end of 2013.
social and economic costs and health burden of FGM/C. The programme will therefore result in greater gender equality and improved health, psychological well-being, relationships, education and economic opportunities for women and girls as a result of not undergoing FGM/C. These additional benefits will be measured throughout the programme, particularly through the research component of this programme.
Strategic Case

A. CONTEXT

What is FGM/C and why does it matter?

1. FGM/C comprises all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for non-therapeutic reasons. In its most extreme form (commonly practiced by Somali and Sudanese communities among others) the external genitalia are cut out and the girl’s vagina sewn up, to be re-opened on her wedding night, and opened and closed for each birth (see the table of types below). FGM/C usually involves some form of cutting; cauterisation is practised in some cultures.

<table>
<thead>
<tr>
<th>Table 1. Types of female genital mutilation</th>
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<tbody>
<tr>
<td>Type I – Partial or total removal of the clitoris and/or the prepuce (clitoridectomy);</td>
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<tr>
<td>Type II – Partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (excision);</td>
</tr>
<tr>
<td>Type III – Narrowing of the vaginal orifice with the creation of a covering seal by cutting and a- positioning the labia minora and/or the labia majora, with or without excision of the clitoris (infibulation);</td>
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<tr>
<td>Type IV – All other harmful procedures to the female genitalia for non-medical purposes, for example, pricking, piercing, incising, scraping and cauterisation.</td>
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2. FGM/C has no health benefits and has serious physical and mental health consequences. Immediate effects include haemorrhage, excessive pain, infections and abscesses, and injury to the neighbouring tissues. Death can result from the practice due to haemorrhage or infections, including tetanus and shock. Longer term impacts include painful menstruation and accumulation of menstrual blood in the vagina and uterus, acute urinary retention, long-term disability and severe problems in pregnancy and childbirth. A 2006 WHO study published in the Lancet confirmed that women who have undergone FGM/C are significantly more likely to suffer serious complications in childbirth, for example, to require a caesarean section, and risk extensive bleeding, perineal tear, prolonged labour, the need for episiotomies (cutting the skin between the vagina and the anus – also a procedure that requires a trained physician), and, in the worst case scenario, death. This study also found that FGM/C is harmful to babies: it leads to an extra one to two perinatal deaths per 100 deliveries. It is also thought that FGM/C may be linked to HIV, through two routes: often many girls are cut with the same razor, and FGM/C can increase reproductive tract and lower pelvic infections that increase a woman’s vulnerability to HIV.

3. Emerging evidence indicates that the psychological impacts of FGM/C can be severe, including anxiety, depression and difficulties with relationships. A pilot study of women in Senegal on the mental health impacts after FGM/C found that women in the study who had undergone FGM/C showed a significantly higher prevalence of post-traumatic stress disorder (which was accompanied by memory loss) and other psychiatric syndromes than women who had not undergone FGM/C. A recent study in Iran also demonstrated that girls who have undergone FGM/C are more prone to mental disorders, including post-traumatic stress disorder. A systematic review carried out in 2010 concluded that a paucity of high quality evidence meant that it wasn’t possible to draw causal conclusions, but stated that their results showed that women with FGM/C...
experience pain and reduction in sexual satisfaction and desire compared to other women.

4. **FGM/C is a human rights violation.** It is carried out on children and involves the removal of and/or damage to healthy tissue for no medical benefit. It violates bodily integrity and women's and girl's right to self-determination over their own bodies. It breaks several UN conventions including the Convention for the Elimination of All Forms of Discrimination Against Women (CEDAW), the Convention on the Rights of the Child and the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment. In addition, the UK is committed to the full implementation of the UN’s 1994 International Conference on Population and Development (ICPD) Programme of Action, which urges governments to prohibit FGM/C and protect women and girls from such dangerous practices.

5. **FGM/C is usually carried out in very unhygienic conditions,** using old razors or other cutting instruments, with high risks including infection. Among higher income groups and in urban contexts, the practice is becoming increasingly ‘medicalized’ and carried out in health facilities by health workers, against World Health Organisation guidelines. Medicalization is sometimes considered a positive step because it can remove the initial risk of infection, but FGM/C is a violation of human rights however it is carried out, and much of the physical and psychological damage caused by FGM/C affects girls and women later.

**FGM/C as a social norm**

6. **FGM/C is a deeply embedded social practice** that is thought to be thousands of years old. In the communities where it is practiced, it is carried out because it always has been – it is simply part of life - on the basis that it is considered essential for marriage. Even where there is awareness of the problems caused by FGM/C, the practice is continued because of the link to girls’ and women’s acceptability in society and to their marriageability. Societies which carry out FGM/C believe that they do so out of a genuine concern that girls need to be protected and controlled if they are to be able to be part of society. An individual family taking a decision alone not to cut their daughters would condemn their girls to a life of stigma and ostracism. Girls therefore are cut because it is considered to be their own interests within the societies they live in. Applying UNICEF’s definition of a ‘social norm’, families have their daughters cut because a) they believe that people who matter to them are having their own daughters cut (empirical expectation), and b) they believe that people who matter to them think they should cut their daughters (normative expectation).

**Definition of social norms**

A social norm is a pattern of behaviour that individuals prefer to conform to on condition that they believe that a) most people in their relevant network conform to it (empirical expectations) and that b) most people in their relevant network believe they ought to conform to it (normative expectations). Changing a social norm entails changing current social expectations, creating new social expectations, or both.

7. **FGM/C is not required by any religion,** although in some contexts it is believed to be a requirement of Islam, and in these contexts, this is one driver of the practice.
8. **The practice of FGM/C varies between countries, ethnic groups and communities, but fundamental drivers are common in most places where FGM/C is practiced.** These include:

- The belief that the practice “controls” female sexuality and that, without it, women’s sexual desire is un-checkable;
- That it is a necessary component of what makes a woman a woman and of what makes her a social being; in some practising cultures, an un-cut girl or woman is not allowed to engage in certain social functions or serve food to guests;
- A desire to ensure that girls are marriageable; un-cut girls are not believed to be acceptable;
- To ensure a girl’s purity as a human being (for example, amongst the Masai, un-cut women are thought to be likely to be cursed by ancestral spirits and, being thought to have impure blood, will not be helped by traditional birth attendants during childbirth).14

9. **Social norms are stronger drivers of FGM/C than asset poverty and low levels of education.** Where incomes rise, there is evidence that FGM/C can become ‘medicalized’, but that social norms keep the practice in place. Urbanisation - sometimes associated with freer social expectations and a reduction in adherence to traditions - does not appear to affect the practice; indeed there is some evidence from Sudan of non-practising communities taking up FGM/C when they come into contact with practising communities in urban areas. Egypt has higher incomes, education and urbanisation levels than other practising countries in Africa, but the data does not demonstrate a major effect of any of these factors on the practice. The overall prevalence rate (15-49 year old women) in Egypt is 91%. According to the 2008 DHS, 32% of cuttings in Egypt are now performed by trained medical personnel, a large increase on 17% in 1996. The following table shows a breakdown of FGM/C prevalence in Egypt by urban/rural, education levels and wealth quintile. In terms of wealth, being in the highest quintile seems to offer some protection (although the rate is still high), but otherwise there is little significant variation. The lower rate in urban areas will probably be at least partly accounted for by the lower rate amongst the highest wealth quintile and may therefore not give a clear picture of rural/urban differences.

<table>
<thead>
<tr>
<th>Background Characteristic</th>
<th>Percentage who have undergone FGM/C</th>
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<tr>
<td><strong>Urban – Rural residence</strong></td>
<td></td>
</tr>
<tr>
<td>Urban</td>
<td>85.1</td>
</tr>
<tr>
<td>Rural</td>
<td>95.5</td>
</tr>
<tr>
<td>Frontier governorates</td>
<td>66.3</td>
</tr>
<tr>
<td><strong>Education</strong></td>
<td></td>
</tr>
<tr>
<td>No education</td>
<td>97.6</td>
</tr>
<tr>
<td>Some primary</td>
<td>96.4</td>
</tr>
<tr>
<td>Primary complete/some secondary</td>
<td>88.8</td>
</tr>
<tr>
<td>Secondary complete/some higher</td>
<td>87.4</td>
</tr>
<tr>
<td><strong>Wealth Quintile</strong></td>
<td></td>
</tr>
<tr>
<td>Lowest</td>
<td>95.4</td>
</tr>
<tr>
<td>Second</td>
<td>96.1</td>
</tr>
<tr>
<td>Third</td>
<td>95.2</td>
</tr>
<tr>
<td>Fourth</td>
<td>91.8</td>
</tr>
<tr>
<td>Highest</td>
<td>78.3</td>
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*Extracted from: GoE, (2008) Demographic and Health Survey*

10. **In some contexts, FGM/C is carried out as part of an initiation rite,** for example in Kenya – although there are reports that this is changing and younger girls are being cut without a link to an initiation ritual15. In Sierra Leone and Liberia, the initiation process which includes FGM/C is carried out within the secret societies, which means efforts to end the practice are particularly challenging and politically charged16.
11. **FGM/C is usually**[16] **carried out by older women in the community**, who may also be traditional birth attendants or have other community roles and associated status, depending on the context. It is sometimes a source of puzzlement that this practice which is damaging to women is carried out by women. Again, the critical point is that girls are cut because in practising societies it is believed to be in the girl’s best interest in a society defined by gender inequality, and women are well aware of the stigma that an uncut girl would face in a society in which FGM/C is a social norm.

**Where is FGM/C practiced?**

12. **FGM/C is primarily, but not only, an Africa practice**, with the vast majority of practising communities being located in at least 28 African countries clustered across West Africa, Egypt and the Horn (see the map below). Prevalence is also high in some regions of Yemen, and in smaller numbers in Indonesia, Malaysia, the Iran/Iraq/Kurdistan region, as well as among specific ethnic communities in India, Pakistan and Thailand. Reliable data is not available yet on the prevalence in these countries and anecdotal evidence suggests that it may be increasing in some areas of the Middle East. Prevalence rates tell only part of the story, as the location of ethnic groups – often across national borders - is often more relevant for understanding the geography of FGM/C than national boundaries. Prevalence rates can vary among sub-national regions, masking areas of very high prevalence within countries (for instance, both Ethiopia and Nigeria show large variations between federal states). Absolute numbers are also important: the 2011 MICS data shows that over one quarter of Nigerian women have undergone FGM/C.

13. **FGM/C is also practised across the world by diaspora groups.** Practicing communities bring traditions with them as they migrate and may be more likely to hold on to customs which they perceive as part of their cultural identity. Diaspora communities can play a positive or negative role in ending the practice. For example, in the UK, there are many very active and committed diaspora-led NGOs working both within the UK and overseas to end the practice. At the same time, anecdotal evidence suggests that efforts to end the practice in communities in Africa can be undermined by diaspora returning to have their girls cut. It is also thought that the practice of FGM/C within diaspora communities can take on a slightly different meaning which is more associated with maintaining cultural identity than with marriageability. Evidence of diaspora behaviour more generally indicates that communities living away from their countries of origin often hold on to practices long after they have become less important in those countries[18]. It is said for example that foot-binding continued in San Francisco for decades after it ended in China[19].
The context for UK engagement

14. **There is momentum for change**, in spite of the deeply-embedded and sensitive, nature of the practice. This momentum is seen at community level, nationally within some practising countries, and at the international and regional levels.

15. **Within Africa, there has been increasing political and legislative activity over the last few years**. The Africa Union passed a resolution on 1st July 2011 in support of a resolution at UNGA to ban the practice. This followed several other African-led measures pushing for an end to the practice. In May 2010, an inter-parliamentary conference hosted by Government of Senegal concluded with a Final Declaration stressing the need to work towards a universal ban on FGM/C. In June 2010, the Parliament of Uganda passed a motion supporting a UN resolution banning FGM/C to be presented by the Government of Uganda, the East African Legislative Assembly and the African Union at the 65th Session of the UNGA. In September 2010 a high level meeting was held at the United Nations in New York in support of a resolution was opened by the First Lady of Burkina Faso. A number of African countries have recently passed laws to ban the practice. For example, during 2011, new legislation was passed in Kenya and Guinea-Bissau, and other countries put in place measures to strengthen the implementation of existing laws, including Burkina Faso, Djibouti, Guinea, Uganda.\(^\text{2021}\)

16. **At the global level, there has been significant recent progress**. A Secretary General’s report on FGM/C was presented at the 2012 Commission on the Status of Women. This was followed by an UN General Assembly (UNGA) resolution against the practice, put forward by the Africa Group, which was passed on 20th December 2012. This is the first UNGA resolution on the subject and brings important legitimacy and momentum to efforts to end the practice.
17. Legislation and international political commitment are important but not sufficient to bring about change. They have a role in embedding rights at national level and opening up space to discuss a traditionally taboo issue, and can be used by citizens to advocate for change. At the same time, social change needs to come from the bottom up. There is emerging, promising evidence from community-level interventions in Africa that - with the right support - communities are deciding themselves to end the practice.

18. Emerging evidence of community-level efforts to end the practice is encouraging. For example, following a ‘community empowerment programme’, one village in Senegal decided to abandon the practice in July 1997, followed by more surrounding villages a few months later. By July 2011 this social change had spread through a process of diffusion between communities, and had been documented in over 5000 villages in Senegal and other countries. It is estimated that it is possible that Senegal will have totally abandoned FGM/C by 2015. Similar social change processes, though on a smaller scale, have been documented in Ethiopia and there are reports from other African countries (e.g. Egypt, Kenya, Sudan) of communities deciding to end the practice.

19. Other government departments are supporting efforts to end the practice of FGM/C in the UK and to prevent British nationals being taken overseas to have it carried out. Under the 2003 FGM Act, it is illegal to carry out the practice in England and Wales or to aid or abet a girl being taken overseas to be cut. Scotland has similar legislation. There is a strong focus on prosecutions, but no-one has yet been prosecuted under the 2003 Act. The Home Office chairs a cross-government group on FGM/C which also includes Departments of Health and Education, the Foreign and Commonwealth Office, the Metropolitan Police, Ministry of Justice, Crown Prosecution Service. The Home Office has a very small budget for FGM/C and currently runs an annual small grants fund totalling £50,000 for civil society projects in the UK. The FCO is mostly engaged on the consular side. In November 2012 the government launched the pilot of a declaration document against FGM/C. ‘A Statement Opposing FGM’ is a pocket-sized document which states the law and the potential criminal penalties that can be used against those who allow FGM/C to take place. It is based on a similar tool that has been effective in the Netherlands and is designed to be carried with a passport, to use to help counter any pressure to cut their daughters that people from diaspora groups may face in their countries of origin.

20. There is UK parliamentary and public interest in ending FGM/C, seen in frequent parliamentary questions and mentions in debates; the creation of a new All Party Parliamentary Group in December 2011; a debate on FGM/C in the UK held in Westminster Hall on 8th January 2013; as well as several mainstream news items in recent months (Newsnight, Observer) and active discussion on social media.

B. WHY IS A DFID INTERVENTION NEEDED?

21. Ending FGM/C will fundamentally transform women’s and girls’ lives in practising communities. Directly, ending FGM/C will improve women’s and girls’ physical and psychological health and well-being. Enabling a girl or woman to live life without pain, acute urinary retention and accumulation of menstrual blood, and with reduced risk in childbirth, is likely to be a strong factor in increasing girls’ and women’s ability to gain the education, knowledge, skills and assets they need to live healthy lives, take up economic and political opportunities and support their children. Indirectly, ending FGM/C through
a social norms approach will, based on emerging evidence, involve a process which brings about a wider shift in how communities value their girls. It is likely also therefore to be linked to a raise in the age of marriage, greater support for girls’ education and wider opportunities, and increased gender equality.

22. **Prevalence rates are still high.** While there is increasing political commitment and emerging evidence that, with the right support, communities are choosing to abandon the practice, this is not yet happening at scale. The graph below shows the overall prevalence rates in countries where FGM/C is practised.

23. **FGM/C is a neglected and under-funded issue.** The international community’s caution about getting involved in a sensitive issue has resulted in an overall lack of attention to the issue and the underfunding of interventions to end it. No major donor funding is directed at the issue. In 2011 UNICEF undertook a rapid assessment of the funding situation for ending FGM/C, on behalf of the global Donor Working Group on Ending FGM/C. In 2011, total donor grants for FGM/C globally amounted to approximately $13m. Predicted donor funding for 2012 (in 2011) varied from $10,000s to $1-2m per donor. The main donors include USAID, Netherlands, Norway, Sweden, Italy and Finland. While it was not possible to achieve a full picture of funding plans, it was clear that total funding is small and usually project-based. It was reported by donors that funding to the sector was decreasing, and that underfunding often prevented promising community-level work from going to scale.

24. **The largest programme to date addressing the issue - the UN Joint Programme ‘Accelerating Change’- is underfunded.** The programme is small relative to the scale
of need, with a budget of $44m for 2008-2013 – and had by 2011 only raised $25m against this budget. This has seriously hindered its ability to deliver. The main donors to this programme are the governments of Iceland, Ireland, Italy, Luxembourg, Norway and Switzerland. WHO engagement has so far been limited, with a focus on research (including a seminal study on health impacts published in the Lancet in 2006). There is potential for greater WHO engagement particularly around addressing medicalization and ensuring health-workers are equipped to deal with FGM/C related complications in childbirth.

25. **DFID’s engagement on FGM/C has been small scale to date**, and has not benefited from an overall strategy. DFID has funded small civil society projects, for example in Ethiopia and Kenya. Plan and World Vision, both DFID Programme Partnership Arrangement (PPA) partners, have some interventions focused on ending FGM/C.

26. **There is a window of opportunity for a strategic, ambitious and catalytic DFID intervention now, to support African and global efforts to end the practice.** The momentum at different levels - communities abandoning the practice, African governments passing new legislation, the recent UNGA resolution led by the Africa Group - demonstrates the possibility of change. With the right support, this could translate into large scale ending of the practice. The UK is well placed to show leadership in providing this support and use its influence to encourage other donors to commit political and financial resources as well.

27. **UK funding would send a clear signal** that a major donor had prioritised support to efforts to end FGM/C, following the UNGA resolution. This would help leverage greater attention, commitment and funding from others.

28. **The programme is directly in line with the UK’s commitment to put girls and women front and centre of its development policy.** Work on ending FGM/C supports all four pillars of the Strategic Vision for Girls and Women, which are: delaying first pregnancy and supporting safe childbirth, getting girls through secondary school, reducing violence against women and girls and getting economic assets to women and girls. As put by Dr Nafissatou Diop of UNFPA ‘The girl who undergoes FGM/C is the same girl who is taken out of school early to marry. And this is the same girl who dies before she reaches age 20, giving birth to her third child’. ‘Choices for Women – the UK’s Framework for Results for reproductive, maternal and new-born health’ also highlights FGM/C as an issue to address to empower girls and women to be able to make healthy reproductive choices. While the opportunity to engage on this issue had not been identified at the time of developing Operational Plans, it fits squarely with DFID’s focus on women and girls.

29. **The UK has recently made public commitments to address FGM/C.** In his speech at the London Summit on Family Planning on July 11th 2012, the Prime Minister underlined the UK’s commitment to supporting efforts to end the practice. At a panel discussion during the annual meeting of the Donor Working Group on Ending FGM/C on December 6th 2012, DFID Parliamentary Under-Secretary of State, Lynne Featherstone, reiterated the UK’s intention to prioritise and invest in this issue.

C. IMPACT AND OUTCOME

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4 Further information on the UN Joint Programme is set out in the appraisal case below.

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Catalysing change towards ending Female Genital Mutilation/Cutting
30. The **impact** will be an end to Female Genital Mutilation/Cutting in one generation. Available evidence (particularly on the social norms approach) suggests that an end to the practice would be possible, within a generation, with the right commitment and support.

31. The **outcome** will be a reduction in the incidence of FGM/C in at least 15 countries.

The specific results will be:

- A reduction in cutting of girls by 30% in at least 10 countries in 5 years (measured by prevalence among 0-14 year olds)
- Robust knowledge and evidence produced and made widely available to key actors, leading to more effective FGM/C policies and programmes
- A Global Movement to end FGM/C – to galvanise unprecedented political commitment and funding for this neglected issue.

This programme is intended to be the first phase (5 years) of DFID’s work toward ending FGM/C in one generation (20 years). This programme will enable the second phase to be implemented within the context of evidence of what works to end the practice as well as greater global support to the vision of a world free of FGM/C.

The programme will have substantial indirect benefits as it will support transformational change in the lives of women and girls and their wider communities in FGM/C-practising societies. These will include social, economic and health benefits, directly to girls and women, and indirectly to their families and communities which in future will no longer have to bear the on-going social and economic costs and health burden of FGM/C. The programme will therefore result in greater gender equality and improved health, psychological well-being, relationships, education and economic opportunities for women and girls as a result of not undergoing FGM/C. **These additional benefits will be measured** throughout the programme, particularly through the research component of this programme.

### Appraisal Case

**A. FEASIBLE OPTIONS TO ADDRESS THE NEED OUTLINED IN THE STRATEGIC CASE**

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Catalysing change towards ending Female Genital Mutilation/Cutting
1. The UK is a signatory to the inter-agency statement, the *Platform for Action Towards Abandonment of FGM/C* which sets out agreement, based on evidence and experience, that an approach based on a process of positive social transformation can occur when policies and programmes focus on enabling communities to come together and decide collectively to abandon FGM/C.

2. Overall, there is limited robust evidence on effectiveness of interventions to end FGM/C and therefore the programme will therefore have a strong focus on research, monitoring and evaluation.

3. **However, there is sufficient evidence to support a focus on changing social norms as the basis for the programme.** The starting point for this approach is the understanding that FGM/C is a social norm that can only be changed through collective agreement – the creation of a new social norm - rather than individual decisions. As set out in the Strategic Case above, this is because FGM/C is fundamentally linked to girls’ and woman’s identity, their full acceptance by society and their marriageability. Individual families deciding alone not to cut their daughters, simply risk condemning them to a life of ostracism and stigma.

4. The available evidence and experience from other change processes suggest that a combination of approaches is needed to deliver results. These can be categorised as:
   - Programming which is **targeted** at community-level social change
   - Interventions which build a supportive **enabling environment** for social change
   - Interventions which are **catalytic** and encourage more actors, at different levels, to join and increase the scale of the social change process
   - Research and learning to create an evidence base for future work.

5. **The combination of targeted, enabling and catalytic approaches reflects the experience that no single approach will deliver complex change**, but that a portfolio of sensitive community level work to directly end the practice (usually led by civil society), social communications, education, information, campaigns, political and social commitment, appropriately timed and implemented legislation, have all been key factors which in combination can be instrumental in bringing about change. Targeted, enabling and catalytic approaches have been used in programming for social change in a range of sectors.

6. These approaches are considered necessary to deliver results in this first phase of the programme, and to lay the groundwork for increasingly effective and scaled-up interventions supported by the international community, over the next 10-20 years, to contribute to the programme’s vision of ending FGM/C in one generation.

7. **Targeted community-level programming will contribute directly to actual abandonment of FGM/C through social norms change, at community/local levels.** This type of intervention can include different approaches but will be rights-based, with high levels of community involvement and is likely to involve close engagement with traditional and other community leaders alongside women, men, girls and boys. It will involve approaches that are appropriate to each context and will require understanding of the drivers of FGM/C in context. It will seek to support
communities as they decide for themselves to abandon FGM/C. This is a process which culminates in public declarations or equivalent public demonstration of a collective decision to abandon the practice that can lead to diffusion of the decision through community networks. This component of the programme will involve testing and expanding successful approaches, community level capacity strengthening, and encouragement and support so that people are able to maintain change.

8. **Enabling interventions are necessary to contribute to the creation of a supportive environment for the abandonment of FGM/C.** They include support to the development of structures, mechanisms and systems, at all levels, which regulate and support the changes made. For example, building a policy, legislative and regulatory environment; fostering political will and leadership; systems to implement the legal and policy framework; developing and supporting mechanisms for regional and cross-border agreements and collaboration. FGM/C is not an apolitical issue – and is highly political in some contexts - and this component will require sensitive and strategic engagement based on ongoing political analysis. Enabling interventions also include working with the health system to ensure measures are in place to educate health-workers on not carrying out FGM/C and on good practice in managing its consequences e.g. during childbirth; developing and implementing frameworks for monitoring, accountability and lesson learning.

9. **Catalytic interventions will facilitate better knowledge and understanding of the issues and change processes to bring more stakeholders on board.** Through an ambitious social change communication strategy, this component will encourage more people, in wider populations, to join and support the process of change through multi-pronged and co-ordinated campaigns aimed at different audiences. It will involve an increasing number and range of actors including influential leaders and champions, and women’s and youth movements. This will all be based on solid evidence. The production of knowledge - through the Research and Learning component and the Monitoring and Evaluation of the community and legislative/policy components - to help to maintain abandonment of the practice will be critical. This component will in effect be the ‘glue’ that links the independent research with targeted and enabling action, and ensures stories from the ground and the emerging evidence are communicated at all levels - community, national, regional and global.

10. **Research and Learning.** This component will focus on building the global evidence base on what works to end FGM/C; for example, through research on the political economy, economic, social, cultural and programming factors involved in ending FGM/C in specific contexts, and carrying out baseline/endline studies. It will also contribute to global understanding of the issue, for example, improving global data on the prevalence and impact of FGM/C.

11. The evidence supporting this proposed social norms change approach is set out below (from para 17).

<table>
<thead>
<tr>
<th>Consultation</th>
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<tbody>
<tr>
<td>As part of the consultation process for this programme, DFID hosted a facilitated Open Space event on 6th December 2012, during the annual meeting of the global Donor Working Group on FGM/C. Participants in the Open Space included about 40 experts on FGM/C and related areas, from UN agencies, bilateral donors, international NGOs, diaspora organisations, the research community and others. Participants took part in small group discussions on a range of self-identified topics in answer to the question, ‘What are the opportunities now for ending FGM/C?’, after which they were invited to vote on statements that came out of their discussions. The points that participants prioritised are listed</td>
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Catalysing change towards ending Female Genital Mutilation/Cutting
Catalysing change towards ending Female Genital Mutilation/Cutting

1. Primary victims (girls) need to be educated, empowered and supported whilst changing social norms (13 votes)
2. Implement legislation alongside education (12 votes)
3. Role of young people as leaders and implementers of change (12 votes)
4. Work with community based organisations to build their capacity and their critical thinking of their work (10 votes)
5. Build up a stronger research community and links to public communication so information is accessible from academic to practical/pragmatic for different audiences (10 votes)
6. Co-opt and get endorsements from religious organisations, leaders and institutions to confront the specifically religious 'justifications' for FGM/C (9 votes)
7. Increase the body of evidence and research to demonstrate and prove success and positive impact in addressing FGM/C to make the case to funders for more and better funding (9 votes)
8. Ensure common principles among actors (9 votes)
9. Create more equitable coalitions among civil society organisations so funding can be accessed strategically and have most impact (8 votes)

Other approaches to ending FGM/C

12. The evidence indicates that other approaches to ending FGM/C are less likely to be effective, and there are risks that some may do harm. Experience suggests that top-down approaches that condemn FGM/C, and by implication those who practice it, only serve to alienate people who consider it to be a fundamental part of their culture and can therefore be counterproductive in efforts to end the practice. In the same vein, legislation that is not accompanied by social change approaches, particularly when implementation is heavy-handed and based on prosecutions and sanctions, does not change the fundamental beliefs and social norms that hold FGM/C in place. It is unlikely to be effective and may risk driving the practice underground.

13. Equipping the women who do the cutting with alternative livelihoods, so that they are no longer dependent on FGM/C for their income and status, is also not considered likely to be an effective or sustainable approach. While the future roles and livelihoods of cutters is an element that needs consideration in any programme, the concern with this approach is that it does not address the demand for cutting. Anecdotal evidence suggests that the likely outcome is therefore either that the cutters take up their new livelihoods alongside cutting – particularly in contexts where there is a lucrative cutting ‘season’ - or that others move into the space to meet the demand.

14. Economic incentives, such as cash transfers, have been used to promote and support behaviour change in a range of areas, including keeping girls in school and addressing child marriage. There has however been insufficient work investigating the role of economic incentives in social norms change. The social norms change hypothesis is based on the understanding that agreement to change interdependent social expectations and obligations needs to be reached collectively. There would be a number of risks in taking an economic incentive approach to ending FGM/C. Firstly, cash transfers (or similar) are usually directed at individuals or households, rather than communities. They do not therefore address the deep social norm that holds FGM/C in place nor the social sanctions for non-cutting, and would therefore be unlikely to be effective in enabling individuals to change their practice. There would be major ethical concerns about verifying whether girls had been cut, and nothing to stop the girl being cut after the payment had been made. In this respect, cutting is very different from
child marriage as the aim is to prevent the cutting completely, not to raise the age at which it is done.

15. Secondly, interventions that change social obligations into economic transactions can be counter-productive – as illustrated by the example from Israel of fining parents who collected their children late from childcare, which made the problem worse by monetising the transaction and thereby removing any social obligation to arrive on time\textsuperscript{33}. In relation to cutting, the risk is that cutting becomes a practice that people have to buy the right to do (notwithstanding the same verification problems). Thirdly, it is not known whether any change brought about during the period in which the economic incentive is provided would be sustainable after the intervention ended – i.e. there is no evidence to suggest that the economic intervention would succeed in changing the social obligation. Finally, given the sensitivities of the issue, there would be a risk of accusations of foreigners paying people to change their long-held traditions, which could undermine efforts to end the practice.

16. In contexts where FGM/C forms part of a larger rite of passage ceremony or process, alternative rites of passage are sometimes used to replace FGM/C while maintaining the social function of the coming of age event. Again, evidence is weak but these are likely to be of limited effectiveness as stand-alone measures – because they do not address some of the fundamental drivers of FGM/C around beliefs about girls’ sexuality and purity. There are reports from Kenya that girls who have undergone alternative initiation without FGM/C can be stigmatised\textsuperscript{34}. The connection between cutting and initiation is also not always clear\textsuperscript{35}. But where appropriate it is possible that these can form contributing components of a social norms change approach.

17. **A shift from more extreme to ‘milder’ forms of FGM/C does not uphold girls’ and women’s human rights.** There are reports, particularly from Somalia, of a shift in the practice away from infibulation (Type 3), the most extreme form of FGM/C, to a milder form known as ‘sunna’ (Type 1). While this is sometimes considered a positive step, given the particularly damaging effects of infibulation, two issues arise. The first is pragmatic – anecdotal evidence indicates that the type of cutting carried out in practice can vary widely, irrespective of what it is called, and incidences of ‘sunna’ vary considerably and can in reality be close to infibulation\textsuperscript{36}. But secondly and more importantly, any form of FGM/C is a violation of a girl’s human rights, and all forms of FGM/C are damaging. A shift from a more extreme to a ‘milder’ form does not represent progress towards ending FGM/C, if the social norm that underlies the practice is still in place.

**EVIDENCE UNDERPINNING THE THEORY OF CHANGE**

**Evidence for the social norms change approach**

18. A systematic review carried out in 2012 on interventions to reduce the prevalence of FGM/C in African countries, found only eight evaluation studies that met its inclusion criteria and was unable to draw firm conclusions. Based on what they did find out, the authors formulated tentative recommendations for future programming. These were to ‘include a community analysis and development phase before the intervention is
launched, to consider integrating the issue of FGM/C in a larger set of community-relevant issues, to establish an alliance with traditional and religious leaders, and to base the intervention on an articulated behaviour change theory. They also stressed the importance of contextual factors in contributing to positive developments.

19. The approach that has probably shown the best results on the ground, particularly at some scale, is the community empowerment programme developed by the NGO Tostan, that has been continually refined since it was first implemented in the late 1980s, initially in Senegal and now in other West African and East African countries.

20. This approach is based on a respectful understanding of the social drivers of FGM/C and the norms that hold it in place. It involves a 2-year rights-based education programme, where the NGO builds trust with the community and works collaboratively with men, women, girls and boys and community leaders. FGM/C is not the main or initial focus. The programme covers a range of modules including human rights, literacy, financial skills, problem-solving, health and hygiene. Participating community members team up with non-participating members to share what they learn. There is strong community ownership of the process. FGM/C is typically raised by community members themselves during discussions on health and hygiene, several months into the programme. The community members are supported, over a period of time, to discuss what their aspirations are for their community – and within that, whether FGM/C is still necessary to meet those aspirations. The decision to abandon the practice is the community’s own - no-one is told what to do - and this is critical to the strength and the sustainability of the abandonment.

21. In Tostan programmes, communities that decide to abandon the practice of FGM/C make a public declaration or pledge to this end. The public declaration is a critical part of the process because the decision has to be not only collective - so that everyone knows that it is no longer necessary for their daughters to be cut to get married - but communicated to the inter-marrying group, who then understand that the girls their sons are likely to marry will not be cut. Communities thereby pass on the message and some inter-marrying groups also decide not to abandon the practice of FGM/C. Several thousand communities have publicly abandoned the practice, particularly in Senegal and other francophone West African countries. In Senegal, one community made a public declaration to end FGM/C in 1997. By 2012, over 5000 communities had made similar declarations.

22. Evaluations of Tostan’s work have been positive. An evaluation of their work in Senegal published in 2009 showed positive results for both women’s attitudes towards FGM/C and reported practice of FGM/C. The proportion of women who believed that FGM/C is a social necessity showed a significant decrease amongst women in the intervention villages, from a baseline of 70% to 15% among participants and 29% among non-participants (who will have benefited from the participants’ discussions and sharing of knowledge). It should be noted that there was also a decrease, although smaller, in the comparison group, from 88% to 61%. The evaluation suggests that there was some possibility of ‘contamination’ between the intervention groups and the comparison groups, due to the nature of the programming (social interactions between communities; radio broadcasts in the regions with FGM/C messaging). This illustrates some of the many difficulties in measuring the impact of FGM/C programmes. In terms of practice, the proportion of daughters of women in the intervention group reported as being cut showed a statistically significant decrease, with no change in the comparison group. The evaluation also discusses the challenges
of measuring impact through reported data. Recognising the pitfalls in this approach, it offers some arguments for the reliability of the data based on previous experiences (questions asked within the context of a social change programme rather than in the context of legal change; questions asked by interviewers of the same culture and ethnicity who were independent of the programme). Nonetheless, the evidence from this and similar evaluations, while promising, cannot be considered strong.

23. A UNICEF evaluation of Tostan’s work published in 2008 took a relatively long-term perspective on villages where Tostan had worked before 2000. There were limitations to this study, largely related to the general difficulties of measuring FGM/C as mentioned above. However, the evaluation did conclude that in comparison with control group villages, FGM/C had decreased significantly in the villages that benefited from a Tostan intervention and also in villages which were not beneficiaries of a programme but were associated with a public declaration (providing some evidence for the ‘diffusion’ effect).

24. In this approach, a key part of the theory of change is based on phenomenon of the ‘tipping point’. When a certain proportion of the community no longer practises FGM/C (possibly around 40%), they have effectively reached a ‘critical mass’ where visible change starts to be seen. It is though that a ‘tipping point’ is reached at about 60-50%, at which it has become a new social norm not to carry out FGM/C, and it is thought that most remaining community members will follow the new norm within a short timeframe. As set out in the inter-agency Platform for Action, ‘once a ‘critical mass’ of individuals manifests public support for the abandonment of the practice there are social pressures in motion that lead additional individuals and families to adopt the new norm: change can proceed spontaneously and will be sustained over time’. The social norm change also spreads through networks of communities, through the ‘diffusion’ effect created through the public declarations to inter-marrying groups and through other mechanisms through which community members are supported to spread the word to other communities. The social norm that holds FGM/C in place is deeply embedded and reaching the point of change can take years, but once change begins it is thought to spread rapidly.

25. The process by which this works has been likened to the ending of Chinese foot-binding. The parallel has its limitations, particularly as the context in which Chinese foot-binding ended was a specific moment in Chinese political history which had little in common with the societies where FGM/C is currently practised. There are however some notable similarities to the norms holding both practices in place (particularly the link to marriageability) and some the approaches that are thought to have contributed to ending the practice. These factors are a) an education campaign which explained that the practice did not exist outside China, b) a campaign explaining the harm done by binding feet and the advantages of not binding feet, and c) the formation of ‘natural foot societies’ where members pledged publicly that they would not bind their daughters’ feet nor let their sons marry women with bound feet. Once change took hold, the practice was reduced from over 90% to zero in China over a 20 year period.

26. Another successful approach to ending FGM/C based on close community engagement and social change has been implemented in Ethiopia by the Ethiopian NGO KMG (Kembatta Mentti Gezzima). Their approach is also based on community-led processes, using community conversations to support the community to understand the impact of FGM/C and to decide what action to take. The approach also includes declarations of community commitment to abandon the practice. Local
government officials are involved, which has helped to enforce the declarations. At the same time, other activities are used to reinforce the process, such as community events and rallies. The process has shown positive results.

27. A number of other individual projects addressing FGM/C have shown positive impacts. These include the Navrongo FGM Experiment at Health Research Center, Northern Ghana, also based on community engagement and mobilisation amongst other activities. After overcoming some major reporting and measurement challenges, researchers found a significant decrease in FGM/C\ref{47}. A report for UNICEF in 2009 also sets out some useful lessons learnt, based on analysis of several programmes\ref{49}. Drawing on the experiences of Tostan, KMG, an FGM-free Village Project in Egypt, and alternative rites of passage programmes in Kenya, the report sets out several key principles for programming including: collective abandonment of FGM/C as a prerequisite for marriage; community discussion, decision, and commitment; and programme credibility through broad non-directive approaches that are not only or primarily focused on FGM/C and which have positive content.

28. Evidence from efforts to end child marriage, another social norm related to the value of girls (and which is closely linked to FGM/C) is also useful. Evaluations of Berhane Hewan, a two-year pilot programme in Ethiopia that has now been scaled up within Amhara region, offer some evidence that a well-designed, multi-pronged, community-focused approach can bring about social change. The programme approach combined participation in girls’ groups, promotion of education (both formal and informal), incentives for school attendance and delaying marriage, and participatory community conversations on early marriage and other harmful practices and on reproductive health. The design of the programme acknowledged the complexity of the drivers of child marriage. The evaluation concludes that improvements resulted in age of marriage, school attendance, friendship networks, reproductive health and contraceptive use\ref{50}. However, it has been pointed out that the evaluation does not attempt to measure social norms, so it is not known whether the improvement in the age of marriage relates to a change in perception that girls should marry later\ref{51} or for other reasons (such as economic incentives). The sustainability of results is also not clear yet.

29. CorpoVisionarios, a Colombian NGO, took a social norms approach to ending violence against women in the mining city of Barrancabermeja. The process focused on fostering a) open discussion b) common knowledge on the main problems and their causes and c) collective responsibility for addressing them – in order to create a new social norm against violence. In collaboration with community members, the NGO developed a range of innovative interventions, including staged violent situations on the street, public ‘vaccines against violence’ and a telephone hotline for macho males to talk about their feelings. The programme evaluation concluded that non-violence is now approved of much more than before, which may indicate the start of a change in social norms\ref{52}.

30. The Community-Led Total Sanitation (CLTS) approach to ending open defecation works through a process that creates a new social norm – of not defecating in the open. CLTS works through similar stages – starting with collective awareness raising about the extent of the problem (e.g. through a transect walk through the village), making the issue visible, and building common knowledge about the impact of the problem (making the link between shit, flies on food and health); developing a collective action plan, and finally latrine construction\ref{53}. An evaluation in Nigeria...
concluded that CLTS was an effective approach to improving hygiene and sanitation (reduced open defecation, increased latrine coverage, improved health outcomes, improved dignity for women and girls).\(^{34}\)

31. There is a lack of evidence on how this kind of social norms change approach affects or plays out among different groups within a given ‘community’ or inter-marriage network of communities. The approach is based on the involvement of the whole community, and it is not known to what extent there is a risk of the exclusion of some groups nor how existing structural inequalities play out in relation to the approach. It is possible that social change among higher status, or higher income groups, is more likely to spread to others than change amongst lower status and income groups. But this is not proven. It is also unclear to what extent social norms change involves a risk that social tensions within communities will be increased, or if they may decrease.\(^{55}\) These are areas that require more research.

32. The available evidence on social norms change to end FGM/C focuses mostly on community level interventions, as set out above. There is more limited evidence on the role of laws and policies in relation to social norms change to end FGM/C. The limited evidence available suggests that policy frameworks and legislative change can be important enablers of social norms change to end FGM/C. As measures that are put in place alongside community-level programming and other social change strategies, they can signal changed expectations by government towards the practice and mandate appropriate services and budget allocation.\(^{56}\) They also provide the legitimacy for community-level and social communications work. When not combined with other strategies, policies and laws are at best irrelevant and at worst, damaging (as set out above). It is possible that the most effective efforts will seek to ‘harmonise’ social norms and legal rules, through social mobilisation alongside new legislation and its legal enforcement.\(^{57}\) Efforts to achieve social norm change will not be reach optimal results until the processes and systems which support change are institutionalised and embedded within enabling structures and policy. Without this, change may be achieved, but it is unlikely to be sustained over time.\(^{58}\) More evidence is needed on the most effective balance and combination of interventions focused on laws, policies and community-level approaches.

33. The experience of raising the profile of and commitment to maternal health offers some useful lessons on how to build political commitment at the national level. In his study of Guatemala, Honduras, India, Indonesia, and Nigeria,\(^{59}\) Shiffman identifies a range of factors:

- The work of international agencies to establish a global norm on the unacceptability of maternal death
- The same agencies’ provision of technical and financial resources
- Cohesion among national safe motherhood policy communities
- National political champions
- Clear policy alternatives to show that the problem was surmountable
- Attention-generating events to create national visibility for the issue.

34. In terms of social change communications, the evidence for galvanising a movement for change on a sensitive and taboo issue can be drawn to some extent from the experience of HIV and AIDs. The account by Peter Piot, first head of UNAIDS, of the early years of the global response to HIV and AIDs\(^{60}\) includes many key lessons. These include the importance of rigorous research and robust data, clear
communication and messages, co-ordination of efforts, influential champions, local and national ownership and sufficient funding. Useful lessons can be learnt from the HIV/AIDS field, where global awareness and the massive international financing momentum came ahead of robust evidence of what works to change behaviour. For example, massive investment in billboards, flyers, TV and radio jingles were invested in ahead of evidence that these were effective or value for money. In this programme, it is intended that evidence should lead actions to end the practice. The HIV field also shows the importance of working for social change (initially through change in social norms) and shows how, for example, social attitudes to gender and inter-personal relationships need to change fundamentally to allow greater protection from, and prevention of, HIV transmission.31

35. Robust evidence on the impact of behaviour change communication in general is limited, although the success of the advertising and marketing industry suggests that the strongest evidence may lie within the private sector. A literature review which considered social norms marketing campaigns identified large gaps in the literature and emphasises the importance of targeting the audience effectively to establish the necessary credibility to promote social change messages.62

36. Examples of social change communication on FGM/C at country level include media campaigns by the Tanzania Media Women’s Association (TAMWA) use radio, television, newspapers, and other print media such as posters to educate, mobilise and advocate for social, policy and legal change. In West Africa, music is used to promote an end to FGM/C, for example, in Mali, Sini Sanuman and Healthy Tomorrow have produced albums and music videos of well-known Malian artists who sing about the negative effects of FGM/C, promoting an end to the practice. In Senegal, singer Sister Fa also sings to promote an end to the practice. A project in Guinea by Communication for Change and CPTAFE has involved a youth team performing and filming a drama promoting an end to FGM/C which has been shown schools and on national television.63 Unfortunately it is not clear whether these approaches have been evaluated.

37. Research carried out by the UNICEF Innocenti research centre over the last few years has examined the process of social norms change in relation to programmes addressing FGM/C. It has also emphasised the following: ‘Rather than fighting against local culture and presenting traditional behaviours as negative, effective programmes propose alternative mechanisms to signal adherence to shared community values and to frame the discussion surrounding FGM/C in a non-threatening way’.64

38. It should be noted that much of the evidence on social norms change and FGM/C comes from a relatively small number of linked individuals and organisations. The work is rigorous and cutting-edge, but a wider evidence base is needed.

39. The emerging evidence is promising, but more research and evaluation is needed on many operational questions, to support effective and cost-effective programming at scale to end FGM/C within a generation. Examples of questions where further research is needed include:

- What works, including which elements of successful programme packages are critical to end FGM/C, and what are the causal pathways?
- Effective approaches to ensure sustainable change
• Disaggregating the ‘community’ and how the change process affects or is taken up by different groups within a community
• When and how does a narrowly targeted strategy start to change wider normative frameworks – or does tackling the symptom/one manifestation also address the root cause (gender inequality)?
• What the wider impacts are beyond FGM/C and how these can support or benefit from other development objectives and programmes (such as girls education or changes to economic opportunities for girls and women);
• What are the potential social tensions within and between communities that may arise during the social change process and how can these be managed;
• Will approaches be as effective in all practising communities, even if they are based on an understanding of the context;
• Roles, relationship and relative effectiveness of different stakeholders toward ending the practice (such as health workers, teachers, traditional and religious leaders, traditional birth attendants, local, national and international champions).
• Other approaches – for example, an adaptation of Stepping Stones – that might be effective in ending FGM/C
• Role of policy and legislative change in supporting social norms change – sequencing and balance of approaches

Fragility, conflict and FGM/C

40. Many of the countries and regions where FGM/C is practiced are fragile or conflict-affected. The evidence is however weak on the relationship between conflict, politics and a social practice such as FGM/C. There are anecdotal reports from some vulnerable humanitarian situations (e.g. Somali refugee camps in Kenya) of an increased incidence of FGM/C, carried out to ‘protect’ girls from rape, sexual relationships and unmarried pregnancy. Times of conflict or political flux are also moments when norms and expectations can be redefined and changed. This can be a window of opportunity. For example, in 2012, the new Somali constitution outlawed all forms of FGM/C, setting out a new expectation at the national level. They can also be times when previous gains in human rights can be undermined. Anecdotal evidence suggests that a rise in Islamic conservatism is related to increased prevalence of FGM/C, and there are reports from Egypt since the Arab Spring of proposals to reverse legislation banning FGM/C. Given the high number of fragile and conflict-affected situations where FGM/C is practiced, this is a further area where more research is needed.

Health system issues

41. The policy engagement component will also include a focus on health systems to ensure the actions of health-workers support and do not undermine the process of change. WHO has an explicit policy that FGM/C in any form should not be performed by any health worker, yet as set out above, in some countries, ‘medicalization’ of FGM is on the increase. In some contexts health workers also carry out re-infibulation of women and girls after childbirth. Health workers are however well placed to play a strong role as advocates for change, not least because they are well aware of the complications and harm caused by FGM/C. Ensuring the health system is brought into the discussion of ending FGM/C will be critical to its ending.
**Theory of Change**

42. The Theory of Change is set out on the next page, and draws on the above evidence on social norms change, putting the hypothesis of how this change comes about at its centre.

43. The hypothesis for the social norms approach is that the following process leads to sustainable social norms change at scale\(^6\):
   i. Values deliberation: community discussion on underlying values and the community’s vision of itself and where it would like to be
   ii. Organised diffusion – within the community, and to other relevant communities (eg inter-marriage networks for FGM/C)
   iii. A co-ordinated shift in practice
   iv. A visible manifestation of the shift (eg a public declaration of abandonment of FGM/C). To be effective, this requires the commitment to be real (in the case of FGM/C, communities have to decide themselves if they are ready, and have postponed when they aren’t).

44. The hypothesis suggests that this process requires\(^6\):
   - Trust – within the relevant community
   - Collective deliberation – open discussion that breaks taboos, with a positive focus on the future
   - Attainment of common knowledge – about what everyone else is doing
   - Collective manifestation of commitment – so everyone can trust what each other is doing
   - Pride - the pride of people in communities who have made a positive change this is a major factor in maintaining and spreading change

45. This hypothesis – at the centre of the theory of change - is the crux of the programme. The Community-Level Programming component will be responsible for direct delivery, but will not be able to deliver this alone. The theory of change is based on the assumption that a combination of interventions and outputs is needed to bring about, support, sustain and spread the process of social norms change around FGM/C. Policy Engagement is required to build a supportive enabling environment by changing expectations around FGM/C at the national and regional levels. Social Change Communications are needed at all levels to reinforce and spread messages for change at local and national levels, disseminate success stories and evidence, and galvanise a global movement so that increased international commitment and funding support the scaling-up of efforts at community level. Research and Learning is needed to build the evidence base that underpins the whole programme, and to ensure that by the end of this 5-year phase, a robust evidence base is in place to inform all future policy and programming and accelerate progress towards the programme impact, an FGM/C-free world.
Theory of Change

This sets out the full change process over approximately 20 years. This programme is for the first 5 years of this process. The impact of this programme therefore aligns with outcome level on this Theory of Change.

### Inputs
- Community-level social change programming (targeted)
- Policy engagement interventions (enabling)
- Social change communications interventions (catalytic)
- Research and Learning

### Outputs
- Local, district and sub-national level commitment to ending FGM/C
- Supportive enabling environment for abandonment of FGM/C in countries and regions where it is carried out
- Increased global understanding on FGM/C and global commitment to ending the practice
- Evidence base on what works to end FGM/C underpins policy and programming

### Process of Social Norms Change (Hypothesis)
- Increasing numbers of communities participate in social change programming
- Community members participating in social change programmes spread learning and discussions about FGM/C
- Community members come together and decide collectively not to carry out FGM/C
- Community level change reinforced by national policies and laws and support from leaders, champions

### Outcome
- Reduction in practice of FGM/C

### Impact
- New social norm of not practising FGM/C is in place in communities, across ethnic groups, countries and regions and globally
- More girls complete school
- Girls and women better able to take up economic and political opportunities

### Super Impact
- FGM/C-free world
- First marriage and first pregnancy delayed
- Reduction in VAWG

### Assumptions
- The outputs in combination will support increasing numbers of communities to go through the social norms change process
- Communities decide to abandon FGM/C - key to this approach is that they make their own decisions
- Public declarations are an effective mechanism in all contexts. To be verified in the inception phase
- Community decisions and public declarations signify real and sustainable change in community practice
- The process of ending FGM/C also leads to improved gender equality and women’s and girls’ rights

See appraisal case for evidence on the social norms approach
Programme options

46. The options appraisal considers the mechanisms through which the programme will be delivered to ensure maximum impact and value for money.

47. The UN Joint Programme (UNJP), ‘Accelerating Change’, implemented by UNICEF and UNFPA, is the only existing major programme addressing FGM/C. DFID’s feasible programme options for the first two components (targeted community-level programming and enabling policy engagement) are to support the UNJP or to set up new mechanisms. (Further detail on the UNJP is set out in the options appraisal below).

48. We have rejected the option of the UNJP for components 3 and 4 although the UNJP includes some activities that would fall under these areas. The UNJP is not a viable option for a strategic, multi-level, multi-pronged catalytic Social Change Communications component, which will require an innovative approach, bringing in new actors, to bring about a step change in understanding and commitment.

49. For the Research and Learning component, the UNJP does not have a sufficiently strong track record in this area, and there would be some risks (such as a lack of independence) and missed opportunities in bundling the Research and Learning with any of the other components. It is considered important that this is a stand-alone component of the programme which is closely co-ordinated with, but independent from, the other components. As set out above, this component will be developed by the end of 2013, when this business case will be updated to include the full detail. The full range of feasible options for this component has not yet been identified.

50. The following table sets out the identified feasible programme options against the targeted, enabling, catalytic and research interventions that we consider are required in combination to deliver the programme’s results.

<table>
<thead>
<tr>
<th>Interventions</th>
<th>Options</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community-level social change programming (targeted)</td>
<td>UN Joint Programme ‘Accelerating Change’</td>
<td>With DFID funding under this programme, it would expand its community-level social change work, through a dedicated fund designed to crowd in new players and support capacity building, and operate in new countries. The UNJP’s approach is rooted in ongoing UNICEF research on social norms change. Many FGM/C practicing countries are fragile and the UN is one of the few implementers able to operate. DFID funding would support Output 2 of the UNJP - Local level commitment to FGM/C abandonment</td>
</tr>
<tr>
<td></td>
<td>Challenge Fund (contracted to Fund Manager)</td>
<td>DFID would set up a new Challenge Fund to provide funding in response to calls for proposals. This would be managed and administered by a contracted Fund Manager.</td>
</tr>
<tr>
<td>Policy engagement (enabling)</td>
<td>UN Joint Programme</td>
<td>As above – DFID funding to the UNJP would also include support for policy and legislative change and building political commitment. DFID funding would primarily support Output 1 Effective enactment, enforcement and application of national policy and legal instruments to promote abandonment of FGM/C</td>
</tr>
<tr>
<td></td>
<td>Challenge Fund (contracted to Fund Manager) – as above</td>
<td>The Challenge Fund would include in its call and criteria proposals for interventions that work at this level, on policy, legislation and political commitment.</td>
</tr>
<tr>
<td>Social change communication (catalytic)</td>
<td>Consortium (contracted)</td>
<td>DFID would tender for a Consortium that would probably include civil society organisations and private sector providers, to work in close collaboration with the other components of the programme to design and implement a full and strategic social change communication package, to galvanise a global movement to end FGC – bringing</td>
</tr>
</tbody>
</table>
Catalysing change towards ending Female Genital Mutilation/Cutting

about social change, raising awareness, galvanising commitment and funding, and ensuring diaspora involvement in the change process.

This consortium could also be tasked with a co-ordination/secretariat function for the whole programme to ensure overall collaboration and coherence.

Do nothing. No other viable option identified.

Research and learning

<table>
<thead>
<tr>
<th>Options</th>
<th>Evidence rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consortium (contracted)</td>
<td>DFID would tender for a consortium that would probably include academic institutions and civil society organisations, to design and implement the research, M and E component of the programme, in close collaboration with all the other components.</td>
</tr>
<tr>
<td>Other options to be identified</td>
<td></td>
</tr>
<tr>
<td>Do nothing</td>
<td></td>
</tr>
</tbody>
</table>

B. Assessing the strength of the evidence base for each feasible option

In the table below the quality of evidence for each option is rated as Strong, Medium or Limited

<table>
<thead>
<tr>
<th>Interventions</th>
<th>Options</th>
<th>Evidence rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community-level social change programming (targeted)</td>
<td>UN Joint Programme</td>
<td>Limited – but good track record given low levels of funding so far, and clear results set out in the programme’s annual reviews. Clearer evidence will be available when the programme evaluation is published over the next few months. Full detail is set out in Section C below.</td>
</tr>
<tr>
<td>Challenge Fund</td>
<td>Limited – DFID has some experience of challenge funds applied to a difficult area, e.g. Manusher Jonno’s work on land reform and VAWG in Bangladesh. Unclear how such a fund would operate with a fairly prescriptive type of approach (social norms) and with the risk that the wrong approach could do harm on a very sensitive issue.</td>
<td></td>
</tr>
<tr>
<td>Policy engagement (enabling)</td>
<td>UN Joint Programme</td>
<td>Limited - as above</td>
</tr>
<tr>
<td>Part of above Challenge Fund</td>
<td>Limited - as above</td>
<td></td>
</tr>
<tr>
<td>Social change communication (catalytic)</td>
<td>Consortium (contracted)</td>
<td>Limited – this is new ground for DFID</td>
</tr>
<tr>
<td>Do nothing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Research and learning</td>
<td>Consortium (contracted)</td>
<td>Medium - Tried and tested DFID model for funding research.</td>
</tr>
<tr>
<td>Other options to be identified</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do nothing</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
C. What is the likely impact (positive and negative) on climate change and environment for each feasible option?

Categorise as A, high potential risk / opportunity; B, medium / manageable potential risk / opportunity; C, low / no risk / opportunity; or D, core contribution to a multilateral organisation.

<table>
<thead>
<tr>
<th>Option</th>
<th>Climate change and environment risks and impacts, Category (A, B, C, D)</th>
<th>Climate change and environment opportunities, Category (A, B, C, D)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community-level social change programming (targeted)</td>
<td>UN Joint Programme</td>
<td>There is no difference in likely impact between the programming options.</td>
</tr>
<tr>
<td>Policy engagement (enabling)</td>
<td>Part of above Challenge Fund</td>
<td>This programme is expected to have negligible impacts on climate change – Category C. Main risks are likely to be around vehicle use for community-level programming, and flights taken to facilitate regional and international co-ordination.</td>
</tr>
<tr>
<td>Social change communication (catalytic)</td>
<td>Consortium (contracted)</td>
<td></td>
</tr>
<tr>
<td>Research and Learning (cross-cutting)</td>
<td>Do nothing</td>
<td></td>
</tr>
<tr>
<td>Other options to be identified</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Risks to the climate and environment from the programme

51. Overall risks to the environment and climate change are low and relate to the travel for community outreach across Africa and for social change communications. Recommendations to minimise operational impacts of the programme include:

- Monitor and report of carbon emitted from flights and offset flights through a verifiable carbon offset project.
- Encourage lower emissions from the outputs through
  - Encourage individuals travel in economy class as this reduces the carbon associated with each seat, and ensures better value for money of the programme;
  - Reduce the need to travel by using locally based staff and advocates where appropriate, and teleconference/ videoconference facilities for national/ international meetings;
  - Reduce the wider environmental footprint of outputs through, for example, use of online and mobile-related communications, recycled paper, and minimising printing and printing waste.

D. What are the costs and benefits of each feasible option?

52. This section first sets out possible approaches to quantifying the benefits of preventing FGM/C as further support to the case for intervening. The main focus of this section is on the costs and benefits of the programme options.

Quantifying the benefits of ending FGM/C

53. There is a strong moral case for addressing FGM/C as a human rights issue, which violates girls and women’s bodily integrity. It is not possible, and it would be inappropriate to put a monetary value on women’s genitalia and the full benefits for a
woman or girl of not being cut or otherwise damaged. If we consider FGM/C to be one of the most extreme manifestations of gender inequality, it is relevant to point to the evidence of the economic benefits of overall greater gender equality, which has been well documented.

54. There have been few attempts to date to quantify the benefits of FGM/C prevention – and further research on this will be undertaken through the research component of this programme. The evidence which does exist suggests a potentially very good return. The quantifiable benefits of reducing instances of FGM/C include:

a) **Reduction in the medical costs of FGM/C and its complications to the health system.** A recent WHO study of six African countries found that the annual FGM/C-related obstetric costs – i.e. those related to pregnancy - amounted to 1 per cent of Government health expenditure for women 15-49 years of age. It concluded that, on avoided obstetric complications alone, a unit cost of $5.82 per FGM/C Type 3 or $ 2.50 per FGM/C Type 2 prevented, the value of avoided obstetric complications would entirely offset the costs of prevention.

In addition, an FGM/C programme in Sudan found that the two-year programme helped to get 960 communities to commit to the abandonment, of which 275,000 girls are presumed to have avoided FGM/C as a result of their effort. The programme estimated that the cost of targeting one girl is around $3.00.

b) **Reduction in health care costs to the individual.** Obstetric complications account for only a small portion of the overall health impact of FGM/C, and their financial costs are merely one among the many costs. They include immediate impacts such as severe pain, bleeding and infection and long-term effects such as trauma, death, fistula, urine and menstrual blood retention, cheloid scarring/tumours, infertility, and increased susceptibility to bacterial vaginosis and genital herpes. Complications also include foetal distress and death. There are no estimates of these other, non-obstetric, health costs of FGM/C since they are often not identified to the formal health services. A study on in Burkina Faso founds that the cost of obstetric complications has a significant impact on the welfare of the households and generate significant out-of-pocket expenses. A study in Africa found that out-of-pocket expenses account for about 50% of total health expenditure on average in sub-Saharan Africa and can exceed 75% in some countries.

c) **Increase in the productivity of women due to absence of complications and disability related to FGM/C.** Plausible pathways through which women’s health improvements can influence the pace of economic growth include their effects on labour market participation, worker productivity, investments in human capital, savings, fertility, and population age structure.

Again, there are no direct estimates available, but magnitudes may be roughly inferred from other sources. One study on the impact of better health on economic growth estimates that a one percentage point increase in adult survival rates translates into a 1.68 per cent increase in labour productivity. This implies that health differentials account for about 17 per cent of the variation in output per worker across countries. We cannot go further to apportion any of this result to women, even less to FGM/C, but this is a large effect.
d) **Increase in the educational attainment of young girls of school age due to the absence of complications and disability related to FGM/C.** - The educational and economic consequences of poor health during childhood and adolescence have become increasingly clear. A health disadvantage in *very early childhood*, most often defined by low birth weight, can be demonstrated to be adversely related to academic achievement in school and attainment in adulthood. There is also strong correlation between FGM/C and Early Child Marriage – which greatly reduces girls’ chances of finishing education and joining the labour-market.

It has been demonstrated that education boosts female labour-market participation. Adolescent health may independently shape educational outcomes through its influence on school participation and performance.

55. There is not enough evidence to quantify the reduction in health care costs to the individual or the impact of increased productivity and educational attainment of women. Any assessment of the economic benefits of ending FGM/C would make a conservative assessment, as it would only consider the benefits from the reduction of costs related to obstetric complications.

56. One challenge related to such an analysis would be the time required for the obstetric benefits to be realised. These will only be realised when women will reach their childbearing age, which can be several years later, depending on the age at which girls are cut (which varies according to culture). On the other hand, the return to investment will be very high after the prevalence of FGM/C reaches a tipping point at which large scale abandonment occurs.

57. It is also important to note that the social change approach to reducing FGM/C may have wider benefits. There is an emerging general consensus that community level social change interventions cannot be implemented in isolation from other factors that may influence FGM/C-related attitudes and behaviour. The most successful approaches to reducing FGM/C involve wider community development and empowerment measures which may have other broader benefits (education, health outcomes, raising the age of marriage, etc) beyond a direct reduction in FGM/C, which it is not possible to isolate.

**Measurement challenges**

58. There are significant challenges to measuring progress towards ending FGM/C. It is not possible, nor would it be ethical, to directly measure prevalence through observation. This would be feasible up to a point for women and girls who attend health facilities for childbirth, but in most practising communities most do not. Measurement therefore relies on reported information. The DHS has for some years included a module on FGM/C in most practising countries, and this is considered reasonably reliable as a baseline. There is however no data for some countries. Poor data validity is more likely where there is (still) stigma around non-cutting or where there is enforced criminal legislation in place to ban the practice. There is also the possibility that with increased dialogue, programming and communications about FGM/C at different levels, communities may start to report what they believe they should say, ie that they are no longer carrying out the practice, regardless of actual practice.

59. Even where families become aware of the harm the practice can cause and would prefer not to carry it out, until a wider social norm has changed – where the new social
Catalysing change towards ending Female Genital Mutilation/Cutting

norm is not to cut - they will continue to be under significant pressure to have their girls cut. UNICEF’s recent work on measuring social norms change suggests that attitudes may change gradually, but when a change occurs, it can happen very quickly across a community. The following by UNICEF illustrates the relationship between attitude and practice for a change in behaviour that does not require a social norms change (for example, take-up of oral rehydration therapy) and a social norms change such as ending FGM/C.

60. This suggests that a method to measure progress towards social norms change is critical, particularly for the period shown in the right hand graph where in terms of actual practice, nothing has changed yet. The methods developed by UNICEF and others are based on a precise definition of social norms (see definition in para 6 above), and focus on measuring people’s belief that others in their community are practising FGM/C (empirical expectations) and people’s belief that others in their community expect them to practise FGM/C (and will judge them negatively if they do not – normative expectation). These approaches will also be useful in triangulating DHS and other data.

61. There is a time lag between a family’s decision not to cut their daughter and when this is picked up in national level survey data. This is because the relevant surveys (Demographic and Household Survey, Multiple Indicator Cluster Survey) take place only every few years, and because the age at which a girl is cut (which varies a great deal between cultural contexts) will affect when it is reflected in age cohort data. If for example, girls are cut as infants or between the age of 5 and 10, a decision not to cut a girl may not be reflected in the survey data for her age cohort for up to a decade. This further enforces the importance of methods which measure social norms change.

Costs and benefits - issues

62. Cost-benefit analysis applies a discount rate, reducing the value of costs and benefits according to the length of time it will take for them to be realised. With FGM/C interventions this could be problematic because changing social norms requires a long term approach. In addition, there is the time-lag which means that a change in
behaviour may not be picked up nor realised (in the case of obstetric complications) for a decade or more.

63. A further challenge relates to uncertainty. The social norm around FGM/C is likely to require, and will occur within a context of complex interactions of different factors and interventions (social, policy, legal, communication, media, political, religious etc). An added complication is the idea of the ‘tipping point’ when conditions come together to achieve large-scale abandonment of FGC over a relatively short time. Weighing up costs and benefits is therefore particularly challenging. The timing of the ‘tipping point’ also adds a further difficulty to calculating a net present value.

64. The challenges of measurement and attribution of outcomes are common to all approaches to reducing FGM/C. They effectively render a cost-benefit analysis ineffective for selecting between different programme design options. The selection of the preferred option must therefore factor in a comparison of cost-effectiveness of the most feasible options.

Appraisal of options

65. Annex A sets out the appraisal of each option according to six criteria that focus on effectiveness and cost-effectiveness:

- Delivery of results
- Management costs
- Complexity/transaction costs for DFID
- Risks
- Opportunities
- VFM

66. The section below provides further details of the cost-effectiveness assessment of the options.

Community-level programming (targeted) and Policy engagement (enabling)

Option 1: Channel DFID funds into UN Joint Programme

67. The UN Joint Programme on FGM/C was launched in 2008, originally for 5 years (currently extended to a sixth year through to December 2013). UNFPA acts as the administrative agent, with UNICEF providing support and guidance to the global level and country level work. Since 2008, the main donors have been Austria, Iceland, Ireland, Italy, Luxembourg, Switzerland and Norway.

68. The UNJP currently works in 15 countries across Africa (see table below) and has been running since 2008. Its original end date of 2012 has been extended to 2013. Against a budget of $44m it had by 2011 received only $25m in support (and as a result worked in a reduced number of countries). UNICEF and UNFPA are currently planning a second phase for 2014-17 which will be informed by a major programme evaluation that is due early in 2013.

Table: Countries covered by UN Joint Programme
The UNJP’s objective (goal) is to contribute to a 40% reduction of the practice of FGM/C among girls aged 0-15 years, with at least one country declared free of FGM/C by 2012. The outcomes are:

- Change in the social norm towards the abandonment of FGM/C at the national and community levels
- Strengthened global movement towards the abandonment of FGM/C in one generation.

The outputs are:

a) Effective enactment, enforcement and use of national policy and legal instruments to promote the abandonment of FGM/C
b) Local level commitment to FGM/C abandonment
c) Media campaigns and other forms of communication dissemination are organized and implemented to support and publicize FGM/C abandonment
d) Use of new and existing data for the implementation of evidence-based programming and policies and for evaluation
e) FGM/C abandonment integrated and expanded into reproductive health policies, planning and programming
f) Partnerships with religious groups and other organizations and institutions are consolidated and new partnerships identified and fostered
g) Tracking of programme benchmarks and achievements to maximise accountability of programme partners
h) Strengthened regional dynamics for the abandonment of FGM/C
i) Strengthened collaboration with key development partners on the abandonment of FGM/C
j) Existing theories on the functioning of harmful social norms are further developed and refined with a view to making them applicable to the specific realities of FGM/C

70. The UNJP programme approach recognizes FGM/C as a social norm, builds consensus on human rights, facilitates a coordinated, collective decision by communities to change the social norm and abandon the practice. It puts emphasis on ‘high-level signalling’ – the use of national policy and legal instruments to promote abandonment of FGM/C, global communication campaigns (eg Zero Tolerance Day 2012) and public renouncement of the practice by communities. In 2011, it reported the following results:

- 2,744 communities publicly declared their abandonment of FGM/C and increase of 30% over a year.
- Across the 15 joint programme countries, 141 cases violating national laws against FGM/C were prosecuted in court.
- 19,584 community education sessions took place.
- 3,485 newspapers articles and TV and radio programmes discussed the benefits of ending the practice.
- Nearly 3,000 health facilities included FGM/C in their antenatal and neonatal care.
- Nearly 4,107 religious leaders taught their followers that FGM/C is not sanctioned by Islam.
- Nearly 1,000 religious edicts were issued in support of the abandonment of the practice.
- Over the programme period almost 5,000 communities have renounced the practice.\(^8\)

71. The table below sets out illustrative examples of key programme results over the last two years and the graph sets out data showing a decline in the practice in most UNJP countries. It should however be noted that there is no comparison with non UNJP countries.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>2010</th>
<th>2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of communities publically declaring abandonment of FGM/C</td>
<td>596</td>
<td>2744</td>
</tr>
<tr>
<td>Number of cases violating national laws prosecuted in court/legal actions brought against violators of laws on FGM/C</td>
<td>198</td>
<td>141</td>
</tr>
<tr>
<td>Number of religious leaders teaching their followers that FGM/C is not sanctioned by Islam/ OR declaring publically that FGM/C should be abandoned</td>
<td>6356</td>
<td>4107</td>
</tr>
</tbody>
</table>

72. The budget for the original five year programme was estimated in 2007 at US$ 44 million. That has been scaled back and the present estimated total budget for the six-year period is US $32 million. As of April 2012, $20.6 million had been spent. The programme is still presented as having a shortfall of US$ 16.5 (£10) million for 2012 and 2013.\(^9\) $4 million in commitments have been made for 2013. Therefore $12.5 (£8) million is still outstanding.

73. A new funding proposal (Phase II, 2014-2017) will be developed in the second quarter of 2013, taking into account lessons learned from an evaluation of Phase I and progress made in the various countries. A draft concept note for Phase II was shared at the annual Steering Committee meeting held in January 2013, and set out an intention to maintain the focus and momentum of the programme, with a potential broadening to explicitly recognise impact on other harmful practices such as child marriage. DFID funding would make DFID the largest and therefore an influential donor. DFID will be actively engaged in the development of Phase II of the programme.

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Catalysing change towards ending Female Genital Mutilation/Cutting
Option 2: Set up a challenge fund in a limited number of countries

74. A DFID Challenge Fund for FGM/C could be more focussed - on a smaller number of countries or sub-national areas where the worst forms of cutting exist – could be designed to be more supportive of new and/or smaller NGOs and could more actively integrate research components. They could also ‘free-ride’ to some extent on the UNJP presence and its ‘high-level signalling’ in the country.

75. Setting up and running a challenge fund is administratively costly: a benchmarking study for the African Enterprise Challenge Fund (AECF) in 2010 found that the range of administrative and financial management costs was between 15% - 40% of total fund value with a benchmark of around 20%. Another study conducted for DFID Challenge Funds showed a similar spread although some of the Civil Society Challenge Funds had administration and programme support costs under 15%. Challenge Funds with the private sector might be expected to have higher management costs as DFID’s Civil Society funds are a conduit for grants to established organisations with on-going programmes and monitoring systems. The requirements for due diligence and evaluation with these Civil Society Funds are therefore probably lower. On the other hand, the AECF benchmarking study did find clear economies of scale, since project management time costs tend to be fixed irrespective of the size of the project. Thus a Challenge Fund with smaller projects will inevitably have higher fund management costs. A benchmark for comparative purposes of 15% is proposed.

76. The cost of setting up and operating an in-country programme may also be high. As an illustration of costs (in the absence of other data), the NGO Tostan reported that the cost in 2011 of running 8 country programmes and additional international offices in Washington DC, Sweden, France, Canada was $9.06m.

Comparison according to cost-effectiveness criteria

Table: Value for Money Comparison of Options using 3Es measures for interventions 1 and 2

| Indicator | UNJP | Challenge Fund
<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>Intervention 1 and 2: Community-level social change programming (targeted) and Policy engagement (enabling)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| Economy - Management fee | 7% | 15% - 20%
| Efficiency – Annual country programme cost | $0.5 million | $1 million
| Cost-Effectiveness – Cost per community member reached | $5 | $12.50

5 All costs here are indicative only.
6 UNJP cost to date of $20.6 million across 15 countries over 5 years = $ 1.4 million per country to date, or $0.5 million per country per year.
7 Based on Tostan Annual Report 2011 which reported a cost of running 8 country programmes (with offices) and additional international offices in DC, Sweden, France, Canada of $9.06m in 2011.
8 Assuming approaches similar to Tostan, with similar costs, are supported.
77. The table below shows the MAR assessment (February 2011) of our proposed UN partners, including overall VfM ratings and comments. The next MAR assessment in 2013 will provide new evidence to help strengthen and encourage VfM performance improvements.

<table>
<thead>
<tr>
<th>Agency</th>
<th>Overall VfM Category</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>UNICEF</td>
<td>Very Good</td>
<td>Provides services which drive down procurement costs across the UN system</td>
</tr>
<tr>
<td>UNFPA</td>
<td>Adequate</td>
<td>A good track record on procurement. Provides services which drive down procurement costs across the UN system.</td>
</tr>
</tbody>
</table>

Social Change Communications component: Consortium or do nothing / Research and Learning Component: options still to be identified

78. The two final components will strengthen the VfM of the Community-level programming and Policy Engagement components, improving the effectiveness and the cost-effectiveness of these interventions. To further improve the VfM of the contracted components of the programme, reasonable cost ratios will be established during the inception phase and regularly assessed to ensure that overheads are minimised and, where possible, semi-fixed costs (such as accommodation) are subject to regular challenge and review. There is not enough evidence at this stage to allow us to assess the VfM of the component 3.

79. The Research component of the programme will include a strong focus on improving measures to assess VfM of FGM/C interventions.

E. What measures can be used to assess Value for Money for the intervention?

80. The ideal VfM measure should probably be cost per case averted. If the majority of impact is realised in whole communities, this ought not to be too difficult to capture. In other words it will be known how many girls of a relevant age are in a community that has committed to ending the practice.

81. An intermediate VfM measure for the above could be cost per community pledge or declaration of an intention to end the practice. While not ideal, if the pledge or declaration is reached through a process based on the social norms approach, and is a genuine community decision, it does signify an important moment in the process towards changing social norms.

82. The best measures of VfM relate to local-/community-level change (output 1) because the efforts of the other three components are all ultimately intended to increase the effectiveness of community level programming in changing the social norm around FGM/C, for it is at this level that the decision to cut or not is made. Thus other VfM measures focused on cost per communications event, cost per law passed etc, would not capture the benefit of the programme (as well as being problematic for other reasons).
83. Measures should also include the extent to which the programme manages the main cost drivers.

F. Summary Value for Money Statement for the preferred option

84. There is insufficient data to make a robust VfM assessment that incorporates quantifiable benefits of a programme to end FGM/C. However, the moral case for intervening is strong, and the evidence for the economic benefits for just some measures is also strong, indicating that such a programme would have a high rate of return.

85. Summary of preferred options following appraisal:

<table>
<thead>
<tr>
<th>Interventions</th>
<th>Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community-level social change programming (targeted)</td>
<td>UN Joint Programme</td>
</tr>
<tr>
<td>Policy engagement (enabling)</td>
<td>UN Joint Programme</td>
</tr>
<tr>
<td>Social change communication (catalytic)</td>
<td>Consortium (contracted)</td>
</tr>
<tr>
<td>Research and learning</td>
<td>To be determined</td>
</tr>
</tbody>
</table>

86. This approach is most likely to optimise results on the ground with high quality work in all areas of enabling, catalysing and targeted interventions. The UNJP is the most cost-effective option for DFID. It is also considered to be the most effective. It is well placed to manage the community level programming and policy engagement, not least given their experience over the first five years of the programme. The UN has access to a number of the countries where NGOs have limited access or reach. There are risks associated with funding the UNJP and DFID will need to influence how this funding is used, particularly with regard to regional approaches, to widen the range of community-based partners and to ensure robust M and E. However, there is a significant opportunity to provide the UNJP with a realistic level of support to carry out its intended work (it has never had this). At the same time, there would be substantially higher costs and risks in setting up an alternative mechanism that would potentially compete with the UNJP without the benefit of its legitimacy to work on this sensitive issue (particularly following the UNGA resolution on FGM/C that specifically highlighted the UNJP). The three components will be designed to work very closely together, and to facilitate this essential co-ordination, we have included in the Social Change communication component a co-ordinating function.

87. The Research and Learning component will be developed with DFID’s Research and Evidence Division. It will be developed over a longer timeframe, and it is anticipated that this business case will be updated to reflect the full research component by the end of 2013.

88. As none of the options is without risk, the programme will include a robust review at the end of Year 2 of implementation to assess progress and the balance between the delivery mechanisms, with the option to alter the balance if needed (see the Management Case below).
G. Geographical options

89. FGM/C is practiced in 28 countries in Africa, and up to 6 or more in the Middle East and Asia. This programme intends to have a demonstration effect, while at the same time build an evidence base of what works to end the practice in different contexts. The programme will therefore work in a variety of different cultural contexts in West and East Africa, and with ethnic groups which are at different stages towards ending the practice.

90. The table in Annex B sets out the full appraisal of country options for the Community-level Social Change Programming and Policy Engagement elements of programme which will be implemented by the UN Joint Programme. DFID support to the UN Joint Programme will focus on two regional clusters of inter-linked practising communities, cross-border regions and regional influence.

91. This will include a West African francophone hub where there is already significant momentum towards ending FGM/C through social norms approaches. It will also include a focus on countries in the East Africa/Horn/Yemen region, where there is political commitment to ending the practice, but less progress to date. This region includes Somalia, which is critical to reach given the very high prevalence rate among Somali people, the geographic location of Somali people across several countries in the region, as well as political commitment and initial efforts to end the practice which need further support now.

92. Regional approaches in both West and East are important because of the cross-border location of practising communities and the potential for regional policy engagement. The UNJP is already focused on 15 countries in these two regions, which means that DFID support will enable the UNJP to build on and strengthen existing groundwork, relationships and efforts, adding value rather than starting from scratch on this difficult and sensitive issue. Yemen is not yet within the Joint Programme, but given its location within the wider region, UNICEF/UNFPA have indicated that it would be logical and feasible to extend the programme there.

93. In addition, we have identified Nigeria as a priority country to include as a new focus country within the UNJP, because it includes the largest number of women and girls affected by FGM/C in a context where there is very little momentum or political commitment to the issue. Again, UNICEF/UNFPA agree with this suggestion.

94. As Nigeria and Yemen are both conflict-affected countries with complex politics, where the UNJP has not yet worked and where there is little momentum to end FGM/C, expectations of programming here will be modest. The focus in these two countries over the first 5-year phase of this programme will be to do ground work and start to build the foundations for change and it would be recognised that significant results at outcome or impact level would be unlikely in the first phase. Progress towards outputs would however need to be demonstrated.

95. The Social Change Communication and Research and Learning components will focus primarily on these countries and regions, but will not be restricted from developing strategies that include other countries in Africa (e.g. Sierra Leone, Liberia) and beyond (e.g Indonesia, Malaysia).
96. Several of the focus countries for this programme are fragile or conflict-affected. The UNJP has so far demonstrated an ability to deliver results in these situations and to negotiate national politics effectively. Given shifting security and political situations, the extent and mode of operation of all components of the programme in the FCAS target countries will be continually monitored.

Complementarity with DFID country-level programmes on FGM/C

97. The management arrangements of this regional programme will ensure that this work complements the work of others, including DFID country-based programmes on ending FGM/C. One component of the programme, the communications element, will take on a coordinating and secretariat role for the programme as a whole. Within DFID, the leadership of the programme will be within the MDG Team of the Africa Regional Department.

98. The programme will support DFID offices who may want to develop complementary bilateral work in DFID focus countries. In this way, the programme will not duplicate efforts led by DFID (or others) at country-level, nor will those efforts simply substitute for this programme. The added value of this programme will be its ability to take a regional multi-country approach, prioritising targeted efforts across countries strategically, linking country efforts to regional and global efforts, developing cross-border approaches and agreements, and facilitating south-south lesson-sharing between countries or communities seeking to end the practice. This programme’s efforts on Research and Learning and Social Change Communication will also co-ordinate closely with and strengthen country-level engagement.

99. Country-level DFID programming on FGM/C will also enable this regional programme to invest in interventions in other countries with high levels of need, or where it is otherwise strategic for DFID to support efforts to end the practice, further increasing the reach and impact of DFID’s overall support to efforts to end FGM/C.
Commercial Case

Direct procurement

A. Clearly state the procurement/commercial requirements for intervention

The programme will have three entities managing the implementation of the overall programme. The first will be managed through indirect procurement (United Nations Joint Programme on ending FGM/C) and two that will require direct procurement:

-Social Change Communications:

This component will provide an innovative package of social change communications products operating at multiple levels from global to community level. The UN does not have the core competencies to deliver this critically important strategic and catalytic component of the programme. The procured group will also have a co-ordinating and secretariat function for the whole programme to ensure overall programme coherence.

-Research and Learning

This component will be directly procured through a separate competitive procurement process. We rejected this component from being directly part of neither the UN component nor the social change communications to ensure independence and because there is insufficient track record of this research being undertaken by the UN.

Note that this component will be developed with Research and Evidence Division and it is anticipated that this business case will be updated in mid-2013 to reflect the detail.

B. How does the intervention design use competition to drive commercial advantage for DFID?

Implementing partners for the Social Change Communications and the Research and Learning components will be procured through open tender in accordance with DFID tendering procedures. A detailed evaluation framework will be developed in early 2013 to guide and inform the design and commissioning of the tenders. This will include criteria to ensure value for money and that prospective service providers have capacity to perform to a high standard. DFID’s Procurement Group will provide input into the Terms of Reference, Evaluation criteria, milestones etc.

It is expected that the components being procured through open tender will be reasonably attractive; namely the components on social change communications and that of research and learning. Working together with PrG, a strategy will be developed to undertake some early market engagement, such as an information notice and information days to gauge interest. FGM/C has been a neglected issue in international development and there is therefore a limited number of partners who have experience in this work. These components lend themselves well to tendering as they can utilise generic skills (in research, development communication), particularly if they partner with organisations with some technical expertise on social norms change and FGM/C, and should therefore be attractive to a range of bidders.
The UN Joint Programme on ending FGM/C has experience and technical knowledge of this area. Using a direct procurement mechanism for DFID’s own targeted results could inefficient because of the risk of duplicating effort would risk undermining the UNJP mechanisms. However, there are risks that this UN component could be slow, inflexible, bureaucratic or not achieve the planned results. There will therefore be close monitoring of the performance of this component. If at the end of year 2 we have concerns over performance and results, particularly that of the funding targeted community-level social change work, then we will explore the option of tendering this component to a management agent through open tender. The UNJP aware that this is an option. DFID will measure performance against agreed milestones, linked to an MOU. While we are aware that a management agent option may be a more expensive option, it is critical that the programme delivers results in a timely manner.

C. How do we expect the market place will respond to this opportunity?

FGM/C has been a neglected issue in international development, so putting this programme out to competitive bidding will raise the profile of the issue. This is a good thing in its own right. Raising the profile of FGM/C is an objective of this programme.

We expect the components being tendered will be relatively attractive given they focus on generic skills of communications, advocacy, and research. However, we do acknowledge the risk that the market may be relatively small given the limited work specifically on FGM/C. The wording of the tender will aim to attract those with limited experience as long as they build in mechanisms for bringing in technical expertise.

D. What are the key cost elements that affect overall price? How is value added and how will we measure and improve this?

The major costs relate to:

1. Human resources – Specialist communication and management technical assistance.
2. Communications and media
3. Research

Unlike other health-like issues, ending FGM/C does not require a health system, any drugs or health workers. The costs are driven by ensuring the right people i.e. the agents for social change are in the right place, and there long enough to see a permanent end to FGM/C. In addition, these community mobilisers need the right support to enable them to perform.

Given the neglect of FGM/C in local and international work, another key cost will be that of communications, supporting a process of social change at the local level and advocating for greater attention and resources at the international level. This will include the programme having the right mix of specialist communications and management technical assistance along with innovative use of communications and media.

The other key cost driver will be that of research and building an evidence base. A robust input on research into understanding what works to end FGM/C during this first 5 years of this work will be a significant investment for future years.

Value will be added by ensuring that that right mix of inputs is provided, at the right time, to achieve each activity and an explicitly strong results focus throughout the programme. Activity and process oriented milestones will be closely monitored throughout the programme, through contract management and milestone payments, quarterly meetings of all partners and annual external programme reviews. Where initiatives are seen to be less successful or show slow progress, they will
be discontinued or a performance improvement plan put in place. Where initiatives are discontinued, resources will be shifted in the programme to more promising interventions.

Added value will also be achieved through mobilising Corporate Social Responsibility resources for the programme – and pro-bono input. Already DFID has been approached by companies willing to support communications strategy aspects of this work on a CSR basis.

E. What is the intended Procurement Process to support contract award?

International Competitive Bidding (ICB) will be used. Working together with PrG, a strategy will be developed to undertake some early market engagement, such as an information notice and information days to gauge interest. Terms of reference and evaluation criteria will be developed in consultation with PrG. This will include specifics regarding performance management linked to a suite of Key Performance Indicators (KPIs). It is envisaged that 60% of marks will be assigned to technical proposals, with 40% to financial proposals. Consideration will be made to developing an output based payment mechanism for driving competition in the process. DFID’s existing framework agreements do not fit the requirements of this programme.

F. How will contract & supplier performance be managed through the life of the intervention?

The selected contractors for components social change communication and research components will be required to prepare inception reports and an operational plan 6 months after the date of signing the contract. An annual external performance review will be undertaken by external consultants contracted by DFID. In addition, as laid out in the management arrangements, there will be formal quarterly meetings, with DFID advisor and programme officer leads, of the three components where there will be discussion of the performance of the programme and some peer review by the agents managing the components. Performance will be measured against a suite of jointly agreed KPIs that will be finalised during the inception period. The contracted suppliers will then submit quarterly technical and financial reports to DFID according to key performance indicators (KPIs). A payment mechanism will be developed in consultation with Procurement Group that will link performance to payments, either through output based payments, or payments on the basis of level of KPI achievement.

Indirect procurement

A. Why is the proposed funding mechanism/form of arrangement the right one for this intervention, with this development partner?

1) UN Joint Programme on Ending FGM/C ‘Accelerating Change’: will be funded through indirect procurement, through a Memorandum of Understanding, for their work focussing primarily on policy engagement (including national and regional policy, cross-border and intergovernmental work) plus Community-level social change interventions, implemented by local civil society. This is a programme managed by UNICEF and UNFPA, and is a pooled fund with other significant donors being Iceland, Norway, Italy, Luxembourg and Switzerland. Globally, this is the group currently doing most work on this issue, with experience and expertise. It seems appropriate that this programme should work with the Global technical leaders on this issue. The Joint Programme is in the process of having an external review of its work, with a draft report anticipated in April 2013. This programme will engage with the external reviewers, and any lessons learnt and recommendations will be built into DFID’s programme and the MOU with the Joint Programme.
DFID has had limited engagement with the Joint Programme in the past, and has provided no earmarked funding. However, over the past year DFID did participate in an annual meeting of the Joint Programme.

DFID Sudan will also be partnering with the UN in a programme to end FGM/C in that country. This programme will explicitly work with Sudan and other countries that choose to undertake additional earmarked effort to end FGM/C.

Memoranda of Understanding are the established method of providing funding to the UN, using templates agreed centrally for each agency.

B. Value for money through procurement

Through working with the Joint Programme, DFID has the opportunity to leverage and facilitate more resources than through working alone or in a parallel programme. The Joint Programme is considered to be influential and is the leading organisation working on the issue of FGM/C. Through DFID’s contribution to this work, we will work to encourage others to join the Joint Programme and this global movement to end FGM/C. The MoU will follow standard DFID procedures.

By the nature of the joint pooled mechanism, Coordination/Head Quarters costs, outlined below, will be shared amongst partners, achieving greater value for money for DFID. While the programme will have very little need for any procurement, any procurement through the Joint Programme will be undertaken through standard UN contracting procedures ensuring value for money.

In consultation with UNCD, the programme will not exceed standard admin costs.

As stated above, DFID will closely monitor the performance of the UN joint programme in terms of its results and value for money. There will be an explicit break clause at the end of year 2 within the MoU. If the planned results are not achieved in a value for money manner, then DFID will find an alternative mechanism, such as through a contracted management agent to achieve the results of the programme.

Financial Case

A. What are the costs, how are they profiled and how will you ensure accurate forecasting?

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<td>£ millions</td>
<td>£ millions</td>
<td>£ millions</td>
<td>£ millions</td>
</tr>
<tr>
<td>TOTAL</td>
<td>2</td>
<td>2.7</td>
<td>6.2</td>
<td>7.7</td>
<td>7.7</td>
<td>8.7</td>
<td>35</td>
</tr>
</tbody>
</table>

The Programme Manager in the Africa Regional Programme will keep regular contact with the three agents managing the programme components to ensure accurate forecasting. All delivery institutions will be required to provide quarterly financial and narrative progress reports against agreed milestones. This will also include an assessment of risks associated with delivery. Quarterly meetings of the delivery institutions will consolidate into a collective report. The programme manager will rigorously reconcile these financial and results forecasts against relevant data on Aries, annual work plans and
budgets. Any discrepancies will be quickly raised with the service providers and implementers and necessary adjustments made. The Lead Advisors in both Africa Regional Department and Policy Division will be consults on all financial issues identified as well as any changes to forecasts on Aries that need to be made.

ARD will set up the main ARIES project. Then there will be three components, one for ARD, another for Policy Division and a third for RED each with their own budget centres. ARD, Policy Division and RED will be responsible for forecasting expenditure for their respective departmental input into the programme.

**B. How will it be funded: capital/programme/admin?**

The programme will be fully funded from programme resources which have been budgeted in DFID Africa Regional Department (ARD – up to £24 million), Policy Division (£3 million) and Research and Evidence Division (RED - up to £8 million). Overall finance management of the programme will be in Africa Regional Department – however the day to day administration of the finance on research will be managed through RED.

Based on the performance of the programme and need, consideration will be given in 2014/15 to expand or contract the programme.

There are no contingents or actual liabilities.

**C. How will funds be paid out?**

MOU will be signed between DFID and the UN Joint Programme (UNICEF/UNFPA). This will include the planned schedule of payments as well as reporting and auditing requirements. The funds to the joint programme will be disbursed quarterly based on financial reports received. Disbursement will also depend on satisfactory programme performance and milestone assessment. The funding mechanism will be finalised on consultation with UNCD.

For the contracted components of the programme, the implementers will be paid against quarterly invoices. Payments will be against milestones agreed in contracts.

**D. What is the assessment of financial risk and fraud?**

Low. The programme will not be undertaking large scale procurement, nor providing direct funding to governments.

*Financial mismanagement or fraud within Joint Programme (UNICEF/UNFPA)*

UNICEF and UNFPA have regular assessments by DFID of financial management. Within both organisations, there are procedures to deal with financial mismanagement and fraud. This will be under constant review, including through the Multilateral Aid Review. The new Due Diligence guidance will be followed, and the DFID programme team will work in consultation with UNCD and FCPD on this.

*Financial mismanagement or fraud with contracted partners*

All external contracted partners will be subject to a due diligence assessment ahead of any funds being disbursed and then external auditing on an annual basis. The external audit will be contracted by the management agent following agreement of the terms of reference with DFID. If any instance of fraud, misuse of funds or corruption is discovered then there will be the option for the arrangement to be terminated with immediate effect. Given these factors, the financial risk attached to this work is low.
Financial mismanagement or fraud with sub-contractors.
Some of the countries where this programme will be implemented are highly fragile and are high on corruption perception index carried out by Transparency International. The UN has mechanisms to ensure due diligence of the funds it disburses and these will be monitored throughout the life of this programme. External audits will be undertaken, and any instance of fraud, misuse of funds or corruption is discovered then sub-contracts will be terminated.

E. How will expenditure be monitored, reported, and accounted for?

The Africa Regional Departments Programme Manager will take overall leadership for the administration of the programme. For the UN component and that of communications, ARD will ensure rigorous monitoring of expenditure by closely scrutinising and reconciling all financial reports and invoices against approved work plans and budgets. RED will do the same for the research component. All components will be exposed to annual external audits that will be reviewed and recommendations monitored. Under the contracts for the communications and research components, they will be expected to commission the external audits, once terms of reference have been agreed with DFID.

Funds disbursed to UN agencies will be subject exclusively to the internal and external auditing procedures laid down in the agencies’ financial regulations and rules. These will be reviewed and recommendations monitored.
Management Case

A. What are the Management Arrangements for implementing the intervention?

The Memorandum of Understanding with the UN Joint Programme together with the contracts for implementing partners 2 and 3 will provide the framework within which the programme will be managed. The key points are:

- Each implementing partner will have a framework for monitoring programme effectiveness; for the UN partners this will be the MOU and for others a contract. A performance framework, will an annex to the MOU. Each partner will work to an annually approved work plan with measurable milestones and results targets.
- Day to day management will be the responsibility of the project partners.
- Within DFID, the programme will be led by the Africa Regional Department for all programme management related issues. For technical advisory input, the programme will be co-led by advisors within the AIDS and Reproductive Health Team in Policy Division and the Africa Regional Department.
- A DFID Programme Board will be constituted and will meet six monthly. This board will be multidisciplinary, and provide strategic oversight to the programme. The Africa Regional Department will be the secretariat for this meeting. Members of the board will include members from the following teams/divisions: Africa Regional Department, AIDS and Reproductive Health Team; Communications Division; Research and Evidence Division; Gender Team; Fragile States Team; VAWG Team and Girl Hub. Advisors from country offices with active work on FGM/C will also be included and at least one member of the Board will bring statistics/results expertise. These divisions have been consulted throughout the design of this programme and an informal ‘Friends of the FGC programme’ group has been established. This group will now transition into the Programme Board.
- The programme partners, together with the lead advisors, will meet on a quarterly basis. The Social Change Communications partner will act as the secretariat for this meeting. The purpose of this quarterly meeting will be to review programme progress update reports; ensure results are effectively being tracked and on target; ensure emerging evidence is shared; capture case studies for communications activities; ensure lesson learning between partners and between countries; monitor value for money considerations; and make recommendations to DFID for changes to the programme;
- DFID will actively participate in the UN Joint Programme Steering Committee and attend its annual meetings. There are two meeting per year, one at the UN in New York, and the other usually in one of the target countries. All the donors to the Joint Programme participate in these meetings and monitor progress as well as plans for future years.
- On an annual basis, an external independent review will be undertaken. This will focus on the programme performance against log-frame indicators, work plans and agreed milestones. An assessment of Value for Money will be integrated into the annual external independent review.
- There will be a 6 month inception phase to the programme, following which there will be a mini-review of the programme followed by a Programme Board meeting.
### B. What are the risks and how these will be managed?

<table>
<thead>
<tr>
<th>Risk</th>
<th>Probability</th>
<th>Impact (if realised)</th>
<th>Mitigation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk of criticism of UK involvement</td>
<td>Low</td>
<td>Medium</td>
<td>A robust but sensitive communications strategy will be put in place.</td>
</tr>
<tr>
<td>Lack of evidence on what works to end FGM/C.</td>
<td>Medium</td>
<td>Medium</td>
<td>The programme will include a significant component of research and evaluation – and the programme will be adjusted over time to reflect emerging evidence.</td>
</tr>
<tr>
<td>Religious fundamentalism or other political change (particularly in FCAS) leads to reversing momentum for change in some countries</td>
<td>Medium</td>
<td>Medium</td>
<td>The programme will actively review changes to the environment of FGM/C. Research will examine the links between conflict, political change and FGM/C in relation to effective approaches to ending FGM/C</td>
</tr>
<tr>
<td>Other donors don't come on board</td>
<td>Medium</td>
<td>Medium</td>
<td>The current PUSS has committed to being a global champion for FGM/C – including bringing attention to FGM/C with other donors. The programme will directly support this engagement and advocacy.</td>
</tr>
<tr>
<td>Under estimation of the prevalence of FGM/C globally.</td>
<td>Low</td>
<td>Medium</td>
<td>The programme will actively review evidence of FGM/C across the world and ensure the programme responds to data and evidence.</td>
</tr>
<tr>
<td>Incentives to deliver results create perverse incentives resulting either in unreliable reporting of change or insensitive approaches which drive the practice underground.</td>
<td>Low</td>
<td>High</td>
<td>The preferred option for direct delivery is the UNJP which already has a track record on the ground and which bases its work on a deep understanding of the importance of social norms change in ending FGM/C. Results will be triangulated through different measures including innovative approaches to measuring social norms change.</td>
</tr>
<tr>
<td>UNJP staff in country variable in terms of calibre, commitment and capacity</td>
<td>Low</td>
<td>high</td>
<td>UNJP will have to address this to deliver results. Close monitoring of the UNJP and the review after 2 years (with option to change mechanism) will identify any problems and provides incentive to UN to address this.</td>
</tr>
<tr>
<td>Delays in funding to civil society partners by UNJP slow or hold up delivery</td>
<td>Medium</td>
<td>Medium</td>
<td>UNJP will have to address this to deliver results. Close monitoring of the UNJP and the review after 2 years (with option to change mechanism) will identify any problems and provides incentive to UN to address this.</td>
</tr>
<tr>
<td>Security situations deteriorate in target countries undermining programme activities</td>
<td>Medium</td>
<td>High</td>
<td>All programme components will monitor security situations carefully and adjust their level and mode of engagement in different countries accordingly. If necessary we can rebalance activities across target countries.</td>
</tr>
<tr>
<td>The programme does not reach the poorest and most vulnerable women and girls</td>
<td>Low</td>
<td>Medium</td>
<td>The social norms approach is a whole community approach but this will be monitored and included within the research focus. Research will also confirm whether adoption of a new social norm by higher status groups leads to diffusion to others.</td>
</tr>
<tr>
<td>Programme activities create or increase social tensions within or between communities</td>
<td>Low</td>
<td>Medium</td>
<td>This will be monitored and part of research into greater understanding of how social norms change. It will be explicitly expected that partners will design, implement and monitor interventions according to the principle of 'do no harm'.</td>
</tr>
</tbody>
</table>
Social norms change approach does not work in all target countries

<table>
<thead>
<tr>
<th>Low</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>Robust M and E and research component will have strong focus on this and build the evidence base on the effectiveness of the social norms approach and other approaches</td>
<td></td>
</tr>
</tbody>
</table>

C. What conditions apply (for financial aid only)?

Not applicable

D. How will progress and results be monitored, measured and evaluated?

This programme will have a strong focus on measurement, monitoring and evaluation and research, because of challenges in measuring progress towards ending FMG/C and because of the limited evidence base on what works to end the practice. In addition to the Research and Learning component and requirements on measurement and monitoring in the different components, the programme has up to £1m set aside for programme monitoring and evaluation.

The programme will be monitored through annual external reviews carried out by DFID which will run alongside the Joint Programme’s routine annual monitoring processes. In addition, the programme will have a robust research and evaluation component built into the programme where the effectiveness and value for money of interventions will be monitored.

The UNJP already includes M and E functions which this programme will strengthen. The Social Change Communication component will also be required to develop a robust M and E function. Both of these functions will link closely with the Research and Learning component. Programme M and E will therefore inform the on-going programme, informing changes in strategy and direction to improve the delivery of results, and will contribute to the development of a global evidence base on what works, what doesn’t and why/why not, to end FGM/C.

The programme will have formal quarterly meetings and reports from all implementing partners. The communications partners under the programme will be the secretariat of this meeting, and will use the outputs of this meeting for ensuring cross organisational and cross country learning – and well as international dissemination of best practices.

Logframe

Quest No of logframe for this intervention: 3847541
## Annex A Appraisal of Programme Options

<table>
<thead>
<tr>
<th>Options for delivery</th>
<th>Brief summary</th>
<th>Delivery of results</th>
<th>Management costs</th>
<th>Complexity/transaction costs for DFID</th>
<th>Opportunities</th>
<th>Risks</th>
<th>VFM</th>
<th>Conclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community-level social change interventions (targeted)</td>
<td>UN Joint Programme</td>
<td>‘Accelerating Change’ UNICEF/UNFPA Joint Programme on ending FGM/C – with multi-donor support, in operation since 2008. (see more detail of the programme in the main text of appraisal case)</td>
<td>Good: If run on more capacity-strengthening, new partners, challenge fund type basis. Could reach range of communities including significant results in some areas. Has legitimacy to work (eg where difficult for other actors) Allows portfolio approach: testing models; developing new approaches (e.g. potentially a Stepping Stones-type approaches) sets basis for robust and rigorous M&amp;E. This more than offsets complexity/transaction costs</td>
<td>May be up to 20% of budget for UN, but requires little new administrative set-up as operates through existing mechanisms and systems. Low transaction costs on diaspora funds</td>
<td>Low complexity. Would build on existing work including in-depth thinking over many years on social norms change. But requires strong DFID influence in building new type of partnership with UNJP with strong emphasis on improving UNICEF/UNFPA partnership style with grantees and ensuring more user-friendly grant protocols (difficult) to ensure more organisations are able to access funding.</td>
<td>Strengthen UNJP and its profile with committed funding. Strong potential partners in UNICEF UNFPA HQ. Requires strong HQ input and cooperative working to develop new structures and systems for funding civil society. Strengthen UN approaches through DFID partnership - such as influence on development of challenge fund, and rigor on results monitoring (results based funding). Leverage new funding into UNJP from other donors. This has the potential to build on the work of the</td>
<td>Low risk. Reports of delaying in funding to CSOs/NGOs but these have largely been justified by claims that funding from donors has been late/reduced. UNJP staff in country variable. We would need to ensure UNJP addresses this to deliver results. Requires UNJP to negotiate with partner countries to ensure cross-border cooperation and geographical coverage – even if outside priority areas for other UNICEF/UNFPA programmes</td>
<td>Builds on existing structures so reduces administration and other transaction costs. Can fund models and approaches known to be successful: both leading to abandonment of FGM/C and in indirect benefits. Allows rigorous testing and comparison of different successful models – leading to increased VFM by EOP.</td>
</tr>
<tr>
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<tr>
<td><strong>Challenge Fund</strong></td>
<td>DFID to set up new Challenge Fund to fund proposals. To be managed by fund manager</td>
<td>Potentially good, depending on understanding and experience of fund management agency, but will start from scratch. Time will be lost whilst Fund is established and community-based organisations apply through new channel. Would bring in new partners.</td>
<td>High given likely costs of Fund Manager, and time lost on establishment of new infrastructure, especially for community-based fund</td>
<td>Very high; requires strong management and influence to ensure cooperation and coherence. Would need significant DFID interaction to ensure suitable criteria for funding based on social norms change. Would need to ensure Fund Manager understood social norms approach which is a relatively new re-introduction to development.</td>
<td>More potential control. Would ensure opportunities for broad-base and wide approach to community-based funding – could include opportunities for small organisations otherwise &quot;lost&quot;. Opportunities to require capacity-strengthening of community-based organisations, especially on Research, M&amp;E, and to build a portfolio approach, crowd in new partners and test hypotheses on approaches</td>
<td>High risk. High cost of fund manager (optics with UK); high transaction costs for DFID staff. No guarantee that community-based fund-manager will optimise opportunities for results. Some risk of doing harm given sensitivities of the issue. Sets up competition between UNJP and the community-based fund. May dis-empower UNJP and damage ongoing community level work, leading to reduction in results Disjointed, danger that synergies and cross-learning lost. Political risk if programming too costly.</td>
<td>Expensive. Transaction costs of establishing new fund high. Initial time wastage is likely to be cumulative as grantees build new relationships with the fund, learn new protocols etc. – Means time taken away from implementatio n work.</td>
<td>Expensive plus high risks associated with setting up alternative mechanism which could undermine existing multi-donor UN programme and would have greater political risk.</td>
</tr>
<tr>
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<tr>
<td><strong>Policy engagement (enabling)</strong></td>
<td><strong>UN Joint Programme</strong></td>
<td>As above</td>
<td>Good: UN JP well-placed to influence, can promote regional political commitment; proper use of law and justice etc. Strong track record backed up by legitimacy</td>
<td>As above</td>
<td>As above</td>
<td>To build on and strengthen progress to date in this area and especially maximise role of UNJP in cross-border and regional work. Opportunity to support states, with legitimacy of UN programme, to put UNGA resolution into practice. Requires UNJP HQ to engage in country level dialogue to ensure cross-border co-operation.</td>
<td>Low risk: As UNJP above</td>
<td>Good – mechanism already in place. Has shown good returns on money invested so far (see ARs). Changes made in policy are improving work at national and community levels, e.g. “vulgarisation de la loi” in Senegal</td>
</tr>
<tr>
<td><strong>Part of above Challenge Fund</strong></td>
<td>As above – the Challenge Fund would also fund projects focused on policy and legislation development and building political commitment at national level</td>
<td>Unclear. Risk of disjointed, piecemeal activities, and unclear which actors would respond to this opportunity.</td>
<td>High, as above.</td>
<td>High risk: Political risk if programming too closely associated with UK without legitimacy of UN especially following the UNGA resolution</td>
<td>More potential control.</td>
<td>No indication that there would be added value. Effects may be negative because of piecemeal approach</td>
<td>✗</td>
<td>Not suitable based on above assessment of the fund plus added disadvantage of less legitimacy than UN to work</td>
</tr>
<tr>
<td>Options for delivery</td>
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<tr>
<td>Social change communication (catalytic)</td>
<td>Consortium (contracted). To include small-scale funding for diaspora community-based and advocacy activities.</td>
<td>DFID would tender for a consortium that would probably include civil society organisations and private sector providers, to work in close collaboration with the other components of the programme. This consortium could also be tasked with a coordination/secretariat function for the whole programme to ensure overall collaboration and coherence. This would also include funding for diaspora organisations for advocacy and micro interventions</td>
<td>Strong: choosing the right social change communication consortium will ensure optimal use of good data and M&amp;E, using expertise in communications for development, to inform hearts and minds work.</td>
<td>May be possible to get some pro-bono input from private sector (offset by them as part of CSR initiatives). Involvement of private sector could increase management efficiencies.</td>
<td>High initially to tender and contract.</td>
<td>Can encourage new types of partners in to support this component (private sector). Offers best opportunity to ensure global buy-in and support. “Time is right”: political and public will high to become involved and make change. Provides a opportunity to bring together a wide range of actors and to ensure synergies. Creates a varied, but coordinated approach which can lead to social movement.</td>
<td>Medium risk: Main risk is that this is relatively new type of venture for DFID. Investment is high, but potential impact from global engagement and support for abandonment is very high.</td>
<td>Preferable approach to bring in a consortium that draws on a range of social communication for development expertise for this innovative component of the programme</td>
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<td>Do nothing – no other viable</td>
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<td>X</td>
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Catalysing change towards ending Female Genital Mutilation/Cutting
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<tr>
<th>Options for delivery</th>
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</tr>
</thead>
<tbody>
<tr>
<td>option for this component</td>
<td>DFID would tender for a consortium that would probably include academic institutions and civil society organisations, to design and implement the research, M and E component of the programme, in close collaboration with all the other components.</td>
<td>Strong: choosing the right Research and Learning consortium will deliver rigorous evidence which will inform planning. Results will be strongest because of coordination through communications component— ensuring that R, M&amp;E are geared to action learning. To be determined</td>
<td>High initially to tender and contract</td>
<td>Strong advantage to separate research component that is closely linked but independent from operational and social change communications component. Benefits from overall coordination through communications component— ensuring that R, M&amp;E are geared to action learning.</td>
<td>Low risk: There are a number of interested agencies in the field. They are willing to tender and well-prepared to form consortia in bidding for this component. Experience suggests that they will understand the action-orientated approach to R,M&amp;E and will be able to work closely with all actors</td>
<td>Strong: To date, R.M&amp;E on abandonment of FGM?C is insufficient to show either a) whether there is more than one social change approach to FGM/C abandonment that works b) whether there is any long-term value in small/micro-scale approaches or c) how to judge the VFM of different approaches. The proposed R,M&amp;E consortium will seek inter alia to answer these questions.</td>
<td>To be decided</td>
<td></td>
</tr>
<tr>
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<td>Delivery of results</td>
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</tr>
<tr>
<td>Do nothing</td>
<td>n/a</td>
<td>none</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>High risk: Huge opportunities missed. This is a key moment of opportunity for FGM/C abandonment. Groundwork set by first 5 years of UNJP and legitimacy to act following UNGA resolution. Increasing genuine commitment in countries and growing awareness and political</td>
</tr>
</tbody>
</table>

Research results may have higher impact at national level with co-ordinated approaches.

To be decided

Other options (contracted) to be identified as this component is fully developed during 2013

Catalysing change towards ending Female Genital Mutilation/Cutting
<table>
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commitment in UK and Europe. Possibility for political and development gains. Future of JP threatened without DFID renewed funding. Would probably continue but at a much reduced scale. Some DFID country programmes will support activities but missed opportunity for strategic multi-country programme and to leverage others to invest in ending FGM/C. High prevalence and incidence rates will continue which will undermine social and economic progress in the relevant countries especially for girls and women.
## Annex B Appraisal of country options

<table>
<thead>
<tr>
<th>Country where FGM/C is practised (in order of prevalence)</th>
<th>Prevalence % of women aged 15-49 (UNJP data)</th>
<th>Population (UN World Population Prospects 2010 revision)</th>
<th>UN Joint Programme focus country – groundwork in place and progress to date to support</th>
<th>West Africa francophone regional cluster where there is momentum and progress on ending FGM/C</th>
<th>East Africa/ Somali/ Yemen regional cluster, High prevalence, commitment to change but mostly limited progress so far</th>
<th>Results and VFM</th>
<th>To be included in DFID support to Community Social Change Programming and Policy Engagement (through UN Joint Programme)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Somalia</td>
<td>98</td>
<td>9.3m</td>
<td>✔️</td>
<td>✔️</td>
<td>Likely results and VFM stronger because efforts already in place by UNJP. Political commitment and early signs of momentum for change. In regional cluster. Difficult but improving context. Highly important because wide diaspora connections can help lead to increased results and VFM. Additional benefit because most prevalent form of FGM/C is type 3 (infibulation).</td>
<td>✔️</td>
<td>[The Social Change Communication and Research and Learning components will focus primarily on the target countries but with the flexibility to go beyond if strategic and appropriate]</td>
</tr>
<tr>
<td>Guinea</td>
<td>96</td>
<td>10.0m</td>
<td>✔️</td>
<td>✔️</td>
<td>Likely results and VFM stronger because efforts already in place by UNJP and in regional cluster.</td>
<td>✔️</td>
<td></td>
</tr>
<tr>
<td>Djibouti</td>
<td>93</td>
<td>0.9m</td>
<td>✔️</td>
<td>✔️</td>
<td>Likely impact and VFM stronger because efforts already in place by UNJP and in regional cluster. Small country with progress – complete abandonment possible. Important because it provides a hub for diaspora in region, can lead to strong influence and therefore increased VFM. Additional benefit because most prevalent form of FGM/C is type 3 (infibulation).</td>
<td>✔️</td>
<td></td>
</tr>
<tr>
<td>Sierra Leone</td>
<td>91</td>
<td>5.9m</td>
<td></td>
<td></td>
<td>Very high prevalence but not in UNJP or either regional cluster. Although high need, low political commitment and highly sensitive. Important because it offers opportunity to build evidence on abandonment efforts in very different social context – will lead to longer-term VFM.</td>
<td></td>
<td>Should be a priority for any additional donor funding to UNJP or 2nd phase of this DFID programme. There may also be possibilities for the DFID country programme to address the issue.</td>
</tr>
<tr>
<td>Egypt</td>
<td>91</td>
<td>81.1m</td>
<td>✔️</td>
<td>✔️</td>
<td>Difficult in spite of being UNJP focus country because of changing politics. However important to stay engaged for that reason because influential in region, and very high prevalence. Offers</td>
<td>✔️</td>
<td></td>
</tr>
</tbody>
</table>

Catalysing change towards ending Female Genital Mutilation/Cutting
<table>
<thead>
<tr>
<th>Country</th>
<th>Population</th>
<th>Likely Impact</th>
<th>VFM</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>North Sudan</td>
<td>89</td>
<td>Yes</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>South Sudan</td>
<td>Unknown</td>
<td>Yes</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Eritrea</td>
<td>89</td>
<td>Yes</td>
<td>Yes</td>
<td></td>
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<tr>
<td>Mali</td>
<td>85</td>
<td>Yes</td>
<td>Yes</td>
<td></td>
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<tr>
<td>Gambia</td>
<td>78</td>
<td>Yes</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Ethiopia</td>
<td>74</td>
<td>Yes</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Burkina Faso</td>
<td>73</td>
<td>Yes</td>
<td>Yes</td>
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</table>

Opportunity to build evidence on abandonment efforts with highly urbanised and educated populations as well as rural ones – increases VFM as lesson-learned will have wide implications in region.

Note that the new DFID country programme will provide focused support to in-country activities; the added value of this programme is to link to regional efforts.

Likely impact and VFM stronger because efforts already in place by UNJP and in regional cluster. 

FGM/C carried out amongst major tribes, e.g. Dinka and Nuer, as well as smaller tribes. Important cross-border connections within the region. Likely impact and VFM because of work already conducted in region.

Should be a priority for any additional donor funding to UNJP or 2nd phase of this DFID programme. There may also be possibilities for the DFID country programme to address the issue.

Likely impact and VFM stronger because efforts already in place by UNJP and in regional cluster. High level of progress already in small country – complete abandonment possible within 10-15 years.

Note that any potential DFID country level programming would support activities in country; the added value of this programme is the regional approach.

Likely impact and VFM stronger because efforts already in place by UNJP and in regional cluster.

Political commitment, potential to reach high numbers and potential complementary efforts by DFID office. Accelerated abandonment to date, in one region, offers good opportunity to build evidence on efforts to reach last quintile and complete abandonment. Will help too increase VFM in other areas/countries.
<table>
<thead>
<tr>
<th>Country</th>
<th>Rank</th>
<th>Population</th>
<th>Likely Impact</th>
<th>Likely VFM</th>
<th>Strong Progress</th>
<th>Strong Complete Abandonment Possible</th>
<th>Strong Political Commitment</th>
<th>Strong VFM</th>
<th>Strong Lessons Learned</th>
<th>Potential for Cross-Border Cooperation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mauritania</td>
<td>72</td>
<td>3.5m</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
<td>✓</td>
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<tr>
<td>Liberia</td>
<td>58</td>
<td>4.0m</td>
<td></td>
<td></td>
<td></td>
<td>High prevalence but not in UNJP or either cluster. Although there is need, political commitment is low and the issue is highly sensitive. Important to ensuring regional support for abandonment. Should be considered for additional donor funding to UNJP or 2nd phase of this DFID programme.</td>
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<tr>
<td>Guinea-Bissau</td>
<td>50</td>
<td>1.5m</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>Likely impact and VFM stronger because efforts already in place by UNJP and in regional cluster. Strong progress in very small country; complete abandonment possible within 5 years with correct investment.</td>
<td></td>
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<tr>
<td>Chad</td>
<td>44</td>
<td>11.2m</td>
<td></td>
<td></td>
<td></td>
<td>For potential inclusion in Research and Learning component. Could be considered for any additional donor funding to UNJP or 2nd phase of this DFID programme, as extension to WAfrica cluster.</td>
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<tr>
<td>Cote D'Ivoire</td>
<td>36</td>
<td>19.7m</td>
<td></td>
<td></td>
<td></td>
<td>For potential inclusion in Research and Learning component. Could be considered for any additional donor funding to UNJP or 2nd phase of this DFID programme, as extension to W Africa cluster.</td>
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<tr>
<td>Nigeria</td>
<td>30</td>
<td>158.4m</td>
<td></td>
<td></td>
<td></td>
<td>Very difficult, UNJP not operational in Nigeria yet; difficult context and low political commitment. Potential results in the medium to long term however are high because of high population. Not in UNJP already nor in either regional cluster, but important to include because of very high absolute numbers of women and girls affected by FGM/C.</td>
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<tr>
<td>Senegal</td>
<td>28</td>
<td>12.4m</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>Likely impact and VFM stronger because efforts already in place by UNJP and in regional cluster. Strong progress already in relatively small country, complete abandonment possible within 10 years. Also important because lessons learned here can increase VFM in other countries and political will can stimulate cross-border cooperation.</td>
<td></td>
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<tr>
<td>Kenya</td>
<td>27</td>
<td>40.5m</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td>Likely impact and VFM stronger because efforts already in place by UNJP and in regional cluster, plus strong political commitment. Good opportunities for creating a regional “hub” of learning and sharing experiences.</td>
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<tr>
<td>Country</td>
<td>Country Code</td>
<td>Population</td>
<td>Added to UNJP?</td>
<td>Rationale</td>
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<tr>
<td>Central African Republic</td>
<td>26</td>
<td>4.4m</td>
<td>unknown</td>
<td>Difficult context; aim would be to build initial foundations for social change during this phase. Earliest results likely among Somali community following wider regional work. Results also possible amongst coastal Yemeni population. Good indications that moderate clerical support will be gained.</td>
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<tr>
<td>Yemen</td>
<td>23</td>
<td>24.1m</td>
<td>✓</td>
<td>Not in UNJP but important to include because prevalence is high in some regions and part of wider East Africa/Horn cluster. Strong potential for broadening evidence base on what works and initial expansion into Middle East region.</td>
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<tr>
<td>Tanzania</td>
<td>15</td>
<td>44.8m</td>
<td>✓</td>
<td>Not to be included because we are already adding 2 difficult countries to UNJP with Yemen and Nigeria. Should be considered for any additional donor funding or 2nd phase of this DFID programme.</td>
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<tr>
<td>Togo</td>
<td>4</td>
<td>6.0m</td>
<td></td>
<td>Low prevalence, low population – no strong rationale for adding to UNJP at this stage</td>
<td></td>
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<tr>
<td>Ghana</td>
<td>4</td>
<td>24.4m</td>
<td></td>
<td>Low prevalence, no strong rationale to add to UNJP at this stage.</td>
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<tr>
<td>Niger</td>
<td>2</td>
<td>15.5m</td>
<td></td>
<td>Low prevalence, low population – no strong rationale for adding to UNJP at this stage.</td>
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<tr>
<td>Zambia</td>
<td>1</td>
<td>13.1m</td>
<td></td>
<td>Low prevalence, low population – no strong rationale for adding to UNJP at this stage.</td>
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<tr>
<td>Uganda</td>
<td>1</td>
<td>33.4m</td>
<td>✓</td>
<td>Likely impact and VFM stronger because efforts already in place by UNJP and in regional cluster. Very low prevalence so complete abandonment possible. Practice restricted to specific groups/areas – however prevalence is high in these areas</td>
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<tr>
<td>Cameroon</td>
<td>1</td>
<td>20.0m</td>
<td></td>
<td>Low prevalence, no strong rationale for adding to UNJP at this stage.</td>
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<tr>
<td>Indonesia</td>
<td>Unknown</td>
<td>240.0m</td>
<td></td>
<td>Unknown prevalence, lack of political commitment to end the practice and no evidence base on what works to end the practice. Potentially to be included in Social Change Communication component and in Research and Learning component</td>
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<tr>
<td>Malaysia</td>
<td>Unknown</td>
<td>28.4m</td>
<td></td>
<td>Unknown prevalence, lack of political commitment to end the practice and no evidence base on what works to end the practice. Potentially to be included in Social Change Communication component and in Research and Learning component</td>
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</tbody>
</table>

Catalysing change towards ending Female Genital Mutilation/Cutting
<table>
<thead>
<tr>
<th>Country</th>
<th>Status</th>
<th>Population</th>
<th>Description</th>
<th>Potential Inclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Iran</td>
<td>Unknown</td>
<td>74.0m</td>
<td>Unknown prevalence (may be rising), but lack of political commitment to end the practice and no evidence base on what works to end the practice.</td>
<td>For potential inclusion in Research and Learning component</td>
</tr>
<tr>
<td>Iraq</td>
<td>Unknown</td>
<td>32.0m</td>
<td>Unknown prevalence (may be rising), lack of political commitment to end the practice and no evidence base on what works to end the practice.</td>
<td>For potential inclusion in Research and Learning component</td>
</tr>
<tr>
<td>India</td>
<td>Unknown</td>
<td>1225.0m</td>
<td>Very low prevalence as practice restricted to specific ethnic groups. However, reports suggest practice is growing within these groups and that they have connections to the diaspora in UK.</td>
<td>Potentially to be included in Social Change Communication component</td>
</tr>
<tr>
<td>Pakistan</td>
<td>Unknown</td>
<td>173.6m</td>
<td>Very low prevalence as practice restricted to specific ethnic groups.</td>
<td>Potentially to be included in Social Change Communication component</td>
</tr>
</tbody>
</table>

Catalysing change towards ending Female Genital Mutilation/Cutting
2. WHO estimates, see http://www.who.int/reproductivehealth/topics/fgm/prevalence/en/index.html See also Population Reference Bureau (2010) Female Genital Mutilation/Cutting: Data and Trends, Update 2010
4. See for example http://www.who.int/reproductivehealth/topics/fgm/heath_consequences_fgm/en/ and many personal testimonies from practising communities talk of girls’ deaths following FGM/C
   a systematic review of quantitative studies
17. There are reports in some contexts of FGM/C being carried out by men but this is thought to be unusual. See Behrendt A (2005) ‘Tradition and rights: female genital cutting in West Africa, Plan.
Feldman-Jacobs, C and S Ryniak (2006), ‘Abandoning Female Genital Mutilation/Cutting: an in-depth look at some promising practices’, Population Reference Bureau (PRB);


25 The arguments employed here for delaying marriage and first pregnancy are equally relevant – see ‘Reaching married girls/youngest first time parents: strategic value, policy considerations and program experiences’ – presentation by Bruce, J (2012), Workshop on Married Adolescent Girls, Jan 2012, Girl Hub. See also DFID’s recent work on Gender and the Golden Thread.


27 For example, see Crawford, S. et al (2010), Situation Analysis of children and Women in Egypt, "Making Systems Work for all Children and Women in Egypt", OPM for UNICEF, as well as the Health Sector Support Programme, Somalia; Strengthening Accountability in Uganda; Social Contracts and Representation (SCAR) Zambia.

28 12th International Donors Working Group – Open Space Forum – ‘What needs to happen to end FGM/C’ (December 2012)


32 During consultations for Berhane Hewan, a programme to end child marriage in Amhara state, Ethiopia, income poverty was identified as one driver of child marriage and in response, goats were presented to participating families if they completed the 2 year programme without marrying their daughter. See Erulkar, AS and E Muthengi (undated) Evaluation of Berhane Hewan: A Program To Delay Child Marriage in Rural Ethiopia, International Perspectives on Sexual and Reproductive Health. Also Shinha, N and J Yoong (2009), Long-Term Financial Incentives and Investment in Daughters. Evidence From Conditional Cash Transfers in North India, RAND. Also Baird, S, C McIntosh and B Oezler (2011) ‘Cash or condition? Evidence from a cash transfer experiment’, World Bank


34 Mackie, G (2009) More Effective and Less Effective Programs to Abandon Harmful Practices in Five Countries, Innocenti Research Centre


37 R Berg and E Denison (2012) Interventions to reduce the prevalence of female genital mutilation/cutting in African countries, Campbell Systematic Reviews


40 See Askew, I (2005), ‘Methodological issues in measuring the impact of interventions against female genital cutting’, Culture, Health and Sexuality 7 (5) 463-477


42 Askew, I (2005), ‘Methodological issues in measuring the impact of interventions against female genital cutting’, Culture, Health and Sexuality 7 (5) 463-477


Catalysing change towards ending Female Genital Mutilation/Cutting
Experience has shown that interventions that focus solely on the negative health consequences of FGM/C, or laws that ban FGM/C without any accompanying information, education and communication, may well have the effect of changing people’s attitudes toward FGM/C but in ways that are not desirable or conducive to the abandonment of the practice.” C. Feldman-Jacobs and S. Ryniak, Abandoning Female Genital Mutilation/Cutting: An In-Depth Look At Promising Practices. Population Reference Bureau (PRB), 2006.

See also Askew, I (2005), ‘Methodological issues in measuring the impact of interventions against female genital cutting’, Culture, Health and Sexuality 7 (5) 463-477


All the above from UNJP powerpoint 6/09/2012. This from UN Joint Programme Funding Proposal Update Sept 2012.
