

Joint Evaluation of the UNFPA-UNICEF Joint Programme on the Elimination of Female Genital Mutilation: Accelerating Change Phase III (2018-2021)

Adapting programming to different humanitarian situations

[COVID-19](#)[Evidence](#)[Clusters](#)[Adaptation](#)

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The purpose of the joint evaluation is to assess the programme contributions to outputs and outcomes during Phase III of the Joint Programme on the Abandonment of Female Genital Mutilation (2018-2021). The evaluation aims to inform the design of the Joint Programme post-Phase III in the framework of the 2030 Agenda for Sustainable Development.



Challenge

Historical lack of focus on FGM in humanitarian settings



Observation

COVID-19 presents an excellent example of what the Joint Programme can do, both in terms of collecting and analysing information on the effect of a crisis (in this case, the global pandemic) on prevalence rates and on how programmes can flexibly adapt to rapidly changing – and deteriorating – circumstances



Action

There is the opportunity to review and reflect on evidence gathered on the impact of COVID-19 and develop a Joint Programme roadmap to extend this more broadly to humanitarian crises

COVID-19 adaptations highlight the ability of the Joint Programme to flexibly modify programming modalities when necessary.

A key challenge for the Joint Programme is the historical lack of focus on FGM in humanitarian settings for (a) understanding the impact of humanitarian crises on FGM prevalence rates, and (b) how to best programme against this data. Since the COVID-19 pandemic started in 2020, the Joint Programme has collated and analysed a number of impacts of COVID-19 specifically on FGM, going far beyond what has been previously understood. This can provide an important example to the programme of what can be done to enhance understanding, and adjust rapidly to changing humanitarian situations.

This Thematic Note pulls together findings on FGM and humanitarian crises from an evaluation of the third phase of the UNFPA/UNICEF Joint Programme on the Abandonment of Female Genital Mutilation: Accelerating Change. The note responds to an evaluation question: *'to what extent has the Joint Programme responded to and adapted programming to respond to challenges resulting from humanitarian crisis including during the COVID-19 pandemic?'*

There are three headline findings which this note is structured around:

1. Evidence of impact of humanitarian crises (including COVID-19) on FGM prevalence rates
2. Ability of FGM programming to adapt to humanitarian crises (including COVID-19)
3. Commitment of the humanitarian GBV sphere to the inclusion of FGM in analysis and programming.

About the UNFPA/UNICEF Joint Programme on FGM

The Joint Programme on the Abandonment of Female Genital Mutilation: Accelerating Change (referred to here as 'the Joint Programme') is currently being implemented in 17 countries, and links community-level transformation of social norms that often drive FGM with laws banning the practice and access to quality sexual and reproductive health and child protection services for girls and women at risk of and affected by FGM. It is global in nature and began in 2008.

This thematic note is an output of an evaluation of the third phase (2018-2021) of the Joint Programme.

The problem

While there is a wide evidence-base of how Gender-Based Violence in general is exacerbated and flourishes within humanitarian contexts, there is only limited evidence of how the practice of FGM is specially impacted. **The lack of robust data about the implications of humanitarian crises on FGM hinders the ability of the Joint Programme or the humanitarian spheres within UNICEF and UNFPA to respond and adapt programming to changing humanitarian contexts.**

To 'set the scene' of the information base for linkages between FGM and humanitarian settings, or the lack thereof, we refer to a (2014) 28 Too Many briefing report. It took an important step and, drawing upon logical assumptions, asserted plausible links between FGM and humanitarian crises:

- **Population displacement.** The most effective advocates for ending FGM, women and men within practicing communities, are "few in number and difficult to track" due to population displacement in humanitarian settings. This evaluation notes, however, there is no evidence of how or whether this perpetuates or exacerbates FGM in reality
- **Mutual reinforcement of FGM and other harmful practices.** There is evidence of child marriage increasing in some emergencies, based on a number of complex and interwoven factors. Therefore, it is possible that where both child marriage exists and increases significantly and FGM is highly prevalent, the two will be mutually reinforcing. This evaluation found no other specific evidence to support or refute this
- **Lack of healthcare and psychosocial services** and related consequences exacerbated and heightened instances of other forms of GBV. This evaluation found wider material to support the assumption that a clear and evidenced consequence of emergency situations (particularly the issue of limited comprehensive emergency obstetric care) is a grave danger to women and girls who have undergone FGM. However, this risk factor is not itself a cause of increasing FGM
- **FGM becoming a secondary concern** for the international community. However, this evaluation does not fully support the assumption. It is clear that where FGM is prevalent it remains an ongoing concern for both the Health Cluster (under WHO), the associated reproductive health working group under UNFPA, and the GBV sub-cluster under UNFPA within emergency situations. Where emergency response displaces longer-term development work, such as social norm changes, there may be an impact on FGM prevalence
- **Disruption to the education of girls.** This evaluation agrees that this is a clear and evidenced consequence of humanitarian situations and therefore logically does have a resulting impact on FGM, given the existing evidence of how education links to both FGM outcomes for a girl now and FGM outcomes for her future daughters.

Findings

1. Evidence of impact of humanitarian crises (including COVID-19) on FGM prevalence rates

Finding: The Joint Programme attempted to rapidly understand COVID-19 effects and offer guidance in this regard and the recent compilation of evidence at the global level highlights a continued attempt through 2020 to analyse the impact of COVID-19 on FGM prevalence rates, despite the lack of quantitative data. This in fact serves to highlight the lack of robust analysis on FGM prevalence rates being impacted by other humanitarian crises, where there are often major assumptions made at country level as FGM is subsumed under general GBV changes or linked to child marriage. The COVID-19 response can be considered good practice for the future of FGM and humanitarian response.

Early in the COVID-19 pandemic, both UNICEF and UNFPA – separately, rather than as part of the Joint Programme – produced technical notes/briefs on the perceived, or potential, impact of COVID-19 on FGM prevalence rates.

The UNICEF technical note recommended increased investment in research and evidence for impact of COVID-19 on FGM and effective activities to address or counter negative effects,¹ and highlighted that:

COVID-19 has upended the lives of children and families across the globe and is impacting efforts to end child marriage and female genital mutilation (FGM). Actions taken to contain the spread of the pandemic – such as school closures and movement restrictions – are disrupting children’s routines and their support systems.²

The UNFPA technical brief highlighted that:

Based on previous experience in responding to humanitarian crises including outbreaks, the COVID-19 pandemic will compound existing gender inequalities and increase the risk of gender-based violence (GBV). The protection and promotion of the rights of girls and women should be prioritized. UNFPA and UNICEF are committed to preventing, mitigating and responding to GBV in emergencies (GBV Guidelines)... Where movement is restricted and people are confined, priority should be given to ensuring access to prevention, protection and care services, including psychosocial support, and adapting community-based surveillance systems for girls and women at risk of and affected by female genital mutilation, especially in hard-to-reach areas. Female genital mutilation risk mitigation and response should be integrated in GBV and child protection COVID-19 preparedness and response plans.³

The 2020 Joint Programme Highlights Report provides some excellent examples of analysis at different levels of impact of COVID-19 on FGM rates from different countries (Table 1), with common factors being the removal of protective aspects of girls’ lives (being in school, access to media, access to livelihood opportunities), and the reduction in household wealth (with FGM usually linked to lower wealth demographics).

TABLE 1: Compiled country analysis of impact of COVID-19 on FGM prevalence rates⁴

| Country | Rapid analysis/data sources |
|----------------------|---|
| Burkina Faso | The Burkina Faso Child Protection Sub-Cluster reported an increase of FGM, as access to health, sexual and reproductive health and protection services continue to decrease. A Save the Children spotlight series found pressure to marry in Burkina Faso may also support the continued practice of FGM where it is considered to improve a girls’ perceived marriageability. |
| Ethiopia | The Gender and Adolescence: Global Evidence (GAGE) programme found an expansion of FGM in Ethiopia following the government’s focus on responding to COVID-19, creating “fertile ground” for harmful practices, especially FGM. Adolescents reported local administrators were aware that girls were undergoing FGM but did nothing to stop it, and religious and local leaders even support the practice. Adolescent girls reported FGM is being performed as a precursor to marriage. According to a United Nations Office for the Coordination of Humanitarian Affairs (OCHA) report from Ethiopia, school closures and ongoing conflicts have resulted in child marriage, FGM, and sexual violence becoming more common, and families increasingly resorting to negative coping strategies. |
| Guinea-Bissau | A UNDP COVID-19 socio-economic analysis for Guinea-Bissau states that physical distancing measures and lockdowns preclude successful community empowerment programmes to reduce FGM and many potentially averted cases will occur during the pandemic. |

1 UNICEF. 2020. Technical Note On Covid-19 And Harmful Practices. <https://www.unicef.org/media/67506/file/TechnicalNote-COVID-19-and-HarmfulPractices-April%202020.pdf>.

2 Ibid.

3 UNFPA. 2020. Covid-19 Disrupting SDG 5.3: Eliminating Female Genital Mutilation. https://www.unfpa.org/sites/default/files/resource-pdf/COVID-19_Disrupting_SDG.3_Eliminating_Female_Genital_Mutilation.pdf.

4 All information from the Joint Programme 2002 Highlights Report. 2021.

| | |
|-------------------|--|
| Kenya | An assessment of the gendered effects of COVID-19 on households conducted by UN Women, UNFPA, and other partners found that gender based violence (GBV) and harmful practices, including FGM, increased in Kenya due to school closures, movement restrictions, and limited knowledge about where to seek help. An Amref assessment found that 63 per cent of respondents believe there was a decrease in FGM prior to COVID-19 in Kajiado, Samburu and Marsabit counties, 55 per cent of respondents believe the pandemic led to an increase in the practice, with 50 per cent of respondents claiming it was due to school closures. |
| Mauritania | According to a study completed by UNFPA and UN Human Rights in Mauritania (yet to be published), 44.9 per cent of those surveyed believe there is an increase in FGM. Respondents linked the increase with growing unemployment and poverty in households. |
| Somalia | A UNFPA assessment found almost twice as many Somali women, compared to men, believe there is a rise in GBV, and 31 per cent of those surveyed reported an increase in FGM during the pandemic, with 39 per cent of respondents attributing the increase to school closures. OCHA also found an increase in FGM in Somalia due to food insecurity and school closures, with families adopting negative coping closures, movement restrictions, and limited knowledge about where to seek help. |

The Joint Programme should be credited with conducting rapid analysis of the impact on COVID-19 on FGM prevalence rates. This is more than has previously been collected on FGM in humanitarian situations.

It is worth noting that while the studies above highlight increases in FGM due to the public health responses by governments, some of the explanations given may not hold up with further scrutiny. For example, FGM is indeed associated with lower wealth demographics, but as a cultural issue it is not necessarily a harmful practice that higher wealth demographics adopt when their circumstances deteriorate.

Evaluation data was more nuanced, with some country-level Joint Programme respondents across the countries reporting anecdotal increases and some actually reporting anecdotal decreases (with several contradictory reports within the same countries).

One potential challenge with regard to the collected data is that increases were not disaggregated into different types of FGM or different ages of cutting. For example, cutting in infancy compared to cutting in pre-pubescent girls: school closures would not necessarily impact on cutting in infancy practices. Also, available data was not disaggregated into where there are direct linkages to marriageability and high child marriage rates, and where there are not.

Further, there was also limited information which did not necessarily fit into the overall narrative that in some circumstances FGM would decrease due to the pandemic, particularly where the practice was linked to large ceremonial celebrations when large gatherings were banned. In **Guinea**, respondents reported that data collection on the COVID-19 impact was led by a ministry, but it was to monitor GBV rather than FGM specifically. It was concluded that FGM had not increased for the same reasons it did not increase during Ebola.⁵ In **Sudan**, some respondents reported that FGM is a cultural norm practiced by the community whether there is a crisis or not, and therefore do not foresee an increase.⁶

In some instances, the anecdotal evidence with regard to FGM increases has been collapsed within broader evidence of GBV and/or child marriage increases due to the global pandemic. While some respondents across countries reported the potential for FGM increases based on girls being out of school and the link with increased FGM in school holidays in normal times, others clearly conflated FGM and child marriage and/or broader GBV. For example, in **Sudan**, some respondents suggested that child marriage data might be proxy data for FGM increases.⁷ **Nigeria** respondents highlighted the fact that the Government of Nigeria declared a state of emergency for COVID-19 during 2020 and it is a “well-known fact” that a state of emergency increases GBV generally, such as rape and assault, and this includes FGM.⁸

5 Guinea key informants.

6 Sudan key informants.

7 Ibid.

8 Nigeria key informants.

In **Ethiopia**, respondents reported concern around school closures and the impact on child marriage, and subsequently how this then links to an increase of FGM, but without specific explanations of the linkages between the two.⁹

Linkages between child marriage and FGM is obvious and intuitive when cutting occurs in pre-pubescent/soon-to-be-married girls at which point the more concrete data on increases in child marriage related to school closures and economic impacts of the pandemic might be applied to FGM. However, in contexts where cutting happens in infancy the linkage is not straightforward. A key challenge is the lack of disaggregation of anecdotal evidence across different characteristics of FGM, including types, form of ceremony, and (importantly) age of cutting.

Global respondents highlighted that there is divergent opinion about the value of collecting statistical data about the impact of COVID-19 on numbers of girls that have gone through FGM (with regard to the cost-benefit of the investment of resources considering the utility of the data). Overall, it is generally assumed that confidence in broad and relatively consistent anecdotal information is sufficient to allocate resources as necessary.¹⁰ However, the challenge emerges when: 1) only part of the narrative is utilised – so for example, the evidence in decreases of FGM is ignored, and 2) when the ‘anecdotal information’ with regard to FGM is in fact a mixture of information relating to FGM, child marriage, and broader GBV issues.

The COVID-19 pandemic has provided a lens through which connections between FGM and broader humanitarian crises can be understood. It has highlighted the global gap in evidence on how different types of emergencies (conflict, natural disaster, slow onset, rapid onset, protracted etc) affect FGM rates (of different characterisations – type, form of ceremony, age of cutting). It has also demonstrated how data on FGM is generally assumed to fit under broader evidence on GBV. Addressing these insights is an opportunity for the Joint Programme in the future.

2. Ability of FGM programming to adapt to humanitarian crises (including COVID-19)

Finding: There is significant evidence that the Joint Programme has adapted to the COVID-19 pandemic in innovative and thoughtful ways both at the global level in terms of prompt provision of guidance and at the country level with adaptive strategies, some of which will be useful for continuation post-pandemic (such as new digital and media strategies). This provides a useful example of the potential for rapid and flexible adaptation of the Joint Programme to other humanitarian crises which has been less visible to date.

At the global level the Joint Programme was quick to provide guidance for the COVID-19 pandemic in March 2020. Technical guidance was swiftly developed and provided to Joint Programme countries, supported by a series of webinars. The initial expectation was that the COVID-19 pandemic would impact the Joint Programme in ways similar to how previous Ebola outbreaks had impacted programming in affected countries. As the COVID-19 pandemic evolved, the Joint Programme recognised the emerging differences.¹¹

Regional respondents highlighted the promptness with which global guidance was produced and also reported that the guidance was provided to countries with devolved authority to make bold, contextually appropriate choices with regard to adapting the FGM Joint Programme at country level, based on the global guidance and local level understanding of impact on programming.¹² This “*allowed programmes to innovate*”¹³ in a manner that was highly beneficial: a view supported by survey respondents, both internally with the Joint Programme and externally across Joint Programme partners.

9 Ethiopia key informants.

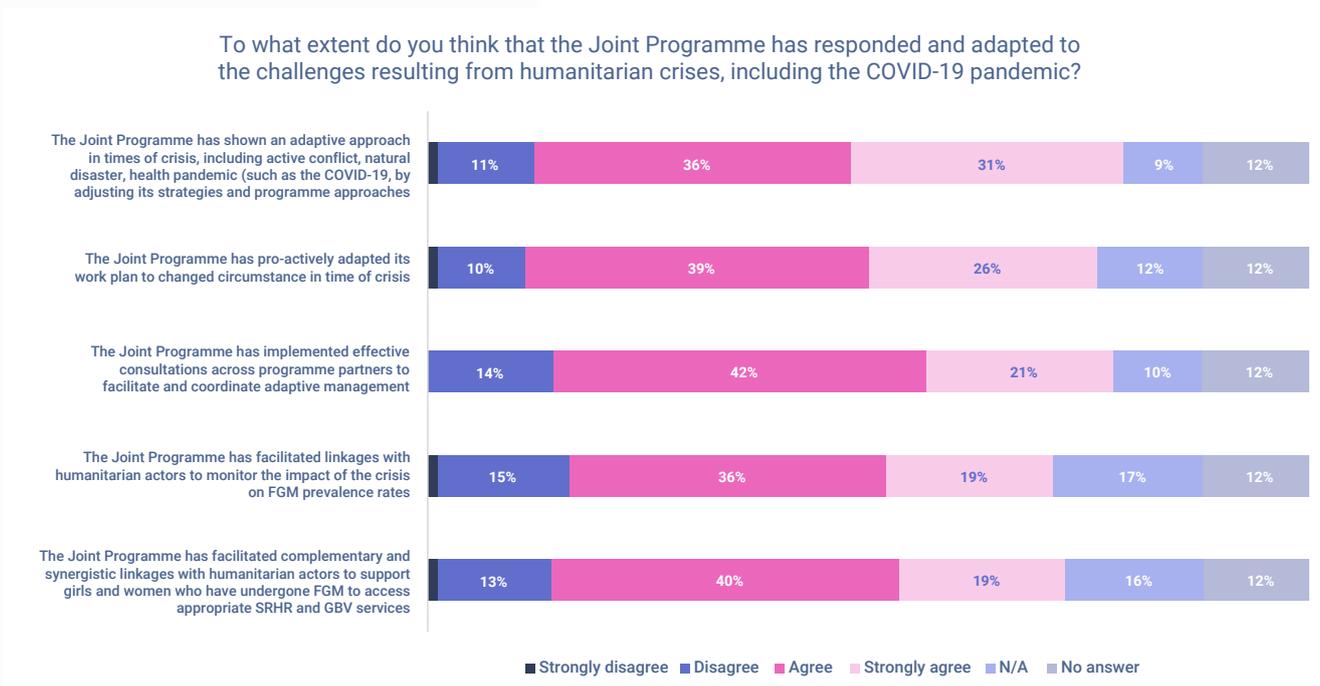
10 Global key informants.

11 Global Joint Programme key informants.

12 Regional Joint Programme key informants.

13 Regional Joint Programme key informant.

FIGURE 1: Joint Programme implementing partner survey respondents, regarding Joint Programme adaptation to COVID-19



The evaluation highlighted how the use of digital platforms – such as Twitter, Facebook, Instagram, and YouTube – has significantly increased during COVID-19, which ‘forced’ more innovative remote social norm change programming (further described in Technical Note 1). There are now plentiful examples at country level of innovative adaptation to programming for COVID-19 both in terms of social norm change and for other aspects of the programme. In most countries, for example, Joint Programme programming modified budget lines to include the distribution of preventative measure kits (masks, handwashing gel etc) for staff, implementing partners, and communities.¹⁴

Further, most Joint Programme countries studied by this evaluation significantly increased digital communication activities. In **Mali** for example, evaluation respondents highlighted increased mass communication activities, both online and through utilising radio, brochures, and posters. In **Guinea**, the Joint Programme adjusted and adapted its working methods and intervention strategies by favouring telework and the use of the media, community radios and digital tools (online applications and platforms) to provide children, adolescents and their families with information on the COVID-19 pandemic (barrier gestures) and the consequences of FGM and child marriage practices.¹⁵ In **Ethiopia**, the Joint Programme supported community radios and FM radios, transmitting both FGM and COVID-19 messaging through those channels.¹⁶

In **Sudan**, respondents reported that while community dialogues were affected, community facilitators created WhatsApp groups. Also, there was an increased use of the Saleema campaign website, which provided space for discussion and debate and information among all the users. In 2020 this was utilised to increase interactions between youth and the website.¹⁷ Indeed, in Sudan the Joint Programme partners with Al Amag Media Centre and the Development Studies and Research Institute (DSRI) within the University of Khartoum, both of which have experience utilising media and digital platforms for social messaging. For COVID-19, DSRI worked with their internal experts on media and youth to create content for online digital forums for FGM, child marriage, and COVID-19 messaging. This included video clips of experts providing information, and artists popular with youth in Sudan. A Facebook page was also established.¹⁸

¹⁴ Global level respondents highlighted that this was better compared to other programmes, for example, there was less flexibility under the Spotlight Initiative with budget reallocation.

¹⁵ Guinea key informants.

¹⁶ Ethiopia key informants.

¹⁷ Sudan key informants.

¹⁸ Ibid.

Regional experience

UNFPA ESARO, as part of the Regional Working Group on GBV, organised a donor roundtable to discuss the impact of the COVID-19 on women and girls in East and Southern Africa, including discussion on harmful practices such as FGM and Child Marriage.

The UNFPA, UN Women and UNICEF Regional Offices developed a joint Op-Ed piece that highlighted the risks of the COVID-19 pandemic vis à vis jeopardising progress made towards protecting women and girls from violence and harmful practices (child marriage and female genital mutilation) in the region. A call to action was also included for all the governments in the region to invest in adolescents programming during the pandemic. The Joint Op Ed was placed in various media houses in the region on the Day of the African Child, 16 June 2020.

Source: <https://esaro.unfpa.org/en/news/covid-19-jeopardises-progress-made-towards-protecting-women-and-girls-violence-and-harmful>

Adaptation of more traditional engagement methods was undertaken where it was still possible to engage face-to-face. This depended on country context and time period, based around national or localised lockdown rules. In **Mali**, gatherings were conducted with reduced numbers of people in outside spaces while maintaining social distance.¹⁹ In **Guinea**, traditional community gatherings have continued with reduced numbers, distribution of hygiene kits (masks and gel, hand washing kits, thermometers), and social distancing. Sensitisation on COVID-19 preventive measures has been integrated into the start of each session.²⁰

In **Kenya**, Joint Programme staff reported that while the programme had to scale down, it was able to restructure some activities to comply with the WHO and the Ministry of Health guidelines on COVID-19 preventive measures. This included reducing the number of participants in every forum and community dialogues (which increased implementation costs, as more sessions were needed), and strengthening community surveillance mechanisms thanks to Child Protection volunteers in the communities (who helped to provide reliable data on FGM during the pandemic).²¹

In **Nigeria**, the National Orientation Agency (NOA), a Joint Programme partner for community sensitisation, led on innovative ways to ensure community sensitisation for COVID-19 and were able to integrate continued FGM messaging.²² In **Ethiopia**, community conversations were reduced from 60-70 people, to a maximum of 10 people, but managed to continue.²³ In all cases, (digital or face-to-face) topics of discussion included COVID-19 as well as FGM.²⁴

While Joint Programme programming was well-adapted, there is limited evidence of programming adaptations being formalised at the national level. One example where this did happen is in **Nigeria**, where respondents reported that the national technical committee on FGM held an emergency meeting to ensure that experiences from programming in 2020 were reflected in new policy. This included issues such as social workers being recognised as essential workers, and the establishment of helplines.²⁵

Overall, COVID-19 adaptations clearly illustrate the ability of the Joint Programme to flexibly modify programming modalities when necessary. This was enabled by prompt guidance from HQ and follow-up support from HQ and regional offices, but especially on a clear message of devolving authority from HQ to country programmes to take adaptive measures relevant and necessary to the context. This is even highlighted in the UNFPA technical note on COVID-19 and FGM: *The brief in no way suggests a "one size fits all" approach. Prevention and containment measures (e.g. gathering restrictions and quarantine) are contextual and may shift over time.*²⁶

19 Mali key informants and Mali Joint Programme Annual Report 2020.

20 Guinea key informants.

21 Kenya key informants.

22 Nigeria key informants.

23 Ethiopia key informants.

24 Information from Mali, Guinea, Kenya, Sudan.

25 Nigeria key informants.

26 UNFPA. COVID-19 Disrupting SDG 5.3. Eliminating Female Genital Mutilation. Technical Note. April 2020.

https://www.unfpa.org/sites/default/files/resource-pdf/COVID-19_Disrupting_SDG.3_Eliminating_Female_Genital_Mutilation.pdf

COVID-19 adaptations have also highlighted the potential agility of the programme, given the same conditions of global guidance and devolved authority to countries, for other humanitarian crises.

COVID-19 had prompted us to think about how to include the humanitarian response. We ask the country offices what have you changed since COVID-19? ²⁷

One thing I would put forward is the extent to which this programme could be more agile. COVID-19 has challenged all programmes we are working around in terms of agility, ability to respond and adjust quickly to what nobody has expected. To what extent can we have that agility built into programmes? ²⁸

3. Commitment of the humanitarian GBV sphere to the inclusion of FGM in analysis and programming

Finding: On paper there is a low level of reference to FGM in global, regional and country GBV and child protection preparedness plans but these rarely extend beyond basic references to either (a) FGM as a form of harmful practice (without any further details pertaining to humanitarian contexts) or (b) the needs of FGM survivors should be taken into account. Linkages to humanitarian actors are weak for both access to services for FGM survivors in humanitarian situations, understanding the impact of crises on FGM, and identifying windows of opportunity to accelerate social norm change.

This evaluation firstly notes that UNFPA and UNICEF are both humanitarian actors, and the lead actors under Inter-Agency Standing Committee (IASC) for GBV and child protection sub-clusters respectively. All humanitarian actors look to the appointed Cluster Lead Agency for sector humanitarian guidance and policy under the IASC model (see box). FGM is considered under GBV rather than child protection, so UNFPA is the lead actor for this sector and all aspects of coordination and programming fall under the responsibility of UNFPA at both global and country levels.

UNFPA as lead agency for GBV in humanitarian settings

Since 2016, UNFPA has been sole lead agency for the GBV Area of Responsibility (AoR) which sits under the Global Protection Cluster (GPC). UNHCR has been the cluster lead agency for the GPC since 2005 and over time the internal structure (more complex than other clusters) has also evolved to its current form of four distinct Areas of Responsibility (AoRs) of Child Protection, GBV, Housing, Land and Property, and Mine Action. The GPC is unique in its sub-structure architecture. The 2005 IASC Cluster establishment originally mandated that AoRs were integral components of the GPC but that the four AoRs as created had a clear “*history of UN and institutional mandates that pre-date the cluster system*”.²⁹ The lack of coherence within the GPC has been raised multiple times by multiple actors.³⁰

The GBV AoR has experienced some internal challenges arising from sharing of leadership roles between UNICEF and UNFPA. However, the GBV AoR has been boosted by the 2013 Call to Action for GBV in emergencies and the specific focus, particularly by donors, that this *Call to Action* (led first by the UK and Sweden, and now by the US) affords the issue. Furthermore, the updated *GBV Mainstreaming Guidelines* released in 2015, backed up by a well-designed and well-funded dissemination strategy, have also served to increase focus and attention to GBV in general and therefore, *de facto*, to the GBV AoR.

27 Regional office key informant.

28 Ethiopia key informant.

29 <https://reliefweb.int/sites/reliefweb.int/files/resources/protection-funding-study-final-report-1.pdf>

30 https://www.globalprotectioncluster.org/_assets/files/news_and_publications/gpc-evaluation-final-report_itad-october-2017.en.pdf

The GBV AoR (www.gbvaor.net) includes a number of tools and resources and maintains a team of Regional Emergency GBV Advisors ('REGA') who are rapidly deployable senior technical experts used to strengthen country level humanitarian responses. A core toolbox for the GBV AoR includes the 2010 *Handbook for Coordinating Gender-based Violence in Humanitarian Settings*, *GBV Standard Operating Procedures*, information on the GBV information management system (GBVIMS), and the 2015 IASC *GBV Mainstreaming Guidelines*. The GBV AoR has a 2015-2020 capacity building strategy which outlines how the GBV AoR “works to promote a comprehensive and coordinated approach to GBV at the field level” through four key areas of work: (1) supporting field operations; (2) building knowledge and capacity; (3) setting norms and standards; and (4) advocating for increased action, research and accountability at global and local levels.

A sampling of global- and country-level preparedness and response documentation highlights limited reference to FGM, with no substantive reference to:

- impact of crises on FGM prevalence rates
- preparedness activities to reduce potential impact on FGM prevalence rates, or
- guidance for FGM programming within humanitarian responses.

TABLE 2: Sampling of global and country level humanitarian GBV documentation³¹

| Document | FGM reference |
|---|---|
| Global level | |
| GBV AoR Helpdesk: GBV case management and the COVID-19 pandemic. 2020. | None |
| WHO: COVID-19 and violence against women. What the health sector/system can do. 2020. | None |
| IASC. Interim Guidance: Gender alert for COVID-19 outbreak. March 2020. | None |
| GBV AoR. Handbook for coordinating gender-based violence interventions in emergencies. 2019. | Reference under “types of violence” table for both FGM specifically and referenced under harmful traditional practice. No other reference |
| GBV AoR. Core Function #5: Building national capacity in preparedness and contingency planning. | None |
| (IRC). GBV emergency preparedness and response: Facilitator’s guide. | None |
| Country Level | |
| Ethiopia | |
| Executive summary of the rapid assessment to Filtu woreda. August 2020. | None |
| UNICEF, UNOCHA, WFP. Joint assessment: Afar IDP situation. April 2020. | None |
| UNICEF. Ethiopia: El Nino driven drought child protection rapid assessment (CPRA). 2015. | None |
| Nigeria | |
| Adamawa State: COVID-10 Gender Based Violence Response Teams, 2020. | None |
| Adamawa State GBV Response Teams, Women’s Committees, no date. | None |
| Gender Based Violence Sub-Sector – Nigeria: Situational update. August 2019. | None |
| Borno State: COVID-10 Gender Based Violence Response Teams, 2020. | None |

³¹ FGM is addressed more under GBV than under Child Protection. For global Child Protection guidance, there is only reference to FGM in terms of a description of what it is as a harmful practice in the Child Protection Minimum Standards (2019) edition and the Child Protection Coordination Handbook. No further reference beyond highlighting harmful practices include female genital mutilation/cutting.

| | |
|--|---|
| Adamawa State GBV Response Teams, Women's Committees, no date. | None |
| Gender-Based Violence Sub Sector: Addressing critical needs of dignity and menstrual hygiene through the Nigeria Humanitarian Fund (HNF). June 2019. | None |
| GBV Sub-Sector. Dignity Kits Guidance Note – Nigeria. March 2019. | None |
| GBV Sub-Sector. Guidance Note: GBV service provision in the context of COVID-19. 2020. | None |
| Sudan | |
| Sudan: Conflict – Flash Update #9. West Darfur. February 2021. | None |
| Sudan. Situation Report. March 2021. | None |
| UNFPA Sudan. Response to the Ethiopia Refugees. Situation Report #6. March 2021. | None |
| Yemen | |
| UNFPA Inter-Agency Standard Operating Procedures (SOPs) for prevention and response to protect women and girls in Yemen. | Reference in acronyms and under “types of violence” table for both FGM specifically and referenced under harmful traditional practice. No other reference |
| UNFPA GBV Briefing. Protection of women and girls from gender-based violence in Yemen. 2019. | None |

As can be seen from the sample selection of documentation, there is extremely limited reference to FGM and no substantive reference to appropriate responses to FGM (meaning an overview of how humanitarian crises may impact on FGM; and what humanitarian preparedness and response for FGM programming looks like).

This is true at both global and country levels. While at country levels it is true that areas with high FGM prevalence rates do not necessarily overlap with areas of humanitarian crises, this is not always the case. For example, in Nigeria, the GBV sub-sector concentrates on the conflict in the north-east while the Joint Programme focuses on five states in the south. In Mali, the GBV sub-cluster focuses on the conflict in the north of the country while high FGM prevalence rates are historically found further south.³² In Ethiopia, the current Tigray crisis is occurring in an area with generally low FGM prevalence rates. However, in Sudan, conflict and civil unrest certainly overlap with areas of high FGM prevalence rates and this is true in multiple Joint Programme countries.

Even for the UNFPA-led Minimum Standards for the Prevention and Response to Gender-Based Violence in Emergencies (2015), FGM is only referenced in the acronym list and then as a potential indicator of social norm change (“percentage women/men who have committed to not let their daughters undergo female genital mutilation”). There is nothing more in the standards with regard to planning, programming, implementation, or monitoring of FGM.³³ Therefore there are limited linkages between the Joint Programme and the lead GBV agency coordinating all GBV response in humanitarian agency with regard to FGM.

32 UNFPA respondents in Mali reported that UNFPA has, in partnership with the National Directorate on Population, conducted a study to understand the increase in FGM prevalence in the Tombouctou region (50 per cent, 2018 DHS), which used to be a region with low prevalence (like Gao and Kidal where FGM is around 1 per cent). The population movements are considered to be the cause of this increase. However, this area is not a part of the Joint Programme.

33 UNFPA. Minimum Standards for Prevention and Response to GBV in Emergencies (GBViE). 2015. https://www.unfpa.org/sites/default/files/pub-pdf/GBViE.Minimum.Standards.Publication.FINAL_ENG_.pdf

Humanitarian contexts and linkages with cross-border FGM

In addition to general humanitarian settings and the possible impact of crises on FGM prevalence rates, there is also a potentially strong link between humanitarian settings and cross-border FGM. Humanitarian crises tend to fuel displacement – both within and across countries – and this means FGM-practicing communities being displaced into non-FGM practicing communities, and vice versa. It further means that messaging for FGM and FGM services is potentially not being provided in the necessary language for displaced FGM practicing communities, thus raising significant risk to the wellbeing and health of displaced women and girls.

In Sudan, evaluation respondents raised the issue of northern states on the border with Egypt and the fact that neither the Sudan nor Egypt Joint Programme focus in on those states but there is displacement across those borders and this impacts on FGM practices. Ethiopia and Sudan both did discuss, independently, the FGM impact on the Tigray displacement of the current Ethiopia context, although Tigray is not a particularly prevalent community for FGM. However, there then becomes the question of how FGM practices may be negatively affected among displaced Tigray people, given that currently there are more than 60,000 Tigray refugees in Sudan in areas with higher prevalence rates and the desire to 'fit in' and ensure girls in particular 'fit in' with host communities is strong, particularly among refugees who lack hope of returning home in the foreseeable future.

Source: <https://www.bbc.co.uk/news/av/world-africa-56374725>

In evaluation interviews, country-level respondents highlighted that, in practice, sexual and reproductive health and rights (SRHR) and maternal healthcare services consider high prevalence rates of FGM in the design of service delivery, although there was no evidence provided as to how this is implemented. Specifically for COVID-19, the UNFPA technical brief provides guidance on conducting rapid assessments of the impact of the pandemic on FGM (as can be seen in the Box below).

While in more general GBV humanitarian programming there is a modest increase in (still relatively nascent) focus on identifying windows of opportunity to accelerate social norm change. This does not explicitly extend to FGM, and there is no evidence available to highlight how social norms programming on GBV relates to FGM in particular, other than through addressing the foundational gender inequalities which operate as the unifying underlying driver of GBV, child marriage, and FGM.

Moving beyond the GBV or Child Protection Sub-Clusters, UNCHR, as the Protection Cluster lead agency has a GBV strategy. This only references FGM once, and only as a type of harmful practice.³⁴ WHO leads the Health Cluster, and global health cluster guidance documents have no reference to FGM.³⁵

Guidance on conducting rapid assessments of the impact of COVID-19

Rapid assessment of the impact of COVID-19 on female genital mutilation. Conduct a rapid assessment using remote surveys, phone calls or third party monitoring to understand the impact of COVID-19 on girls and women at risk of or affected by female genital mutilation. In conducting assessments, care must be taken to directly involve girls and women to ensure their voices are heard. The assessment should identify challenges and gaps in current female genital mutilation policies and programmes, as well as opportunities for prevention of the harmful practice.

Priorities in developing preparedness and response plans for COVID-19. Target government and NGOs responding to COVID-19 at the national and local level. This will ensure integration of GBV and female genital mutilation risk mitigation and response are priority issues in COVID-19 plans at all levels. Integrate GBV (GBV Guidelines and GBV Pocket Guide) and female genital mutilation risk mitigation across all humanitarian clusters including health, WASH, education, protection, and food security. Given that in most contexts the Ministry of Health is leading the COVID-19 response, support the Ministry of Gender/Families/Child Protection in playing an active role in ensuring the integration of GBV and female genital mutilation in all COVID-19 preparedness and response plans.

Source: UNFPA, 2020, *Covid-19 Disrupting SDG 5.3: Eliminating Female Genital Mutilation*.
https://www.unfpa.org/sites/default/files/resource-pdf/COVID-19_Disrupting_SDG.3_Eliminating_Female_Genital_Mutilation.pdf

34 UNHCR. UNHCR policy on the prevention of, risk mitigation, and response to gender-based violence. 2020.
<https://www.unhcr.org/5fa018914/unhcr-policy-prevention-risk-mitigation-response-gender-based-violence>.

35 Specifically, Health Cluster Guide: A practical handbook. 2020. (Global Health Cluster and WHO) and Health Cluster Coordination Guidance for Heads of WHO Country Offices as Cluster Lead Agency 2019 (Global Health Cluster and WHO).

The fact that rapid assessments of FGM are not conducted as a matter of course for general humanitarian situations is important and highlights both a substantial gap in humanitarian GBV preparedness planning and the challenge of now including FGM in preparedness planning specifically for COVID-19. There was no available evidence at country level to conclude that the recommendation in the UNFPA technical brief as outlined above has been implemented.

While UNFPA and UNICEF are both the lead UN agency actors for GBV and child protection in emergencies, respectively, respondents highlight that at global, regional, and country levels development and humanitarian staff work in different spheres and there is a lack of linkages between the two.³⁶ This is contrary to the concept of working across the humanitarian-development nexus, which is the fundamental aspect of the new way of working (NWOW) under the Agenda for Humanity:

Humanitarian Development Nexus and The New Way of Working. The volume, cost and length of humanitarian assistance over the past 10 years has grown dramatically, mainly due to the protracted nature of crises and scarce development action in many contexts where vulnerability is the highest. For example, inter-agency humanitarian appeals now last an average of seven years, and the size of appeals has increased nearly 400 per cent in the last decade. This trend has given new urgency to the long-standing discussion around better connectivity between humanitarian and development efforts. At the same time, the adoption of the 2030 Agenda and the Sustainable Development Goals (SDGs) set out not just to meet needs, but to reduce risk, vulnerability and overall levels of need, providing a reference frame for humanitarian and development actors to contribute to the common vision of supporting the furthest behind first and a future in which no one is left behind. Strengthening the humanitarian-development nexus was identified by the majority of stakeholders as a top priority at the World Humanitarian Summit (WHS), including donors, NGOs, crisis-affected States and others, and it received more commitments at the WHS than any other area. The New Way of Working (NWOW) as outlined in the Secretary-General's Report for the WHS and the Agenda for Humanity represents an approach to put this into practice.³⁷

At regional level, respondents acknowledged the need to focus on systems strengthening and “bridging the humanitarian development divide”³⁸ – essentially, working across the nexus – and highlighted that this is work that necessarily starts at the national level. This would include how well the relevant line ministry responsible for humanitarian/emergency preparedness and response links with the line ministries responsible for gender, children and health. It cascades into how well humanitarian and development actors link up with each other. However, there is no specific evidence that this has happened for FGM within preparedness and response planning in any substantive manner. This presents another clear opportunity for the Joint Programme to expand and ensure genuine nexus approaches.

36 Global and regional key informants.

37 <https://www.unocha.org/es/themes/humanitarian-development-nexus>

38 Regional key informant.

Conclusions and future considerations

Conclusion: COVID-19 adaptations clearly highlight the ability of the Joint Programme to flexibly modify programming modalities when necessary. This is based both in prompt guidance from HQ and follow-up support from HQ and regional offices, but also on a clear message of devolving authority from HQ to country programmes to take adaptive measures relevant and necessary to the context.

While some assumptions have been made with regard to anecdotal evidence of COVID-19 impacts on FGM, including both collapsing FGM impacts into child marriage and broader GBV impacts, in simplifying the narrative and not necessarily reviewing the whole nuanced continuum of suggested impacts across both increasing and potentially decreasing effects; and not disaggregating assumed impacts across different FGM practices, including type, ceremonial context, and age of cutting. However, the efforts of the Joint Programme with regard to COVID-19 and FGM have far exceeded the generalised context of understanding, or lack thereof, of FGM within general humanitarian settings.

With regard to non-Joint Programme humanitarian action, there is limited mention of FGM in global, regional and country GBV and child protection preparedness plans and references rarely relate to anything substantive with regard to guidance for (a) understanding impact on prevalence rates and (b) programming. While all social norm change programming in humanitarian settings under GBV (trying to identify and utilise windows of opportunity) can be understood as addressing the unifying underlying driver of gender inequality which links GBV and all harmful practices, there is no evidence of humanitarian programming aimed specifically at FGM social norms.

Considerations for the future:

There are implications for both the Joint Programme and for UNFPA and UNICEF as humanitarian actors.

- 1. Understanding of impact of crises on FGM:** there is the opportunity to review and reflect on evidence gathered on impact of COVID-19 on SDG Target 5.3 and develop a Joint Programme roadmap to extend that more broadly to humanitarian crises. Potential areas to include in the roadmap are:
 - Humanitarian-specific considerations
 - The opportunities presented with working across the humanitarian-development nexus to integrate FGM considerations into building resilience, in relation to more gender equal societies across preparedness and response programming.
- 2. FGM Programming:** there is the opportunity to review and map the COVID-19 adaptations to FGM programming and to see:
 - Which might be useable for other humanitarian crises
 - Which are useful as ongoing strategies (instead of or as well as more traditional approaches) longer-term – such as digital strategies, linked to stronger youth engagement work.

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