PROPOSAL FOR PHASE III OF THE UNFPA-UNICEF JOINT PROGRAMME

Elimination of Female Genital Mutilation: Accelerating Change

October 2017
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## Programme Summary

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<th>UNFPA-UNICEF Joint Programme on Eliminating Female Genital Mutilation: Accelerating Change</th>
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<td>Country and Region(s)</td>
<td>Global</td>
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<tr>
<td>Total Proposed Budget</td>
<td>US$77,000,000</td>
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<td>Programme Duration</td>
<td>1 January 2018 – 31 December 2021 (four years)</td>
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<td>Vision</td>
<td>Contribute to the elimination of female genital mutilation by 2030.</td>
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<td>Goal</td>
<td>The goal of the Joint Programme is to accelerate efforts towards the reduction of FGM, fulfilling the rights of girls and women by realizing social and gender norms transformation by 2021.</td>
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<td>Focus Population</td>
<td>Girls and women, communities, institutions</td>
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<td>Relevant SDGs, UNFPA and UNICEF’s Strategic Plan Outcome Areas</td>
<td><strong>SDG Goal 5, Target 5.3:</strong> “Eliminate all harmful practices, such as child, early and forced marriage, and female genital mutilation.” <strong>UNFPA Strategic Plan 2018-2021 Outcome 3:</strong> “Gender equality, the empowerment of all women and girls, and reproductive rights are advanced in development and humanitarian settings” and <strong>Output 12:</strong> “Strengthened response to eliminate harmful practices, including child, early and forced marriage, female genital mutilation and son preference.” <strong>UNICEF Strategic Plan 2018-2021 Goal 3:</strong> “Every child is protected from violence, exploitation and harmful practices” and <strong>Result 2</strong> “By 2012, girls are reached with UNICEF-supported multisectoral at-scale programmes to address harmful practices, namely [female genital mutilation] and child marriage.”</td>
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<tr>
<td>Geographical Focus</td>
<td>Global: Burkina Faso, Djibouti, Egypt, Eritrea, Ethiopia, Gambia, Guinea, Guinea-Bissau, Kenya, Mali, Mauritania, Nigeria, Senegal, Somalia, Sudan, Uganda *Yemen will continue to be included in regional and sub-regional capacity-building and consultative initiatives. **Indonesia and Tanzania for knowledge sharing, tools and resources</td>
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<td>Key Partners</td>
<td>Regional political structures, governments, civil society organizations and communities, and development partners</td>
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## Acronyms

<table>
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<tr>
<th>Acronym</th>
<th>Description</th>
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<tr>
<td>CSO</td>
<td>Civil Society Organization</td>
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<tr>
<td>DHS</td>
<td>Demographic and Health Survey</td>
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<tr>
<td>FGM</td>
<td>Female Genital Mutilation</td>
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<tr>
<td>MICS</td>
<td>Multiple Indicator Cluster Survey</td>
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<td>SDG</td>
<td>Sustainable Development Goal</td>
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<td>SRH</td>
<td>Sexual and Reproductive Health</td>
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<td>UNFPA</td>
<td>United Nations Population Fund</td>
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<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
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Executive Summary

Background

It is estimated that more than 200 million girls and women have experienced female genital mutilation (FGM)\(^1\) in 30 countries across three continents, with half those cut living in three countries: Egypt, Ethiopia and Indonesia. More than three million girls are at risk of undergoing FGM every year, with most girls cut before the age of 15.\(^2\) FGM is internationally recognized as a violation of human rights and constitutes an extreme form of violence against girls and women. Girls and women subjected to FGM are at risk of early marriage, dropping out of school, and reduced opportunities for growth, development and sustainable incomes. FGM involves medical, emotional, social, legal and economic repercussions at all levels of society. Given that 22 out of 30 FGM-affected countries are least-developed,\(^3\) these costs place a burden on personal, household, community and state economies.

Since 2008, the United Nations Population Fund (UNFPA) and the United Nations Children’s Fund (UNICEF) have been implementing the Joint Programme on Eliminating Female Genital Mutilation: Accelerating Change to end FGM in one generation. The Joint Programme, currently being implemented in 17 countries, links community-level transformation of social norms that often drive FGM with laws banning the practice and access to quality sexual and reproductive health (SRH) and child protection services for girls and women at risk of and affected by FGM. Over the last nine years, working in partnership with governments, civil society, development partners and communities, the Joint Programme has made significant progress in eliminating FGM by:

- **Integrating FGM elimination** into the UNFPA and UNICEF Strategic Plans and the Sustainable Development Goals (SDGs).
- **Increased knowledge on FGM as a social norm** as a result of research and expert consultative processes.
- **Strengthening political commitment**: Thirteen countries have legal and policy frameworks banning FGM. Following intensive capacity development initiatives, to date, there have been almost 700 cases of legal enforcement.
- **Increasing government ownership**: All 17 countries have a national coordination mechanism in place, and 12 countries established budget lines funding services and programmes to specifically address FGM.
- **Providing access to appropriate and quality services**: More than 2.3 million girls and women in all 17 countries benefited from FGM-related protection and care services.\(^4\) FGM prevention information has also been mainstreamed into the curricula of schools, from primary to tertiary, and in some countries, in medical, paramedical and social worker training programmes.
- **Building information management systems**: In all 17 countries, information management systems have been developed to track and share data on FGM, increasing the efficiency of operations and enhancing analysis and decision-making.
Promoting community-led engagement: Following education, dialogue and consensus-building processes, more than 25 million individuals in over 18,000 communities in 15 countries made public declarations on the abandonment of FGM.

As a result of global efforts such as the Joint Programme, critical progress is being made in ending FGM. Today, a girl is about one-third less likely to be cut than 30 years ago. A major challenge is sustaining the achievements that have been made while addressing the population growth that puts more girls at risk of being cut. By 2030, more than one in three girls worldwide will be born in the 30 countries where FGM is prevalent, with projections that about 54 million girls aged 0 to 15 will be at risk of FGM.

If interventions are not scaled up and accelerated to outpace the impact of the demographic trends, the number of girls and women undergoing FGM will continue to increase, and the absolute number of girls who have gone through the practice will be higher by 2030 than it is today. There is also the issue of rising trends such as the medicalization of FGM, in which health professionals are carrying out FGM, another area of concern that calls for fast action.

In launching Phase III of the Joint Programme, UNFPA and UNICEF seek to strengthen the involvement of regional political bodies to create a more enabling environment, enhance political accountability at the national level, harness the potential of youth to enhance gender equality and end FGM, and scale up the social movement to end FGM. Such interventions are critically needed to accelerate the ongoing effort and achieve meaningful impact in addressing the practice of FGM.

The rate at which the practice of FGM is eliminated must be accelerated.

The annual average rate of change (AARC) towards eliminating FGM must be accelerated to achieve the 2030 SDG goal of its elimination for two reasons:

1. The practice of FGM on girls aged 15 to 19 has declined in 16 countries covered by the Joint Programme’s Phase II, particularly in the last 10 years. Kenya has achieved the highest AARC of 4.3 per cent, followed by Nigeria (2.8 per cent) and Burkina Faso (1.5 per cent). In the rest of the countries, AARCs are 1.1 per cent and below.

   These change rates are insufficient. The AARC required to abolish FGM by 2030 must increase, ranging anywhere from four times in Kenya to 1,309 times in Mali.

2. If we add to this the estimated growth of the population of girls, the AARC must be accelerated even further. The projected demographic growth neutralizes the existing decline in FGM prevalence, and inaction on FGM will lead to a situation in which more girls will be subject to FGM in 2030 than today.

   That is why interventions in Phase III of the Joint Programme focus on accelerating the rate of elimination of FGM. See annex II.
Launching Phase III of the Joint Programme

Drawing on best practices and lessons learned from nine years of programme implementation, Phase III will build on the Joint Programme’s momentum in galvanizing a global movement to end FGM by intensifying efforts and increasing resources to address the growing number of girls and women at risk of FGM. **The vision of the Joint Programme in Phase III is to contribute to the elimination of FGM by 2030, in line with Target 5.3 of the SDGs, which calls for the elimination of harmful practices.** This will be achieved through intergenerational change, in which girls in the immediate term are kept intact and future generations of mothers are free to choose not to cut their daughters. **The goal of the Joint Programme is to accelerate efforts towards the reduction of FGM, fulfilling the rights of girls and women by realizing social and gender norms transformation by 2021.**

The Joint Programme’s direct impact population is girls and women at risk of or affected by FGM, especially in hard-to-reach areas in 16 countries: Burkina Faso, Djibouti, Egypt, Eritrea, Ethiopia, Gambia, Guinea, Guinea-Bissau, Kenya, Mali, Mauritania, Nigeria, Senegal, Somalia (interventions focused on Somaliland), Sudan and Uganda. The Joint Programme in Phase III will target approximately 8 million girls who will receive FGM preventive services and 4 million who will receive protection and care services. In addition, more than 8,200 new communities, covering approximately 18.45 million people, will make public declarations abandoning FGM across 16 countries, helping to ensure that girls will remain free from FGM.

The global theory of change under Phase III continues to embrace a holistic and multi-sectoral approach that supports ending FGM at the household, community, national and global levels while also introducing strategic and innovative interventions:

**Outcome 1: Countries have an enabling environment for the elimination of FGM practices at all levels and in line with human rights standards.** The Joint Programme will work with regional and sub-regional political entities to increase accountability among governments ensuring the implementation of laws and policies. The Joint Programme will facilitate links between governments, civil society organizations (CSOs) and networks in developing policies and programmes.

**Outcome 2: Girls and women are empowered to exercise and express their rights by transforming social and gender norms in communities to eliminate FGM.** In supporting social norms change, the Joint Programme will continue to educate, encourage dialogue, engage in consensus-building and facilitate community commitments for the collective abandonment of FGM. Scaling up the amplification of a new norm that supports keeping girls free from FGM will be a key innovation. Phase III will be marked by a greater emphasis on gender norm transformation, addressing gender roles and power relations that often contribute to perpetuating FGM.

**Outcome 3: Girls and women access appropriate, quality and systemic services for FGM prevention, protection and care.** The Joint Programme will continue to prioritize access to quality and appropriate services to meet child protection and SRH needs, as well as the rights of
girls and women at risk of and affected by FGM. The Joint Programme will also focus on creating a cadre of service providers advocating to end the medicalization of FGM.

**Outcome 4: Countries have better capacity to generate and use evidence and data for policymaking and improving programming.** The Joint Programme is introducing a fourth cross-cutting domain in Phase III, focused on piloting a social norm measurement framework and establishing a global knowledge hub – a platform for sharing the programme’s FGM content across countries and with the diaspora.

The Joint Programme will focus its interventions in Phase III on the 16 countries listed above, as a way to maximise resources and bring the international community closer to achieving SDG Target 5.3. However, the mode of engagement will use a three-dimensional model. In addition, the Joint Programme will also play a broader, systemic catalytic role in a few selected countries where FGM is prevalent such as Indonesia and Tanzania. This will be done through knowledge exchange, sharing Joint Programme tools and resources.

**Intensifying Global Efforts and Investments to End FGM**

In 2012, the United Nations General Assembly passed Resolution 67/146 on intensifying global efforts to eliminate FGM, reaffirmed by Resolution 69/150 in 2014 and 71/168 in 2016. The United Nations Human Rights Council in 2014 passed a similar resolution, 27/22, and shared good practices to effectively eliminate FGM. These commitments by United Nations Member States reflect an unprecedented awareness of FGM and growing efforts to stop it. With these resolutions calling for more support to the UNFPA-UNICEF Joint Programme, the next four years are a critical time for donors, Member States and the international community to increase resources and investments, including sustainable and predictable funding for FGM elimination.

The launch of Phase III in January 2018 marks a critical juncture and opportunity to consolidate the considerable gains made by the programme in the last nine years while also addressing the growing number of girls and women affected by and at risk of FGM. **UNFPA and UNICEF are seeking US$77,000,000 over four years to help accelerate the elimination of FGM by elevating attention, resources and accountability so that girls and women may realize their rights, contributing to the health and productivity of their families and communities and improving prospects for the next generation.**
I. Situational Analysis

FGM refers to “all procedures involving partial or total removal of the female external genitalia or other injury to the female genital organs for non-medical reasons.” FGM is recognized internationally as a violation of the human rights of girls and women, as stated in numerous international and regional human rights instruments such as the Convention on the Elimination of All Forms of Discrimination against Women, the Universal Declaration of Human Rights, the Convention on the Rights of the Child, the International Covenant on Economic, Social and Cultural Rights, and the International Covenant on Civil and Political Rights. As a harmful practice, FGM presents a significant obstacle for addressing poverty and advancing other areas of human development.

Social Drivers and Root Causes

There are numerous social drivers and root causes of FGM stemming from gender inequality, including: a desire to control female sexuality, supporting religious narratives, ritual marking of a girl’s transition to adulthood, limited access to education and economic opportunities for girls and women, and assurance of girls’ or women’s social status, chastity or marriageability. Research and assessments have shown that FGM operates as a social convention and norm, and is held in place by reciprocal expectations within communities. As a result, the social rewards and sanctions associated with FGM are a powerful determinant of both the continuation and the abandonment of the practice.

Researchers have also studied various influences and protective factors to better understand the link between FGM abandonment and household income, urbanization and education. There are numerous factors that may be influential in the abandonment of FGM, such as the weakening of traditional family structures, shifts in women’s economic and social roles, shifts in their influence on household and community decision-making processes, and changing attitudes about the link between marriageability and FGM. Several studies point to the strong positive association between support for FGM and household poverty. Similarly, there is a strong link between women’s education and FGM. A daughter’s risk of FGM is higher in poorer households and when mothers have no education. Approximately one in five daughters of women with no education has undergone FGM, compared with about one in nine daughters of mothers that have at least a secondary education.

Statistical Overview

Levels of and Trends in FGM

While exact numbers remain unknown, at least 200 million girls and women have undergone FGM in the countries with representative data on prevalence. Available data from large-scale representative surveys show that the practice of FGM is highly concentrated in a swath of countries from the Atlantic Coast of Africa to the Horn of Africa, in areas of the Middle East such as Iraq and Yemen, and in some Asian countries such as Indonesia. However, FGM is a human rights issue that affects girls and women worldwide.
Within the 17 countries supported by the Joint Programme in Phase II, there is a wide range of national prevalence, from a low of 1 per cent of women aged 15 to 49 having undergone FGM in Uganda to over 90 per cent in Somalia, Guinea and Djibouti. In many countries with low to moderate national prevalence of FGM, the practice is concentrated geographically or among certain ethnic groups.

There is some evidence of reduction in the practice over time (figure 1). Overall, the chance that a girl will be cut today is about one-third lower than it was three decades ago, though not all countries have made progress and the pace of change has been uneven.

In the following 10 countries supported by the Joint Programme, there is evidence of at least some generational change in FGM prevalence: Guinea, Egypt, Eritrea, Sudan, Burkina Faso, Ethiopia, Mauritania, Kenya, Nigeria and Yemen. The magnitude of change in these countries includes smaller incremental reductions in Guinea, Sudan and Mauritania, as well as substantial reductions in Kenya and Nigeria.

**Attitudes toward FGM**

Data indicate that even in many countries where FGM is widespread, individuals report opposition to the practice. In fact, the majority of people in countries for which data is available think FGM should end. Within the Joint Programme countries, more than half of women opposed continuing FGM in 11 countries (of the 17 with data), and more than half of men opposed the practice in six countries (of the 10 with data). While these findings can be interpreted as readiness to abandon the practice, social norms may play a key role, as some individuals may be reluctant to act on their beliefs if there is an expectation of rewards for adhering to the practice or sanctions for nonconformance.

**Figure 1: Percentage of girls and women who have undergone FGM**

In line with the principle of promoting positive change from within, an important element of the Joint Programme’s approach is that efforts need to leverage and support existing positive social forces. It therefore builds on the evidence that many – and, in some countries, most – individuals do not want to continue the practice; it also sets out that if more individuals discover that others important to them do not practice FGM, have abandoned it or would like to abandon it, they too
will tend to shift to the new norm of keeping girls intact. This is especially true today compared
to a decade ago because many people are already aware of the harms of FGM and report that it
has no benefits.\textsuperscript{xiv}

\textit{Medicalization of the Practice}

An alarming trend in some countries is FGM being performed by health personnel, referred to as
medicalization of the practice. Within the Joint Programme, there are seven countries in which
more than one in 10 girls who have undergone FGM are cut by health personnel: Egypt, Sudan,
Guinea, Djibouti, Kenya, Yemen and Nigeria. In these countries, more than 20 million girls and
women have undergone FGM at the hands of a medical professional. FGM being performed by
health personnel is most common in Egypt and Sudan – in Egypt by doctors, and in Sudan by
midwives. Egypt alone is home to 11 million girls and women who were cut by health personnel,
nine million of whom were cut by doctors. In Egypt, health personnel were responsible for 68
per cent of FGM among girls aged 15 to 19, compared to only 17 per cent of cases among
women 45 to 49. In other countries such as Guinea, women report that among their daughters
who have undergone FGM, 30 per cent were cut by health professionals, whereas among the
oldest cohort of women (45 to 49 years old), the figure was three per cent.\textsuperscript{xv} Not only does
medicalization violate medical ethics given that FGM is a harmful practice, it may also confer a
sense of legitimacy to FGM or give the impression it is without health consequences.

\textit{Measurement Challenges and Limitations}

The standard measurement of FGM prevalence, including the indicator used in the SDGs under
Target 5.3, is the percentage of girls and women aged 15 to 49 who have undergone FGM. The
challenge with this indicator is the time lag between when the cutting occurred and when it is
reported. The time lag will vary depending on the current age of the respondent and the age at
which she is cut. For example, in a country in which the mean age at cutting is one month old,
respondents aged 15 to 19 are reporting on an event that took place an average of 15 to 19 years
before the survey. In this case, the impact of recent campaigns aimed at ending FGM won’t be
reflected.

A second challenge in evaluating the prevalence of FGM is the degree to which the practice, and
the interventions to prevent it, are localized. While interventions may address areas in which the
practice is concentrated, the extent to which the target population represents the national
practicing population will affect the potential impact on national prevalence. Thus, robust
monitoring and evaluation of the programme must supplement the periodic national-level
measurement of FGM prevalence through household surveys.

\textit{Impact of Demographic Dynamics}

Youth demographic dynamics are a critical factor in estimating the number of girls at risk of
being cut globally.\textsuperscript{xvi} As FGM mostly happens to girls before they reach 15, age structure of the
population is important. The majority of FGM-prevalent countries (22 of 30) are least-developed
countries,\textsuperscript{xvii} and the population of the least-developed countries is expected to reach over 1.8
billion by 2050.\textsuperscript{xviii} All 30 FGM-prevalent countries with available data are experiencing high
population growth and a young age structure, with 30 per cent or more of their female populations under the age of 15.\textsuperscript{xix} As shown in Figure 2, slightly more than one in three of all girls worldwide will be born in the 30 countries with national FGM prevalence data by 2030.

This means an increase in the number of girls globally at risk of FGM. Overall, the observed reductions in the prevalence of FGM are not sufficient to offset the expected population growth. If progress is not accelerated to a rate faster than what has been seen in the past generation, the number of girls undergoing FGM will grow. This is a further reminder of the urgent need to invest resources now to counteract the demographic challenges.

\textbf{Figure 2: Proportion of girls born in FGM-prevalent countries}

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\includegraphics[width=\textwidth]{fgm_prevalence}
\end{figure}


\section{Background on the Joint Programme}

\textit{Phases I and II of the Joint Programme}

Phase I of the Joint Programme (from 2008 to 2013) piloted a holistic and integrated approach in eight countries, collaborating with government, civil society and communities to promote legal and policy reform, support service provision and work with communities to abandon the practice. As reflected in the Joint Programme’s Phase I final evaluation, the programme helped
expand or accelerate existing change processes towards FGM abandonment at the national, sub-national and community levels, as well as helped strengthen the momentum for change at the global level. Some achievements included the establishment of legal frameworks, coordination mechanisms and access to services; however, measuring actual changes in behaviours and practices remained a challenge, and the programme lacked predictable, longer-term financing from donors.

UNFPA and UNICEF launched the second phase of the Joint Programme (from 2014 to 2017), expanding its work to 17 countries – Burkina Faso, Djibouti, Uganda, Egypt, Ethiopia, Eritrea, Gambia, Guinea, Guinea-Bissau, Kenya, Mali, Mauritania, Nigeria, Senegal, Sudan, Somalia and Yemen – while also supporting regional (i.e., Africa and the Arab States) and global efforts to eliminate FGM. Drawing on lessons learned from the findings of the Phase I evaluation, the Joint Programme introduced the following strategies to enhance its effectiveness:

- **Increased focus on addressing social norms that result in harmful practices** by supporting large-scale social transformation and positive social change at the household, community and society levels. The Joint Programme invested in more in-depth research on social norms and its linkages to changes in individual and collective behaviours. The programme provided capacity building to governments, CSOs, and United Nations staff members in the use of a social norms approach.

- **Strengthened systems and tools, capacities and resources available for longer-term data collection and analysis** to provide solid monitoring data on the effectiveness of the Joint Programme’s different strategies. Steps included developing 17 nested databases linked to a global database called DiMonitoring; training 1,260 data managers from governments, civil society, and UNFPA and UNICEF staff to roll out the database; and setting realistic programme targets and results-based management programming.

**Contributions of the Joint Programme toward Ending FGM**

In the final year of Phase II, reflecting on the accomplishments over the last nine years, programme results, impact and long-lasting changes include:

- **Integrated FGM elimination** into the SDGs and the UNFPA and UNICEF Strategic Plans.

- **Increased global knowledge on FGM as a social norm** by conducting several research and expert consultative processes.

- **Strengthened political commitment**: Thirteen of the 17 countries have legal and policy frameworks banning FGM, and two countries are close to adopting similar laws. Capacity development of the judiciary system and law enforcement led to about 700 cases of the enforcement of FGM legislation. In all countries, policies and plans of action related to gender, SRH and gender-based violence have integrated FGM.

- **Increased government ownership**: National government coordination mechanisms have been established in all 17 countries, and decentralized committees are actively monitoring the practice. Twelve countries also established **budget lines** to specifically address FGM. Introducing a budget line on FGM in the public budgeting process is an important tool,
making it possible to measure the scope of public policies on girls and women at risk of and affected by FGM.

- **Increased access to appropriate and quality services:** The Joint Programme supports prevention efforts such as education and social mobilization, linking FGM screening and response to existing SRH services, and building the capacity of the police, judicial and social service sectors. As a result of capacity-building efforts, 2,354,041 girls and women benefitted from strengthened FGM-related protection and care services. FGM prevention information has also been mainstreamed into the curricula of schools, from primary to tertiary, and in some countries, in medical, paramedical and social worker training programmes.

- **Community-led responses:** The Joint Programme not only raises awareness about the health risks of FGM, but also tries to change the deeply rooted social norms that perpetuate the practice. By mobilizing community leaders, encouraging dialogue, raising awareness, educating girls and women, and empowering communities, 25 million individuals in 18,756 communities made public declarations on abandoning FGM.

With the Joint Programme in its last year of implementation under Phase II, the Programme is likely to meet all targets. In addition to the global monitoring and evaluation framework that captures data across the Joint Programme countries, several country offices carried out rigorous evaluations of the programme to measure the effectiveness of interventions. As an example, Sudan completed a midterm evaluation in June 2017 of the Saleema campaign, implemented as part of the Joint Programme’s social norms work. The Saleema campaign promotes the concept of the girl who is “natural, as God made her,” and free from FGM. A quasi-experimental design was used to test for a dose-response effect to the campaign on its expected outcomes related to changing social norms associated with the continuation of FGM. Data are collected through a repeated cross-sectional approach, with four planned time points from 2015 to 2018. A midline analysis shows preliminary evidence of change in key FGM indicators. Regression models suggest that the change in FGM outcomes is generally positive when respondents have higher levels of exposure to the campaign.

### III. Building on Proven Experience and Lessons Learned

Building on proven experience and lessons learned in Phase I and Phase II, the design of Phase III of the Joint Programme is informed by: i) the Joint Programme’s annual consultation conducted in April 2017, which provided more than 50 field staff with an opportunity to critically reflect on the effectiveness of interventions; ii) the programme’s country evaluations; iii) a value for money assessment and analysis of the programme’s social norms measurement approach commissioned by the United Kingdom’s Department for International Development; and iv) a literature review of current research on emerging, promising and good practices on ending FGM. Additionally, consultations were held with Joint Programme Steering Committee members/donors.
Key findings and recommendations integrated into Phase III of the Joint Programme include:

- **Defining ‘community’ and ensuring sustainable results following public declarations of FGM abandonment remain challenging.**

Addressing social norms upholding FGM was an innovation introduced in Phase I, putting attitudinal and collective behavioural change at the forefront of social change. The social norms approach was validated as a key intervention in the literature review,.xxii in addition to the need to work with a wide range of stakeholders within a community as gatekeepers of social norms and gender equality.xxiii

Sixteen countries contextualized and adapted a social norms perspectivexxiv following several capacity-development initiatives cascading from global to local partner CSOs. While partner organizations fully understood and successfully implemented the collective approach to abandonment, a key lesson is that the definition of ‘community’ is often country-specific – from embracing large geographical areas to targeting specific ethnic groups. While there has been a strong rationale for each country’s definition of ‘community’, it has made comparing the results of this indicator across countries difficult.

Another key lesson learned is the need to ensure post-public declaration mechanisms are in place such as community surveillance. The Joint Programme understands that public declarations do not guarantee compliance to keep the girls free from FGMxxv; for some people, it represents a milestone in the process of abandoning FGM because it signals a change in social expectations. Ensuring follow-up and support are embedded in the programme is critical for communities and to achieve change.

- **Developing laws criminalizing FGM is important for creating an enabling environment, but implementation of policies and legislation is the next critical step.**

At the national level, legislation is critical to making explicit the government’s disapproval of FGM, to supporting those who have abandoned the practice or wish to do so, and to acting as a deterrent. A key lesson learned is to implement legislation in ways that contribute to a social change process that ultimately results in the decision by communities to abandon the practice. Building on the progress to date on policies and legislation, the Joint Programme will focus on holding governments accountable for the dissemination of laws and policy, investigation, and the prosecution and enforcement of laws, in addition to the monitoring and development of budget lines in support of interventions for FGM abandonment.

The literature review also highlighted the importance of developing, introducing and implementing legislation in ways that contribute to a social change process that ultimately results in communities’ decision to abandon the practice.xxvi

- **Ensuring integration of rights-based and culturally sensitive approaches is essential in promoting lasting change.**
A key finding for the Joint Programme has been that cascade trainings to support social norms change did not necessarily lead to civil society partners embracing girls’ and women’s rights discourse. In some cases, CSOs focused on FGM’s health consequences as an entry point. With the rise in medicalization of the practice, the Joint Programme under Phase III will work to strengthen the capacity of grassroots CSOs and local governments in understanding and integrating education sessions on adolescent SRH rights, child protection, gender equality, and the rights of girls and women. While the Joint Programme has developed training tools on social norms, gender and FGM, the programme will ensure all stakeholders are given opportunities to take the training and integrate the learning into working with communities.

- **FGM is a discriminatory social norm, and therefore change requires a more explicit focus on girls’ and women’s agency and empowerment.**

While the Joint Programme has always engaged governments, service providers and communities on human rights and gender equality, an explicit focus on girls’ and women’s empowerment has been identified as a limitation to the programme. In some countries, interventions in support of girls’ and women’s agency have been relatively weak. Empowering girls and women to claim their rights will provide the central source of energy for changing social norms at the community level while working in complementary ways with political, religious and other community leaders to provide legitimacy for the programme's focus on social norms change. Strengthening and spreading this core model by increasing partnerships and alliances with civil society, service providers and local government structures will accelerate the process of enhancing girls’ rights and life choices (including ending FGM), aided by greater governmental political and resource support.

Girls’ and women’s empowerment in addressing FGM as a discriminatory social norm was also identified as a critical intervention for ending FGM in the literature review. xxvii

- **More emphasis is needed on the health needs of girls and women living with FGM.**

With greater emphasis placed on ensuring services for girls and women at risk of and affected by FGM through SRH services, the programme in Phase II has not been comprehensive enough in addressing the health needs of girls and women who have been subjected to FGM. The literature review also highlighted the need to strengthen interventions working with girls and women who have been cut. xxviii In Phase III, greater attention will be paid to system-building, including the integration of FGM into all health services.

- **The Joint Programme’s monitoring and evaluation framework must be strengthened to capture programme results.**

In 2014, a stronger results-based management online reporting system was instituted based on recommendations from the 2013 Joint Programme final evaluation of Phase I. This greatly strengthened the target-setting and results reporting of the Joint Programme in Phase II. However, country offices faced challenges to ensuring that systems and human resources were in place to produce accurate data. Under Phase III, a baseline data collection survey will be established at the global level.
The lack of rigorous evaluations on FGM was often cited in the literature review as a gap in monitoring and evaluation within the development community working on FGM-related issues. As the largest global FGM programme, the Joint Programme is prepared to make the investments needed to capture and share programme learning.

• **Indicators and tools must be developed to capture social norms change.**

While UNFPA and UNICEF have invested resources in supporting cutting-edge research around measuring social norms change, it has proven challenging during Phase II. To respond to that challenge, the Joint Programme has been working with Drexel University to produce a social norms framework with indicators and measurement tools that will be piloted in Phase III.

• **A systemic approach to service delivery is necessary in order to ensure sustainability.**

UNFPA and UNICEF have faced challenges in strengthening health and protective services and systems related to FGM. There are systems, service platforms and protocols that fall under sectors facing considerable financial and human resource capacity constraints. Adding another issue (i.e., FGM) to these sectors’ responsibilities has, in many cases, proven problematic. The Joint Programme in Phase III will develop guidelines for mainstreaming FGM into health, SRH, education and other sectors. This is closely linked to a larger commitment by the agencies to strengthen overall systems to prevent and respond to violence in the coming strategic plans.

• **One UN provides a unified voice in ending FGM and leveraging resources**

During the nine years of implementation of the Joint Programme, UNFPA and UNICEF built strong complementarities and brought together the added value of their partners – including governments, civil society and communities – in addressing FGM. The Joint Programme’s success stems from working together and ensuring components build on each other, there is clarity on the roles and responsibilities of each partner, and there is mutual accountability on the delivery of the programme. The Joint Programme maximized this programme leveraging and had clarity on programmatic scope, thresholds and accountability. The benefits outweighed some of the challenges, including differing geographical presence in some countries and staff turnover.

IV. **Programme Structure and Content**

*Programme Goal*

The vision for Phase III is that the Joint Programme will contribute to the SDG target of eliminating FGM by 2030. The goal of the Joint Programme is to accelerate efforts towards the reduction of FGM, fulfilling the rights of girls and women by realizing social and gender norms transformation by 2021.
Theory of Change: Programme Outcomes and Outputs

The Joint Programme’s hypothesis remains: *If* policies and legislation are in place and appropriately resourced for the elimination of FGM, *and* women and girls at risk of and affected by FGM access comprehensive services, *and* individuals, families and communities accept the norm of keeping girls intact (i.e., not subjected to FGM), *then* there will be elimination of FGM at the household, community and society levels by 2030.

In building on the programme’s proven approach, the Joint Programme will introduce in Phase III the following cross-cutting strategic interventions to enhance the programme’s effectiveness:

- Strengthen the enabling environment by holding governments accountable for the development of policies and legislation, and for ensuring adequate resources to end FGM;
- Scale up the amplification of social norms change interventions that support expanding collective knowledge and strengthening champions for the elimination of FGM using a broad range of interpersonal and innovative mass/social media communications strategies;
- Address gender norms in support of gender equality and girls’ and women’s rights;
- Expand youth engagement to harness the strengths and advantages of demographic growth and empower them to drive the end of FGM in their communities and countries;
- Address the trend of medicalization by galvanizing health professionals to champion the end of FGM as a human rights violation; and
- Establish a global knowledge hub for the measurement and dissemination of social norms and good practices captured by the Joint Programme for policymaking and improved programming.

At the heart of the programme is the recognition that eliminating FGM on a large scale requires a collective and coordinated choice so that no single girl or family is disadvantaged by the decision. The Joint Programme seeks to collectively create new social norms by creating a supportive and enabling environment – that is, an environment that is conducive to and facilitates change, as well as removes bottlenecks that inhibit change at the household, community, organizational and policy levels. For this reason, the Joint Programme’s approach continues to be holistic, with domains of change or outcomes that are complementary and mutually reinforcing.
The Joint Programme is managed to achieve maximum, sustained economy, efficiency, effectiveness, and equity: Theory purity with virginity, fidelity and FGM being a ritual marking cultural Social, religious and treatment violence, to life and physical integrity, to non-discrimination, and to be free from cruel, inhuman or degrading treatment

Accelerate efforts towards the reduction of FGM, fulfilling the rights of girls and women by realizing social and gender norms transformation by 2021

- Countries have an enabling environment for the elimination of FGM practices at all levels and in line with human right standards
- Girls and women are empowered to exercise and express their rights by transforming social and gender norms in communities to eliminate FGM
- Girls and women receive appropriate, quality and systemic services for FGM prevention, protection and care
- Countries have better capacity to generate and use evidence and data for policy making and improving programming

**Problem**

Over 200 million girls and women have experienced FGM in 30 countries across three continents. About 64 million girls and women are estimated to be at risk of being cut by 2030, violating their rights to health, to be free from violence, to life and physical integrity, to non-discrimination, and to be free from cruel, inhuman or degrading treatment

**Drivers**

Social, religious and cultural beliefs that consider FGM being a ritual marking to transition to womanhood and marriageability linked with virginity, fidelity and purity

Legal frameworks that do not protect girls and women and the desire to control women’s sexual and reproductive health, bodily integrity, autonomy, and decision making

Economic opportunities and structure of the economy, financial gains accessible from illicit perpetration within formal and informal healthcare structures

Policies/institutions: FGM medicalization; weak national coordination body for elimination of FGM; the clash between cultural practices and political will

**Interventions**

- Engage with regional entities to issue political decisions and peer review mechanisms to track progress at national levels
- Support implementation of laws and policies and line ministries’ to design and implement costed plans, strategies & budgets for FGM
- Convene CSOs, youth and Government dialogue; Forge partnerships with medical associations
- Promote interpersonal, intergenerational and community dialogue, including with religious leaders
- Set up surveillance systems
- Amplify social norms change with organized diffusion of knowledge, attitudes, positive expectations
- Equip girls and women with skills
- Create spaces for dialogue between girl/boy/ women/men
- Build capacity on FGM in health, social and legal service organizations
- Support the development and application of standard tools and guidelines
- Mainstream FGM in curricula at medical, para-medical schools
- Train and mobilize medical associations for FGM prevention
- Develop and test social norms measurement and tools
- Establish online platforms for knowledge management and organize forums for dissemination, discussion and use of practices and evidence
- Build capacity for uptake of evidence in policy development

**Output**

- Strengthened regional accountability mechanisms
- Increased national capacity for the development enactment and implementation of FGM laws and policy
- Increased engagement of CSOs and young people with policy makers

**Goal**

Contribute to the elimination of Female Genital Mutilation by 2030

**Assumptions**

- Enabling environment that promotes poverty reduction and gender equity and advance zero tolerance for FGM; significantly reduced new cases of FGM as a result of increased global investments; and rapid abandonment of the practice.
- National political commitment increased/sustained; Women’s empowerment realized; girls’ education preserved; rapid progress in advancing social changes; demographic trends; reinforcement of deterrent mechanisms and sanctions

Risk: National FGM agenda under-resourced; social resistance and political instability

- Strengthened capacity of UNFPA and UNICEF country offices and partners for implementation, monitoring and reporting; adequate resources and mobilization capacity; national scale-up of interventions in select countries

Risk: Sustained funding support and humanitarian situations

- UNFPA and UNICEF corporate commitments to FGM sustained; Tailored interventions to context specificities

Risk: inadequate resources
Interlinkages between Results Areas

Recognizing the complex interplay of social, cultural, economic and political factors that increase girls’ and women’s likelihood of undergoing FGM, the Joint Programme promotes sustainable social norms change and gender transformation leading to gender equality by increasing girls’ and women’s agency to claim their rights and their ability to access information opportunities under Outcome 2, and at the same time promotes institutional change in terms of policies, legislation (Outcome 1) and service provision (Outcome 3). Using information- and dialogue-based processes and mechanisms to empower populations, especially those that are marginalized and vulnerable, the Joint Programme facilitates and builds collective efficacy and actions that lead to the elimination of FGM, as well as creates demand and utilization of quality services as outlined in Outcome 3. The Joint Programme also focuses on initiatives to harmonize legal norms with social norms and moral norms through multiple platforms, channels of communication, dialogue and collective decision-making.

Under Outcome 1, a legal framework that clearly states that FGM is unacceptable is undeniably necessary to ending the practice. However, when laws banning FGM are introduced in contexts in which people are still socially expected to engage in the practice and fear social punishment if they do not, FGM will continue and may be driven underground. The challenge is therefore to develop, introduce and implement legislation in ways that contribute to a social change process that ultimately results in the decision by communities to abandon the practice, which relates to Outcome 2 around community-level transformation of social norms.

Key results expected from Phase III are the strengthened ability of girls and women to claim their rights and the ability and willingness of governments to support the enforcement of policies and legislation for the elimination of FGM. Hence, the Phase III strategy is built around essential, complementary intervention areas with increased focus on girls’ and women’s agency, providing girls and women with the knowledge, skills and networks that support them in claiming their rights – including increased autonomy in decision-making processes at the household and community levels (Outcome 2); facilitating their access to technical expertise and legal representation (Outcome 3); and supporting governments and civil society in creating an enabling political and organizational environment (Outcome 1).

Outcome 1 is linked to Outcome 3 in that policies and legislation would provide for coordinated action through child protection and SRH systems to identify, report, refer and support girls and women at risk of or affected by FGM. Through policies and legislation, resources would be provided to establish and support comprehensive, child-/adolescent-friendly and gender-balanced integrated support services to assist those who have been cut. Services would include health care, psychosocial support, girls clubs, in- and out-of-school support, and legal assistance and legal protection that are integrated through the establishment of referral systems that link them to law enforcement, programmes for perpetrators and helplines. In terms of amplification of social norms change, which is part of Outcome 2, service providers are a critical voice in championing the end of FGM.

Finally, Outcome 4 cuts across all of the intervention areas, as it seeks to generate and disseminate robust lessons learned and best practices from the Joint Programme and to create an evidence base for scaling up effective interventions to end FGM. The need for the rigorous
measurement of social norms change remains a gap in the global development community. The global knowledge hub will serve as a platform to provide much-needed information, innovative intervention models, lessons learned, data and studies to strengthen programmes focused on the prevention and management of FGM.

While the theory of change developed for Phase III is comprehensive and designed to address the complexities involved in eliminating FGM, UNFPA and UNICEF recognize the importance of collaborating with development partners to achieve the expected change and of avoiding duplication in order to maximize the use of available resources.

**Outcome 1: Countries have an enabling environment for the elimination of FGM practices at all levels and in line with human right standards.**

**Output 1.1: Strengthened regional accountability mechanisms for ensuring increased national commitment to end FGM.**

In Phase III, the Joint Programme will work towards getting FGM on the political agenda of regional and sub-regional political entities and institutions such as the African Union, the League of Arab States, the Organization of Islamic Cooperation, regional economic communities and relevant organs of the African Union such as the African Commission on Human and Peoples' Rights and its special rapporteur. Engagement with these regional political bodies will primarily focus on achieving enhanced and visible political commitment, strengthening the accountability of African Union member States to regional frameworks and global human rights treaties, establishing a functional peer review mechanism to systematically monitor national-level actions and progress in the elimination of FGM, and following up on the fulfillment of member States’ reporting obligations on issues related to FGM. Furthermore, regional dynamics conducive to ending FGM will be strengthened through increased South-South collaboration among the countries. High-level political champions will be engaged to galvanize and amplify regional- and national-level commitment and movement towards the elimination of the practice. The outcome will be the implementation of policies and legislation and the existence of a national FGM monitoring mechanism.

**Output 1.2: Increased national capacity for the development, enactment and implementation of FGM laws and policies.**

The Joint Programme will continue to support the implementation of laws and policies and the government in developing innovative models to bring laws closer to communities. Capacity building will be provided in developing and monitoring a comprehensive set of policies, undertaking assessments and data analysis, and providing training and capacity-building for law enforcement officials and other professionals and stakeholders. The FGM case-tracking tool will be promoted to track cases. To address the medicalization of FGM, a partnership will be established with medical syndicates and associations to enforce policies and legislation, including legal sanctions for health professionals who engage in FGM. Greater emphasis in Phase III will be on governments developing national plans and budgets for the implementation of FGM-related policies and legislation.
**Output 1.3: Increased engagement of civil society and young people with policymakers for the elimination of FGM.**

Recognizing the critical convening role of the United Nations in bringing together key stakeholders to address FGM, the Joint Programme in Phase III will support building government capacity in participatory and consultative engagement with civil society (especially youth groups) while strengthening the capacity of civil society to engage in dialogue for the development and implementation of the country’s national action plan on FGM.

A critical component under this output is youth civic engagement. Civic engagement provides young people with opportunities to acquire new skills and to learn responsibility and accountability – all while contributing to the elimination of FGM in their communities. The Joint Programme intends to support youth engagement innovative strategies that provide meaningful opportunities for youth to work with policymakers to end FGM. The Joint Programme will promote the value of young people in public problem-solving and provide youth and policymakers with information and support innovative digital tools to work effectively together as partners, allowing opportunities for youth to take ownership of parts of the process, mobilize others and become powerful role models.

**Outcome 2: Girls and women are empowered to exercise and express their rights by transforming social and gender norms in communities to eliminate FGM.**

**Output 2.1: Improved community and interpersonal engagement to address and amplify social and gender norms transformation.**

Under Phase III, the Joint Programme will continue to support social norms change initiatives at the community level while also strengthening interventions following public declarations of FGM abandonment. The Joint Programme will provide opportunities for critical reflection on the practice as a violation of girls’ and women’s rights, as well as exposure to alternative discourses, values and models of social organization and work with opinion leaders and role models who may also play a pivotal role in catalysing norms change. The programme will work with communities to reach a ‘critical mass’ in which a new social norm is established through education, dialogue, organized diffusion of information and collective public declarations of FGM abandonment.

The Joint Programme will also continue to work with religious and community leaders as social influencers and support intergenerational dialogue.

**Joint Programme’s approach to social norms change**

The Joint Programme’s approach to challenging social norms consists of community dialogues and empowering or transformative human rights education; this provides community members with the opportunity to discuss new knowledge, relate it to their situation and consider alternatives to FGM. Once a core group of people is ready to denounce FGM through an organized diffusion of the information, a larger portion of the community is reached and larger debate on FGM’s harm reaches consensus, then a collective commitment is made through public declarations; this signals a shift from conditional commitment to actual commitment to abandon the practice.
with family influencers (such as grandmothers) so that communities can reach a consensus on abandoning the practice.

The Joint Programme will strengthen post-public declaration mechanisms and establish community-level surveillance and support systems to ensure families and communities follow through on their commitment to abandon FGM. Depending on the country context, post-public declaration initiatives will rely on either community leaders, women’s or youth groups, or law enforcement actors. Functional helplines with rapid intervention groups will be developed within the surveillance system.

As shown in Figure 4, amplification interventions will be used by young people, communities, service providers and governments to shift social norms into a new equilibrium supporting the end of FGM. Amplification interventions will include the identification, support and capitalization on open source technologies, role models, documenting the stories of how these individuals reached their positions on abandoning FGM. It will be critical to ensure that it reaches the diaspora community.

The Joint Programme will mainstream FGM elimination into existing youth networks mobilized throughout Africa under the African Union Commission leadership on ‘Harnessing the Demographic Dividend through Investments in Youth’. Youth engagement is a key component not only in the amplification of social norms change, but also as an accountability mechanism ensuring governments and community and religious leaders uphold their commitments to supporting the end of FGM. Young people will be encourage to support innovation-specific functioning knowledge sharing mechanisms and a scaling-up framework and surveillance system for successfully impact solutions.

Figure 4: Resonance and amplification movement to accelerate the end of FGM
Output 2.2: Strengthened girls’ and women’s assets and capabilities to exercise their rights.

The Joint Programme will partner with other United Nations agencies and programmes and CSOs to mainstream FGM into their asset- and capability-building packages for girls and women. An example of an intervention that builds assets and capabilities are girls’ clubs – in and out of school settings – that empower girls by giving them a chance to learn about issues that affect their lives and expand their social networks. The girls’ clubs will integrate FGM into their comprehensive sexuality education (based on UNFPA’s curriculum, which includes human development, anatomy and reproductive health, as well as information about contraception, childbirth and sexually transmitted infections (including HIV) and vocational and life skills training. Another deliverable will include mentorship programmes in which girls will have support from women serving as mentors to navigate life transitions from childhood to adolescence, keeping girls intact through interventions such as alternative rites of passage. Mainstreaming FGM into partners’ leadership programmes will improve the way women’s leadership and decision-making protect girls from FGM. If appropriate the use of innovative open source technologies will complement the package of services.

It is expected that the above two interventions will strengthen girls’ and women’s self-confidence and support to speak out and advocate for their rights, raising awareness and spurring peers and community members to action against perpetuating the practice of FGM.

Output 2.3: Increased engagement of men and boys on changing social and gender norms.

For the Joint Programme’s efforts to sustainably influence and change social and gender norms, men and boys will be actively engaged in interrogating and challenging power dynamics in their own lives, as well as in their communities and societies more broadly. A partnership will be developed with the Men Engage Alliance networks to ensure systematic and institutionalized efforts at the national level. Where culturally appropriate, a dialogue will be facilitated between girls and boys to deepen the discussion around power relations, sexuality and harmful practices. Men and boys will be encouraged to be more vocal against the medicalization of FGM in countries like Egypt. The amplification activities will include promoting positive masculinities such as role models among fathers, male politicians, and community and religious leaders who support gender equality and the abandonment of FGM.

Outcome 3: Girls and women receive appropriate, quality and systemic services for FGM prevention, protection and care.

Output 3.1: Improved availability and quality of FGM services in Joint Programme intervention areas.

The Joint Programme will support the government and civil society frontline healthcare, social services and legal provider organizations to increase their capacity to provide FGM-related services to girls and women at risk of or who have undergone FGM. Those can be medical (such as treating complications of FGM) and can also go beyond the medical aspect – for example, psychosocial counselling on FGM during pre- and postnatal check-ups and SRH information.
sessions; temporary shelter referrals to psychosocial, legal or other social services; and in- and out-of-school support and referrals.

Additionally, the Joint Programme will continue to mainstream FGM into the curricula of medical and paramedical schools. Activities under this output will also include disseminating the 2016 World Health Organization guidelines on managing health complications from FGM to improve care for millions living with the consequences of this practice.

**Output 3.2: Existence of a cadre of advocates amongst FGM service providers, including social workers, teachers, midwives, nurses and doctors.**

The Joint Programme will continue to mainstream FGM into training programmes and mobilize doctors, nurses and midwives in support of FGM prevention and care, as well as empower them to serve as role models, counselors and advocates in the campaign to end FGM.

The Joint Programme will also support: strengthened knowledge and enforcement of the law on FGM; amplification of positive social norms to create a movement of medical professionals who support the elimination of FGM; and facilitation of public declarations by medical associations, syndicates, the International Federation of Gynecology and Obstetrics, and the International Confederation of Midwives.

Teachers, community facilitators and youth leaders will receive training so that they can support the community change process. This group will play a pivotal role in the amplification of social norms change as role models and advocates for the rights of girls and women.

**Outcome 4: Countries have better capacity to generate and use evidence and data for policymaking and improving programming.**

**Output 4.1: Increased generation of evidence for social norms change and programme improvement.**

The Joint Programme will develop a measurement framework and indicators on social norms, piloting the resulting data collection tools in participating countries. Identifying efficient and effective methods for measuring social norms change will be a major contribution to the development community and programmes addressing FGM, child marriage, gender-based violence, SRH, and violence against women and girls more broadly.

**Output 4.2: Enhanced knowledge management and exchange of good practices for policy and programme improvement.**

The Joint Programme will establish a global knowledge hub, an online platform for sharing and downloading digital content generated by the programme in all the countries at the regional and global levels. A knowledge management team from regions, countries and Headquarters will support the virtual discussions on cutting-edge trends, themes and results from research generated by partners and UNICEF/UNFPA to facilitate the uptake of lessons learned that can improve policy and programmes. The global hub will raise the profile of diverse perspectives on
FGM, including encouraging the contribution and exchange of content by the Global South and North (specifically with the diaspora), through peer support, help-desk and shared learning where the programme doesn’t have a presence.

**Output 5: The Joint Programme is managed to achieve maximum, sustained economy, efficiency, effectiveness and equity.**

The United Nations is committed to the best use of resources to attain desired results through the Joint Programme. The management of FGM activities and supported programmes covered under all funds directed through the Joint Programme are guided by criteria such as economy, efficiency, (cost-)effectiveness and equity. The Joint Programme results framework includes outputs to ensure:

- **Interventions target the most vulnerable/marginalized populations**, such as minority groups and rural populations. An equity analysis is undertaken as part of the situation analysis conducted at the beginning of all country programmes.
- **Consistent planning and coordination of the interventions between UNFPA and UNICEF and with key FGM stakeholders.** An inventory of FGM stakeholders at the global, regional and country levels is available and will be actively used while planning Joint Programme interventions to avoid overlaps and duplication of efforts.
- **Funds are disbursed in a timely manner** from Headquarters to regional and country offices and from all offices to implementing partners according to established procedures and deadlines.
- **A high budget utilization rate** through quarterly expenditure monitoring. Under the Joint Programme, implementing partners must submit detailed, itemized budgets to request funds disbursements from UNFPA/UNICEF and detailed/itemized expenditure reports showing expenditures against activities and results.
- **Expenses match the budget by outcomes and outputs** and any strategic adjustments made in the course of implementation are justified because they improve achievement of intended results.
- **Savings are achieved** – for example, by using the United Nations’ existing competitive, quality-assured procurement processes, making long-term agreements with vendors, and negotiating the costs of interventions and support costs with implementing partners.

**UNFPA and UNICEF Joint Efforts and Collaboration**

The Joint Programme has demonstrated how effectively two United Nations agencies can work together as equal partners to achieve one goal. In many countries, the UNFPA-UNICEF Joint Programme is a model of close collaboration, knowledge-sharing, mutual support and synergy in achieving results among agencies and leveraging attention and resources from a variety of partners.

The comparative advantages to the UNFPA-UNICEF Joint Programme include:

- **Contribution to the SDG targets** through improved financing mechanisms and enhanced United Nations partnerships that help diversify the donor base and achieve

- **Ensuring policy and programmatic coherence** by identifying synergies and adding the value of participating agencies, which allows for integrated programme formulation, the implementation and monitoring for long-term impact, and the development of knowledge management and tools for joint advocacy that help expand donor base and attract large investments.

- **Having stronger impact to national systems, bringing together governments and CSOs** through improved coordination of technical assistance as opposed to a focus on a small-scale, fragmented approach with limited impact.

- **Ensuring greater synergy in results achievement** among agencies and leveraging attention and resources from a variety of partners.

- **Ensuring transparency** through the representation of all stakeholders (i.e., donors, national authorities and implementing partners) in managing joint programmes/pooled funds, also contributing to reduced operational cost.

- **Improving risk management** through a blended financing approach and multi-stakeholder participation committed to common objectives leading to sharing risks and achieving results.

*Joint Programme’s Alignment with the Quadrennial Comprehensive Policy Review and UNFPA’s and UNICEF’s Strategic Plans*

The design of Phase III is guided by the strategies and principles of the Quadrennial Comprehensive Policy Review, which strongly emphasizes the importance of strengthening national systems, building on national priorities/needs, pooling resources and coordinating United Nations operations to respond to the 2030 Agenda.

The Joint Programme aligns with UNFPA’s Strategic Plan (2018 to 2021). Addressing FGM is central to one of the three people-centered transformative results at UNFPA for reaching universal access to SRH and reproductive rights (i.e., “an end to gender-based violence and all harmful practices, including FGM and child, early and forced marriage”). Outcome 3 of UNFPA’s Strategic Plan – “Gender equality, the empowerment of all women and girls, and reproductive rights are advanced in development and humanitarian settings” – recognizes the critical role of the Joint Programme, using one outcome indicator and three output indicators to capture the expected changes in the area of FGM. Given the elevated focus on addressing social and gender norms transformation for realizing gender equality in UNFPA’s Strategic Plan, the same vision drives the Joint Programme's shift to pursue girls’ and women’s empowerment and the elimination of FGM through social and gender norms changes.

Phase III is also aligned with UNICEF’s Strategic Plans. For UNICEF, the Joint Programme contributes to Goal 3 (“Every child is protected from violence, exploitation and harmful practices”) and Result 2 (“By 2012, girls are reached with UNICEF-supported multisectoral at-scale programmes to address harmful practices, namely FGM and child marriage”). Two indicators in UNICEF’s Strategic Plan relate to FGM. Moreover, UNICEF has created a team within the Child Protection Section to address harmful practices, most notably child marriage and FGM.
V. Critical Assumptions and Risk Mitigation

There are several critical and interrelated assumptions that were considered in the design of Phase III of the Joint Programme. In terms of assumptions, the Joint Programme considered the following factors that support and/or affect programme impact and results: poverty and inequality, women’s economic empowerment, girls’ education, child-friendly and gender-responsive policies and laws, demographic perspectives and FGM as a social norm.

There are multiple risks involved in the elimination of FGM that the Joint Programme intends to mitigate during programme implementation. The risks are related to the country context, programme development/delivery, partners, financial resources and reputation. Details on risks and mitigation are presented in annex I.

VI. Geographic Coverage

Figure 5: Countries included in Phase II of the Joint Programme

A Three-Dimensional Model

Over the past 10 years, funding to support the elimination of FGM has been limited and irregular, not reflecting the commitment by Members States in the United Nations General Assembly resolutions 67/146, 69/150 and 71/168 on intensifying efforts to eliminate FGM, which call for more funding to the UNFPA-UNICEF Joint Programme. The Joint Programme will strengthen its resource mobilization strategy to move towards achieving SDG 5.3. However,
given the current limited funding and following the Steering Committee’s recommendation, the Joint Programme coordination team proposes changing its mode of engagement with countries. The prioritization approach considers a set of criteria, essentially demographic trends with sensitivity to FGM prevalence and rate of change – particularly the rate of acceleration toward FGM elimination by 2030, as well as the congeniality of environmental conditions for FGM elimination. Table 1 presents a limited list of criteria considered at this incipient stage, which holds potential for further improvement given the availability of reliable data.

‘FGM prevalence’ considers the risk among girls and women aged 0 to 14 and 15 to 49 given the need for prevention and protection and care services for the age bracket of population at risk. While these criteria are clear, it is worth noting that the criterion on the rate of acceleration required for FGM elimination by 2030 is a projection based on the current prevalence rate among girls aged 15 to 19, where elimination is defined as FGM prevalence of less than 1 per cent. However, there is a caveat and limitation – by 2030, countries may not have achieved exactly less than 1 per cent FGM prevalence; elimination may have occurred, but there could be a time lag between when elimination began and when prevalence data begins to reflect the social change (subject to the availability of reliable methodology and data). Table 1 shows the analysis undertaken for different countries.

Table 1: Repartition of countries based on selected criteria

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<th>S/N</th>
<th>List of Countries</th>
<th>Prevalence of FGM*</th>
<th>Expected number of girls at risk of FGM aged 0 to 14 years by 2030</th>
<th>Government Commitment</th>
<th>Acceleration required for elimination by 2030***</th>
<th>Availability of other funding sources</th>
<th>Political and humanitarian situation (fragile/stable political situation, humanitarian situation)</th>
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<td>% of girls aged 0-14 years have undergone FGM/C, 2010-2015</td>
<td>women aged 15 to 49 years have undergone FGM/C, 2004-2015</td>
<td>National Coordination Mechanism</td>
<td>Legislation on FGM</td>
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<td>9</td>
<td>Kenya</td>
<td>3</td>
<td>377,708</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
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<td>10</td>
<td>Mali</td>
<td>78</td>
<td>4,602,960</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>1,205</td>
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<tr>
<td>11</td>
<td>Mauritania</td>
<td>53</td>
<td>611,680</td>
<td>Yes</td>
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<td>Yes</td>
<td>124</td>
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<tr>
<td>12</td>
<td>Nigeria</td>
<td>27</td>
<td>9,778,678</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>13</td>
<td>Senegal</td>
<td>24</td>
<td>557,144</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
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<td>14</td>
<td>Somalia</td>
<td>46</td>
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<td>No</td>
<td>No</td>
<td>257</td>
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<tr>
<td>15</td>
<td>Sudan</td>
<td>92</td>
<td>3,200,120</td>
<td>Yes</td>
<td>No (in 4 states)</td>
<td>Yes</td>
<td>42</td>
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<td>16</td>
<td>Uganda</td>
<td>1</td>
<td>147,850</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>10</td>
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<tr>
<td>17</td>
<td>Yemen</td>
<td>28</td>
<td>968,560</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>27</td>
</tr>
<tr>
<td>18</td>
<td>Indonesia</td>
<td>45</td>
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<td>Yes</td>
<td>No</td>
<td>No</td>
<td>6</td>
</tr>
<tr>
<td>19</td>
<td>Tanzania</td>
<td>0.4</td>
<td>71,635</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>5</td>
</tr>
</tbody>
</table>

Sources:
** Proportion based on national FGM prevalence and world population projection data per country (UNFPA, 2017)
*** Data, Research & Policy, UNICEF 2016
**Classification of Countries by Tier**

**Tier 1 Countries**

These countries represent a significant number of women and girls affected by FGM, as well as a significant number of girls at risk; they are characterized by a conducive environment and government commitment to ending FGM, which is envisioned to have some impact on reducing the global burden as well. Tier I countries hold great potential for stamping out FGM entirely in their countries, provided strategic prioritization of programmatic and financial investment is put in place.

**Tier 2 Countries**

Tier 2 comprises countries with a high to medium need for support to accelerate current efforts towards eliminating FGM. These countries are characterized by a lower numbers of girls affected than those in Tier 1, ongoing positive developments, positive engagement from governments and possibilities in terms of accelerating change. They show clear signs of progress through the successive interventions of the Joint Programme and other partners, given the conduciveness of their environments and the mixed category of demonstrable readiness and response of their governments to sustain current efforts towards FGM elimination.

**Tier 3 Countries**

These countries are characterized by a lower number of women and girls at risk and/or the absence of a comprehensive legal framework to address FGM.

**Phase III Country Classification**

Based on this analysis, in Phase III, countries are categorized by tier depending on the number of girls at risk, government commitment, good practices to capitalize on, and possibilities in terms of accelerating change.

**Table 2: Classification of countries by tier**

<table>
<thead>
<tr>
<th>Tier I</th>
<th>Tier II</th>
<th>Tier III</th>
</tr>
</thead>
<tbody>
<tr>
<td>Burkina Faso</td>
<td>Eritrea</td>
<td>Guinea-Bissau</td>
</tr>
<tr>
<td>Djibouti</td>
<td>Gambia</td>
<td>Mali</td>
</tr>
<tr>
<td>Egypt</td>
<td>Guinea</td>
<td>Somalia (interventions focused on Somaliland)</td>
</tr>
<tr>
<td>Ethiopia</td>
<td>Mauritania</td>
<td>Uganda</td>
</tr>
<tr>
<td>Kenya</td>
<td></td>
<td>Indonesia*</td>
</tr>
<tr>
<td>Nigeria</td>
<td></td>
<td>Yemen*</td>
</tr>
<tr>
<td>Senegal</td>
<td></td>
<td>Tanzania*</td>
</tr>
<tr>
<td>Sudan</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
*Yemen will continue to be included in regional and sub-regional capacity building and consultative initiatives

** Indonesia and Tanzania: Interventions on policy advocacy and knowledge management will be supported depending upon funding availability

### Modes of Engagement of the Joint Programme

Joint Programme support at the country level is operationalized through four modes of engagement: (a) advocacy and policy dialogue focused on the development, improvement and reform (including performance monitoring) of legislation, policies and strategies; (b) knowledge management that improves programmes through data analysis and the timely delivery of high-quality knowledge products and the provision of innovative solutions; (c) partnerships and coordination, including South-South cooperation (through the systematic exchange of knowledge solutions and innovation); and (d) service delivery at the community level of services to prevent, protect and provide care on FGM-related issues. These four modes of engagement are key components of an integrated, synergetic approach to strengthen and maintain the skills, capabilities, resources and commitment of people, organizations and societies as a whole towards abandoning the FGM practice.

Based on the global theory of change and results framework, Joint Programme country coordination teams will work on the contextualization of the Phase III theory of change and results framework, and they will propose the main interventions needed based on the theory of change they are going to contextualize. The reality of varied programming across different contexts need to be captured. Countries will also reflect in their results framework what ‘success looks like’ in the country and sub-country contexts. Qualitative information will be key to explain social change.

Over Phase III, the Joint Programme will prioritize Tier 1 countries for resource allocation, taking advantage of the ripe environment and progress made and leveraging the catalytic potential of their favourable conditions to accelerate change, achieving maximum impact and eliminating FGM through intensifying strategic fiscal and programmatic investments. The Joint Programme will deploy all four modes of engagement for countries in Tier I. However, the mode of engagement for those countries will be context-based, depending on the adapted theories of change and results frameworks.

Tier II countries will be the second-level priority countries, and interventions will be mainly focus on services and community engagement in the first year (2018). As funds become available, activities will be expanded to cover the other areas of the Joint Programme. Tier II countries require sustained capacity and fiscal support to preserve, maintain and accelerate the development gains made over the period of Joint Programme engagement to prevent a reversal. Joint Programme investments and intervention are justified in keeping with the spirit and principles of the 2030 Agenda of universality, integration and leaving no one behind.

Tier III countries will not be prioritized for funding at the beginning of the Phase III given the limited expected resources in January 2018. However, at the initial stage, they will be included in learning innovative approaches at the regional level, advocacy and policy dialogue, engagement
with regional institutions, and cross-border activities. However, as more funds become available, more funding will be channeled towards the Tier III countries.

Policy dialogue will continue in all countries using strategic political decisions and peer review processes by regional institutions. An important goal of the work with regional institutions (the African Union, the League of Arab States and regional economic communities/commissions) will be to specifically support policy dialogue and advocacy for countries in Tiers II and III. The Joint Programme will seek to broker high-level expertise, critical for providing innovative and integrated policy solutions to country in Tier III. South-South cooperation creates a platform to exchange know-how and support between the countries in need and those with deployable expertise.

The Joint Programme will continue to follow and share technical resources with other countries to identify catalytic strategic support in their advocacy and resource mobilization strategies, particularly on regional political engagement with the African Union and regional economic communities/commissions. Another focus will be to increase the effectiveness of actions against FGM by building bridges between young people from the CSOs and communities from targeted African countries and migrant communities in Europe, sharing good practices, strengthening links and adapting existing best practices with a mutual learning and exchange perspective.

Table 3: Country contexts and modes of engagement

<table>
<thead>
<tr>
<th>Modes of Engagement</th>
<th>Tier I countries</th>
<th>Tier II countries</th>
<th>Tier III countries</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enabling environment, advocacy, policy dialogue</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Knowledge management</td>
<td>x</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Service delivery/ community education, mechanisms of prevention/protection/care</td>
<td>x</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>Partnerships incl. South-South cooperation, regional dynamics, cross-border</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
</tbody>
</table>

VII. Governance Structure and Programme Management

Governance Structure

The Joint Programme will continue to have a Steering Committee with broader oversight responsibility for the overall management and functioning of the programme. Its members include one senior-level technical staff member to be officially designated by each donor financially supporting the Joint Programme and directors from UNFPA and UNICEF. The Steering Committee will be co-chaired by the directors of UNFPA and UNICEF.

The role of the Steering Committee includes the following main tasks:
• Facilitate the effective and efficient collaboration between participating United Nations agencies and donors for the implementation of the Joint Programme;
• Review and approve the Joint Programme document, including the monitoring and evaluation framework, and any subsequent revisions;
• Review the overall implementation of the Joint Programme on a semi-annual basis;
• Review and approve annual consolidated narrative and financial reports;
• Review and approve terms of reference for the evaluation exercise, review evaluation findings, and follow up on the implementation status of accepted recommendations from the evaluation;
• Support advocacy with regional political structures, national governments, and civil society actors for enhanced commitment and accountability in the effort to eliminate the practice of FGM; and
• Support advocacy and resource mobilization efforts for the Joint Programme.

The Steering Committee will hold two regular meetings each year. One will be in March, when the coordination team will have received all annual reports, to ensure the quality of the databases and conduct analysis of progress. The second meeting will be in September to look at the budget and approve allocation of funds for the next year. A field visit in one of the programme countries will also be organized once a year. Additional technical meetings can be organized as necessary to have more detailed discussions on issues of strategic importance for the Joint Programme. The chief of the Gender, Human Rights and Culture Branch (UNFPA), the chief of the Child Protection Section (UNICEF), and Joint Programme Coordination Team, resource mobilization, finance and evaluation staff (from both UNFPA and UNICEF) will attend the Steering Committee meetings.

As much as possible, the Steering Committee will reach decision by consensus as a preferred way of working. However, if a situation dictates it, decisions can also be reached by voting to adopt the option supported by the majority voting.

In addition, all Steering Committee members will be invited to attend a field visit once a year in a country of implementation of the Joint Programme on a rotational basis.

**Programme Management**

Day-to-day programme and financial management and administrative work will be handled by the Joint Programme Coordination Team at the Headquarters level. The team will be responsible for the following main tasks and responsibilities:

• Promote partnership, undertake advocacy initiatives at the global level, and support resource mobilization;
• Engage and solicit technical inputs from relevant units of UNFPA and UNICEF at the Headquarters level to benefit from the institutional knowledge base and expertise;
• Develop knowledge on social change and emerging issues, and facilitate documentation of best practices and knowledge management;
• Ensure timely preparation and submission of work plans at the Headquarters, regional and country office levels;
• Provide technical support and follow-up for programme implementation and financial management;
• Implement capacity-building initiatives for the Joint Programme team;
• Prepare the global annual report for the Joint Programme based on the inputs from the regional and country offices;
• Organize annual consultation meetings for the Joint Programme;
• Facilitate and ensure the smooth conduct of Steering Committee meetings and serve as a secretariat to the Steering Committee;
• Respond to requests from the Steering Committee, donors, and senior management of UNFPA and UNICEF;
• Facilitate undertaking the evaluation exercise for the Joint Programme; and
• Represent the Joint Programme on the various technical forums and advocacy events.

Figure 6: Management structure of the Joint Programme
A programme coordinator at UNFPA will lead the Joint Programme Coordination Team with close support from the joint technical team both at UNFPA (monitoring and evaluation specialist – P4, technical specialist – P4, knowledge management and communication consultant, and programme assistant – G6) and UNICEF (child protection specialist – P5 (50%), P4 and P3, G5 (50%)). For UNFPA, the Joint Programme will be situated within the Gender, Human Rights and Culture Branch of the Technical Division, while it will be within the Child Protection Section under the Programme Division for UNICEF. The governance and programme modalities will continue to be characterized by UNFPA and UNICEF co-management at the global, regional and country levels.

Regional offices will have direct responsibility to follow up on programme implementation at the country level, support monitoring and reporting on results, and provide specific technical support required by country offices. Regional offices will also develop a plan of action to support regional and country efforts. The Joint Programme will fund specific posts at regional offices while benefitting from the existing senior advisors for gender, child protection, and monitoring and evaluation funded by other resources of the regional offices of UNFPA and UNICEF. To strengthen the partnership with the African Union, the Joint Programme will place consultants in Addis Ababa to ensure coordination among the African Union units, CSOs, and UNFPA and UNICEF.

Country offices will develop an annual work plan in a consultative process engaging partners at the national level and also considering the comparative advantages of UNFPA and UNICEF. All country offices will officially designate a focal person to follow up on the management and implementation of the Joint Programme. The Joint Programme will fund staff at the country office level based on expressed need and availability of funding on a case-by-case basis.

Both government and (international) non-governmental organizations will be eligible to apply for funding from the Joint Programme. Government partners may receive funding at the country level, while international CSOs can receive funding at the Headquarters level. CSOs will be a key partner at the regional and country levels. (International) non-governmental organizations may have their own administrative and operational support costs, which are negotiable at the time of signing an agreement.

**Fund Management**

UNFPA continues to be the administrative agent and as such is responsible for:

- Signing a new memorandum of understanding with UNICEF for Phase III;
- Negotiating and signing a standard administrative arrangement with donors contributing to the Joint Programme;
- Receiving financial contributions from donors;
- Disbursing funds to UNFPA and UNICEF for programme implementation in accordance with instructions from the Steering Committee, approved annual work plans and fund availability (written request from Joint Programme Coordination
Team will be presented to the administrative agent whenever there is a fund transfer request; and

- Consolidating financial statements and reports, incorporating submissions from UNICEF, and presenting and submitting them to Steering Committee.

In line with United Nations Development Group guidance and procedures on United Nations joint programmes, the pass-through fund management structure is subject to the following fees and indirect costs:

- As administrative agent, UNFPA charges a 1 per cent fee on funds received into the Joint Programme account; and
- As participating agencies, UNFPA and UNICEF recover 7 per cent indirect costs against expenses incurred under their components.

**Accountability**

Accountability for programme implementation and financial management rests with the implementing units at different levels (country offices, regional offices or at the global level). At the country level, where a significant proportion of the financial resources are expected to be utilized, UNFPA and UNICEF country representatives are responsible for programme implementation (ensuring the technical quality, relevance and timeliness in delivery/planned results) and financial management under the system of the United Nations Resident Coordinator. Regional directors are similarly accountable for all regional-level initiatives in addition to overseeing country-level programme implementation. Global-level responsibility entails following up on the overall programme implementation at the country and regional levels, in addition to leading global-level initiatives. In general, required efforts will be made to enhance capacity and institutionalize results-based management throughout the implementation of the Joint Programme at different levels.

**VIII. Delivering on Cross-Cutting Themes**

The following cross-cutting themes will be mainstreamed into the design and implementation of country office theories of change. Relevant analyses and studies will be conducted as the basis for integrating the cross-cutting issues listed below into the design of Joint Programme policies and programmes.

**Disabilities**

More than 200 million women with disabilities live below the poverty line. Girls and women are at an increased risk of becoming disabled because of ongoing gender inequalities. Lack of equal access to food, inadequate healthcare and unsafe labour conditions increase the number of girls and women living with a disability. FGM, child marriage, early pregnancy, exposure to disability, HIV/AIDS, and violence against women and girls also increase the risk. In responding to girls and women affected by FGM, the Joint Programme will ensure the needs of disabled girls and women are met through protection and care services.
**HIV/AIDS**

The use of the same surgical instrument without sterilization could increase the risk for transmission of HIV between girls who undergo FGM together. An increased risk for bleeding during intercourse may increase the risk for HIV transmission. The increased prevalence of herpes in women subjected to FGM may also increase the risk for HIV infection, as genital herpes is a risk factor in the transmission of HIV. The Joint Programme will ensure the link between FGM and HIV/AIDS, especially in countries with high HIV/AIDS prevalence rates, is considered in designing interventions appropriate for the country context.

**IX. Strategic and Implementation Partnerships**

As Member States announced the adoption of the post-2015 development agenda and SDG framework in September 2015, the global community was reminded that partnership is at the heart of the global effort to accelerate the movement to end FGM. The Joint Programme recognizes how critical partnerships are in sustaining global momentum, bringing together new players and advancing results on the ground. The main categories of partnerships include global, regional and national partners, with specific types of partnerships within each category ranging from donors to grassroots and youth groups. It is the expectation of UNFPA and UNICEF that various global-, regional-, national- and community-level partners will support the implementation of the global theory of change developed for Phase III.

**Key Global Partners**

Beyond the UNFPA-UNICEF partnership, the Joint Programme will continue to engage UN Women and the World Health Organization on specific areas of the results framework in which their programming and competencies align. A new partnership will be developed with the Innovation Fund to promote a culture of innovation through activities such as Innovation Days, and by providing staff with opportunities to develop and test innovations. This effort will be underpinned by the real-time monitoring of lean data, a renewed focus on communications and enhanced capacity to innovate. The Global Media Campaign, AIDOS and the End FGM European Network will remain key global partners. The Joint Programme will also collaborate with the Department for International Development-funded The Girl Generation on advocacy initiatives and Evidence to End FGM, led by the Population Council, on data generation and dissemination. Beyond the Joint Programme, the Donors Working Group provides a global forum for discussion, knowledge-sharing and leadership.

**Key Regional Partnerships**

The Joint Programme will continue to actively support and engage with the African Union Commission, the League of Arab States, the Organization of Islamic Cooperation and other relevant sub-regional political structures, including regional economic communities/commissions. Regional-level CSOs such as the Inter-African Committee on Traditional Practices will also be engaged to enhance momentum at the regional level.
**Key Country Partners**

The Joint Programme works with sectoral ministries and their systems to promote better policy and programming for girls and women at risk of and affected by FGM. The Joint Programme will also use its convening role with governments to ensure that existing mechanisms maximize coordination among actors already engaged in eliminating FGM, as well as to expand partnerships to include other stakeholders. Government coordination bodies will usually fall under the national plans of action and will include key stakeholders across government and civil society.

The design of Phase III of the Joint Programme and its theory of change involved partnerships with girls, women and communities. Local actors and stakeholders, especially young people, are better aware of the contexts in which this programme will work and will be engaged to effectively interact with the programme participants.

**X. Results-Based Management and Learning**

Phase III of the Joint Programme interventions will be managed through results-based planning, monitoring, evaluation and learning activities based on the theory of change approach. It will follow the cycle set out in figure 7. The elements of the figure are briefly detailed below. As a whole, the results-based management and learning process is:

- **Iterative and participatory**, involving local and national government authorities, civil society, communities, country offices, regional offices and Headquarters, with the aim developing their capacity to identify their goals and manage to achieve them sustainably;
- Thoroughly **based on evidence**, quantitative and qualitative, sourced from the Joint Programme activities, partners and stakeholders at the country, regional, and global levels;
- A **real-time learning process** in which everyone shares and communicates data, evidence, experience, and knowledge and reflects analytically on emerging opportunities to exploit and on how to creatively address bottlenecks step by step;
- A process during which everyone will be held accountable for collaboration, coordination, and contribution towards results;
- Ultimately, a process that should enable stakeholders and communities to see their potential for change, what is already changing, where change is stuck, and how they can facilitate change in the direction they want to achieve their objectives.
The foundation of the results-based management and learning process is a global theory of change and results framework (see Section XII). The Joint Programme results framework includes an explicit work area on strengthening systems to generate and use evidence to inform ongoing programme implementation across the participating countries. This is in recognition of the need to strengthen capacity across countries in the formulation of evidence-based policy and programme design, monitoring and evaluation, including evidence generation.

A global menu of indicators has been identified at the outcome and output levels based on global standards of good practice, United Nations Development Group indicator guidelines, and both agencies’ expertise, Strategic Plan indicators and reporting systems. The global alignment of indicators, while allowing for some degree of variation at the country level, will enable annual tracking of progress and reporting across countries. Past experience of Joint Programme implementation indicates that providing countries with harmonized guidance on indicators, ongoing technical assistance, and ensuring regular reporting has enhanced the quality of programming, reporting, knowledge-generation and results.

At the start of Phase III, participating countries and the regional offices will operationalize and adjust the global results framework to ensure relevance to the local context and accountability while aligning with the overall theory of change and results framework. This work will constitute the basis for developing biennial work plans.
**Work Plans**

The development of results-based work plans with detailed budgets follows a bottom-up approach to ensure that the work reflects the regional and national/sub-national contexts and interventions are designed to achieve the intended results. Countries will prepare and submit a joint biennium work plan engaging all implementing partners in a consultative process. Work plans will be jointly reviewed by regional advisors and the global coordination team to provide feedback to country teams. Countries will then submit final work plans.

Regional offices (UNFPA and UNICEF) will develop and submit a joint biennium work plan for review by the global coordination team. Global-level implementing partners will develop work plans on specific agreed-upon areas to be managed either by UNFPA Headquarters or UNICEF Headquarters. UNFPA Headquarters and UNICEF Headquarters will work together closely in terms of identifying and managing global-level partners. The global coordination team will compile all biennium work plans for review and final approval. Approved work plans will serve as a basis for resource allocation to all offices.

**Programme Monitoring**

Programmatic and financial performance will be closely monitored throughout the year at the country, regional and global levels. Field monitoring visits and review meetings will be organized at different levels as part of the monitoring mechanism. Annual consultations involving all country offices, regional offices and the global coordination team will be organized at the country level on a rotational basis to provide the opportunity to observe initiatives in the different countries and promote sharing of experiences.

Programme monitoring at the country level is a process of collecting information on the implementation and results of the programme at regular intervals in order to inform management decisions at all levels – on the ground with implementing partners, at the country level and globally – and document progress towards desired results. Global guidance on standard data sources/means of verification, as well as units of analysis, will be disseminated to country offices, and a quality-control process will be installed to ensure that data aggregation is meaningful across countries.

The programme monitoring function is a shared responsibility. While some UNFPA and UNICEF offices have planning and monitoring specialists, these staff often have responsibility for the entire country programme. Consequently, technical focal points charged with programme implementation will be responsible for aligning specific interventions within the approved country strategies with global indicators at the output level (but also higher levels), ensuring that appropriate data collection systems are in place and reporting data on an annual basis.

The Joint Programme core team in Headquarters and regional offices will provide tools and technical assistance to country office focal points to ensure high-quality planning for and implementation of programme monitoring such as:
• Work plan templates that allow country offices to align specific activities to specific indicators, baselines, and targets;
• Indicator definitions, numerators and denominators, recommended frequency, sample data sources, and sample questions for monitoring forms; and
• Data management systems using existing corporate reporting software and innovative monitoring technologies (that permit more dynamic learning and improvement cycles).

At the end of 2018, with the results of the evaluation, the Joint Programme will conduct a global mid-term review of the programme in preparation for the work plan for 2019. The review will take stock of implementation progress and review management processes to strengthen management effectiveness. The results and lessons learned from the Phase II evaluation (to be available by the time of the mid-term review) will serve as a basis to re-orient and/or fine-tune Phase III interventions.

**Operational Research**

Data collection will go beyond monitoring efforts to include the measurement of social norms. Research design can better measure the outcomes of specific interventions or packages of interventions within countries during a defined period of implementation. The specific interventions and research questions will be established during the first year of the programme in line with other research efforts led by UNFPA and UNICEF (including the Innocenti Office of Research), the Population and Development Branch, and the Population Council research programme Evidence to End FGM/C.

**Reporting**

Country offices and regional offices will submit joint results-oriented annual progress and financial reports (one per country and one per region) systematically summarizing all interventions and achievements in a given year. However, implementing partners – both government and (international) non-governmental organizations – at all levels are expected to submit quarterly progress and financial report as per the internal guidelines of UNFPA and UNICEF. The global coordination team will prepare a comprehensive consolidated annual progress report for the Joint Programme for wider public circulation. UNFPA, as the administrative agent, will prepare a certified financial statement on an annual basis for submission to the Steering Committee, donors and others as required. Financial records of implementing partners are subject to financial audit based on the internal rules and regulations and the accountability framework of UNFPA and UNICEF.

**Evaluation**

Programme monitoring conducted throughout the regular process of implementation by UNFPA and UNICEF will be complemented by an evaluation plan implemented independently by the
evaluation offices of UNFPA Headquarters and UNICEF Headquarters. The evaluation plan consist of:

- A forward-looking independent evaluation of Phase II. The objective of this evaluation is to improve the implementation of Phase III by learning lessons, measuring outcomes and assuring accountability for results. The evaluation work will start during the first half of 2018.
- A second evaluation is planned, the final outcome evaluation in 2022.

The management and governance of the evaluation mechanism will be separate from the Joint Programme core teams situated within the technical/programme divisions of the agencies. While the evaluation plan will draw from the data generated by the Joint Programme, it will generate independent information to both ensure high-quality delivery of the Joint Programme framework and bring an additional layer of external accountability (see annex III).

**Online Databases: Data-for-All Monitoring**

In Phase II, the Joint Programme introduced an online framework to systematize data capture from all the countries in line with the programme’s results-based framework. The system is housed within the global DevInfo initiative, the database system endorsed and widely used by the United Nations. DiMonitoring was the initial version of the framework, which has been functional since the end of 2016. As part of operationalizing the framework, more than 1,830 programme managers and experts from UNFPA, UNICEF, government and CSO partners were trained in using it. The Joint Programme has continued its efforts to further enhance the framework and introduced the second version – Data-for-All (DFA). DFA has additional features on data quality assurance and a dashboard to graphically present the information captured in the framework and, more importantly, financial information at the outcome and output levels.

**Knowledge Management and Dissemination**

The global knowledge hub as a knowledge management system will cut across the Joint Programme to take advantage of the collective lessons being generated by the countries in order to enhance programme quality and results achieved. The DFA is a central part of the global knowledge hub.

The knowledge management strategy will be facilitated through several regular processes:

- Annual global meetings of UNFPA and UNICEF regional and country offices to exchange learning on specific programme management issues and technical topics and to provide a forum for peer review of work plans and results;
- Thematic webinars to facilitate exchange of experiences and best practices across countries and regions; and
- Existing regional network meetings (on child protection, education, adolescent health, gender, human rights, planning/social policy, monitoring and evaluation, communication, communication for development, etc.) where FGM can be placed on the agenda.
The knowledge management strategy will center on building an inter-agency, multi-country community of practice, enabling staff in UNFPA and UNICEF to share technical knowledge with each other. The role of Headquarters and regional offices will be to facilitate knowledge exchange and pair knowledge seekers with knowledge holders. The knowledge hub will emphasize cross-country and cross-regional exchange. The knowledge management strategy will also utilize the latest technologies available to facilitate knowledge exchange and support programme management.

XI. Resource Requirement and Allocation

Resource requirements for Phase III are calculated taking into account the trend of contributions received from Joint Programme donors over the years and also noting the need to scale up efforts to realize the SDG target on FGM. Total budget for the four years of Phase III (2018 to 2021) is estimated at US$77,217,036 to cover overall costs at the Headquarters, regional office and country office levels. The budget appears realistic at the moment, but it is subject to revision as more resources are mobilized beyond the currently indicated levels to implement a more ambitious programme to accelerate efforts to end FGM.

In terms of thematic focus areas, community-level engagement and girls’ and women’s empowerment-related interventions will be allocated substantial portions of the resources (58 per cent), followed by policy and legal interventions (24 per cent), service provision (13 per cent) and knowledge generation and management (5 per cent). Outcome 2 (girls and women are empowered to exercise and express their rights by transforming social and gender norms in communities to eliminate FGM) will have the largest share of the resources due to the investment in behaviour change with education, capacity-building of girls, women and communities, amplifying change processes, and expanding social networks to galvanize a movement to abandon FGM. As has been the case over the years, significant proportions of the available resource (74 per cent) will be allocated to support national-level efforts. The tier approach introduced to inform programming in Phase III and the different quantitative indicators for analysing the national context will be used to decide resource allocation to countries. Details on resource requirements and allocation are presented in table 4 and figure 8.
Table 4: Estimated resource requirements and allocation for Phase III (2018-2021)

<table>
<thead>
<tr>
<th></th>
<th></th>
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<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Country level interventions</td>
<td>10,600,000</td>
<td>11,740,000</td>
<td>12,994,000</td>
<td>14,373,400</td>
<td>49,707,400</td>
</tr>
<tr>
<td>Regional level interventions</td>
<td>400,000</td>
<td>440,000</td>
<td>484,000</td>
<td>532,400</td>
<td>1,856,400</td>
</tr>
<tr>
<td>Global level interventions</td>
<td>1,100,000</td>
<td>1,700,000</td>
<td>1,700,000</td>
<td>1,300,000</td>
<td>5,800,000</td>
</tr>
<tr>
<td>Programme Management and Coordination:</td>
<td>3,200,000</td>
<td>3,200,000</td>
<td>3,200,000</td>
<td>3,200,000</td>
<td>13,000,000</td>
</tr>
<tr>
<td>Human Resources (UNFPA &amp; UNICEF)</td>
<td>600,000</td>
<td>400,000</td>
<td>1,000,000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Programme review and evaluation (HQ)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sub-total</td>
<td>3,800,000</td>
<td>3,600,000</td>
<td>3,200,000</td>
<td>3,200,000</td>
<td>14,800,000</td>
</tr>
<tr>
<td>Grand Total</td>
<td>15,970,000</td>
<td>17,150,000</td>
<td>18,448,000</td>
<td>19,875,800</td>
<td>71,443,800</td>
</tr>
<tr>
<td>Grand Total (with 7% Indirect cost)</td>
<td>17,087,900</td>
<td>18,350,500</td>
<td>19,739,360</td>
<td>21,267,106</td>
<td>76,444,866</td>
</tr>
<tr>
<td>Grand total (including 1%)</td>
<td>17,260,505</td>
<td>18,535,859</td>
<td>19,938,747</td>
<td>21,481,925</td>
<td>77,217,036</td>
</tr>
</tbody>
</table>

Figure 8: Resource allocation by outcome area (USD)

The UNJP places special emphasis on savings achieved during planning and implementation. The concept of savings is embedded through UN standard operating procedures (UN operations strategy1). UNFPA and UNICEF respect the policies and guidelines to respond to the Quadrennial Comprehensive Policy Review (QCPR). For example, UNFPA and UNICEF, Procurement policies and procedures are already including clauses of the cost economy, and both Regional Offices, HQ and Country Offices are complying with this. This is also one of the internal audit priorities of the organizations.

---

1 Business Operations Strategy: seek the ways to have more joint activities while maximizing efficiencies and benefits; ensure the efficiency, transparency, accountability and sustainability of the programs and projects in the country through an integrated delivery platform for common operations. Minimize duplication and transaction costs; Address gaps in the strategic planning, coordination of inter-agency activities. Reduce operating costs by leveraging economies of scale of operations and/or. Enhance the quality of services provided.
XII. Results Framework

The results framework is presented in two distinct tables:
1. Outcome and output indicators that will be reported annually.
2. Outcome indicators to measure social norms change, which will be measured at the beginning and end of Phase III of the Joint Programme (2018 and 2021).

<table>
<thead>
<tr>
<th>Vision</th>
<th>Contribute to the elimination of FGM by 2030</th>
</tr>
</thead>
<tbody>
<tr>
<td>Goal</td>
<td>Accelerate efforts towards the reduction of FGM, fulfilling the rights of girls and women by realizing social and gender norms transformation by 2021</td>
</tr>
<tr>
<td>Key indicators</td>
<td></td>
</tr>
<tr>
<td>• Prevalence of FGM in selected countries among:</td>
<td></td>
</tr>
<tr>
<td>• Girls aged 0 to 14 years old</td>
<td></td>
</tr>
<tr>
<td>• Girls aged 15 to 19 years old</td>
<td></td>
</tr>
<tr>
<td>• Percentage of girls and women aged 15 to 49 who have undergone FGM</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Outcome 1</th>
<th>Key Indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td>Countries have an enabling environment for the elimination of FGM practices at all levels and in line with human rights standards</td>
<td>a. Proportion of countries having in existence <strong>features of an enabling environment</strong> for FGM elimination:</td>
</tr>
<tr>
<td></td>
<td>• Enforced legislation criminalizing FGM: # arrests, # cases brought to court, # convictions and sanctions</td>
</tr>
<tr>
<td></td>
<td>• Evidence-based, costed national action plan to end FGM developed with all government sectors, CSOs, faith-based organizations, and other actors</td>
</tr>
<tr>
<td></td>
<td>• National budget line for FGM</td>
</tr>
<tr>
<td></td>
<td>• At least 50 per cent of the national government budget line for FGM is utilized</td>
</tr>
<tr>
<td></td>
<td>• Existence of a national FGM monitoring mechanism characterized by:</td>
</tr>
<tr>
<td></td>
<td>• National FGM administrative data</td>
</tr>
<tr>
<td></td>
<td>• National coordination body/committee for FGM</td>
</tr>
<tr>
<td></td>
<td>• Annual implementation review system</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Outputs</th>
<th>Key Indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1 Strengthened regional accountability mechanisms for ensuring increased national commitment to end FGM</td>
<td>a. Existence of African Union, League of Arab States and regional economic communities’ political decisions on FGM elimination in line with the SDGs</td>
</tr>
<tr>
<td>b. Number of <strong>peer review processes</strong> of relevant African Union, League of Arab States, ministerial-level specialized technical committees and regional economic communities’ technical specialized committees that incorporate an FGM elimination progress component</td>
<td></td>
</tr>
<tr>
<td>1.2 Increased national capacity for the development, enactment and implementation of FGM laws and policies</td>
<td>a. Proportion of countries using <strong>FGM tracking tool</strong> for monitoring the implementation of laws and policies</td>
</tr>
<tr>
<td>1.3 Increased engagement of civil society and young people with policymakers for the elimination of FGM</td>
<td>a. Number of annual <strong>progress reports</strong> with recommendations on FGM elimination <strong>produced by country and regional CSOs and young people’s networks</strong> and presented to policymakers to influence policy directions and implementation</td>
</tr>
<tr>
<td>b. Proportion of <strong>medical and paramedical associations declaring FGM performed by health professional an unethical practice</strong></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Outcome 2</th>
<th>Key Indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td>Girls and women are empowered to exercise and express their rights by transforming social and gender norms in communities to eliminate FGM</td>
<td>a. Number of <strong>communities making a public declaration</strong> or formal statement that they will abandon the practice of FGM</td>
</tr>
<tr>
<td>b. Number of <strong>people making a public declaration</strong> that they will abandon the practice of FGM</td>
<td></td>
</tr>
<tr>
<td>c. Proportion of communities that made a public declaration to abandon FGM that have established a <strong>community-level surveillance system</strong> to monitor compliance with commitments made during public declarations, including addressing the medicalization of FGM</td>
<td></td>
</tr>
<tr>
<td>Outputs</td>
<td>Key Indicators</td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>2.1 Improved community and interpersonal engagement to address and amplify social and gender norms transformation</td>
<td>a. Number of people who participate actively in education/sensitization/social mobilization sessions promoting the elimination of FGM</td>
</tr>
<tr>
<td></td>
<td>b. Number of listeners to radio/TV programmes on FGM in Joint Programme target areas</td>
</tr>
<tr>
<td></td>
<td>c. Social media activity by the population living in the Joint Programme areas</td>
</tr>
<tr>
<td>2.2 Strengthened girls’ and women’s assets and capabilities to exercise their rights</td>
<td>a. Proportion of communities implementing a capacity package for girls related to FGM elimination</td>
</tr>
<tr>
<td>2.3 Increased engagement of men and boys on changing social and gender norms</td>
<td>a. Proportion of countries where ‘Men Engage Alliances’ are actively advocating for the elimination of FGM</td>
</tr>
<tr>
<td>Outcome 3</td>
<td></td>
</tr>
<tr>
<td>Girls and women receive appropriate, quality and systemic services for FGM prevention, protection and care</td>
<td>a. Number of girls and women who have received health services related to FGM</td>
</tr>
<tr>
<td></td>
<td>b. Number of girls and women who have received social and legal services related to FGM</td>
</tr>
<tr>
<td></td>
<td>c. Proportion of countries where FGM is mainstreamed into the curricula of medical and paramedical schools</td>
</tr>
<tr>
<td>Outputs</td>
<td>Key Indicators</td>
</tr>
<tr>
<td>3.1 Improved availability and quality of FGM services in Joint Programme intervention areas</td>
<td>a. Proportion of health service delivery points in Joint Programme intervention areas:</td>
</tr>
<tr>
<td></td>
<td>- That provide FGM-related services to girls and women</td>
</tr>
<tr>
<td></td>
<td>- Where health care staff apply FGM case management protocols</td>
</tr>
<tr>
<td></td>
<td>- Where at least one health care staff member is trained on FGM prevention, protection and care services</td>
</tr>
<tr>
<td></td>
<td>b. Proportion of organizations (government/non-governmental organizations/private sector) in Joint Programme intervention areas that provide social and legal services to girls and women</td>
</tr>
<tr>
<td>3.2 Existence of a cadre of advocates amongst FGM service providers, including social workers, teachers, midwives, nurses and doctors</td>
<td>a. Number of doctors and midwives who sign up to become members and support the cause of the ‘Doctors and Midwives against FGM Initiatives’ in the six focus countries of the Joint Programme with high prevalence of medicalization of FGM</td>
</tr>
<tr>
<td>Outcome 4</td>
<td></td>
</tr>
<tr>
<td>Countries have better capacity to generate and use evidence and data for policymaking and improving programming</td>
<td>a. Proportion of countries using data and evidence to improve policies and programmes targeting FGM elimination</td>
</tr>
<tr>
<td>Outputs</td>
<td>Key Indicators</td>
</tr>
<tr>
<td>4.1 Increased generation of evidence for social norms change and programme improvement</td>
<td>a. Existence of a global-level framework and related data collection tools for the measurement of social norms change related to FGM</td>
</tr>
<tr>
<td>4.2 Enhanced knowledge management and exchange of good practices for policy and programme improvement</td>
<td>a. Existence of a functional FGM online knowledge hub</td>
</tr>
<tr>
<td></td>
<td>b. Number of virtual thematic discussions taking place through the FGM online knowledge hub.</td>
</tr>
<tr>
<td>Output 5</td>
<td></td>
</tr>
<tr>
<td>The Joint Programme is managed to achieve maximum, sustained economy, efficiency, effectiveness, and equity:</td>
<td>a. The extent to which the Joint Programme interventions include those areas “left behind” (vulnerable and marginalized) where FGM is prevalent (EQUITY)</td>
</tr>
<tr>
<td></td>
<td>b. Number of countries where there is joint planning, monitoring, review and reporting between UNFPA, UNICEF and other FGM stakeholders (EFFECTIVENESS)</td>
</tr>
</tbody>
</table>
c. Funds are timely disbursed from HQ to Regional / Country Offices and from all Offices to implementing partners (EFFICIENCY)

d. Budget implementation rate: proportion of funds out of the allocated budget spent by global, regional and country levels (EFFICIENCY).

e. Expenses by outcomes and outputs (EFFECTIVENESS).

Social and Gender Norms Transformation Measurement

<table>
<thead>
<tr>
<th>Outcome 2</th>
<th>Key Indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td>Girls and women are empowered to exercise and express their rights by</td>
<td>a. Percentage of girls and women demonstrating knowledge and capacity on FGM and gender issues to influence and protect the next generation from FGM</td>
</tr>
<tr>
<td>transforming social and gender norms in communities to eliminate FGM</td>
<td>b. Percentage of women (15 to 49 years old) who exercise agency in making decisions in the household jointly with male household members</td>
</tr>
<tr>
<td></td>
<td>c. Percentage of women (15 to 49 years old) who exercise agency in influencing decisions regarding keeping their daughters intact</td>
</tr>
<tr>
<td></td>
<td>d. Percentage of women (15 to 49 years old) who exercise agency in regularly attending or participating in women’s group/mentorship or leadership programmes</td>
</tr>
<tr>
<td></td>
<td>e. Percentage of people who believe that others cut their daughters</td>
</tr>
<tr>
<td></td>
<td>f. Percentage of people who think others will judge them negatively if they do not cut their daughters</td>
</tr>
<tr>
<td></td>
<td>g. Percentage of people who do not support the continuation of FGM</td>
</tr>
<tr>
<td></td>
<td>h. Percentage of individuals from the target population who believe that people in their community approve of FGM abandonment</td>
</tr>
<tr>
<td></td>
<td>i. Percentage of individuals who can identify benefits (rewards) associated with FGM abandonment</td>
</tr>
<tr>
<td></td>
<td>j. Percentage of young men and boys who express readiness to marry uncut girls</td>
</tr>
</tbody>
</table>

NOTE: Click here for the detailed results framework:
Annex I. Critical Assumptions, Risks and Mitigation

There are several critical and interrelated assumptions and risks that were considered in the design of Phase III of the Joint Programme. In terms of assumptions, the Joint Programme considered the following factors that support and/or affect programme impact and results:

1) **Poverty and inequality**: FGM is linked to low levels of economic development and poverty. Gender inequality and FGM in many respects perpetuate the cycle of poverty. Dealing with gender inequality starts with tackling the root causes of all forms of violence against women and girls (such as FGM). As long as these inequalities are not dealt with, the participation and empowerment of girls is not possible and the eradication of poverty remains a challenge, where half of society is harmed for the supposed benefit of the remainder. Societies do not benefit economically or socially in an unequal society in which FGM is practiced. The Joint Programme recognizes the need to address poverty and inequality more holistically in promoting the end of FGM and achieving sustainable development. In terms of gender inequality, this includes transforming gender roles and power relations and integrating FGM activities into programmes addressing poverty.

2) **Women’s economic empowerment**: Programmes that foster women’s economic empowerment are likely to contribute to progress, as they can provide incentives to change the patterns of traditional behaviour in which a woman is bound as a dependent member of the household or women are losing traditional access to economic gain and its associated power. Gainful employment empowers women in various spheres of their lives, influencing SRH choices, education and healthy behaviour, including regarding FGM. As a result, the Joint Programme will encourage partners to link programme activities with government-, civil society- and donor-supported interventions aimed at increasing women’s economic empowerment.

3) **FGM and girls’ education**: There are ample evaluations looking at the relationship between girls’ education (i.e., grade transition, retention, academic performance and completion rates) and the harmful practice of child marriage, while there is limited evidence on the links between FGM and girls’ education. There is, however, evidence that suggests there is a relationship between FGM and dropping out of school or reduced participation in school-related activities as a result of FGM. Previous studies point to a lower prevalence rate of FGM and greater support for abandoning FGM among highly educated women compared to those with lower levels of education. While the Joint Programme does not include direct interventions in girls’ education, the programme will continue to partner with organizations that support girls remaining in school and school-based community activities in support of the amplification of social norms change. Moreover, the Joint Programme will support girls’ clubs.

4) **Child-friendly and gender-responsive policies and laws**: Interventions will include developing and implementing laws that include strong anti-discrimination clauses reflecting international standards. Laws will establish effective child- and gender-
sensitive systems and procedures for reporting and investigating FGM cases that provide rapid response to reported cases, methodologies for interviewing survivors, procedures for recording and filing cases, legal advice to survivors, support services for survivors and evidence-gathering procedures. Clear guidelines and procedures that define the role and responsibilities of all the entities involved will be developed.

Support will also include ensuring comprehensive, child-friendly and gender-balanced integrated support services by trained professionals to assist those who have been cut, as well as developing specific child- and gender-sensitive guidelines and procedures that enable the police, prosecutors, judges and social workers to properly interview, assess, investigate and adjudicate FGM cases.\textsuperscript{xxxvi}

5) **Demographic perspectives on FGM:** Several demographic characteristics are common to countries where FGM is prevalent. Those countries have young populations, high fertility levels, and high child and maternal mortality rates. The Joint Programme recognizes that these characteristics define the complexity and consequences of the practice and make its elimination more challenging.\textsuperscript{xxxvii} As the population grows, the number of girls at risk of being cut increases. The Joint Programme is working with stakeholders to better understand the impact of demographic dynamics and developing responses to the growing number of girls at risk, including working with youth as an opportunity for promoting social change in future generations.

6) **Engaging community and religious leaders:** A wide range of actors play a critical role in the perpetuation and abandonment of FGM, including men, women (including grandmothers), and community and religious leaders. The Joint Programme sees the engagement of community and religious leaders as a multiplier effect that entails reaching girls beyond those directly targeted by the programme and creating an enabling environment.

7) **FGM as a social norm:** FGM is a social norm that involves social pressure to conform to what others do or have been doing, the need to be accepted socially and the fear of rejection by the community; these are strong motivations for perpetuating the practice.\textsuperscript{xxxviii} In some communities, FGM is almost universally performed and unquestioned. As a result, interventions to shift social norms target social groups rather than focus on individual behaviour change. The Joint Programme’s interventions are designed with the understanding that the abandonment of FGM on a significant scale must be systemic and that social norms change is slow and incremental.

There are multiple risks involved in the elimination of FGM that the Joint Programme intends to mitigate during programme implementation. The risks are related to the country context, programme development/delivery, partners, financial resources and reputation. Details on risks and mitigation are presented in table A.
<table>
<thead>
<tr>
<th>Risk</th>
<th>Probability</th>
<th>Impact</th>
<th>Mitigation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Country Risks (Political and Security)</td>
<td></td>
<td></td>
<td>The Joint Programme has strategically selected countries where some amount of momentum exists against FGM. Strong working relationships with the authorities and national ministries will be maintained to build a sense of common purpose and enhance national ownership of the process. The programme will also amplify civil society voices, including alliances and external funds, which tend to enhance government accountability.</td>
</tr>
<tr>
<td>Political will of Member States, including commitment to legal and legislative change and financial investments, is lacking, thereby hampering positive changes.</td>
<td>Low</td>
<td>Medium</td>
<td>Country programmes are designed to implement strategic plans, in consultation with national governments and in alignment with national priorities. Both UNFPA and UNICEF have longstanding relationships with the legislative and executive arms of Member States, which permits a high degree of continuity and sustainability of action through the most promising lead ministries in any given context. Country commitments enshrined in international declarations and conventions will also be utilized as the basis for sustaining action.</td>
</tr>
<tr>
<td>Changes in the political context in countries (such as changes in leadership) and shifts in national priorities affect continuation and sustainability of ongoing positive change processes.</td>
<td>Low/Medium</td>
<td>Medium</td>
<td>When strategic direction, performance management and delivery on results can no longer proceed as envisioned, agencies undertake a programme criticality exercise that scales back programming to the achievable minimum. To the extent possible, programme activities in unaffected regions will continue. Programme managers and leadership at the regional and Headquarters levels will closely monitor the situation and implementation rate so that decisions can be made swiftly. Technical support will be increased to help countries redefine their deliverables and re-programme funds as needed to still meet the objectives of the programme. Funds will be reallocated to other programme countries if needed in consultation with the Steering Committee.</td>
</tr>
<tr>
<td>Political unrest and security situations hamper or completely restrict implementation.</td>
<td>Medium</td>
<td>High</td>
<td>Country offices of both agencies prioritize disaster preparedness and temporarily shift to emergency response in affected regions – which tends to include girls and women at risk of or affected by FGM. As above, in consultation with the Steering Committee, to the extent possible, programme activities in unaffected regions will continue and FGM programme activities will be reactivated in affected regions as early as possible including during the reconstruction phase.</td>
</tr>
<tr>
<td>Humanitarian crises hamper or completely restrict implementation.</td>
<td>Medium</td>
<td>High</td>
<td>The option of working jointly with multiple donors (Norway, the European Union, Italy, the Netherlands, the United Kingdom, Finland, Germany, Iceland, Ireland, Luxembourg and Sweden) through the Joint Programme is already going a long way to mitigate this risk. In addition, Phase III will ensure programmatic resources are complementary and reach the areas of greatest need. At the country level, UNICEF and UNFPA are coordinating with governments to ensure that their strategy is aligned with national priorities, and supporting unification of civil society efforts, in order to avoid duplication.</td>
</tr>
<tr>
<td>Risk</td>
<td>Probability</td>
<td>Impact</td>
<td>Mitigation</td>
</tr>
<tr>
<td>----------------------------------------------------------------------</td>
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<td>-------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Inadequate coordination occurs between UNFPA and UNICEF.</td>
<td>Low</td>
<td>Medium</td>
<td>The UNFPA-UNICEF Joint Programme will work with a formalized structure that both facilitates and mandates various coordination systems including through the AA/CA function and the Steering Committee.</td>
</tr>
</tbody>
</table>

### Development/Delivery Risks

<table>
<thead>
<tr>
<th>Risk</th>
<th>Probability</th>
<th>Impact</th>
<th>Mitigation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Progress is not measurable in the current four-year timeframe.</td>
<td>Medium</td>
<td>Medium</td>
<td>The Joint Programme has developed a strong monitoring and evaluation framework in close cooperation with monitoring and evaluation experts of both agencies. Programme baselines and regular monitoring will be established to track progress. An evaluation in 2018, a management-led mid-term review, and a final evaluation will be carried out. In addition, the programme’s Outcome 4 will generate data and evidence that will stand alone, but also critically inform the final evaluation of the Joint Programme. Put together, these elements will be able to track the programme’s effectiveness at the outcome and output levels, which will provide useful benchmarks for assessing progress.</td>
</tr>
<tr>
<td>Programme outcomes or outputs are not completed.</td>
<td>Low/Medium</td>
<td>Medium</td>
<td>The entire structure of the Joint Programme, from the governance down to the implementation arrangements, are focused on delivering results, primarily through delivery against programme outcomes and outputs. Both UNFPA and UNICEF have a strong reputation in-country as United Nations agencies with high technical and management capacity, as well as transparency and accountability. Regular monitoring at all levels and dynamic adjustments in programme delivery will ensure completion of programme outputs.</td>
</tr>
<tr>
<td>The programme does not reach the most-at-risk/vulnerable girls and women.</td>
<td>Low/Medium</td>
<td>Low</td>
<td>In designing the Joint Programme, UNFPA uses population data to conduct age, gender and geographically disaggregated analysis to estimate prevalence and burden. UNICEF applies a MoRES approach (Monitoring Results for Equity System), which is an approach to equity-focused planning, programming and monitoring. This tool supports monitoring programmes and policies to ensure that an equity approach of reaching the most marginalized children is evidence-based and in support of the expected impact. At the core of both these approaches are: the identification and targeting of the most vulnerable, holding services providers accountable, and creating better access for the most disadvantaged communities, including girls and women at risk of or affected by FGM.</td>
</tr>
</tbody>
</table>

### Partner Risks

<table>
<thead>
<tr>
<th>Risk</th>
<th>Probability</th>
<th>Impact</th>
<th>Mitigation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inadequate capacity of government partners, civil society or UNFPA/UNICEF staff lowers effectiveness, efficiency, relevance, etc.</td>
<td>Low/Medium</td>
<td>Low/Medium</td>
<td>One of the key assumptions underlying the Joint Programme is the need for capacity building at the country level for a variety of stakeholders. Capacity tends to vary across countries and financial support dedicated to boosting capacity will be adjusted accordingly. Technical support across the programme (from Headquarters, from regional offices, between countries, from external technical partners) will also be allocated as per capacity and needs. Where needed, external consultants and partners will be brought on board to bridge the capacity gaps.</td>
</tr>
<tr>
<td>Risk</td>
<td>Probability</td>
<td>Impact</td>
<td>Mitigation</td>
</tr>
<tr>
<td>------------------------------</td>
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<td>------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Financial Risks</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The Joint Programme does not</td>
<td>Medium</td>
<td>Medium/High</td>
<td>The option of working jointly with other donors through the Joint Programme will go a long way to mitigate this risk. The Joint Programme intends to address the availability of resources through a resource mobilization strategy that includes funding requests for the duration of Phase III in addition to leveraging bilateral funding to expand the programme’s donor base by attracting support from foundations and corporations.</td>
</tr>
<tr>
<td>attract sufficient funding to</td>
<td></td>
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</tr>
<tr>
<td>deliver results at-scale due</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>to changes in partner priorities or other reasons.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Reputational Risks</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Risk of cultural sensitivity of the topic and risk of conservative backlash from within the communities.</td>
<td>Low</td>
<td>Low/Medium</td>
<td>It is crucial that the programme is not perceived as imparting a particular agenda or ideological framework, which is not in the best interests of the community. Hence, careful consideration will be given to how issues are conceptualized and framed in any given country and sub-national context with adherence to basic do-no-harm guidelines. Community leaders, parents and guardians will be involved from the start as per ethics protocols, as well as cultural considerations. UNFPA and UNICEF have strong backgrounds in community-level work, and through its FGM work has demonstrated that it is indeed possible to avoid any reputational risks to the agencies or development partners.</td>
</tr>
<tr>
<td>Fiduciary Risks</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Risk that funds are not used for the intended purposes, do not achieve value for money and/or are not properly accounted for.</td>
<td>Low</td>
<td>Medium/High</td>
<td>UNFPA and UNICEF are implementing the new Harmonized Approach to Cash Transfers (HACT), which the United Nations Development Group approved in January 2014. The new HACT approach strengthens the management of the risks of working with implementing partners and enables UNFPA and UNICEF to engage partners with a successful track record in delivering results and effectively managing resources. All implementing partners to which UNFPA/UNICEF transfer material amounts of funds undergo a pre-assessment of their financial and programme management internal controls (micro-assessment for those they intend to contract above US$100,000 and simplified financial assessments for those below this amount) before engagement. Under HACT, UNFPA/UNICEF carry out other assurance activities in the course of Joint Programme implementation, including results and financial management monitoring, implementing partner audits and capacity-development activities with a focus on improving implementing partners’ financial, accounting and results-based management internal controls. UNFPA and UNICEF policies on fraud and procurement are publicly available and strictly applied. Within the Joint Programme framework, the Steering Committee is the highest body for strategic guidance and fiduciary and management oversight and coordination. The administrative agent will be accountable for effective and impartial fiduciary management. Outside the direct Joint Programme framework is the United Nations Development Group Fiduciary Management Oversight Group, which will serve as the first point of contact in Headquarters for fiduciary matters. It oversees the implementation of the fiduciary aspects of the United Nations Development Group policies on joint funding mechanisms and discusses any required departures from the standard memorandum of understanding, letters of agreements and Steering Committee terms of reference.</td>
</tr>
</tbody>
</table>
Annex II. Identifying Population of Girls at Risk of FGM by 2030

The number of girls at risk of FGM aged 0 to 14 from 30 countries where FGM is prevalent by 2030 is estimated to be about 54 million from 2015 to 2030. These girls are the population at risk of FGM if no effort is made to eliminate the practice.

Methodology

The above estimate is derived in Table B using multiple sources of data, including the Demographic and Health Survey (DHS) and Multiple Indicator Cluster Survey (MICS), to obtain the probability of FGM among girls aged 0 to 14 for the selected countries and the most recent 2017 revision of population estimates from World Population Prospects: The 2017 revision. xxxix

Probability of FGM in ages 0 to 14 was taken from the DHS programme (i.e., the prevalence of FGM in this age group). For countries with no FGM prevalence before age 14, the probability of FGM among girls aged 15 to 19 was substituted for FGM for ages 0 to 14 (the source again being the DHS programme).

Girl birth estimates from 2015 to 2030 were computed from birth estimates and sex ratio at birth data from World Population Prospects: The 2017 revision. The formula used to compute girl birth estimates from 2015 to 2030 is:

\[ N_f = \frac{T_B}{(1 + S_R)} \]

Where \( N_f \) is the number of girls born from 2015 to 2030, \( T_B \) is the total number of births from 2015 to 2030, and \( S_R \) is the sex ratio at birth (male births per female birth) from 2015 to 2030. Countries with missing prevalence of FGM from among ages 0 to 14 have been replaced with values of the prevalence of girl aged 15 to 19.

The expected number of girls at risk of FGM aged 0 to 14 years by 2030 was computed by multiplying the current probability of FGM among girls aged 0 to 14 by the total number of female births from 2015 to 2030.
Table B: Expected number of girls at risk of FGM aged 0 to 14 by 2030

<table>
<thead>
<tr>
<th>Country</th>
<th>Girls aged 0-15 by 2030 (in 1000)</th>
<th>FGM prevalence aged 0-14*</th>
<th>Probability of FGM in aged 0-14**</th>
<th>Data source for the probability estimates</th>
<th>Expected number of girls at risk of FGM aged 0 to 15 years by 2030 (in 1000)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benin</td>
<td>3233</td>
<td>0.2</td>
<td>0.002</td>
<td>2014 MICS</td>
<td>6,586</td>
</tr>
<tr>
<td>Burkina Faso</td>
<td>5821</td>
<td>13.3</td>
<td>0.133</td>
<td>2010 DHS</td>
<td>787,433</td>
</tr>
<tr>
<td>Cameroon</td>
<td>6784</td>
<td>0.4</td>
<td>0.004</td>
<td>2004 DHS</td>
<td>27,136</td>
</tr>
<tr>
<td>Central African Republic</td>
<td>1318</td>
<td>0.8</td>
<td>0.008</td>
<td>2010 MICS</td>
<td>10,544</td>
</tr>
<tr>
<td>Chad</td>
<td>5,157</td>
<td>9.3</td>
<td>0.033</td>
<td>2014-15 DHS</td>
<td>510,543</td>
</tr>
<tr>
<td>Côte d’Ivoire</td>
<td>7,173</td>
<td>9.8</td>
<td>0.058</td>
<td>2012 DHS</td>
<td>703,542</td>
</tr>
<tr>
<td>Djibouti</td>
<td>156</td>
<td>48.5</td>
<td>0.485</td>
<td>2006 MICS</td>
<td>76,630</td>
</tr>
<tr>
<td>Egypt</td>
<td>17,457</td>
<td>14.1</td>
<td>0.141</td>
<td>2015 Health Issues Survey (DHS)</td>
<td>2,467,077</td>
</tr>
<tr>
<td>Eritrea</td>
<td>1214</td>
<td>33.2</td>
<td>0.332</td>
<td>2010 Population and Health Survey</td>
<td>403,048</td>
</tr>
<tr>
<td>Ethiopia</td>
<td>24,434</td>
<td>15.7</td>
<td>0.157</td>
<td>2016 DHS</td>
<td>3,836,536</td>
</tr>
<tr>
<td>Gambia</td>
<td>658</td>
<td>56.5</td>
<td>0.556</td>
<td>2013 DHS</td>
<td>366,480</td>
</tr>
<tr>
<td>Ghana</td>
<td>6618</td>
<td>0.5</td>
<td>0.005</td>
<td>2011 MICS</td>
<td>33,095</td>
</tr>
<tr>
<td>Guinea</td>
<td>3602</td>
<td>45.5</td>
<td>0.455</td>
<td>2012 DHS</td>
<td>1,638,910</td>
</tr>
<tr>
<td>Guinea-Bissau</td>
<td>514</td>
<td>23.6</td>
<td>0.236</td>
<td>2014 MICS</td>
<td>152,144</td>
</tr>
<tr>
<td>Indonesia</td>
<td>34,666</td>
<td>43.3</td>
<td>0.432</td>
<td>2013 RISKEDESAS</td>
<td>17,065,512</td>
</tr>
<tr>
<td>Iraq</td>
<td>38,800</td>
<td>4.9</td>
<td>0.049</td>
<td>2011 MICS</td>
<td>484,120</td>
</tr>
<tr>
<td>Kenya</td>
<td>120,612</td>
<td>2.8</td>
<td>0.028</td>
<td>2014 DHS</td>
<td>337,708</td>
</tr>
<tr>
<td>Liberia</td>
<td>1272</td>
<td>26.4</td>
<td>0.264</td>
<td>2013 DHS</td>
<td>335,808</td>
</tr>
<tr>
<td>Mali</td>
<td>6321</td>
<td>76</td>
<td>0.76</td>
<td>2012-13 DHS</td>
<td>4,803,360</td>
</tr>
<tr>
<td>Mauritania</td>
<td>1173</td>
<td>53</td>
<td>0.53</td>
<td>2011 MICS</td>
<td>62,130</td>
</tr>
<tr>
<td>Niger</td>
<td>9008</td>
<td>1.4</td>
<td>0.014</td>
<td>2012 DHS</td>
<td>125,112</td>
</tr>
<tr>
<td>Nigeria</td>
<td>124,630</td>
<td>16.3</td>
<td>0.168</td>
<td>2013 DHS</td>
<td>9,776,679</td>
</tr>
<tr>
<td>Senegal</td>
<td>43,541</td>
<td>13.6</td>
<td>0.136</td>
<td>2014 DHS</td>
<td>592,144</td>
</tr>
<tr>
<td>Sierra Leone</td>
<td>1333</td>
<td>74.3</td>
<td>0.743</td>
<td>2013 DHS</td>
<td>1,473,363</td>
</tr>
<tr>
<td>Somalia</td>
<td>5267</td>
<td>46</td>
<td>0.46</td>
<td>2006 MICS</td>
<td>2,422,820</td>
</tr>
<tr>
<td>Sudan</td>
<td>105,022</td>
<td>31.5</td>
<td>0.315</td>
<td>2014 MICS</td>
<td>3,308,130</td>
</tr>
<tr>
<td>Togo</td>
<td>23,963</td>
<td>0.3</td>
<td>0.003</td>
<td>2013-14 DHS</td>
<td>6,249</td>
</tr>
<tr>
<td>Uganda</td>
<td>14,762</td>
<td>1</td>
<td>0.01</td>
<td>2011 DHS</td>
<td>147,620</td>
</tr>
<tr>
<td>United Republic of Tanzania</td>
<td>17,909</td>
<td>0.4</td>
<td>0.040</td>
<td>2015 DHS</td>
<td>71,636</td>
</tr>
<tr>
<td>Yemen</td>
<td>6,457</td>
<td>15</td>
<td>0.15</td>
<td>2013 DHS</td>
<td>966,550</td>
</tr>
<tr>
<td>Total</td>
<td>290,328</td>
<td></td>
<td></td>
<td></td>
<td>53,628,272</td>
</tr>
</tbody>
</table>

Source: Projection based on national FGM prevalence and world population projection data per country (UNFPA Population and Development Branch, UNFPA 2017).

* Prevalence of FGM in ages 0 to 14 (Source: DHS, MICS).
** Probability of girls aged 15 to 19 was replaced for countries with no data for ages 0 to 14 (Source: DHS, MICS).

In addition to the challenge of a growing population of girls at risk, the average annual rate of change (AARC) must increase substantially in the majority of Joint Programme countries in order to achieve the target of eliminating FGM by 2030 as shown in the graphs produced by UNICEF below.

The acceleration needed to eliminate FGM by 2030 is calculated on the basis of annual rates of change observed over time in each country and the calculation of what multiple of the observed
rate of change would be needed. It is important to note that the annual rates of change observed over time do not take into consideration confidence intervals. Results are therefore to be interpreted with caution, as they may underestimate the levels of acceleration required to reach the target.

Some countries require minimal acceleration to achieve elimination by 2030

Many programme countries require substantial acceleration to achieve elimination by 2030

Notes: Elimination is defined as a prevalence less than 1 per cent. Uganda is excluded since levels of FGM/C are not well captured at the national level. See notes slide for details on trend analysis and projections.
Five countries with persistently high levels of FGM/C would need an AARC of at least 30% to achieve elimination by 2030

FGM/C prevalence among girls aged 15-19 years, at observed AARC and AARC required for elimination by 2030

Notes: Elimination is defined as a prevalence less than 1 per cent. Uganda is excluded since levels of FGM/C are not well captured at the national level. See notes slide for details on trend analysis and projections.
Table C: Comparison of prevalence rates of FGM among girls aged 10 to 14 and 15 to 19, estimated number of girls at risk of FGM by 2030, and distribution of age-at-cutting before 10 for selected Joint Programme countries

<table>
<thead>
<tr>
<th>Country</th>
<th>Proportion of girls who have undergone FGM</th>
<th>Expected number of girls at risk of FGM aged 0 to 14 by 2030 (x1,000)</th>
<th>Proportion of girls and women aged 15-49 who have undergone FGM with cutting occurred before age 10</th>
<th>Source for prevalence data</th>
<th>Source for age-at-cutting data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Burkina Faso</td>
<td>57.7 (15-19) 13.3 (10-14)</td>
<td>787 (x1,000)</td>
<td>89</td>
<td>2010 DHS</td>
<td>2010 DHS</td>
</tr>
<tr>
<td>Egypt</td>
<td>69.6 (15-19) 14.1* (10-14)</td>
<td>2,467 (x1,000)</td>
<td>36</td>
<td>2015 Health Issues Survey (DHS)</td>
<td>2014 DHS</td>
</tr>
<tr>
<td>Eritrea</td>
<td>68.8 (15-19) 33.2 (10-14)</td>
<td>403 (x1,000)</td>
<td>99</td>
<td>2010 Population and Health Survey</td>
<td>2002 DHS</td>
</tr>
<tr>
<td>Guinea</td>
<td>94.0 (15-19) 45.5 (10-14)</td>
<td>1,639 (x1,000)</td>
<td>66</td>
<td>2012 DHS</td>
<td>2012 DHS</td>
</tr>
<tr>
<td>Guinea-Bissau</td>
<td>41.9 (15-19) 29.6 (10-14)</td>
<td>152 (x1,000)</td>
<td>84</td>
<td>2014 MICS</td>
<td>2010 MICS</td>
</tr>
<tr>
<td>Kenya</td>
<td>11.4 (15-19) 2.8 (10-14)</td>
<td>338 (x1,000)</td>
<td>29</td>
<td>2014 DHS</td>
<td>2014 DHS</td>
</tr>
<tr>
<td>Mali</td>
<td>90.3 (15-19) 67.6 (10-14)</td>
<td>4,273 (x1,000)</td>
<td>93</td>
<td>2012-13 DHS</td>
<td>2012-13 DHS</td>
</tr>
<tr>
<td>Mauritania</td>
<td>65.9 (15-19) 54.8 (10-14)</td>
<td>643 (x1,000)</td>
<td>100</td>
<td>2011 MICS</td>
<td>2011 MICS</td>
</tr>
<tr>
<td>Nigeria</td>
<td>15.3 (15-19) 16.9 (10-14)</td>
<td>9,779 (x1,000)</td>
<td>88</td>
<td>2013 DHS</td>
<td>2013 DHS</td>
</tr>
<tr>
<td>Senegal</td>
<td>21.1 (15-19) 12.9 (10-14)</td>
<td>562 (x1,000)</td>
<td>89</td>
<td>2014 DHS</td>
<td>2014 DHS</td>
</tr>
<tr>
<td>Sudan</td>
<td>81.7 (15-19) 31.5 (10-14)</td>
<td>3,308 (x1,000)</td>
<td>-</td>
<td>2014 MICS</td>
<td>-</td>
</tr>
</tbody>
</table>

* Percentage of girls aged 1 to 14 who have undergone any form of FGM

In many of the 11 Joint Programme countries where data are available, substantially fewer girls aged 10 to 14 have undergone FGM compared to girls aged 15 to 19, despite a mean age of cutting reported to be before age 10. This discontinuity suggests a declining trend in the practice. This decline cannot be inferred in countries where a high proportion of cutting occurs after age 10, such as Kenya.
Figure A: Distribution of women who have undergone FGM with age-of-cutting data

Source: UNFPA 2017

Note: The size of the bubble refers to the estimated number of girls aged 0 to 15 at risk of FGM by 2030. For Egypt, the prevalence rate among the 0-14 age group is the proportion of girls 1 to 14 who have undergone any form of FGM.
Annex III. Evaluation Plan

Background

The evaluation plan guides evaluative work to be undertaken and jointly managed by the Evaluation Offices of UNICEF and UNFPA within the Joint Programme to generate evidence on the implementation of the programme. This evaluation plan covers programme implementation from January 2018 until December 2021. It is important to note that the evaluation plan and corresponding budget cover only the joint independent evaluative exercises conducted by the UNICEF and UNFPA Evaluation Offices. Any evaluation activities undertaken at the country/regional level or by programme partners will be planned and budgeted separately and are not covered by this document. Country offices are encouraged to undertake joint evaluation activities at the country level for learning and accountability.

The Evaluation Offices of UNFPA and UNICEF will conduct a formative evaluation of Phase II of the programme with a goal to support with evaluative evidence the programming in Phase III. The final evaluation report will be available in the second half of 2018. The terms of reference are being prepared through a scoping study and will be finalized by September or October 2017. The Joint Programme will adapt its Phase III interventions once the results of the Phase II evaluation are available and analysed.

The Evaluation Offices of UNFPA and UNICEF will also undertake and manage a final evaluation of the programme in 2020 to be available in mid-2021 for the development of a potential Phase IV. Evaluation management will follow a participatory approach and will entail close collaboration with concerned programme colleagues and development partners to engage them in key decision-making moments of the evaluation process.

The Joint Programme is a complex programme receiving financial contributions from multiple development partners. Evaluative work will serve the objectives of accountability and learning. The independent Evaluation Offices will work with the programme managers to ensure that funding for the evaluation will be included in the programme budget so as to meet the costs set out in the evaluation plan. Any specific requirements by development partners in terms of evaluation focus and questions will be negotiated and included at a very early stage of the evaluation process.

The evaluation plan does not cover evaluative work conducted by the Joint Programme at the Headquarters, regional or country levels, nor does it include evaluations by programme partners. As such, it is important that evaluation work falling outside this evaluation plan be addressed as part of an integrated monitoring, evaluation and research plan that generates and makes available evidence to inform (i) real-time decision-making and (ii) the outcome evaluation. This will ensure that data from other monitoring and evaluation components such as performance monitoring, research and process evaluation at the regional and country levels can be used as needed.
**Evaluation of the Programme**

Objectives of the evaluation are:

- To assess the relevance, efficiency, effectiveness and potential for sustainability of the results achieved in programme countries to inform management decision-making on the Joint Programme.
- To assist UNICEF and UNFPA in meeting their accountability objectives by assessing whether both agencies have effectively used their complementarity and the most efficient coordination and management/operational arrangements to achieve results and ensure broader replication and up-scaling of the programme.
- Facilitate learning, capture good practices and generate knowledge from programme implementation in different contexts.

The evaluations will be conducted in 2018 and 2020-2021 to validate the achievement of programme outputs and progress towards outcomes of Phase II and Phase III. It is important to note that measuring attribution in a joint programme working at this scale is very difficult. This evaluation will therefore focus on whether and how the intended results were achieved.

The evaluation will provide feedback on programme implementation and performance. It will assess the achievement of outputs and progress towards outcomes (if possible), as per programme objectives, in line with the evaluation criteria of relevance, efficiency, effectiveness, coordination, coherence, coverage, partnerships and potential for sustainability. It will also identify the key factors responsible for the achievement (or lack thereof) of programme objectives. The evaluation will look at whether programme results are likely to continue after the programme ends (including environmental and financial sustainability). The evaluation will also assess programme implementation and management arrangements in place.

The principles of equity, human rights, gender equality and cultural contextualization are essential to programming aiming to advance the elimination of FGM. As such, these principles will be integrated in the evaluation design, scope, approach, methods and analysis. The evaluation will build on the 2018 management-led mid-term review of the programme and fill any gaps needed to highlight programmatic and technical lessons learned for the benefit of UNICEF, UNFPA and the broader development community. The results of the evaluation will feed into management decision-making regarding the programme and future interventions in the area of FGM, including a fourth phase of the FGM programme.

The evaluation will include a preparatory phase to start in late 2020 to develop the terms of reference, which will lay out the scope, approach, specific evaluation questions, methodology and management arrangements for undertaking the evaluation. The draft terms of reference will be jointly developed by the UNICEF and UNFPA Evaluation Offices and shared with the reference group for comments. Evaluation results will also be presented to the Executive Boards of UNFPA and UNICEF.
Governance and Management of the Evaluation

Due to the joint nature of the programme, the governance structure of the evaluation activities will be joint. The following governance and management arrangements are proposed:

The evaluation of the programme will be conducted jointly and managed by the UNICEF and UNFPA Evaluation Offices.

A joint Evaluation Management Group will be the main decision-making body for the outcome evaluation and have overall responsibility for managing the evaluation process, including hiring and managing the team of external consultants. The Evaluation Management Group also will act as liaison for the evaluation with programme units within UNICEF and UNFPA. The Evaluation Management Group will manage the entire evaluation process, from the selection of the evaluation team to dissemination and follow-up to the final report. While both the UNICEF and UNFPA Evaluation Offices will share in management decision-making, UNFPA will act as the coordinator. All milestones decisions will be made jointly by the Evaluation Management Group.

The joint Evaluation Management Group is responsible for ensuring the quality and independence of the evaluation and to guarantee its alignment with United Nations Evaluation Group Norms and Standards and Ethical Guidelines.

The management of the evaluation will follow a participatory approach in close collaboration with concerned programme colleagues and development partners in order to engage them in key decision-making moments of the evaluation process.

The Evaluation Management Group will set up an Evaluation Reference Group and Country Reference Groups and ensure close coordination with the Joint Programme Steering Committee.

Key roles and responsibilities of the Evaluation Management Group include:

• To prepare the terms of reference for the programme evaluation in coordination with the Evaluation Reference Group;
• To lead the selection and hiring of the team of external consultants with inputs from the Evaluation Reference Group to conduct the evaluation of the programme;
• To supervise and guide the evaluation team in each step of the evaluation process;
• To review, provide substantive comments and approve the inception report, including the work plan, analytical framework, methodology, and selection of countries for in-depth case studies for the programme evaluation;
• To review and provide substantive feedback on the country reports and the draft and final evaluation of the programme reports;
• To quality assure the entire evaluation processes for both exercises;
• To approve the final report for the programme evaluation in coordination with the Evaluation Reference Group;
• To liaise with the Evaluation Reference Group and convene and chair the Evaluation Reference Group review meetings with the evaluation team;
• To identify and ensure the participation of relevant stakeholders in coordination with the Evaluation Reference Group throughout the evaluation process; and
• To contribute to learning, knowledge sharing, the dissemination of the evaluation findings and follow-up on the joint management response.

The UNFPA Evaluation Office will act as chair of the joint Evaluation Management Group. The UNFPA Evaluation Office will act as the main interlocutor for the evaluation team, represented by the team leader, and (with the support of the joint Evaluation Management Group) will facilitate interactions with other agencies’ counterparts to ensure a smooth implementation process.

The UNFPA Evaluation Office will chair and provide the secretariat function for the Evaluation Management Group, and will thus lead the management of independent evaluative work.

Key roles and responsibilities of the chair of the Evaluation Management Group include:
• Leading the call for proposals, selection, and recruitment of the evaluation teams for all evaluative work utilizing UNFPA establishment procedures;
• Managing the contract with the selected firm;
• Acting as the main contact for the evaluation team;
• Providing guidance to the teams in close coordination with the members of the Evaluation Management Group throughout all phases of execution of the exercises and formally approving all deliverables;
• Ensuring quality control for all deliverables in close coordination with the members of the Evaluation Management Group and in consultation with the Evaluation Reference Group;
• Sharing approved deliverables with the Evaluation Reference Group, Global Programme Support Unit, Global Programme Steering Committee, key stakeholders, and those who may benefit from the evaluation;
• Collecting Evaluation Management Group and Evaluation Reference Group members’ comments on the deliverables; and
• Assessing the overall performance of the evaluation teams for the mandate, in close consultation with the members of the Evaluation Management Group.

The joint Evaluation Management Group will be comprised of representatives from the UNFPA and UNICEF Evaluation Offices.

A joint Programme Unit Committee comprised of UNICEF and UNFPA programme managers will be part of the Evaluation Reference Group and facilitate access to information, data, stakeholders, and UNICEF and UNFPA staff at all levels.

The Evaluation Reference Group will support the evaluability assessment and programme evaluation at key moments of the evaluation process. Members will provide substantive technical inputs, will facilitate access to documents and informants, and will ensure the high technical quality of the evaluation products. The main responsibilities of the reference group are to:
• Provide inputs to the draft terms of reference for the programme evaluation;
• Contribute to the preparation and scoping of the exercises during the inception phase, including the selection of case studies;
• Provide feedback and comments to evaluation reports;
• Act as the interface between the evaluators and UNICEF/UNFPA services, notably to facilitate access to informants and documentation;
• Assist in identifying external stakeholders to be consulted during the evaluation process;
• Participate in review meetings with the evaluation team as required; and
• Play a key role in learning and knowledge sharing from the evaluation results, contributing to disseminating the results of the evaluation.

The Evaluation Reference Group will be engaged from the preparatory stage of the evaluation (including the development of the terms of reference) to the dissemination phase. The Evaluation Reference Group will be comprised of representatives from programme staff of UNFPA and UNICEF, key experts in the field of FGM (including CSOs), and development partners. The role of the reference group is advisory. It should be noted that, in order to safeguard the independence of the evaluation, the independent Evaluation Offices of UNICEF and UNFPA will be responsible for the management of the exercise and approval of all evaluation products. Country Reference Groups shall be established in countries where field visits will take place; the options for arranging these groups should be discussed and agreed upon with UNFPA and UNICEF staff in the country offices who will, in turn, consult with national partners. It is important that broad participation is sought, including the participation of civil society and non-governmental organizations at the forefront of advancing the eradication of child marriage.

The evaluation will ensure a regular flow of information and may consult on specific issues as needed with the Joint Programme Steering Committee.
Annex IV. Bibliography

Coffey International Development, *Value For Money Assessment of UNFPA-UNICEF Joint Programme on Female Genital Mutilation/Cutting*, ITAD, United Kingdom, 2017.


Mackie, Gerry, et al., *What Are Social Norms? How are they measured?* UNICEF and the University of California, San Diego, Center on Global Justice, 2015.


UNFPA, *Demographic Perspectives on Female Genital Mutilation*, UNFPA, New York, 2015.


i. Female genital mutilation (FGM) comprises “all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons” (World Health Organization [WHO] 2008).


iv. The data provided is only for Phase I of the Joint Programme, as Phase I did not track access to services.

v. UNICEF 2016

vi. The expectation is that each participating country in the Joint Programme will contextualize the global theory of change, adapting domains and pathways according to drivers, determinants and trends in addition to FGM status and prevalence rates.

vii. WHO 2008

viii. UNFPA 2014

ix. Modrek and Liu 2013


xi. UNICEF global databases, 2016, based on demographic and health surveys, multiple indicator cluster surveys and other nationally representative surveys from 2004 to 2015

xii. UNICEF global databases, 2016

xiii. UNICEF global databases, 2016

xiv. UNICEF global databases, 2016

xv. UNICEF 2017 analysis of global databases

xvi. UNFPA 2015

xvii. The least-developed countries are classified by the United Nations based on their low gross national income, weak human assets and high degree of economic vulnerability.

xviii. United Nations Department of Economic and Social Affairs, Population Division 2013

xix. UNFPA 2014

xx. These data are only from Phase II implementation of the Joint Programme.

xxi. The Joint Programme distinguishes between emerging, promising and best practices. Emerging practices are interventions that are new, innovative and hold promise based on some level of evidence of effectiveness or change that is not research-based and/or sufficient to be deemed a ‘promising’ or ‘best’ practice. Promising practices are when there is sufficient evidence to claim that the practice is proven effective at achieving a specific aim or outcome, consistent with the goals and objectives of the activity or programme; a best practice is an intervention, method or technique that has consistently been proven effective through the most rigorous scientific research (especially conducted by independent researchers) and has been replicated across several cases or examples.


xxiii. Feldman-Jacobs 2013; Spindler 2015

xxiv. For security reasons, Yemen has not been implementing interventions related to community-level social norms change.

xxv. Operations research (Population Council 2005) and an evaluation (UNICEF 2007) found that about 70 per cent of community members will comply.


xxix. ICRW 2016; Berg and Denison 2013; Shell-Duncan et al. 2016

xxx. WHO and World Bank 2011


xxii. UNFPA 2015

xxiii. Modrek and Liu 2013

xxiv. ICRW 2016

xxv. UNICEF and UNFPA 2013

xxvi. UNICEF 2010; UNFPA 2014

xxvii. UNFPA 2015

xxviii. UNICEF 2015

xxix. United Nations Department of Economic and Social Affairs, Population Division 2017