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THE GIRL GENERATION

Support to the Africa-Led Movement
to End Female Genital Mutilation



ENDLINE EVALUATION IN
ETHIOPIA, KENYA AND SENEGAL

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About TGG-ALM Programme

The Girl Generation: Support to the Africa-led Movement (TGG-ALM) to end Female Genital Mutilation (FGM) is a programme aimed at significantly reducing the practice of FGM in Ethiopia, Kenya, Senegal and Somaliland by 2026. The programme was implemented by a consortium of partners led by Options Consultancy, and including Amref Health Africa, ActionAid, Orchid Project and Africa Coordination Centre for Abandonment of FGM (ACCAF), and the University of Portsmouth. The consortium implemented multilevel interventions to accelerate positive shifts in social attitudes towards ending FGM, fostering a vision where girls and women have agency and are free from violence. The programme was funded by UK International Development from the UK government; however, the views expressed do not necessarily reflect the UK government's official policies.

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Conflicts of interest statement

The African Population and Health Research Center (APHRC) was commissioned by Options Consultancy and the Population Council to conduct this evaluation. While the evaluation was collaborative rather than fully independent - given the involvement of Options and the Population Council in discussions on the evaluation approach, review of tools, and feedback on findings and conclusions - the research team confirms that no conflicts of interest existed. To ensure the credibility and integrity of the findings, APHRC applied rigorous internal protocols, ensuring that the study design, data collection, analysis, and conclusions were developed independently and without undue influence from the commissioning organisations.

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Abbreviations and acronyms

AAS	: Action-Aid Senegal
ACCAF	: Africa Coordinating Centre for the Abandonment of Female Genital Mutilation
APHRC	: African Population and Health Research Center
CAMB	: Community Advocacy and Movement Building
CBO	: Community Based Organisation
FGD	: Focus Group Discussion
FGM	: Female Genital Mutilation
GBV	: Gender-Based Violence
IDI	: In-depth Interview
KDHS	: Kenya Demographic and Health Survey
KES	: Kenyan Shillings
KII	: Key Informant Interview
MCA	: Multiple Correspondence Analysis
OH	: Outcome Harvesting
SGD	: Sustainable Development Goals
TGG–ALM	: The Girl Generation: Africa-Led Movement
UOP	: University of Portsmouth
WHO	: World Health Organisation

Executive summary

Introduction

The Girl Generation: Support to the Africa-Led Movement (TGG–ALM) to end Female Genital Mutilation (FGM) programme supports community-driven efforts to end female genital mutilation (FGM) across Ethiopia, Kenya, Senegal and Somaliland by strengthening local movements, expanding knowledge and advocacy, and shifting harmful social norms. Implemented through a consortium of organisations, the programme combines direct end FGM education with in-school and out-of-school girls, boys and youth, community dialogues, mentorship initiatives, health system integration, survivor-led advocacy, media engagement, and policy-influencing activities. These interventions operated within complex social systems, and alongside many other actors to contribute to broader ecosystem change rather than deliver isolated, linear impacts. Thus, to investigate the effect of these interventions, a programme evaluation that used a mixed-methods design, combining quantitative household surveys with in-depth qualitative studies (including outcome harvesting (OH)) was conducted. These approaches are believed to provide a comprehensive understanding of how the programme contributed to change, what worked, what did not, and how shifts in norms and attitudes are unfolding across diverse contexts.

Evaluation purpose and objectives

The overall purpose of the endline evaluation was to assess the extent to which the programme achieved its intended outputs and outcomes and to capture lessons to inform future programming. The specific objectives were to:

- Assess shifts in knowledge, beliefs, attitudes, leadership and movement building around FGM.
- Understand the contribution of the TGG–ALM programme to any changes documented.
- Document learnings from programme implementation, including what worked, what did not, and the probable sustainability of achievements.

This report presents findings and conclusions from APHRC-led components of the evaluation. Additional reports (focusing on other TGG–ALM geographies) authored by Population Council are also available to supplement these findings.

Methods

Quantitative Component

The endline evaluation implemented comparative household surveys across intervention and control sites. The samples included 560 respondents in the Amhara region (Ethiopia), 554 in Garissa County (Kenya), and 2,268 in the Kedougou, Kolda, Sedhiou, and Tambacounda regions (Senegal). These surveys covered women, men, girls, and boys aged 15 and older. For additional comparison, the evaluation also utilised baseline household surveys with sample sizes of 801 in Ethiopia, 535 in Kenya, and 750 in Senegal. Descriptive statistics were generated to present comparisons among different groups. Logistic regression models were used to estimate associations between exposure to FGM-related activities and nine secondary outcomes, as well as a composite overall social attitude index. This included integrating intention (to perform FGM on a daughter), social sanctions (anticipated sanctions imposed on girls/women and families who have not undergone or performed FGM), and encouragement of someone to abandon FGM. Exposure was defined as participation in FGM-related activities from any actor, reflecting the reality of a multi-actor intervention landscape.

For the endline analysis, we compared three groups of respondents: (1) those exposed to FGM-related activities in intervention sites, (2) those exposed in non-intervention sites, and (3) those who reported no exposure, regardless of whether they were in an intervention or non-intervention site. This grouping allowed us to separate the effect of exposure itself from the effect of living in an intervention area. For

the pooled analysis, we applied the same conceptual logic while considering the two survey rounds. Respondents were classified into three exposure groups: (1) those exposed in intervention sites, (2)

those exposed in non-intervention sites (including exposure at baseline and exposure in control sites at endline, as both represent exposure occurring outside intervention sites), and (3) those who reported no exposure in either round. This structure created analytically comparable exposure groups across rounds and enabled us to test whether associations between exposure and FGM-related outcomes were consistent in the combined dataset. Including both rounds in a pooled model increases statistical power and avoids the noise that would arise from directly comparing baseline and endline samples. Some baseline respondents had already been exposed; some endline respondents in intervention sites reported no exposure; and some endline respondents in control sites reported exposure. Thus, the pooled approach isolates exposure more cleanly across rounds and sites, even though exposure in intervention areas does not necessarily imply exposure specifically to TGG activities.

Table i summarises the exposure groups used in the endline and pooled analyses.

Type of analysis	Exposure comparison groups
Endline analysis	1. Exposed people in intervention sites 2. Exposed people in control sites 3. Never exposed people (control and intervention sites)
Pooled analysis (baseline + endline)	1. Exposed people in intervention sites 2. <u>Exposed people in non-intervention sites (baseline + endline control)</u> 3. <u>Never exposed in either round (All non-exposed people (at (baseline and endline)</u>

Qualitative Component

To deepen and contextualise the quantitative findings, a multi-phase qualitative study was conducted between April 2025 and January 2026 across programme sites in Ethiopia, Kenya, and Senegal. The qualitative component included:

- Ethnographic fieldwork between April and July 2025 and involving participant observation of communities and programme activities in Garissa (Kenya), Tambacounda and Sedhiou (Senegal).
- A qualitative study conducted between November 2025 and January 2026, including in-depth interviews, key informant interviews and focus group discussions with girls' and boys' champions, community and religious leaders, former FGM practitioners, healthcare providers, medical students, policymakers, consortium partners, and actors involved in advocacy, movement-building, and health-system integration, and grantee organisations in all three countries.

Participants were purposively selected based on their involvement in the programme. Interviews were conducted in person or virtually depending on feasibility. Qualitative data also informed the development of case studies documenting the organisations' implementation approaches, community leadership, and individual stories of change.

Outcome Harvesting (Kenya and Senegal)

Given the complexity of social norm change and the involvement of multiple actors, outcome harvesting was used to identify and verify both intended and unintended outcomes. Three participatory workshops were held, one in Kenya and two in Senegal in November 2025, bringing together civil society

organisations, survivor networks, youth champions, media actors, religious leaders, and government stakeholders.

Participants identified outcome statements describing what changed, why the change was significant, and how TGG–ALM plausibly contributed. Selected outcomes were independently substantiated through key informant interviews. Outcome harvesting findings complement the quantitative and qualitative results by capturing non-linear, emergent, and policy-level changes that traditional evaluation methods may overlook.

Key Findings

Kenya (Garissa)

Garissa shows the strongest and most coherent pattern across all outcomes, as exposure was consistently associated with more progressive attitudes. At endline, when compared with non-exposed respondents across sites, exposed respondents from intervention sites were:

- 110% higher odds of rejecting beliefs that support FGM (OR=2.1)
- 90% higher odds of reporting high FGM-related knowledge (OR=1.9)
- 220% higher odds of opposing social sanctions against women, girls and families who abandon or want to abandon FGM (OR=3.2)
- 290% higher odds of having ever encouraged someone to abandon FGM (OR=3.9)
- 380% higher odds of reporting agency to oppose FGM (OR=4.8)
- 250% higher odds of holding a progressive overall attitude towards ending FGM (OR=3.5)

These patterns are reinforced in the pooled analysis, where exposure in intervention sites is associated with 4.0 higher odds of holding a progressive overall attitude compared with non-exposed respondents across all sites. They suggest that community dialogues, school clubs, and awareness-raising activities, whether delivered by the TGG programme or other actors, have reinforced a normative environment where opposition to the most severe forms of FGM is increasing, even if this does not yet translate into full abandonment of FGM.

However, progress is uneven across outcome domains. While opposition to the most severe forms of FGM is increasing, gender-inequality beliefs remain comparatively resistant, and so-called ‘Sunna’ FGM persists as a perceived acceptable alternative. Together, these patterns illustrate a partial decoupling of attitudinal change around FGM from broader gender-equality shifts in Garissa, where opposition to FGM is often driven by religious, legal, or health-based reasoning rather than gender-transformative change.

Other reported shifts include a move away from Type III (Pharaonic) towards forms perceived as less harmful, allowing communities to reconcile religious and cultural expectations. Despite the country’s strong anti-FGM laws, secrecy, cross-border FGM, and FGM at younger ages continue, underscoring the need for sustained, communitywide engagement.

Ethiopia (Amhara)

Associations based on exposure are strong across beliefs, knowledge, sanctions, and immediate behaviour-proximal outcomes. In contrast, comparisons based solely on study site (intervention vs control) showed weaker and less consistent patterns, reflecting the fact that exposure did not align neatly with site assignment. At endline, when compared with non-exposed respondents across sites, exposed respondents in intervention sites were:

- 150% higher odds of rejecting FGM-supportive beliefs (OR=2.5)

- 120% higher odds of reporting high FGM-related knowledge (OR=2.2)
 - 220% higher odds of opposing social sanctions against women for FGM abandonment (OR=3.2)
 - 550% higher odds of having ever encouraged someone to abandon FGM (OR=6.5)
 - 160% higher odds of reporting agency to oppose FGM (OR=2.6)
-
- 160% higher odds of holding an overall social attitude against FGM (OR=2.6)

Although some models were limited by sparse data, the direction of effects is consistently progressive. The pooled model for overall social attitude was not statistically significant, but the direction of the association remains positive (OR = 1.65), reinforcing the broader pattern in Ethiopia where exposure aligns with more progressive attitudes. Gender-inequality beliefs show partial responsiveness. Exposure appears as a better predictor of progressive outcomes than site assignment (control versus intervention), reflecting a context where multiple actors contribute to a favourable normative environment.

Pockets of youth conservatism temper overall progress, and resistance persists in hard-to-reach areas due to insecurity, cultural traditions, and economic reliance on FGM.

Senegal (Kedougou, Kolda, Sedhiou and Tambacounda)

Senegal shows a markedly different and less coherent pattern compared with Kenya and Ethiopia, with exposure associated with higher knowledge and agency but less favourable overall attitudes. When comparing with non-exposed respondents across sites, the endline data reveal that:

- exposed respondents in intervention sites were:
 - 710% higher odds of reporting high FGM-related knowledge (OR = 8.1)
 - 200% higher odds of having ever encouraged someone to abandon FGM (OR = 3.0)
 - 52% lower odds of intending to cut their daughters (OR = 0.48)
 - 420% higher odds of reporting agency to oppose FGM (OR = 5.2)
- However, they had 85% lower odds of holding a progressive overall attitude (OR = 0.15).
- Associations for beliefs, sanctions, and discrimination were mixed or negative.
- Non-exposed respondents consistently display the most favourable attitudinal distributions
- Exposure appears concentrated in more conservative sub-regions.

This suggests contested norms, uneven readiness for change, and selective participation by individuals or communities less supportive of FGM abandonment. In addition, behaviour proximal outcomes such as encouragement and agency improve even as broader attitudes remain less favourable, underscoring a divergence between private actions and perceived social expectations.

Qualitative findings show uneven reach, regional and ethnic heterogeneity, and adaptations such as FGM at younger ages, cross-border FGM, and medicalisation.

Cross-country synthesis

Across the three countries, three domains show the strongest and most consistent positive associations with exposure:

- Beliefs opposed to FGM
- FGM-related knowledge
- Opposition to social sanctions against FGM abandonment

These represent early-shifting components of social norm change. Other secondary outcomes, including gender-inequality beliefs, having ever encouraged someone to abandon the practice, discrimination against girls who have undergone FGM, opinion about FGM continuation, agency to oppose FGM and intention to perform FGM on daughters also show positive associations, particularly in Kenya and Ethiopia. Gender-inequality beliefs remain the least responsive domain across all contexts, though more progressive gender-equal beliefs in Ethiopia.

Exposure in control sites showed significant associations, sometimes positive, sometimes negative, reflecting the presence of multiple actors, historical programming, and diffusion of information. This reinforces that findings capture ecosystem-level effects, not isolated programme impacts. Outcome harvesting findings indicate that TGG-ALM contributed to strengthening youth-led advocacy platforms and enhancing collaboration between civil society and religious leaders, which helped amplify anti-FGM messaging across multiple regions.

In Kenya and Ethiopia, the most favourable distributions consistently appear among respondents exposed in intervention sites, while non-exposed respondents cluster at the least favourable end of the distributions. In Senegal, the pattern reverses: non-exposed respondents consistently show the most favourable distributions across beliefs, sanctions, discrimination, intentions, and overall attitudes, while those reached through activities, particularly in control/baseline sites, cluster in less favourable normative positions. This reversal underscores that exposure in Senegal is occurring disproportionately in communities or sub-groups where norms remain strongly supportive of FGM. More information can be found in Table 31.

Conclusion

Community-level engagement has contributed to positive shifts in knowledge, beliefs, and some attitudes, but the direction and magnitude of change vary substantially by context. Kenya and Ethiopia show coherent patterns where exposure aligns with progressive attitudes and behaviours. Senegal shows a more complex picture: knowledge, encouragement to abandon FGM, agency to oppose the practice, and intention not to cut daughters improve, but FGM-related beliefs, gender-inequality beliefs and overall attitudes remain less favourable. This reflects contested norms and exposure concentrated in conservative environments.

These results underscore the importance of:

- Strengthening implementation designs to ensure accurate exposure measurement.
- Improving coordination among actors by strengthening inter-actor synergies and supporting collaboration across organisations, sectors, and community groups. .
- Prioritising domains that consistently respond to engagement.
- Addressing resistant domains, especially gender inequality norms, which were only indirectly influenced through community dialogues, youth engagement, and broader social norm messaging.
- Tailoring interventions to regional and cultural contexts.
- Investing in the narrative around FGM to eliminate misinformation and emphasise zero tolerance against any form of FGM.

The qualitative and OH findings, presented in the main text of the report, provide deeper insight into *how* and *why* these patterns emerge, the pathways through which change occurs, and the sustainability of programme achievements.

Introduction

Between March 2024 and January 2026, the African Population and Health Research Center (APHRC) conducted an evaluation of The Girl Generation: Support to the Africa-Led Movement (TGG–ALM) to end Female Genital Mutilation (FGM) programme to assess its effects and outcomes in Ethiopia, Kenya and Senegal. This report presents the findings from APHRC-led components of the endline evaluation and key learnings that could inform future end FGM programming. Additional endline evaluation reports, from other programme geographies, have been authored by Population Council and supplement these findings.

Background

FGM is a severe form of gender-based violence involving the removal or injury of the female genitalia for non-medical reasons (OHCHR et al., 2008). It was officially recognised as a violation of human rights and violence against women in 1993 (UN, 1993). It further gained global attention with the 1995 Beijing Declaration, which galvanised international commitment to ending the practice. Since then, FGM has been included in global development frameworks, such as the Millennium Development Goals, the International Conference on Population Development commitments (ICPD, 25), the Kigali Declaration 2023, and the Sustainable Development Goals (SDGs), to drive efforts towards its eradication.

The World Health Organisation (WHO) classifies FGM into four types: Type I (clitoridectomy) involves removing part or all of the clitoral glans and/or prepuce; Type II (excision) entails removing the clitoral glans and labia minora, with or without the labia majora; Type III (infibulation) involves narrowing the vaginal opening by cutting and stitching the labia minora and/or labia majora, sometimes with clitoral removal; and Type IV covers all other harmful practices such as pricking, piercing, incising, scraping, and cauterisation of the female genitalia (OHCHR et al., 2008).

Evidence from 31 countries in Africa, the Middle East, and Asia shows that over 230 million girls and women have undergone FGM (Shell-Duncan et al., 2016; UNICEF, 2024). Most cases are in Africa at 144 million, while over 80 million and 6 million are from Asia and the Middle East, respectively. In addition, 1 to 2 million are affected in small practicing communities among migrant populations in destination countries (UNICEF, 2024). In Africa, as of 2022, Somalia reported the highest prevalence of girls and women aged between 15 and 49 having undergone the cut, with a 98% prevalence, followed by Guinea-97%, Djibouti-93%, Egypt-91%, and Ethiopia-75 (UNICEF, 2023).

Although FGM rates have decreased by one-third over the past 30 years (World Health Organisation, 2025), rapid population growth in regions where FGM is prevalent puts more girls at risk. In 2020, approximately 4.1 million girls were at risk of FGM, with projections indicating this number could rise to 4.6 million annually by 2030 (UNFPA, 2019; UNICEF, 2020). The problem was further exacerbated by COVID-19 restrictions that disrupted prevention programmes. The projections were to reduce new cases by 5.3 million between 2020 and 2030 (UNFPA, 2020), but the target may not be achieved, and it is estimated that an additional 68 million girls may undergo the cut by 2030 (UNFPA, 2019; UNICEF, 2020). These projections underscore the need for intensified efforts and accelerated interventions to combat FGM (UNFPA, 2020).

Overview of FGM and approaches to ending FGM

Developed against the backdrop of rising vulnerability for women and girls, the TGG–ALM programme provides a strategic framework to reverse these trends and foster lasting resilience. Funded by the UK's Foreign, Commonwealth and Development Office (FCDO) and implemented by a consortium led by Options Consultancy Services, the programme was implemented in four countries from 2022 to 2026: Ethiopia, Kenya, Senegal, and Somalia (specifically Somaliland). It seeks to contribute to global efforts to achieve a world free from FGM by 2030 by accelerating positive changes in social attitudes towards

ending FGM. The programme works in partnership with the broader movement to end FGM, including grassroots civil society organisations, women and girls' movements, national and sub-national

governments, to implement interventions at both national and sub-national levels such as school and community girls and boys end FGM clubs/forums, community dialogues, media engagement, policy advocacy, integrating FGM into health and medical training curriculums, and implementing grassroots granting mechanism.

The TGG–ALM programme and theory of change

The overall goal of the programme is to have a world where girls and women can exercise their power and rights, have expanded choice and agency, and be free from violence, including FGM. The overall vision was realised through capacity development of the Africa-led movement to end FGM, which included: mobilising and catalysing non-financial resources to strengthen the programmatic and organisational capacity of the movement; collaboration with other key actors to enable collective action and implementation of effective approaches, strategies, and interventions across multiple levels of the socioecological model to support ending FGM; providing platforms and opportunities for women and girls (especially survivors) to shape and lead the global end FGM movement; and providing flexible funding to grassroots organisations through grant making.

The intended outcome of these interventions is the acceleration of positive change in social attitudes towards ending FGM in countries/regions in which the programme is operational, in addition to the following intermediate outcomes:

- Positive change in beliefs, knowledge and agency relating to FGM in programme regions;
- Advances in policies and legislation, including effective financing mechanisms that support gender equitable efforts to end FGM;
- Stronger and more resilient civil society movements led by women, girls and survivors working to end FGM;
- Evidence, learning and knowledge sharing to strengthen a portfolio of effective strategies and models to end FGM; and integration of FGM prevention and response approaches into aligned sectors.

These interventions and expected outcomes are intended to contribute to the reduction of FGM in four focus countries/regions by 2026; thriving intersectional movements advancing an end to FGM for all, especially marginalised populations; legal, policy, and other structural barriers that support or promote FGM are eliminated; and evidence-based FGM prevention and evidence-based FGM prevention and response strategies integrated within local, national and global programmes and systems. Ultimately, the programme seeks to ensure FGM is eliminated as per SDG target 5.3. Figure 1 presents a summary of the programme theory of change.

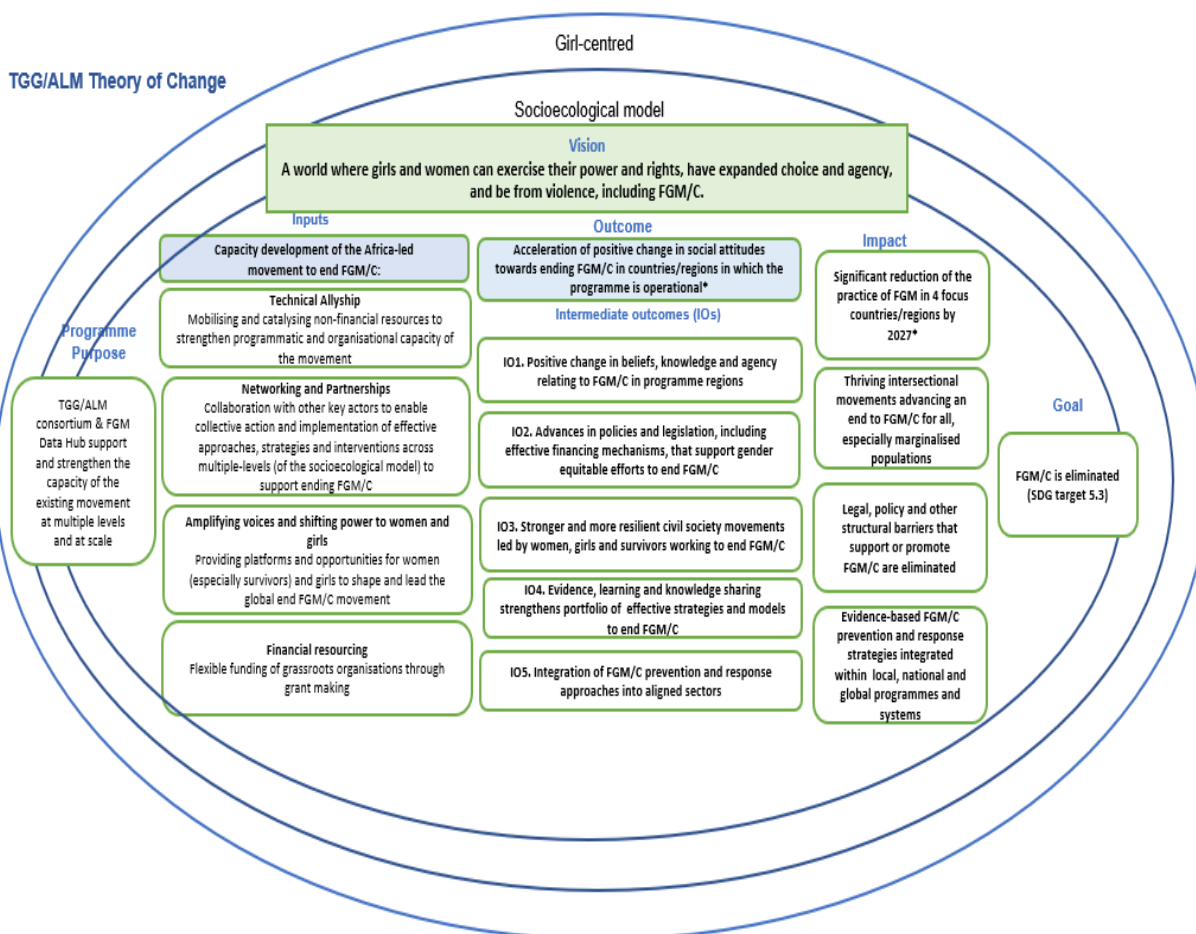


Figure 1: TGG/ALM Theory of Change

Purpose and objectives of the endline evaluation

The purpose of this endline evaluation was to assess the extent to which the programme has achieved its desired outputs and outcomes based on the programme result framework (described above) and to capture lessons learned to inform future programming, including the sustainability of the results achieved across the three programme countries. The specific objectives were to:

- Assess changes in attitudes and dynamics around FGM¹ in the study areas, including:
 - Assess changes in knowledge, beliefs, attitudes and agency around FGM
 - Document the presence of stronger and more resilient civil society movements led by women, girls and survivors working to end FGM/C
 - Document the integration of FGM prevention and response approaches into aligned sectors
- Understand the contribution of the TGG-ALM programme to any changes documented.

¹ A note on language: throughout this report, the term FGM is used by the authors. However, where direct quotations from respondents are included, the most direct translation of the term for FGM is used, which may be, for example, 'female circumcision'. Names and other identifying features of respondents (e.g. case studies, in quotations) have been changed.

- Document learning from the programme implementation, especially what worked or did not work, and how sustainable the programme achievements are.

Evaluation Methods

Study design and settings

The evaluation of TGG–ALM programme used a quasi-experimental repeated cross-sectional design with baseline and endline surveys conducted in the same broad geographic regions but with independently drawn samples. The study did not follow the same individuals or the same villages over time. In addition, it is important to note that the baseline was not a true pre-intervention baseline, as the first round of data collection took place after programme activities had already begun in some areas. For this reason, what we named as baseline should be understood as a delayed baseline (Round 1 data) throughout the report. At endline, the number of interventions-classified sites increased because several areas originally intended as controls had, in practice, been exposed to FGM-related activities. This reclassification altered the distribution of sites and resulted in greater heterogeneity within the intervention areas. The design aimed to assess differences and changes in knowledge, beliefs and attitudes related to FGM across implementation sites in Ethiopia, Kenya, and Senegal by comparing patterns observed at baseline and endline.

Geographical coverage

The study was implemented in three of the programme countries, focusing on regions where TGG–ALM activities were concentrated: Ethiopia in Guna and Farta districts in Amhara region, Kenya in Garissa County (with additional qualitative and outcomes harvesting activities at national level), Senegal in Kedougou, Kolda, Sedhiou, and Tambacounda regions. These settings reflect diverse socio-cultural contexts and normative environments surrounding FGM, enabling a comparative understanding of programme contribution across countries.

Intended counterfactual structure and adaptation of the design due to ecosystem-level exposure

At inception, the evaluation relied on a baseline–endline comparison between intervention and control sites, enabling a difference-in-differences approach. This structure was designed to estimate programme-attributable effects by comparing individuals exposed to programme activities in intervention areas, and individuals in comparable control areas not targeted by the programme. This design assumed that exposure would be largely confined to intervention sites, preserving a clear counterfactual. However, during implementation, the evaluation encountered substantial contamination across sites, as FGM-related activities were delivered by multiple actors, including TGG-ALM grantees, in both intervention and control areas. Therefore, exposure no longer aligned with site classification: some respondents in intervention areas reported no exposure, while others in control or remote areas reported engagement in FGM-related interventions. This compromised the original counterfactual and made it impossible to attribute exposure solely to TGG-ALM.

To maintain analytic validity, the evaluation shifted from a site-based comparison to an exposure-based analytic framework, focusing on who was reached by FGM-related activities rather than where they lived. This adaptation means that:

- the evaluation captures ecosystem-level patterns of engagement,
- quantitative findings describe associations rather than causal programme effects, and
- interpretation focuses on how exposure aligns with social norm change, not on isolated programme attribution.

The technical reconstruction of the exposure variable is detailed later under *Exposure Measurement*.

Mixed-methods integration

The study design was strengthened through a mixed-methods approach, combining:

- Quantitative baseline and endline surveys,
- Ethnographic fieldwork,
- In-depth qualitative interviews and focus group discussions, and
- Outcome harvesting in Kenya and Senegal.

Data collection approaches

We employed a mixed-method approach to enable robust triangulation of data sources, allowing for a deeper and more nuanced understanding of the effects and impacts of the interventions. This approach included leveraging cross-sectional quantitative and qualitative data collection approaches, engaging a wide range of stakeholders, and secondary data analysis. The data sources and evaluation phases are summarised in Table 1. Each of the proposed approaches contributed to answering the main and intermediate outcomes targeted in the programme results framework.

Table 1. Summary of the phases of evaluation activities

Evaluation phases	Lead	Timeline	Type of survey	Target population	Country and region/County	Sample size
QUANTITATIVE						
Baseline	UOP	February and April 2023:	Community base survey	Men and Women aged 15 to 65 years	Ethiopia (Guna and Farta districts, Amhara region)	802
					Kenya (Garissa County)	536
					Senegal (Kolda, Sedhiou, Tambacounda regions)	750
Endline	APHRC	April-December 2025	Community base survey	Men and women, 15-65 years	Ethiopia (Guna and Farta districts, Amhara region)	560
					Kenya (Garissa County)	554
					Senegal (Tambacouda, Kedougou, Kolda and Seldhiou regions)	2268
QUALITATIVE						
Endline ethnography	APHRC	April-July 2025	Ethnography (participant observation, IDI, KII, participatory methods/FGD)	Community members, champions, leaders, programme implementers,	Kenya (Garissa County)	55
					Senegal (Tambacounda and Sedhiou)	90
Endline Qualitative	APHRC	November 2025 – January 2026	Qualitative (IDI, FGD and KII)	champions, leaders, programme implementers, grantees,	Ethiopia (Guna and Farta)	51
					Kenya (national)	72

					Kolda + National)	
				Programme implementers, beneficiaries, national stakeholders	Kenya	22
Endline Outcome harvesting	APHRC	November 2025	Outcome harvesting		Senegal	55

*UOP-University of Portsmouth

Endline quantitative data collection

The baseline quantitative study was done by the University of Portsmouth (UOP) between February and April 2023 in Ethiopia, Senegal and Garissa (Kenya). APHRC carried out the endline quantitative study between April 2025 and January 2026. The study settings included two intervention sites (Guna and Farta districts) in the Amhara region in Ethiopia; Bura, Nanighi and Dhekarhya in Garissa, Kenya; and Tambacounda, Sedhiou, Kolda and Kedougou regions in Senegal. The study population included women, girls, boys, and men aged 15 years and older. The initial age range (15–50 years) followed standard demographic and health survey conventions and ensured representation of both younger and mature respondents. Following stakeholder recommendations, the upper age limit was expanded to include individuals older than 50 years, recognising that older adults, particularly grandparents, elders, and other custodians of tradition, play a central role in shaping and enforcing social norms around FGM and were also reached by programme activities. Including them enabled a more accurate assessment of community-wide social norm change.

Sample size estimation followed Cochran's (1963) formula for proportions, using a 95% confidence level ($Z = 1.96$), a 5% margin of error, and an assumed population variance of 0.5. This yielded a minimum sample size of 384 respondents per country. Accounting for an anticipated nonresponse rate of 30%, the final target sample size was set at 550 individuals per study region. Samples were proportionally allocated across counties/regions and further distributed across wards/communes and villages based on population size.

Village selection was conducted in collaboration with local administration and community-based organisations, including programme implementers. Within each selected village, five key areas or directions were identified: the central area of the village and the four cardinal directions of the village to ensure a heterogeneous sample. Depending on the number of households per village (25 or 30), 5 or 6 households were selected using a systematic skip pattern: the first household was approached, two were skipped, and the fourth was selected, continuing until the required number was achieved. A household was eligible if it included at least one individual aged 15 years or older. One respondent per household was randomly selected, with deliberate efforts to balance gender and age groups. This combination of systematic household selection and within household randomisation ensured a diverse and representative sample across study sites.

Data were collected using structured questionnaires administered by trained interviewers. The tools were adapted from the UOP baseline instrument and Population Council's validated measures of social norms and attitudes toward FGM. The questionnaire covered sociodemographic characteristics, knowledge and perceptions of FGM, social attitudes, gender inequality, and awareness of legal frameworks.

Interviews were conducted in English, French, Kiswahili, or relevant local languages depending on respondent preference. In Senegal, the French questionnaire was orally translated into Puulaar, Mandingue, Bambara, Soninké, or Wolof as needed. During the training, emphasis was placed on

clarifying key terms to ensure consistent understanding. Interviews were conducted primarily in respondents' homes or in private nearby locations. Informed consent was obtained from all participants. Interviews lasted approximately 30–60 minutes, including the consent process.

Endline qualitative data collection

To deepen the quantitative findings, we conducted a multi-phased qualitative study across TGG/ALM programme implementation sites in Ahmara region (Ethiopia), Garissa and Narok Counties (Kenya), and Kedougou, Kolda, Sedhiou and Tambacounda regions (Senegal) between April 2025 and January 2026. This approach aimed at deepening the findings on the programme's effectiveness, document lived experiences of shifts in beliefs and attitudes and capture individual stories of change. Data collection phases included an ethnographic study between April and July 2025. Data were collected by local research assistants (female in Garissa, and both male and female in Senegal) who received extensive training in ethnographic data collection on sensitive topics. The data collection approach combined participants' observations of communities and programme activities, in-depth interviews (IDIs) with champions (girls, boys, religious and community leaders, former FGM practitioners, etc), key informant interviews (KIIs), and focus group discussions (FGDs) with community members, including participatory approaches (i.e., community mapping, body-mapping, free-listing).

The ethnographic data were complemented with qualitative interviews (FGDs, IDIs, and KIIs) in the implementing sites in Ethiopia, Kenya, and Senegal between November 2025 and January 2026. Key informants and FGD participants included regional and national policymakers, communication advocacy and movement-building stakeholders (CAMBS), community and religious leaders, leaders and members of grantee organisations, and individuals involved in integrating FGM training into existing health systems or medical training curricula. In-depth interviews were conducted with FGM survivors, Anti-FGM champions, healthcare providers, and medical students. The number of interviews and type of interviews are provided under the country-specific sections of the report. Participants were purposively selected based on their involvement in the programme. Interviews were conducted either in person or virtually, depending on feasibility and participant availability.

In addition to deepening the endline quantitative findings, the data produced helped us draw case studies documenting grantee organisations, networks, and individual stories of change and leadership.

Outcome Harvesting (OH) in Kenya and Senegal

TGG-ALM operates in complex and adaptive social and political systems where change is influenced by multiple actors and pathways. In such contexts, direct attribution between programme interventions and observed changes is often difficult to establish. Conventional evaluation approaches may therefore overlook important, non-linear, and emergent outcomes, especially those related to policy influence, movement strengthening, and shifts in beliefs and practices. The OH approach was selected to address this complexity, enabling the evaluation team and programme partners to systematically identify, formulate, and verify both intended and unintended outcomes.

For the endline evaluation of TGG-ALM, we used OH to achieve the following:

- Identify and document observable changes at individual, community, institutional, and policy levels, including shifts in attitudes, beliefs, and practices related to ending FGM.
- Analyse how TGG-ALM interventions plausibly contributed to these changes, alongside other influencing actors and contextual factors.
- Generate credible, substantiated outcome evidence to inform the endline evaluation and future programme design.

We convened three participatory in-person workshops between November 12 and 19, 2025:

- Kenya: Nairobi, with 22 participants from Isiolo, Narok, Garissa, and Samburu counties on November 12.
- Senegal: Tambacounda (Tambacounda and Kedougou regions) on November 17, attended by 27 participants, and Kolda on November 19 (Kolda and Sedhiou regions) with 28 participants.

Participants included civil society organisations, survivor networks, youth and community champions, media actors, religious leaders, consortium partners, and government and policy stakeholders. Participants were purposively selected in consultation with the consortium partners. Through facilitated group work, participants identified outcome statements describing what changed, why the change is significant, and how TGG-ALM interventions plausibly contributed alongside other actors. An

independent substantiation process involving KIIs with knowledgeable persons to verify selected outcomes was also done.

Data management and analysis

Quantitative data management and analysis

Data were collected electronically using SurveyCTO on password-protected tablets. Built-in skip patterns, consistency checks, and validation rules ensured high-quality data capture. Completed interviews were uploaded to secure APHRC servers when internet connectivity was available. Field supervisors reviewed submissions daily, and any inconsistencies or missing data were flagged for clarification with field teams. After data collection, all identifying information was removed, and tablets were wiped to ensure confidentiality.

Cleaned datasets were exported to Stata for initial processing and subsequently analysed using R (version 4.5.2). Descriptive statistics were used to summarise the distribution of respondents by their socio-demographic characteristics and other variables of interest across countries and regions.

Construction of Composite Indices Using Multiple Correspondence Analysis (MCA)

Four multidimensional constructs (Table 2) (beliefs related to FGM, gender-inequality beliefs, FGM-related knowledge, and social sanctions associated with FGM abandonment) were measured using multiple binary or categorical items. We applied MCA to each set of items to reduce dimensionality and capture latent structures (Husson, Lê et Pagès, 2017; Greenacre, 2017; Le Roux et Rouanet, 2010; Greenacre et Blasius, 2006). The first MCA dimension was retained, as it captured the dominant pattern of association across items. Individual scores from that dominant pattern were categorised into two groups using Jenks natural breaks optimisation, which minimizes within group variance and maximises between-group variance (Slocum et al. 2009; Brewer et Pickle, 2002; Jenks, 1967). This ensures our composite indexes reflect meaningful contrasts in beliefs, knowledge and attitudes. Sensitivity checks confirmed that the binary categorisation of MCA indices preserved the substantive meaning of the constructs and did not distort associations.

Table 2. Variables used to construct MCA-based composite indexes

Indexes	Variables used	Categories
FGM-related knowledge	FGM is a form of violence against women	1-Yes, 2-No
	FGM can lead to death	1-Yes, 2-No
	FGM can lead to pain in the female genitalia and cause urinary tract infections and menstrual problems	1-Yes, 2-No
	FGM contributes to sexual problems (pain during intercourse, decreased satisfaction)	1-Yes, 2-No
	FGM increases the risk of childbirth complications and new-born deaths	1-Yes, 2-No
	FGM reduces self-esteem and increases depression	1-Yes, 2-No
Beliefs related to FGM	FGM is a mandatory religious practice	1-Yes, 2-No
	FGM ensures that girls remain pure before marriage, are respectful, clean and can become women	1-Yes, 2-No
	FGM is safer if done by a trained medical professional	1-Yes, 2-No
	Young men in the community want to marry girls who have not undergone FGM	1-Yes, 2-No
	FGM reduces sexual desire	1-Yes, 2-No
Potential social sanctions associated with FGM-abandonment	Social exclusion	1-Yes, 2-No
	Bullying	1-Yes, 2-No
	Girl will not mature into a woman	1-Yes, 2-No
	Reduced marriage prospects	1-Yes, 2-No
	Negatively affects girl's reputation	1-Yes, 2-No
	Negatively affects family's reputation	1-Yes, 2-No
	Considered unclean/impure	1-Yes, 2-No
	Violence	1-Yes, 2-No
	Loss of influence in the community	1-Yes, 2-No
	Loss of friends	1-Yes, 2-No
Gender equality beliefs	It is important that sons have more education than daughters	1-Agree, 2-Disagree
	Daughters should only be sent to school if they do not need to help at home	1-Agree, 2-Disagree
	If there is a limited amount of money to pay for education, it should be spent on sons first	1-Agree, 2-Disagree
	A woman's most important role is to take care of the home and the children and cook for the family	1-Agree, 2-Disagree
	Men and women have equal importance and value	1-Agree, 2-Disagree
	Boys and girls should have the same opportunities and rights in life (choosing a marriage partner, the right to work and income etc.)	1-Agree, 2-Disagree
	Women who have not been through FGM should not participate in any form of meetings/gatherings	1-Agree, 2-Disagree

In addition to these four indices, an overall social attitude index was created using attitudinal variables available at both baseline and endline. This index combined “intention to perform FGM on daughters”, “having ever encouraged someone to abandon FGM” and the nine sub-items used to construct the social sanctions index. The resulting MCA score was classified into two categories using Jenks natural breaks reflecting positive attitude (opposed to FGM) and negative attitude (in favour of FGM). Two additional attitudinal variables were available only at endline and were therefore used exclusively in the endline-only analysis:

- Whether FGM should continue
- Whether girls who have not undergone FGM should be discriminated against

A final endline-only outcome captured “Agency to oppose FGM”, defined as the ability of girls to refuse FGM and the ability of boys to prevent their sisters from undergoing FGM.

Exposure variable construction

Exposure to FGM-related activities was measured at both baseline and endline, but in both rounds the survey captured general involvement in FGM-related activities, without distinguishing whether these activities were implemented by the TGG-ALM programme or by other actors. Importantly, respondents typically recognise the local organisations or grantees delivering activities rather than the overarching TGG programme name or logo. Asking whether activities were “TGG-related” would therefore not have yielded reliable information, as community members do not identify interventions by programme name.

At baseline, exposure was assessed through the question “Have you ever participated in community-based activities linked to FGM abandonment?”. Because this question referred to any past involvement, it captured historical exposure, whose timing could not be determined. At endline, exposure was captured through the question “Which of the following have you been engaged in?”, with the following response categories:

- 1-School boys’ and girls’ clubs – mentorship*
- 2-Community dialogues*
- 3-National and county (or departmental) level interventions*
- 4-Engagement with civil society organisations (CSOs) in fighting FGM*
- 96-Other*
- 99-None*

These categories again captured involvement in any FGM-related activities. As with baseline, the instrument did not allow identification of whether the reported activities were delivered by TGG grantees or by other programmes operating in the same areas. Because exposure was reported across both intervention and control areas, it was reconstructed using two variables:

- **Exposure:** through self-reported participation in FGM-related activities (baseline or endline)
- **Study site:** originally classified into three site types: intervention sites and two categories of non-intervention sites (neighbouring and remote). For analytical purposes, the two non-intervention categories were combined into a single control group to mitigate small sample effects while preserving the core comparison between intervention and control sites.

Respondents were categorised as:

- **Exposed in intervention site:** Respondents who reported engagement in FGM-related activities while residing in intervention sites.
- **Exposed in control/baseline sites:**
 - For the endline-only analysis: respondents who reported engagement in FGM-related activities while residing in control sites.

- For the pooled baseline–endline analysis: we applied the same conceptual logic used at the two survey rounds (baseline and endline). Respondents who reported exposure at baseline were grouped with those exposed in control sites at endline, as both represent exposure occurring outside the intervention sites.
- **Non-exposed:** Respondents who did not report engagement in FGM-related activities, regardless of study site or survey round. For the pooled analysis, respondents who reported no exposure at either baseline or endline were combined into a single non-exposed category across all sites for the pooled analysis.

This approach ensured analytically comparable exposure groups across rounds and allowed examining consistent associations between exposure and FGM-related outcomes in the combined dataset. Pooling the two rounds also increased statistical power, stabilised estimates for small exposure categories, particularly intervention site exposure, reduced noise arising from sparse endline cells, and enabled assessment of whether observed associations held across the broader combined sample.

Exposure in intervention sites is not a perfect proxy for exposure specifically to TGG-ALM activities, as respondents may also have engaged in other FGM-related initiatives or may have been exposed prior to the programme, given that the timing of exposure is unknown. Although this approach does not eliminate misclassification noise, distinguishing exposure occurring within intervention site areas from exposure occurring outside them helps reduce it and preserves a cleaner analytical contrast. This grouping therefore reflects analytically comparable exposure contexts for the pooled baseline–endline analysis. The reconstructed exposure variable provides a more accurate representation of reported engagement in FGM-related activities across study sites, but it does not allow attribution to TGG-specific programming and does not restore the original experimental structure.

Outcome variables

Overall, 10 outcome variables are considered in this report as summarised in Table 3. All variables were assessed at endline. However, only seven were included in the pooled baseline-endline analysis, as three variables were not captured in the baseline.

Table 3. List of outcome variables

	Variables	Baseline	Endline
1	Do you think that the practice of FGM should continue?		X
2	Do you think that girls who have not undergone FGM should be discriminated against?		X
3	Agency to oppose FGM		X
4	Intention to perform FGM on daughters	X	X
5	Have you ever encouraged anyone to abandon FGM?	X	X
6	Beliefs related to FGM*	X	X
7	Gender inequality index*	X	X
8	FGM-related knowledge index*	X	X
9	Social sanction for FGM-abandonment *	X	X
10	Overall social attitude* (4 + 5 + 9)	X	X

Note: (*) these are indexes

Regression Modelling

Binary logistic regression was used for all outcomes, including the MCA-derived indices, which were converted into binary variables using Jenks natural breaks as follows:

- **Beliefs related to FGM:** defined as “in favour” for respondents holding beliefs that support the continuation of FGM, and “opposed” for those holding beliefs that disapprove of or oppose the practice.
 - **Gender-inequality beliefs:** coded as “unequal” for respondents holding overall gender unequal beliefs, and “equal” for those holding gender equal beliefs.
 - **FGM-related knowledge:** dichotomised into “high” for respondents demonstrating a high overall level of knowledge, and “low” for those demonstrating a relatively low level.
 - **Social sanctions for FGM abandonment:** coded as “in favour” for respondents who support the application of social sanctions to individuals or families who decide to abandon FGM, and “opposed” for respondents who do not support such sanctions.
-
- **Overall social attitude:** coded as “in favour” for respondents expressing an overall attitude supportive of the continuation of FGM, including supporting the practice, intending to perform FGM on their daughters, or opposing social sanctions for individuals or families who abandon the practice. Coded as “opposed” for respondents expressing an overall attitude that disapproves of or opposes FGM, including encouraging abandonment.

Endline-only models

The main explanatory variable was the three-category exposure variable (exposed in intervention site, exposed in control site, non-exposed in both sites). All models were adjusted for sex, age group, education, and marital status. For Senegal, models additionally controlled for ethnicity, religion, and region. In the overall social attitude model, to evaluate the exposure effect on the social attitude outcome, we further adjusted for beliefs related to FGM, gender inequality, and FGM-related knowledge.

Baseline-endline pooled models

We combined baseline and endline in pooled models, distinguishing three groups: respondents exposed in intervention sites, respondents exposed elsewhere (baseline and control sites), and those who were not exposed in any site. Marital status was excluded due to missing baseline data. For Senegal, analyses were limited to the three regions included in both rounds (Kolda, Sedhiou, and Tambacounda). All models were adjusted for sex, age group, and education, with additional adjustment for beliefs, gender inequality, and knowledge in the overall social attitude model.

Interpretation of odds ratios

Results are presented as adjusted odds ratios (ORs) with 95% confidence intervals. ORs quantify relative differences in the odds of an outcome between categories of an explanatory variable, one category being set as reference for comparison. ORs greater than 1.0 indicate higher odds of the outcome in the comparison group and ORs less than 1.0 indicate lower odds. Logistic regression does not estimate absolute probabilities, but instead how the *odds* of the outcome change from one group to another, odds being another way of expressing likelihood. For example, if the OR for “being against FGM” is 2.0 in the intervention site compared with the control site, this means people in the intervention site are twice as likely to be against FGM as people in the control site. An OR of 0.5 would mean they are half as likely. For communication purposes, odds ratios can also be expressed as percentage differences in odds. ORs greater than 1.0 are converted by subtracting 1 and multiplying by 100 (e.g., OR = 3.0 corresponds to 200% higher odds). ORs less than 1.0 are converted by subtracting the OR from 1 (e.g., OR = 0.48 corresponds to 52% lower odds). These percentage expressions refer to differences in odds, not absolute probabilities.

All analyses used anonymised data, and modelling decisions, including MCA construction, Jenks classification, and exposure reconstruction, were prespecified to ensure methodological rigour.

Qualitative data management and analysis

Qualitative interviews and discussions were recorded using digital voice recorders, and the audio files were transcribed verbatim, then translated from Swahili, Amharic into English and from Wolof and other local languages to French and then to English for purposes of writing this report. All transcripts were processed and edited in Microsoft Word. Participant observations, along with related discussions and conversations, were documented in field notes, transcribed, and labelled by research assistants before being shared with and stored by the project manager, who also kept the audio recorders. The data were then shared with project staff for analysis.

Data analysis involved content and thematic analysis. We first developed a coding framework using the study objectives in addition to identifying themes and sub-themes from a sample of transcripts and field notes. The framework was then applied across all data. Transcripts were imported into Dedoose software for open and axial coding to build a comprehensive understanding of the phenomenon and its underlying relationships. The transcription and coding were done by qualified transcribers and coders.

Quality assurance, ethical considerations

The study received ethical approval in all participating countries: Kenya (License No: NACOSTI/P/25/416722; AMREF ESRC-P1809/2024), Ethiopia (EPHA/OG/671/25), and Senegal (SEN 25/14 Version 2- 08/11/2025). All procedures adhered to established ethical guidelines for research involving human participants. Members of the research team were trained on ethical principles, including informed consent and assent for adolescent girls and boys younger than 18 years, confidentiality, voluntary participation, and respectful engagement with participants. Research assistants underwent additional training in research ethics prior to data collection to ensure consistent application of these principles across study sites. Importantly, the surveys established safeguards to protect against potential distress caused by asking for sensitive information. The data collectors' training sessions covered the ethics of sensitive research, confidentiality, and how to address potential psychological risks in case they happen. To maintain data quality, a structured field leadership system was established, comprising field supervisors and team leaders responsible for overseeing and monitoring data collection activities. This supervision ensured adherence to study protocols, ethical standards, and data quality assurance procedures throughout the research process.

Findings

The findings are presented in a structured sequence: descriptive distributions; endline analyses combining bivariate associations, multivariable models for secondary outcomes, and multivariable models for the overall social attitude; followed by pooled baseline–endline analyses using the same sequence of bivariate and multivariable models. Qualitative findings are integrated throughout to contextualise and deepen interpretation. This structure moves from simple distributions to progressively more controlled analyses, allowing a clearer understanding of patterns across exposure groups.

Kenya: Garissa county and national level outcomes

Background to findings

Kenya has experienced considerable declines in the prevalence of FGM, as evidenced in successive nationally representative demographic and health surveys. The national trend in FGM prevalence among girls and women aged 15–49 years shows a steady decline from 38% in 1998 to 32% in 2003, 27% in 2008–09, 21% in 2014, and 15% in 2022 (KNBS and ICF 2023). However, the prevalence of FGM varies significantly by county, ethnicity, religion, and age cohorts, with some counties reporting a high prevalence due to cultural and religious practices, among others (Shell-Duncan et al., 2017; Kimani et al., 2020). For example, the overall prevalence of FGM among girls aged 15–19 years in the

2022 Kenya Health and Demographic Survey (KDHS) was only 9% compared to 23% among women aged 45–49. In addition, there were marked differences in the prevalence rate by county with Mandera having a prevalence of (95.9%), Wajir (97.2%), Marsabit (83.0%), Samburu (75.6%), Garissa (82.5%), Kisii (77.3%), Nyamira (74.7%), Tana River (60.1%), Isiolo (66.0%), West Pokot (44.2%), and Narok (51.0%). There has also been a significant decline in FGM prevalence in certain ethnic groups such as the Meru, Kikuyu, and Kalenjin that traditionally practiced FGM (Shell-Duncan, Gathara, and Moore 2017). In contrast, Sheikh et al. (2023) report a prevalence rate of 90% among Kenyan Somalis.

The rising medicalisation of FGM is expected to hinder progress in FGM abandonment and reduce the gains made in the fight against it (Leye et al. 2019; Kimani & Shell-Duncan, 2018). FGM is also pervasive and mutating in form among different communities (Kimani et al., 2020) despite the well documented associated harms, including early child marriage and school dropout, which lowers girls' prospects in life (Mukadi, 2017; Evidence to End FGM Programme Consortium, 2018).

This evaluation focused on Garissa County, located in northern Kenya, and predominantly inhabited by ethnic Somali communities. By 2026, the county's population is expected to reach 911,006, up from 841,353 in 2019 (KNBS, 2024; CIDP, 2023). The population is predominantly young, with 22.2% adolescents (10–19) and 31.4% youth (19–34) (UNICEF, 2024), offering potential for economic growth

if effectively integrated into productive sectors. However, the high average household size (5.9) strains resource allocation and service delivery, and school attendance remains below the national average, reflecting persistent socio-economic marginalisation (KIPPRA, 2023). Garissa's population is over 95% Somali (County Government of Garissa, 2023; KNBS and ICF, 2023), and more than 98% are Sunni Muslim, making religion central to social life. The economy is largely pastoralist and vulnerable to climate shocks such as drought, alongside some agro-pastoralism and small-scale business. Education is shaped by semi-nomadic livelihoods and systemic barriers; while urban literacy is improving, primary enrolment is declining due to climate emergencies and insecurity (United Nations Children's Fund, 2024). The gender gap remains stark, with 52% of women aged 15–49 lacking formal education (KNBS and ICF, 2023). Education infrastructure includes 347 ECD centres, 224 primary schools, and 41 secondary schools, among other institutions; however, literacy remains low (8.2%), and 74% of the population is illiterate. Madrassa and Duksi (Quranic schools) are more prevalent than formal early childhood centres, and nearly all Somali children receive religious education before or alongside primary school. Healthcare is supported by one Level 5 referral hospital and 110 other facilities, yet maternal and newborn outcomes remain poor, including a neonatal mortality rate of 28 per 1,000 live births.

The county has one of the highest prevalences of FGM in the country, estimated at over 83% according to the 2022 KDHS. Similarly, a study conducted in 2021 by Derowa and colleagues reported persistently high levels of FGM in the county (Derowa et al., 2021). In Garissa, FGM is widely viewed as a deeply rooted cultural and traditional practice linked to social norms and religious beliefs and is often perceived as a rite of passage marking girls' transition into womanhood (Esho et al., 2010). Despite the enactment of the Prohibition of Female Genital Mutilation Act 2011, the practice continues, and there are indications that it has increasingly shifted from urban areas to more remote rural settings where monitoring and enforcement are limited, with religious interpretations within the community reported to reinforce the practice, with some associating it with Islamic teachings (Republic of Kenya 2011; Derowa et al., 2021; Mubaiwa, O., & Chilo, D., 2025).

The Constitution of Kenya (2010) ushered in a robust legal and policy environment in Kenya that guarantees women and girls the right to dignity and physical integrity, freedom from violence, abuse, and harmful cultural practices, including FGM (Republic of Kenya, 2010, 2015). Earlier, the passage of the Children's Act in 2001 and shifting sentiments about the rights of children sparked a cascade of community-based social movements aimed at ending FGM and early or child marriage. The legal restriction against FGM was expanded in 2011 following the enactment of the Anti-FGM Act (2011). This law prohibits FGM from being performed on women of any age, criminalises aiding, abetting, or counselling a person who performs FGM, procures a person to perform FGM, allowing the use of one's premises for performing FGM, failing to report cases of FGM, and the use of abusive or derogatory

language against someone who has not undergone FGM. The Act also bans any resident or citizen of Kenya from performing FGM outside of the country. Those who violate this law are liable to a penalty of imprisonment for up to seven years or a fine of Kenyan Shillings (KES) 500,000. The Act further provides for the creation of the Anti-FGM Board, which was established in 2013, to design, supervise, and coordinate a public awareness programme against the practice and to advise the government on matters relating to FGM and the implementation of the Anti-FGM Act (Republic of Kenya, 2010, 2015).

In 2019, the government launched the National Policy for the Eradication of Female Genital Mutilation, whose objectives were to: (i) accelerate eradication of FGM in the country; (ii) strengthen multi-sectoral interventions, coordination, networking, partnership, and community participation in eradicating the practice; (iii) address emerging trends and practices that avoided law enforcement; (iv) address gender inequality in promoting empowerment of women and girls; and (v) strengthen research, data collection, and information and knowledge management on FGM (Republic of Kenya, 2019). Against this favourable legal and policy environment, TGG-ALM programme was successfully implemented to accelerate efforts to end FGM.

The interventions were implemented at various levels: individual, community, and regional/county levels and included:

Individual level:

- **School Clubs:** ActionAid trained and supported teacher-patrons to lead school-based clubs using a girl-centered curriculum. These sessions covered critical topics including human rights, FGM awareness, gender roles, and protection mechanisms against violence. To ensure no one was left behind, similar outreach initiatives were implemented to empower out-of-school girls.

Community level and county level:

- **Champions:** Action-Aid trained and supported ‘Champions’ committed to ending FGM to hold various engagements in all the intervention sub-counties, providing them with coaching and facilitation materials. Champions included women, religious leaders, chiefs, and former FGM practitioners. Activities implemented included sensitisation sessions, couple dialogues, and intergenerational dialogues.
- **Strategic grant mechanisms.** Options managed a small grants mechanism to provide financial and technical resources and training to support or expand the reach of local organisations (Small, Medium, Anchors grantees²) with preexisting work and commitment to ending FGM (or closely aligned areas), and to develop their capacity and leadership further. These funds supported a range of local activities to end FGM through media, arts, schools, community meetings, survivor forums and policy advocacy.
- **TGG-ALM movement building.** TGG-ALM supported movement building in a range of ways: convening women’s rights and youth networks, connecting them with each other and with duty bearers; supporting ‘Men4Change’ networks; and training and amplifying the voices of survivors to promote their leadership of the end FGM movement.
- **Multisectoral interventions.** A host of multi-sectoral interventions were implemented to support an enabling policy environment at county level. Key interventions included promoting the enforcement of FGM law, gender and child protection policies, and the insertion of implementation frameworks into county integrated development plans; formation of sector-specific technical working groups and child protection structures that include cross-sectoral experts and professionals; and engagement in gender technical working groups and children advisory councils to strengthen local surveillance systems for at risk girls and reporting systems

² Small grants: £2,000 for 6 months renewable; Medium grants: £20,000 for up to a year renewable, Anchor grants: £100,000 per year

for FGM cases and other forms of violence against girls, and to advocate for county resource allocation.

Data sources

The findings for Garissa are drawn from baseline and endline quantitative community-based surveys conducted by UOP and APHRC, respectively. This data is complemented with qualitative data collected by APHRC at endline (Table 4).

Table 4. Summary of sample size for each methodological approach in Garissa, Kenya

Data collection approach	Target participants	Sample size
Baseline community-based survey	Girls, boys, women and men (15-65 years)	535
Endline community-based survey	Girls, boys, women and men (15-65 years)	554
In-depth interviews	Champions, leaders, medical students, patients, nurses, CHPs/Former FGM practitioners/local journalists/activists	46
Focus group discussions/Body and Community Mapping FGDs	Women, Girls, Boys, Men	11
Key informant interviews	Grandmothers/Teachers/Healthcare providers/Options/ActionAid leads/Grantee managers	19
Outcome harvesting (substantiation interviews)	Civil society organisations, survivor networks, youth and community champions, media actors, consortium partners, and government and policy stakeholders. The participants were from Narok, Isiolo and Garissa and national level stakeholders	22

Socio-demographic information and differences in FGM-related knowledge and attitudes

The Garissa sample included 535 respondents at baseline and 554 at endline (Table 5). Several differences in demographic and attitudinal characteristics were observed between the two data rounds. Women constituted the majority at both time points, though their proportion decreased from 76% at baseline to 64% at endline. The age distribution also differed, with a higher proportion of respondents aged 45 years or older at endline (21%) compared with baseline (4%). Educational attainment was notably higher at endline, with 26% of respondents reporting secondary education or above, compared with less than 1% at baseline.

Differences were also observed in FGM-related knowledge and attitudes. The proportion classified as having high FGM-related knowledge was 65% at baseline and 43% at endline, while the proportion holding beliefs in favour of FGM stood at 41% and 60%.

Conversely, opposition to social sanctions for FGM abandonment was 63% at baseline compared to 71% at endline. The overall social attitudes appear more favourable to abandonment (59% opposed at baseline vs. 72% at endline).

These descriptive differences should not be interpreted as linear change. Baseline and endline samples were not necessarily drawn from the same set of villages, and the baseline sample in particular may have covered fewer and more homogeneous villages. Differences in village composition, including levels of conservatism, education, age structure, and prior exposure to other initiatives, can shift the distribution of individual indicators even when underlying attitudes have not changed. For this reason, our analysis does not compare baseline and endline descriptives as change but instead examines differences between exposure groups within the endline and pooled samples, which provides a cleaner analytical contrast and avoids misleading conclusions driven by sample composition heterogeneity.

Table 5. Sample description by characteristics in Garissa, Kenya

Characteristic	Baseline N = 535 ¹	Endline N = 554 ¹
Study site		
Baseline	535 (100%)	—
Control	—	302 (55%)
Intervention	—	252 (45%)
Exposure to FGM-related activities		
Non-exposed	320 (60%)	387 (70%)
Exposed	215 (40%)	167 (30%)
Respondent sex		
Men	130 (24%)	198 (36%)
Women	405 (76%)	356 (64%)
Marital status		
Not married	111 (21%)	218 (39%)
Married	293 (55%)	336 (61%)
NA (missing data)	131 (24%)	—
Age group		
< 25yrs	170 (32%)	122 (22%)
25-34	240 (45%)	193 (35%)
35-44	104 (19%)	121 (22%)
≥ 45yrs	21 (3.9%)	118 (21%)
Education		
No formal education*	522 (98%)	320 (58%)
Primary	11 (2.1%)	91 (16%)
Secondary+	2 (0.4%)	143 (26%)
FGM-related knowledge		
Low	186 (35%)	318 (57%)
High	349 (65%)	236 (43%)
Beliefs related to FGM		
In favour	222 (41%)	331 (60%)
Opposed	313 (59%)	223 (40%)
Gender-inequality beliefs		
Unequal	49 (9.2%)	59 (11%)
Equal	486 (91%)	495 (89%)

Social sanction for FGM abandonment		
In favour	200 (37%)	159 (29%)
Opposed	335 (63%)	395 (71%)
Ever encouraged FGM abandonment		
Never	364 (68%)	494 (89%)
Ever encouraged	171 (32%)	60 (11%)
Agency to oppose FGM		
Can't oppose FGM	—	466 (84%)
Can oppose FGM	—	88 (16%)
Whether FGM should continue		
Not for continuation	—	265 (48%)
In favour of continuation	—	289 (52%)
Discrimination against girls not undergone FGM		
Not for discrimination	—	403 (73%)
In favour of discrimination	—	151 (27%)
Intention to subject daughter to FGM		
Opposed	302 (56%)	228 (41%)
In favour	233 (44%)	326 (59%)
Overall social attitude to FGM		
In favour	219 (41%)	156 (28%)
Opposed	316 (59%)	398 (72%)

Note: (*) No formal education refers to respondents with no schooling or those who are literate but have not attended formal education (other literates)

Exposure to interventions

As shown in Table 6 below, exposure patterns differed markedly by study site in Garissa. Overall, 64.9% of respondents reported no exposure to the intervention out of a total of 707 respondents. At endline, 59% of respondents in intervention sites reported exposure, compared with 6% in control sites. At baseline, exposure was higher overall (40%), reflecting the presence of FGM-related activities by TGG-ALM programme (given that the baseline study was conducted almost a year after the beginning of the interventions) or other FGM-related programmes implemented by other organisations prior to TGG-ALM.

Table 6. Overall exposure at baseline and endline by study site in the Garissa region in Kenya

Study site	Exposure to the intervention		Total
	Non-exposed	Exposed	
Baseline	320 (59.8%)	215 (40.2%)	535 (100.0%)
Control	284 (94.0%)	18 (6.0%)	302 (100.0%)
Intervention	103 (40.9%)	149 (59.1%)	252 (100.0%)
Total	707 (64.9%)	382 (35.1%)	1,089 (100%)

Qualitative data also showed exposure to the FGM intervention in Bura and Nanighi, where ethnographic data were collected. Participants reported awareness and education sessions led by Action Aid and grantee organisations through community dialogues, strategic sensitisation activities, training of lecturers and medical students, and school-based club sessions. These activities targeted different demographics, including girls and boys, adult men and women, couples, husbands, religious leaders, FGM survivors, and lecturers and students. The intervention strategically leveraged pre-existing

community platforms, including chief barazas³ health facilities, religious gatherings, and schools. This approach enhanced legitimacy and built on previously established trust, as reported by one participant:

“The community has accepted us with both arms, thanks to Action Aid, which laid the foundation for us before the TGG program. There is a time we were thrown out with Action Aid by the community when we were starting the programme before TGG” (KII, Grantee Manager, Garissa).

As highlighted in this quote, there is increased acceptance of FGM intervention activities, compared to the past. This quote also shows that some individuals in the programme’s region were already exposed to FGM-related activities before the beginning of TGG. School clubs and dialogues were facilitated by teachers and trained champions, including religious and community leaders, community health workers, and FGM survivors. The dialogues, for example, were specifically used to demystify the prevailing beliefs and norms around FGM, including religious arguments that influence continuity of FGM in the community. Moreso, religious scholars were involved to sensitise and demystify existing pro-FGM religious arguments among community members and ex-traditional practitioners:

“We brought all the cutters of Nanighi in one place and sensitised them. We have done mapping for all the cutters, we even brought religious scholars so that they can tell them what the religion says about FGM and its verdict” (KII, member, grantee organisation, Garissa).

In schools, awareness of FGM was institutionalised through the establishment of school clubs led by trained teachers, alongside girl and boy champions. Teachers provided oversight, while student champions managed the day-to-day activities of the clubs.

“ActionAid came and trained us. As head girl, I had to lead other students, organise meetings, and encourage them to come. Every Friday, we have sessions. We talk about rape, early marriage, and FGM. I sometimes speak in front of the group. I tell them: ‘If someone touches you, scream. If someone wants to marry you off early, report it. Focus on your books. Don’t waste your life’” (IDI, girl champion, Garissa).

Exposure was also achieved through sensitisation and advocacy campaigns. The interventions adopted a peer-led approach to drive change in beliefs and practices. The campaigns were conducted by champions and role models, including FGM survivors, male champions, and former FGM practitioners in schools, homes, trading centres, and informal gathering points:

“Yes, we have done sensitisation in Bura. It is a big town. We have several settlements in Bura (settlements) like Athey, we have gone to these areas for sensitisation. Mostly, when we have seminars, the attendees are women with businesses in the market. The women at home don’t attend much, but we were sent to sensitise them in their homes, and we did that.” (IDI, Woman Champion, Garissa).

The findings further reveal that some community members, such as family members, were exposed to the programme through girls’ and boys’ champions. They leveraged on their day-to-day interaction with family members (parents and siblings) and relatives to engage them on ending FGM. One champion reported that she explained the consequences of FGM to her older sister, who then decided not to subject her daughters to FGM, as she explains:

“Thanks to that, none of my older siblings had their daughters circumcised... she said that these children would not go... because her little sister was involved in a program and had explained all the consequences to her.” (IDI, Girl Champion, Garissa)

³ Barazas are open public meetings that gather community members and administrators for constructive dialogue and decision-making on local matters.

Some champions reported discussing FGM and the TGG programme with their parents, which in some cases influenced parental practices related to FGM as noted by two girls participating in a community mapping FGD in Garissa.

“My mother is now convinced and has decided to abandon the practice.” (FGD, Girl champion, Garissa).

“This project enabled me to talk to my dad about FGM.” (FGD, girl champion, Garissa)

However, the study shows the geographic scope of the interventions was limited to trading centres in urban settings of the two study sites, Bura and Nanighi. According to a key informant, the geographical limitations were due to limited access to remote areas, particularly in terms of the high expense of trips to these areas, poor road infrastructure, and insecurity.

“It's true we haven't reached all the remote villages, and it's in our plan for this year to cover those areas. Some areas have security issues and cannot be fully accessed.” (KII, Woman Champion, Garissa)

“Inaccessible roads to the interior villages and insecurity. Sometimes we don't have the financial capabilities to reach the far-end villages” (IDI, male champion, Garissa)

Association between exposure and FGM-related outcomes at Endline

Bivariate association

At endline in Garissa (Table 7), the distribution of outcomes differs across study sites and across the three exposure categories for most indicators. Respondents in intervention sites consistently show more favourable distributions than those in control sites. For example:

- 47% of respondents in intervention sites opposed FGM-supportive beliefs, compared with 34% in control sites.
- 49% of respondents in intervention sites demonstrated high FGM-related knowledge, compared with 37% in control sites.
- Only 18% of respondents in intervention sites endorsed social sanctions for abandonment, compared with 37% in control sites.
- Support for continuation of FGM was lower in intervention sites (43%) than in control sites (60%).
- A higher proportion of respondents in intervention sites reported ever encouraging abandonment (19%) compared with control sites (4%).
- Opposition to practicing FGM on daughters was also higher in intervention sites (53%) than in control sites (31%).
- Agency to oppose FGM was more common in intervention sites (25%) than in control sites (8%).
- Overall, 83% of respondents in intervention sites held a progressive overall attitude, compared with 63% in control sites.

These differences between control and intervention sites are statistically significant for most outcomes ($p < 0.05$).

When outcomes are examined by exposure category, the gradient becomes even clearer. Respondents exposed in intervention sites consistently have the most favourable distributions across nearly all

indicators. Comparisons were conducted between the exposed respondents in the intervention sites and the non-exposed individuals across different outcomes of interest. For example:

- 54% of those exposed in intervention sites opposed FGM-supportive beliefs, compared with 34% among the non-exposed
- High knowledge was reported by 53% of those exposed in intervention sites, compared with 39% among the non-exposed
- Only 15% of those exposed in intervention sites endorsed social sanctions, compared with 35% among the non-exposed
- Support for continuation of FGM was 36% among those exposed in intervention sites, compared with 60% among the non-exposed.
- Ever encouraging abandonment was reported by 21% of those exposed in intervention sites, compared with 6% among the non-exposed.
- Opposition to practicing FGM on daughters was 60% among those exposed in intervention sites, compared with 33% among the non-exposed.
- Agency to oppose FGM was 29% among those exposed in intervention sites, compared with 11% among the non-exposed.
- A progressive overall attitude was held by 87% of those exposed in intervention sites, compared with 66% among the non-exposed.

Respondents exposed in control sites often fall between these two groups, although cell sizes are small and should be interpreted cautiously. For gender-inequality beliefs, proportions are similar across study sites and exposure categories, and p-values indicate no statistically significant differences.

Overall, the endline bivariate results show distinct distributions of beliefs, knowledge, sanctions, discrimination, continuation, encouragement, intentions, agency, and overall attitudes across study sites and exposure categories in Garissa, with the most favourable patterns consistently observed among respondents exposed in intervention sites.

Table 7. Bivariate association of study sites and study-site related exposure by outcome variables at endline in Garissa County, Kenya

Characteristic	Study sites				Study site related Exposure			
	Overall	Control	Intervention	p-value ²	Non-exposed all sites	Exposed control site	Exposed intervention site	p-value ²
		N = 302 ¹	N = 252 ¹		N = 389 ¹	N = 16 ¹	N = 149 ¹	
Beliefs related to FGM	N = 554 ¹			0.002				<0.001
In favour	331 (60%)	198 (66%)	133 (53%)		256 (66%)	6 (38%)	69 (46%)	
Opposed	223 (40%)	104 (34%)	119 (47%)		133 (34%)	10 (63%)	80 (54%)	
Gender-inequality beliefs				0.289				0.288
Equal	495 (89%)	266 (88%)	229 (91%)		343 (88%)	16 (100%)	136 (91%)	
Unequal	59 (11%)	36 (12%)	23 (9%)		46 (12%)	0 (0%)	13 (9%)	
FGM-related knowledge				0.004				0.01
Low	318 (57%)	190 (63%)	128 (51%)		239 (61%)	9 (56%)	70 (47%)	
High	236 (43%)	112 (37%)	124 (49%)		150 (39%)	7 (44%)	79 (53%)	
Social sanction for FGM abandonment				<0.001				<0.001
In favour	159 (29%)	113 (37%)	46 (18%)		135 (35%)	2 (13%)	22 (15%)	
Opposed	395 (71%)	189 (63%)	206 (82%)		254 (65%)	14 (88%)	127 (85%)	

Discrimination against uncut girls				0.276			<0.001
Not for discrimination	403 (73%)	214 (71%)	189 (75%)	260 (67%)	16 (100%)	127 (85%)	
In favour of discrimination	151 (27%)	88 (29%)	63 (25%)	129 (33%)	0 (0%)	22 (15%)	
Opinion about FGM continuation				<0.001			<0.001
Not for continuation	265 (48%)	121 (40%)	144 (57%)	157 (40%)	13 (81%)	95 (64%)	
In favour of continuation	289 (52%)	181 (60%)	108 (43%)	232 (60%)	3 (19%)	54 (36%)	
Ever encouraged FGM abandonment				<0.001			<0.001
Never	494 (89%)	290 (96%)	204 (81%)	364 (94%)	13 (81%)	117 (79%)	
Ever encouraged	60 (11%)	12 (4.0%)	48 (19%)	25 (6.4%)	3 (19%)	32 (21%)	
Intention to perform FGM on daughters				<0.001			<0.001
Opposed	228 (41%)	95 (31%)	133 (53%)	130 (33%)	9 (56%)	89 (60%)	
In favour	326 (59%)	207 (69%)	119 (47%)	259 (67%)	7 (44%)	60 (40%)	
Agency to oppose FGM				<0.001			<0.001
Can't oppose	466 (84%)	278 (92%)	188 (75%)	347 (89%)	13 (81%)	106 (71%)	
Can oppose	88 (16%)	24 (7.9%)	64 (25%)	42 (11%)	3 (19%)	43 (29%)	
Overall social attitude to FGM				<0.001			<0.001
In favour	156 (28%)	112 (37%)	44 (17%)	134 (34%)	2 (13%)	20 (13%)	
Opposed	398 (72%)	190 (63%)	208 (83%)	255 (66%)	14 (88%)	129 (87%)	

¹ n (%)

² Pearson's Chi-squared test; Fisher's exact test

Multivariable association

Table 8 presents adjusted associations between study site, exposure status, and FGM-related outcomes using endline-only models. Across most indicators, respondents living in intervention sites and those

exposed to FGM-related activities showed higher odds of holding more progressive beliefs, knowledge, and attitudes compared with non-exposed respondents.

Beliefs opposed to FGM

People in intervention sites were 1.78 times more likely to oppose FGM than those in control sites ($p = 0.001$). In intervention sites, those exposed were significantly 2.14 times more likely to oppose FGM-supportive beliefs than those who were never exposed to any FGM-related activities ($p < 0.001$). In control sites, exposure also raised the odds of opposing FGM ($OR = 2.90$, $p = 0.05$), but this was only marginally significant. There was no significant difference between intervention and control sites in gender-unequal beliefs ($OR = 0.75$, $p = 0.30$). There was no effect estimate for exposure at control sites due to limited data, and exposure at intervention sites showed no association with gender-based beliefs ($OR = 0.90$, $p = 0.80$). The findings show that the programme had little effect on gender-unequal norms during the study period.

FGM-related knowledge

Respondents in intervention sites had 1.86 times higher odds of having high FGM-related knowledge compared with those in control sites ($p < 0.001$). Those exposed in intervention sites also had higher

odds of high knowledge (OR = 1.91, $p = 0.002$). Exposure in control sites showed no meaningful association (OR = 1.20, $p = 0.70$).

Attitudinal outcomes

The results show more pronounced differences in opposition to social sanctions related to FGM abandonment, intentions, and sense of agency about FGM. Those in intervention sites were 2.88 times more likely to oppose social sanctions for abandoning FGM compared to those in control sites ($p < 0.001$). Those exposed to FGM-related activities in intervention sites were 3.21 times more likely to oppose imposing such social sanctions compared to those who were never exposed ($p < 0.001$). Respondents exposed in control sites also showed higher odds of opposing social sanctions for FGM abandonment compared to those who were never exposed (OR=3.49), but the estimate was imprecise and not statistically significant ($p = 0.11$), as indicated by the wide confidence interval.

Respondents exposed in intervention sites were 67% less likely to support discrimination against girls who have not undergone FGM compared to non-exposed respondents (OR = 0.33, $p < 0.001$). Nevertheless, no meaningful differences were observed between exposed respondents from control sites and non-exposed respondents, nor between intervention sites and control sites overall. Support for continuation of FGM was lower among respondents in intervention sites, who were 56% less likely to support continuation compared to those from control sites (OR = 0.44, $p < 0.001$). Exposure to FGM-related activities, whether occurring in intervention or control sites, was associated with lower support for continuation of FGM, with respondents exposed in intervention sites 65% less likely to support continuation (OR = 0.35, $p < 0.001$) and those in control sites 84% less likely (OR = 0.16, $p = 0.005$).

Attitudinal outcomes followed similar patterns. Respondents in intervention sites were 7.14 times more likely to have encouraged someone to abandon FGM ($p < 0.001$), and those exposed in intervention sites were 3.91 times more likely to have done so ($p < 0.001$). Intentions to perform FGM on daughters were lower among respondents in intervention sites, who were 63% less likely to intend to practice (OR = 0.37, $p < 0.001$). Exposure in intervention sites was also associated with reduced intention (70% less likely) to subject daughters to FGM (OR = 0.30, $p < 0.001$). Finally, respondents in intervention sites were 5.15 times more likely to report agency to oppose FGM ($p < 0.001$), with exposure in intervention sites reinforcing this pattern (4.79 times more likely, $p < 0.001$).

Table 8. Adjusted Odd ratios associated with study site and exposure by outcome variables in endline in the Garissa region, Kenya

Outcomes	Intervention			Exposed control site			Exposed intervention site		
	VS			VS			VS		
	Control			Non-exposed both sites			Non-exposed both sites		
	OR	95% CI	p-value	OR	95% CI	p-value	OR	95% CI	p-value
Holding beliefs opposed to FGM	1.78	1.25, 2.54	0.001	2.90	1.02, 8.95	0.050	2.14	1.44, 3.19	<0.001
Holding unequal gender related beliefs	0.75	0.42, 1.32	0.3				0.90	0.44, 1.75	0.8
Having high FGM-related knowledge	1.86	1.31, 2.67	<0.001	1.20	0.40, 3.41	0.7	1.91	1.28, 2.87	0.002

Being opposed to social sanctions for FGM-abandonment	2.88 1.92, 4.37 <0.001	3.49 0.93, 22.8 0.11	3.21 1.95, 5.51 <0.001
Being in favour of discrimination against uncut girls	0.78 0.53, 1.15 0.2		0.33 0.19, 0.55 <0.001
Being in favour of FGM continuation	0.44 0.31, 0.63 <0.001	0.16 0.03, 0.50 0.005	0.35 0.23, 0.52 <0.001
Having ever encouraged anyone to abandon FGM	7.14 3.65, 15.1 <0.001	2.79 0.56, 10.4 0.2	3.91 2.16, 7.21 <0.001
Intention to undergo FGM on daughters	0.37 0.25, 0.52 <0.001	0.40 0.14, 1.12 0.081	0.30 0.20, 0.46 <0.001
Agency to oppose FGM	5.15 3.05, 8.96 <0.001	2.37 0.51, 8.29 0.2	4.79 2.82, 8.27 <0.001

Abbreviations: CI = Confidence Interval, OR = Odds Ratio

As shown in Table 9, an analysis of overall social attitudes toward FGM found that respondents who reported having been exposed to FGM-related activities in the intervention sites were much more likely to oppose the practice. They were 3.5 times more likely to hold an overall attitude opposed to FGM compared to non-exposed respondents ($p < 0.001$). In control areas, exposure also led to more opposition, but this difference was not statistically significant. Respondents who hold beliefs opposed to FGM were 17.6 times more likely to have an anti-FGM attitude ($p < 0.001$), showing that beliefs are a major driver of social attitude. On the other hand, those with unequal gender beliefs were much less likely to oppose FGM ($OR = 0.16$, $p < 0.001$), which suggests that strong gender norms still support the practice. People with primary, secondary, or higher education were less likely to oppose FGM than those with no formal education. This means that, in this setting, more formal education did not always lead to more progressive views about ending FGM.

Other demographic factors, such as marital status, sex, age (except for a small effect for those under 25), and knowledge about FGM, were not strongly associated to overall social attitude. The lack of association between knowledge and overall attitude indicates that, in this context, differences in factual knowledge do not meaningfully distinguish people who oppose FGM from those who support it once their underlying beliefs and gender norms are considered.

Table 9. Endline exposure to intervention and associated adjusted Odds-ratio to social attitude against FGM in endline in Garissa, Kenya

Characteristic	Holding an overall social attitude opposed to FGM		
	OR	95% CI	p-value
Exposure			
Non-exposed all sites (ref)	—	—	
Exposed in control site	1.89	0.42, 13.4	0.4
Exposed in intervention site	3.5	1.92, 6.66	<0.001
Marital status			
No (ref)	—	—	
Yes	1.12	0.65, 1.92	0.7
Sex			
Men (ref)	—	—	
Women	0.72	0.44, 1.18	0.2
Age group			

≥ 45yrs (ref)	—	—	
35-44	0.91	0.45, 1.81	0.8
25-34	1.43	0.73, 2.79	0.3
< 25yrs	2.09	0.99, 4.50	0.056**
Education			
No formal education* (ref)	—	—	
Primary	0.31	0.16, 0.59	<0.001
Secondary+	0.39	0.19, 0.78	0.008
FGM-related knowledge			
Low (ref)	—	—	
High	0.85	0.53, 1.38	0.5
Beliefs related to FGM			
In favour (ref)	—	—	
Opposed	17.6	8.67, 41.1	<0.001
Gender-inequality beliefs			
Equal (ref)	—	—	
Unequal	0.16	0.08, 0.32	<0.001

Abbreviations: CI = Confidence Interval, OR = Odds Ratio

Note: (*) No formal education refers to respondents with no schooling or those who are literate but have not attended formal education (other literates)

(**) borderline significance

Association between exposure and FGM-related outcomes in Baseline-Endline analysis

Bivariate association

In the pooled baseline–endline analysis for Garissa (Table 10), the bivariate distribution of outcomes differs across the three exposure categories (non-exposed, exposed in control/baseline sites, and exposed in intervention sites), for most indicators.

Across several outcomes, respondents exposed in intervention sites show the highest proportions of responses classified as “progressive.” For example:

- 54% of those exposed in intervention sites opposed FGM-supportive beliefs, compared with 45% among the non-exposed.
 - High FGM-related knowledge was reported by 53% of those exposed in intervention sites, compared with 47% among the non-exposed.
 - Only 15% of those exposed in intervention sites endorsed social sanctions for abandonment, compared with 32% among the non-exposed.
-
- Opposition to subjecting daughters to FGM was 60% among those exposed in intervention sites, compared with 45% among the non-exposed.
 - A progressive overall attitude was held by 87% of those exposed in intervention sites, compared with 66% among the non-exposed.

The gap between the high proportion holding a progressive overall attitude and the lower proportion opposing FGM for their daughters is expected in normal behaviours. The overall attitude index combines three components—encouragement to abandon FGM, a ten-item measure of opposition to social sanctions for abandonment, and intention not to cut daughters—so respondents may be classified as “progressive” overall without being progressive on every element. Intention is more behaviour proximal and therefore more sensitive to social pressure, family influence, marriageability expectations,

and anticipated sanctions, making it consistently more conservative than attitudinal measures. Social desirability bias and the collective nature of decision-making around FGM—where husbands, mothers-in-law, grandmothers, or elders may have final authority—may further contribute to this discrepancy.

Respondents exposed in control/baseline sites often show intermediate distributions, falling between the non-exposed and those exposed in intervention sites. For example:

- 58% of respondents exposed in control/baseline sites opposed FGM-supportive beliefs.
- 74% demonstrated high FGM-related knowledge, the highest of all groups.
- 54% opposed social sanctions for abandonment.
- 52% held a progressive overall attitude.

These differences across exposure categories are statistically significant for all outcomes except gender-inequality beliefs.

For gender-inequality beliefs, the proportions of respondents classified as holding “equal” versus “unequal” beliefs are similar across all three exposure groups (around 90% equal and 10% unequal), and the p-value indicates no statistically significant difference. Although the proportion of respondents classified as holding gender equal beliefs appears high, this is consistent with the structure of the gender inequality scale, which captures broad gender equality attitudes rather than FGM-specific gender power dynamics. Qualitative findings show that many respondents support girls’ education, mobility, and general rights while still upholding FGM for religious, identity, or marriageability reasons. This produces a partial decoupling between general gender equality norms and FGM-related norms. The resulting ceiling effect limits variation across exposure groups, which explains the non-significant differences observed in the bivariate analysis.

For the outcome on whether they have ever encouraged someone to abandon FGM, the pattern differs from other outcomes. Respondents exposed in control/baseline sites have the highest proportion reporting that they have ever encouraged someone to abandon FGM (63%), while non-exposed respondents have the lowest (7%). Those exposed in intervention sites fall between these two groups (21%). These differences are statistically significant.

Overall, the pooled bivariate results show distinct distributions of beliefs, knowledge, sanctions, encouragement, intentions, and overall attitudes across the three exposure categories in Garissa, with statistically significant differences for most outcomes. The most favourable patterns generally appear among respondents exposed in intervention sites, although some indicators, such as encouraging someone to abandon FGM, show different gradients.

Table 10. Bivariate association of study-site related exposure by outcome variables using baseline-endline pooled data in the Garissa region, Kenya

Characteristic	Overall	Study site related Exposure			p-value ²
		Non-exposed	Exposed	Exposed	
		all sites	Control and baseline	Intervention site	
	N = 1,089 ¹	N = 707 ¹	N = 233 ¹	N = 149 ¹	
Beliefs related to FGM					0.001
In favour	553 (51%)	387 (55%)	97 (42%)	69 (46%)	
Opposed	536 (49%)	320 (45%)	136 (58%)	80 (54%)	
Gender-inequality beliefs					0.708

Equal	981 (90%)	633 (90%)	212 (91%)	136 (91%)	
Unequal	108 (9.9%)	74 (10%)	21 (9.0%)	13 (8.7%)	
FGM-related knowledge					<0.001
Low	504 (46%)	374 (53%)	60 (26%)	70 (47%)	
High	585 (54%)	333 (47%)	173 (74%)	79 (53%)	
Social sanction for FGM abandonment					<0.001
In favour	359 (33%)	229 (32%)	108 (46%)	22 (15%)	
Opposed	730 (67%)	478 (68%)	125 (54%)	127 (85%)	
Ever encouraged FGM abandonment					<0.001
Never	858 (79%)	655 (93%)	86 (37%)	117 (79%)	
Ever encouraged	231 (21%)	52 (7.4%)	147 (63%)	32 (21%)	
Intention to perform FGM on daughters					<0.001
Opposed	530 (49%)	316 (45%)	125 (54%)	89 (60%)	
In favour	559 (51%)	391 (55%)	108 (46%)	60 (40%)	
Overall social attitude to FGM					<0.001
In favour	375 (34%)	242 (34%)	113 (48%)	20 (13%)	
Opposed	714 (66%)	465 (66%)	120 (52%)	129 (87%)	

¹ n (%)

² Pearson's Chi-squared test; Fisher's exact test

Multivariable association with qualitative evidence

Table 11 displays the baseline–endline pooled models of the associations between exposure and six outcomes holding the other factors constant (sex, age and education).

Beliefs opposed to FGM

Respondents exposed in intervention sites (OR = 1.61, $p = 0.012$) and those exposed in control or baseline sites (OR = 1.45, $p = 0.018$) had higher odds of holding beliefs opposed to FGM than compared with non-exposed respondents.

The qualitative findings also provided insights into the changes at individual and at the community level, especially among those exposed to the programme. Hawa (pseudonym) is one of them. Hawa is a 36-year-old survivor and community champion from Nanighi (intervention site). Her story as a survivor and mother illustrates both the deeply rooted nature of FGM in the community and the gradual shifts in beliefs and attitudes over time. Reflecting on her upbringing, Hawa explains that FGM was widely accepted as a normal and necessary practice.

When I think about Nanighi today, I see a community learning to question what it once believed beyond doubt. I was born here, cut here, and married here. Back then, no one asked why. We were told it was for our benefit, that cutting made us clean, made us women. It was not just a practice; it was our pride, our identity. Those who refused were shamed. Everyone, even the religious leaders, said it was right. When I returned to Nanighi in 2019, I found those same beliefs still strong. Many women said, “FGM is only wrong when it is Firauni. Sunna is good, it is religious.” That is what made our work so hard. How do you argue with religion when it is woven into people's hearts?

Some men supported us at first but later pulled back, afraid of being mocked. The elders accused us of betraying our culture. But slowly, something began to shift. After the ActionAid

trainings, we started inviting imams and elders to our discussions. At first, they listened in silence. Then they began to speak, some even questioning what they had always preached. Women who once whispered now spoke out in public meetings. Girls started asking their mothers, “Why should I be cut?” At weddings and barazas, I now hear people debating, not defending. Some still hold on to the old ways, performing cuttings in secret, but many more are beginning to doubt. The belief that cutting defines womanhood is fading, replaced by another belief—that a girl can be whole, uncut, and still respected. Change here does not come fast, but it is taking root in people’s hearts

Hawa’s account highlights the important role of community champions in facilitating dialogue and challenging long-standing norms. Her story reflects a gradual but meaningful shift in beliefs, attitudes, and community conversations around FGM in the community.

High FGM-related knowledge

Respondents exposed in intervention sites showed a positive but borderline significant association (OR = 1.39, $p = 0.082$). Those exposed in the control and baseline sites had 2.99 times higher odds of having high FGM-related knowledge compared with non-exposed respondents ($p < 0.001$).

Qualitative findings show that exposure through training of different stakeholders, including community awareness outreach, led to improved knowledge on FGM and its consequences. Stakeholders used this knowledge to educate community members. Participants reported increased understanding of the harmful health and psychological consequences of FGM, contributing to greater awareness at individual and community levels.

“At the community level, we have seen increased knowledge about the harms of FGM, more open discussions about its risks, shifts in attitudes with many families questioning the practice, and a growing willingness to protect girls and resist FGM”. (Programme Implementation Stakeholder, Garissa)

“After the sensitisation and the training, I understood the risks around FGM like painful menses, difficult childbirth and infections. With the campaign and training I came to know the risks of FGM” (IDI, Woman Champion, Garissa)

Moreover, integrating health, legal, and religious perspectives, the programme has successfully shifted mindsets among community members, particularly among younger women. This multifaceted approach has fostered a deeper understanding of the physical and psychological harms of FGM, prompting a critical re-evaluation of the practice.

“There is a story that happened in one of my neighbour’s houses. The girl was to be circumcised, but she ran away and went to her teachers and told them. Her teacher came with the chief to their house... When the police were involved, we all got cold feet, and everyone ran away, and the one who was to perform the cut ran away to another town”. (FGD, Woman, Garissa)

Other transformational experiences including improved knowledge on FGM and motivations to advocate against FGM because of the interventions were also reported:

“I will not just protect my girls; I will fight for every girl” after undergoing her own transformative experience with the intervention” (IDI, Woman Champion, Garissa)

Table 11. Pooled baseline-endline adjusted odds ratios associated with exposure categories by outcome variables in Garissa County Kenya

Outcomes	Exposed Control and Baseline VS	Exposed Intervention site VS
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	Non-exposed all sites			Non-exposed all sites		
	OR	95% CI	p-value	OR	95% CI	p-value
Holding beliefs opposed to FGM	1.45	1.07, 1.98	0.018	1.61	1.11, 2.33	0.012
Holding unequal gender related beliefs	1.06	0.64, 1.84	0.8	1.24	0.68, 2.45	0.5
Having high FGM-related knowledge	2.99	2.14, 4.22	<0.001	1.39	0.96, 2.03	0.082
Being opposed to social sanctions for FGM-abandonment	0.49	0.36, 0.67	<0.001	3.25	2.02, 5.45	<0.001
Having ever encouraged anyone to abandon FGM	22.1	14.8, 33.5	<0.001	3.37	2.03, 5.53	<0.001
Intention to perform FGM on daughters	0.80	0.59, 1.09	0.2	0.46	0.32, 0.67	<0.001

Abbreviations: CI = Confidence Interval, OR = Odds Ratio

Detailed attitude outcomes

In reference to Table 11 above, while differences in gender-related beliefs were limited, several other attitudinal outcomes showed clear patterns. In communities where the programme was active, respondents reported more progressive views on harmful social rules related to FGM. They were 3.25 times more likely to speak out against punishing individuals and families who chose to stop the practice ($p < 0.001$), showing more favourable attitudes toward abandonment. By contrast, people in areas without the programme were less likely to oppose these punishments, which suggests that fear of backlash remains stronger in those settings. It is encouraging that exposure to the programme, whether in intervention or control areas, was associated with higher reports of encouraging others to abandon FGM. In comparison with people who were never exposed to any FGM-related activities, people exposed in non-intervention sites (control and baseline) were 22 times more likely to have encouraged someone to abandon FGM ($p < 0.001$), and those in intervention sites were also about 3 times more likely to offer this encouragement ($p < 0.001$). Most importantly, exposure in intervention sites was associated with lower intentions to perform FGM on daughters. Exposed people in intervention sites were 54% less likely to plan for their daughters to undergo FGM compared to those who were not exposed to the programme ($p < 0.001$). While exposure in control or baseline sites was not significantly related to intention, the patterns observed in intervention communities highlight the importance of continued community engagement, dialogue with local leaders and sustained awareness efforts.

Overall social attitude outcome

Table 12 below comparing baseline and endline data shows a strong association between programme exposure and attitudes against FGM. People exposed in intervention sites were 4.01 times more likely to oppose FGM than those not exposed ($p < 0.001$), indicating more favourable attitudes in settings where programme activities were implemented. In contrast, those in control or baseline sites were much less likely to oppose FGM (OR = 0.30, $p < 0.001$), consistent with the more conservative normative

environments in those areas. People who personally opposed FGM were 7.43 times more likely to report an FGM-opposing social attitude ($p < 0.001$), underscoring the importance of personal beliefs. Those with unequal gender-related beliefs were also 3.23 times more likely to oppose FGM ($p < 0.001$), suggesting that attitudes towards FGM can diverge from broader gender inequality norms. Having more knowledge about FGM showed only a marginal association with overall attitude ($p = 0.052$), implying that knowledge alone does not differentiate attitudes after controlling for other factors.

Individual characteristics such as sex, age, and education did not have a significant effect on overall attitudes. This highlights the importance of engagement strategies that respond to local normative contexts rather than demographics.

Table 12. Pooled baseline-endline exposure to intervention and associated adjusted odds-ratio to social attitude against FGM in Garissa County, Kenya

Characteristic	Holding an overall social attitude opposed to FGM		
	OR	95% CI	p-value
Exposure			
Non-exposed all sites (ref)	—	—	
Exposed Control and baseline	0.3	0.21, 0.44	<0.001
Exposed Intervention site	4.01	2.35, 7.17	<0.001
Sex			
Men (ref)	—	—	
Women	0.91	0.66, 1.25	0.6
Age group			
≥ 45yrs	—	—	
35-44	0.86	0.51, 1.43	0.6
25-34	0.8	0.50, 1.28	0.4
< 25yrs	0.96	0.58, 1.58	0.9
Education			
No formal education* (ref)	—	—	
Primary	0.68	0.41, 1.13	0.14
Secondary+	0.91	0.57, 1.47	0.7
FGM-related knowledge			
Low (ref)	—	—	
High	1.35	1.00, 1.83	0.052**
Beliefs related to FGM			
In favour (ref)	—	—	
Opposed	7.43	5.41, 10.3	<0.001
Gender-inequality beliefs			
Equal (ref)	—	—	
Unequal	3.23	2.03, 5.20	<0.001

Abbreviations: CI = Confidence Interval, OR = Odds Ratio

Note: (*) No formal education refers to respondents with no schooling or those who are literate but have not attended formal education (other literates)

(**) borderline significance

Overall, the results show meaningful differences across exposure groups. Strong gender norms remain persistent and shifts in these areas typically take time. Still, the patterns observed across the endline-only models and the pooled baseline–endline analysis indicate that exposure, particularly in intervention sites, is associated with more progressive attitudes toward abandonment: more respondents in these settings opposed harmful social pressures, more reported encouraging others to abandon FGM, and fewer expressed intentions to continue the practice. These patterns suggest that communities in intervention areas may be more open to questioning established norms and supporting the protection of girls.

Qualitative findings on social attitude changes

The qualitative findings below reflect changes in community knowledge, beliefs and practice, which together signal shifts in social norms regarding FGM, while nuancing some of the patterns identified in the quantitative findings. Overall, qualitative findings show positive shifts driven by awareness-raising campaigns led by trained community champions, FGM survivors, healthcare providers, former FGM practitioners and community leaders, including chiefs and religious leaders. Men, including religious

leaders and county commissioners, also participated through community dialogues and sensitisation meetings.

“They participate a lot in the chiefs barazas, and the county commissioners are invited in the workshops to give speeches and to open. Okay. Yes.

I: And are the religious leaders invited to these talks also?

P: Yes, we are. We are. Isiolo Interfaith Network is a key collaborator, partner in many of these things. So, we also work very closely with the local activists, women groups, and survivors.”
(KII, Religious leader, Substantiation interviews)

The study shows training of male champions and community leaders played a crucial role in easing community entry and facilitating FGM sensitisation given the sensitivity of the practice and its deep cultural roots:

“Initially the community was concerned, we had a point where our staff nearly got beaten but with the help of working with male champions, the religious leaders at least they gave us an ear. First few months were a bit difficult but then again attitude changes, day by day, they started being more welcoming” (FGD, Grantee Organisation, Garissa).

“As men, we aren't involved in the affairs of FGM, but we hear what is being done. I am well equipped with knowledge in terms of religion and can explain about FGM”. (IDI, adult male champion Garissa).

Shifting attitudes towards FGM abandonment

Qualitative findings show that there has been a notable shift in attitudes across different social groups, including women, men, girls and boys regarding FGM and the social sanctions associated with it. These changes are reflected in parents reporting that they are now refusing to subject their daughters to FGM (though in many cases, this was referring rather to a change in the type of FGM, moving from type 3 to Sunna), and in girls and boys taking a stand against the practice. Among girls and women, direct involvement in programme activities not only increased awareness but also motivated some survivors to take on advocacy roles within their communities, including sharing their lived experiences. One survivor described how her own experience with childbirth complications resulting from FGM combined with her physical disability, inspired her to establish an organisation to support and protect other girls facing similar challenges.

“[...] And the doctor told me it's because when you are very young, you know, you have undergone FGM. And because of that cut and the way it has been done, you cannot deliver your children normally. That is why I was delivering the children through CS [caesarean section] ... I decided to form this organisation so that I save young girls who have the same problem that I have. The girls that have the same disability that I have. I have just decided to save them through the organisation that I formed” (KII, FGM survivor, Grantee Manager, Garissa)

FGM-related health risks were raised by participants, drawing on their own experiences or those of others. These personal accounts illustrate how lived experiences can motivate survivors to advocate for change and inspire community action.

Communities were reported to be more receptive to advocacy messages, with local leaders actively supporting abandonment efforts. Increased awareness has encouraged more open discussions, with families increasingly questioning the practice (especially the harm caused by “severe forms” of FGM) and expressing willingness to protect girls.

“FGM is just like the word says—it's mutilation... With the intervention... we have managed to change community perceptions by working with medics to educate the community...” (FGD, University Student, Garissa)

Over time, so-called ‘more severe’ forms such as Pharaonic FGM (Type 3) were reported to be declining as awareness increased. Community leadership involvement and sustained sensitisation were cited as key drivers.

“Over time, Firauni (pharaonic) FGM has declined... awareness, education, and community leaders’ support have helped families resist the practice” (Program Implementation Stakeholder, Garissa).

A male participant added:

“In my opinion, girls should not be tortured with FGM, and if she is to be circumcised, only the Sunna circumcision that won't affect her daily routine be done” (IDI, Man, Garissa).

Religious leaders are part of the champions whose role was critical in driving FGM-related beliefs and attitudes among the community in the intervention sites in Garissa. After their own attitudes were successfully transformed by the programme through training, they became agents of change by actively engaging their community members.

This is illustrated through the following case study (Box 1).

The scholar's shield: Using Islamic jurisprudence to protect girls

On a quiet morning in July 2025, the rhythmic chanting of Qur’anic verses at the Madrasa in provided the backdrop for a profound encounter with religious authority. Imam Ibrahim, a 48-year-old Imam and teacher, sits at the heart of this community as a teacher of Fiqh and Arabic. Since his arrival in the community, his influence has been absolute, yet his journey through the TGG-ALM programme has fundamentally shifted how he wields that authority in the fight against FGM in Garissa County.

Imam Ibrahim’s transformation began with his participation in two pivotal trainings facilitated by ActionAid in 2023 and 2024. These sessions brought him face-to-face with a cross-section of his community, including elders and traditional cutters. The programme served as a catalyst, empowering him to use his deep theological knowledge to decouple harmful cultural practices from religious obligation. With the weight of his Sharia background, he began to publicly declare that the "Pharaonic" (Type 3) FGM - the sewing and mutilating of girls - was not only absent from the Qur’an but was an act of oppression punishable in the sight of Allah. By framing the protection of girls as a return to the true Sunna rather than a surrender to "white man’s practices," he began to dismantle the rigid barriers of tradition.

This change was not only theoretical; it manifested in direct, courageous intervention to prevent FGM (Pharaonic) from happening. Imam Ibrahim recalls traveling to the remote outskirts of Degega, where he stumbled upon a group of women and a cutter prepared to perform FGM on a young girl. In a moment that tested his leadership, he intervened personally, preaching to the group and urging them not to tamper with the girl’s body. His presence and spiritual reasoning were enough to halt the Pharaonic practice in that moment. Though he acknowledges that 100% compliance is difficult in a culture where attitudes vary, he now views the Kenyan law against FGM as being in perfect alignment with Islamic teachings on the rights and dignity of the person.

However, Imam Ibrahim story also highlights the delicate and often suspicious environment in which change-makers operate. Despite his advocacy, he remains a protective gatekeeper of his community’s values and beliefs, shaping his perception on FGM, primarily, the “acceptable” form of FGM (Sunna) rather than promoting zero tolerance for all types of FGM. This friction underscores the complexity of his role; he is a man walking a thin line between ancient social codes and modern human rights. He insists that for FGM to truly end, organisations must provide continuous awareness and further inclusion of Imams and women in training, noting that if the momentum stops, the community risks sliding back into old ways. His evolution from a silent scholar to a vocal, if cautious, protector of girls’ health proves that when religious leaders are engaged with respect and scholarly rigor, they become the most formidable shield against the violation of human rights in Garissa.

Box 1: The scholar's shield: Using Islamic jurisprudence to protect girls

Sensitisation of boys on FGM also contributed to a shift in attitudes, with many no longer insisting on marrying girls who have undergone FGM. Increased awareness of the consequences of FGM also motivated some boys and men to take on protective roles for girls. As one participant noted:

“I thought it was right, done for good reasons. But I learned the truth. FGM should totally be eradicated; no girl deserves such harm” (observation participant, boy, Nanighi, Garissa).

Shifts in attitudes and practices among former FGM practitioners

One notable change observed through the implementation of the TGG-ALM program was the transformation of former FGM practitioners. This change was reported to be largely driven by sensitisation meetings and fear of prosecution. Though FGM had served as a source of income, many chose to stop and seek alternative sources of income.

Catalysing change: From FGM Practitioner to Courageous Reformer

When news spread that a research team had arrived in Nanighi to explore the practice of FGM, Lady S disappeared. Every time we (Research Assistants) visited her home, we were met with the same message: “She’s not here... she’s in the bushes.” S was on the run not from justice, but from fear. She was convinced that we were working with the police. The stress became unbearable. ... We (researchers) waited patiently for nearly three weeks without success until on the 23rd of May 2025, when we returned to her home, and she agreed to meet with us.

In the quiet, arid village of Nanighi lived 58-year-old woman known by many as Aunt S. A mother, a grandmother, and a traditional healer, S had lived most of her life in this tight-knit community. Her presence was both respected and feared. For 17 years, she had served as one of the village’s most active practitioners of FGM. But her story, like many others, is a story of survival, tradition, fear, and transformation.

We approached her with calm and respect, assuring her on confidentiality and told her, ‘We are not here to harm you or judge you’. She didn’t respond at first. With a trembling voice, she said: “I will share everything with you. My fear is not with you it’s the police. They are ruthless. They’ve threatened us many times. Even if I tell them I’ve stopped cutting, they won’t care. They just want someone to arrest... someone to blame”. She added, “We also fear young girls now. Students. When schoolgirls see us the three old practitioners, they look at us like we are death itself.”

She explained how she became a practitioner, and how FGM was not only her source of income but also “restoring our community’s honour.” FGM wasn’t just tradition it was virtue”. She explained how deeply rooted the practice was in ideas of purity, dignity, and social acceptance. “When a girl is cut, she is seen as pure. Her parents are proud. Men want to marry her. But if she’s uncut, she’s seen as shameful... loose. We cut girls to protect their honour. We make sure they know that sex is painful. Their desires are numbed from childhood. That’s the goal.” According to S, women were the primary decision-makers on FGM. Despite her strong cultural convictions, S eventually abandoned the practice not because her beliefs changed overnight, but because of fear and knowledge she received from TGG and experience with one girl who over bled, making her recognise the risk. Her turning point came after attending several trainings organised by The Girl Generation, the Africa-Led Movement, ActionAid, and Wokike. One pivotal meeting brought together local chiefs, police officers, and an Islamic sheikh. “The sheikh said FGM is not obligatory in Islam. If the cut causes harm, we must stop. After that meeting, I have never cut another girl.” S remains proud of her roots, but she’s also come to understand the harm that came from a practice she once believed was righteous. Her transformation is ongoing a quiet resistance against a legacy she once helped uphold. (Fieldnotes case study 2. Former practitioner, 2025).

Box 2. Catalysing change: From practitioner to courageous reformer

Shift in attitude among men

Although it was reported that men were involved in the practice by accepting or providing resources, engagement with community members revealed shifts in men’s perceptions regarding the social sanctions that had been instituted to protect and guard girls from perceived promiscuity. Though the reasons for FGM practice had historically been justified as a means of controlling women’s sexuality and preventing promiscuity, some men have reported reconsidering these beliefs after participating in community dialogues and sensitisation activities. Participants noted that discussions around the health and relational consequences of FGM influence changing attitudes among men. One female participant

shared that men increasingly recognise the negative implications of the practice, particularly the impact on women’s sexual wellbeing and marital relationships:

“Men have no problem with ending FGM. They say, ‘we married women who have less sexual feelings, and we don’t want the younger generation to suffer like us.’ My husband even told me,

'If you circumcise my daughter, I will personally take you to jail'". (IDI, Woman participant, Bura, Garissa)

Cases emerged of men against FGM. The story of 31-year-old Sheikh Ahmed (pseudonym) is a powerful testament to the shifting tides of masculinity and fatherhood in Garissa County as a result of TGG-ALM programme. A respected Madrasa teacher, Ahmed represents a new generation of Somali fathers moving beyond the role of "financial provider" to become active "protectors" of their daughters' physical integrity (Box 3)

"Not My Daughters": A Father's Stand Against FGM

As a respected teacher and 31-year-old father, Ahmed represents a new generation of Somali fathers moving beyond the traditional role of "financial provider" to become active "protectors" of their daughters' physical integrity. His journey, catalysed by the TGG-ALM programme, illustrates how targeted advocacy can bridge the gap between deep-seated traditional expectations and the personal transition into protective fatherhood of the girl-child

For Ahmed, the fight against FGM shifted from a communal concern to a deeply personal mission with the birth of his two daughters, aged two years and eight months when the study team met with him. In a community where FGM is often dismissed as a "women's affair," the TGG-ALM programme empowered Ahmed to recognise that the father's role is the ultimate "yes or no." Hence, he has chosen a resolute "no," transforming his household into a microcosm of a broader cultural struggle.

This change is characterised by Ahmed's refusal to yield to the logic of "we did it, so they must." Despite his wife's struggles with the psychological weight of peer pressure, Ahmed uses the clinical realities he learned through the programme—such as severe bleeding and childbirth complications—to advocate for his daughters at home. He has moved from a passive observer to a hyper-vigilant guardian, acutely aware that "secret cutting" often occurs when fathers are away. To counter this, he has turned his advocacy into a daily mission of protection, warning of clear repercussions should the practice be performed in secret.

Ahmed's evolution through the TGG-ALM programme proves that fathers can be an effective tool against FGM, as they can use their authority not as a means of control, but as a shield. By calling for systemic accountability and regular sensitisation, he ensures that the protection he provides at home is mirrored in the community. His commitment remains absolute: "With God's help, my daughters will never be cut."

Box 3: "Not My Daughters": A father's stand against FGM

The observations and engagements with community members also show an increased acceptance of girls who have not undergone FGM, as illustrated in the field notes below by research assistants who arrived for participant observation in a participant's home in July, at midday. This was their fourth visit:

"Unlike previous days, the pauses between our words were no longer awkward but comfortable, marked by occasional sips of tea or her glancing toward the children playing nearby. (...) Toward midday, the conversation unexpectedly circled around to FGM, though not directly prompted. We spoke about generational change and how things were different for girls now than when she was growing up.

RA: "Do uncut girls face problems in the community?"

Participant: Shook her head. "No. Now it's normal. Before, there used to be issues, not now." She leaned back slightly, looking across the compound. "They used to be called names. If she is married, for example, the man would call her loose and shame her for it. That is why they were sewed. Even when a girl was cut Sunni, they would still say she is loose". Her voice was calm but firm, as if speaking from both memory and observation. I asked if it was something women or girls talk about openly now. "They are now united in stopping it," she said without hesitation. "It is not shameful anymore. Before, it was a shameful topic, but not now."

Despite these reported shifts, findings underscore that the transition away from FGM is far from linear. Deep-seated dilemmas and active resistance persist, largely fuelled by entrenched cultural beliefs. Chief among these is the link between FGM and marriageability; in many communities, the practice remains

a rigid rite of passage, with girls considered "ready" or eligible for marriage only after undergoing the procedure. This cultural gatekeeping continues to pose a significant barrier to total abandonment. It was reported that families continue to play a major role in upholding the practice, creating pressure and relationship poverty for household members who oppose FGM. For such household members who are not the primary decision-makers, the change from practicing FGM is seen as a daunting task, but with the existence of anti-FGM interventions, many community members, especially those opposed to FGM, have been able to reach out and seek intervention to protect the girls in their households.

"In the school-based forum...we target the high school girls and in there we find FGM survivors and who have sisters who had not gone through FGM. During one school holiday, a girl called her teacher and said, "I'm about to get circumcised, please help me" and one of the girl champions went to talk to the parents, and they did not go through with it" (FGD, member, Grantee organisation, Garissa)

One approach that worked to create awareness and in turn change the community members' beliefs regarding FGM included working with community members who are trusted by the community.

"We were not happy at first of the organisation like ActionAid interfering (with) our beliefs, but when they used trusted people from the community members and started increasing awareness of its health risk, and harms to girls' lives; that really brought change from the belief perception" (IDI, Woman, Garissa).

Other intervention strategies included working with religious leaders and former practitioners, "mother-to-daughter sessions" and the "survivors healing circle," where FGM survivors, older women, and teenage girls cooked together and shared personal experiences in a healing and open environment.

"An older mother, about 40 years old, shared with a 15- or 16-year-old that she used to get a lot of cramps during her period because of FGM. Many other women approached the speaker, saying the circle was very nice and asked to be added. The activities included grouping and playing games, which helped them forget about the issues they had gone through as women. The groups in the circle would be changed monthly" (KII, Grantee Manager, Garissa).

One of the challenges encountered in community awareness raising against FGM was financial constraints but also the lack of organisational structures for wide coverage. Through the TGG grant mechanism, community members were supported to establish groups that helped expand the reach across the county (though some areas remained still unreached as explained earlier).

Reasons for lack or limited changes in attitudes and beliefs

The shift from 'Pharaonic' to 'Sunna' (Sunnatul Muakadha) FGM

Implementation of TGG-ALM programme enabled grantee organisations to expand into high-prevalence areas, increasing awareness and advocacy against FGM. This contributed to shifts in community perceptions on FGM practice. However, change was partial, with a transition from the so-called 'more severe' Type III (Pharaonic) to the "less severe" type I and II of FGM referred to as *Sunna*, which is perceived as less harmful. During outreach by the grantee organisations, women in the communities would react to sensitisation efforts by saying "you guys keep coming back to us here, and we're not practicing, and even if we are, we are not doing the extreme one that we used to do before" (KII, Grantee Manager, Garissa). Though FGM-related knowledge had improved women and girls' awareness of the practice and its dangers, type 1 FGM (Sunna) was still seen as more acceptable as it met the perceived religious obligations and "importance" for a girl.

"Before, I thought FGM was just one thing—that it was all good and necessary. But I learned that there are types. Firauni causes pain and damage. It can even kill. Now I know the difference. But I still believe Sunna is important" (IDI, girl participant, Garissa).

"If a girl is to be circumcised there is something called "(sunnatul Muakadha)" it means if a girl is circumcised using the religion's law, she is supposed to be pricked a little and, in the

evening, she is healed and can resume her roles of fetching water. But this type where girls are mutilated, sewn and tied for almost a month is not allowed". (FGD, Women, Garissa)

Persistence of beliefs promoting FGM

FGM was still viewed as a significant rite of passage, marking a girl's transition to womanhood or adulthood, and ritual purification of women prompting parents to seek out the procedure for their daughters. The specific type of FGM practiced varied by context and was influenced by cultural and religious beliefs.

"Many see it as tradition, passed down from our forefathers. Pharaonic has mostly stopped due to awareness, but Sunna still happens" (IDI_woman, Garissa).

Sunna FGM was considered a religious obligation. In a discussion on recent cases of FGM practice in Garissa County, a participant spoke to the continuity of FGM:

"Interviewer: have you seen any recent cases of FGM in the community?"

Participant: (looked thoughtful, then said), "FGM was very common about three years ago. In our community, all of us girls were circumcised back then. But since that time, the cases have decreased. Still, I hear some neighbours whisper about taking their little girls to the bushes where no one can see to carry out the cutting..."

[Participant sighed]. "The funny thing is outsiders like you might be told that FGM has been totally eradicated here. But if I'm honest with you, it's still happening. The Pharaonic type of circumcision was stopped about four to five years ago. But the Sunna type I don't think it will ever be stopped." [Participant paused]: *There was a time when we attended a training session here in Nanighi. It was organised by ActionAid. The facilitators were focused on the Pharaonic type of circumcision and how it affects girls negatively throughout their lives. They talked about infections, severe menstrual cramps, and the pain during childbirth. They really opened our eyes."* [paused], *"There was also an imam at the training. He stood up and said Pharaonic circumcision is haram, unwanted, and very bad. He warned that anyone practicing it would be held accountable in the hereafter. But he also said that Sunna FGM is what our Prophet Muhammad (peace be upon him) practiced. He encouraged the community to stop Pharaonic and adopt Sunna instead."* (Participant observation, Naninghi, Kenya)

Social sanctions

Social institutions such as religious institutions were noted to perpetuate FGM practice. FGM has been promoted as a ticket to marriage, purity and respectability. Within the context of making a 'good' woman or womanhood, parents desperately attempt to ensure their daughter's marriageability through FGM.

"Socially and culturally, FGM is highly valued, especially among Muslim communities. There is a belief that an uncut girl is impure and has not transitioned into womanhood. Although there is no clear Islamic scripture supporting FGM, myths and traditional beliefs continue to influence the practice... Today, the consequences are less severe than before due to changing social dynamics. However, stigma still exists, especially regarding marriage. Uncut girls may be seen as impure or unsuitable for marriage". (KII, Healthcare professional /lecturer, Garissa)

The risk of stigmatisation influenced by societal expectations surrounding FGM. Within social sanctions, men who marry women who have not undergone FGM are often viewed negatively and may face ridicule or emasculation from the community, which perceives them as having deviated from cultural norms. This social pressure reinforces adherence to the practice and shapes negative attitudes toward women who have not undergone FGM.

"People will tell you you've married a woman who has not been circumcised, they will tell you are not a man, you've left your culture, they'll question if you are manly enough, that's our society, just because you have married a woman who hasn't gone through circumcision" (FGD, man, Bura).

Societal pressure, which remains a significant challenge to sustaining progress toward the elimination of FGM in communities where the practice is deeply entrenched as a cultural and traditional norm, as detailed in Ahamed's case (Box 3) above. In nomadic settings, where families often live in communal arrangements, decisions related to FGM are viewed as collective responsibilities and are closely tied to social identity and communal celebrations. The strong influence of extended family members can therefore undermine individual intentions to abandon the practice and frustrate gains made through sensitisation efforts.

At the individual level, change was described as possible but fragile, as social and family pressures can quickly reinforce traditional expectations and behaviours due to societal pressure through stigma and discrimination.

Stigma and discrimination

Fear of stigmatisation and discrimination remains a significant barrier to ending FGM. Social pressure operates at individual, family, and community levels, where the desire to belong and avoid exclusion compels some girls and women to conform to prevailing social norms. The celebratory nature of FGM ceremonies reinforces social cohesion among those who participate, while marginalising families who choose not to subject their daughters to the practice. Participants noted that even in the absence of formal punishment, social exclusion can be powerful. Some families reportedly claim their daughters have undergone FGM to avoid stigma and maintain social acceptance.

"While there are no reported cases of direct punishment, families may face stigma and discrimination. Some families even claim their daughters are circumcised to avoid social exclusion". (KII, Healthcare professional /lecturer, Kenya).

The social sanctions imposed on those who have not undergone FGM led to some of the women and girls embracing the practice. The pressure to conform is often driven by "othering"—a combination of rejection, teasing, and shunning, as explained by one participant, *"They can't even bathe with the others in the river. They feel ashamed. Eventually, many beg their parents to have them cut so that they can blend in."* (KII, male champion, Garissa). Women in a focus group discussion discussed societal pressure and cultural belief:

"Another cultural belief is they use it for cleanliness to clean the girl they feel like as long as girl is uncut. She is not clean; they believe she cannot pray. Another one is I don't know if it's cultural or a myth, we are doing it for men and uncut girls will not be married in this society". (FGD, Woman, Garissa)

Limited reach in training interventions

While TGG-ALM training programme was acknowledged to have a positive impact, some participants perceived it as limited in scope. While programme implementers (including grantees) deliberately trained the same people repeatedly, with the rationale of moving beyond superficial/one off engagement for these 'champions' to meaningfully engage with other community members later, concerns were raised that trainings often targeted individuals who were already knowledgeable or supportive of anti-FGM efforts, thereby restricting broader community transformation and sustained change. As a result, the benefits of the training were largely confined to direct participants and those within their immediate networks. One respondent emphasised the need to expand training to less literate and harder-to-reach community members, while positioning already trained individuals as trainers to widen outreach and impact.

"I will give them five out of 10...Because, you know, there is a problem with these training sessions. They mostly target people who are already knowledgeable. You are adding drops of water in the Indian Ocean. You are preaching to the converted. That is my own opinion. They need to make sure those that are not literate are trained so that they are also adding value."

Those that are already literate should be converted to trainers to achieve this”. (KII, Religious leader, Garissa)

Legal implications and reporting mechanisms

Formal and informal mechanisms exist in the community to report suspected FGM cases. Members may share information with local community-based organisations involved in anti-FGM advocacy, which escalate cases to local authorities. Other reporting channels include local chiefs, community health volunteers, police hotlines, and gender-based violence (GBV) rescue centres. Despite these existing structures, awareness of reporting procedures remains limited due to limited knowledge on the reporting mechanisms, the fear of stigma, the lack of penalties or consequences after reporting, and challenges of accessing reporting stations or persons responsible.

“Kenya has the prohibition of FGM act 2011, which criminalises FGM, aiding FGM, or taking a girl outside the country for FGM. Implementation is through chiefs, police and local administrators. However, enforcement is sometimes weak due to secrecy and community resistance...., accessibility also varies, and remote areas still face barriers such as fear, stigma, and long distances”. (IDI, Medical student, Garissa)

Although anti-FGM legislation exists, enforcement of penalties was reported to be inconsistent. Community members indicated that individuals who continue to carry out the illegal practice often face few or no consequences. While politicians publicly denounce FGM and express support for community education efforts demonstrating political will to end the practice, justice is not always fully realised. Rather, informal community dispute resolution mechanisms frequently override formal legal processes, weakening accountability.

“There is political will to end the practice, though justice is not always fully served due to informal community dispute resolution”. (KII, Healthcare Professional/Lecturer, Garissa)

New cases of FGM are reportedly difficult to identify and report unless immediate medical complications arise. Health professionals noted that most cases encountered involve long-term physical and psychological consequences rather than recent procedures. Community resistance and reluctance to report new instances serve as significant barriers to law enforcement and protection efforts.

“Fresh FGM cases are hard to report unless complications occur immediately. Most cases we encounter involve long-term physical and psychological effects. Community resistance is a major challenge”. (KII, Healthcare Professional/Lecturer, Garissa)

Sustained practice through adaptation and secrecy

Mapping exercises with adolescent girls showed that active practitioners remain present, and they identified high-risk areas such as riverbanks, remote homes, and forests. The girls pointed out “insecure paths” and places where they felt most at risk of being taken for FGM. Ethnographic observations confirmed that practitioners use evasive tactics to avoid detection. For example, a known practitioner fled into the forest for days after learning of researchers’ inquiries. These findings suggest that while public practice has declined, FGM has become more clandestine and harder to monitor:

*“When I was circumcised, my father did not want us to be circumcised. We were staying in *** and my mother told my father we are going for a vacation. We went to *** and we were taken to a woman and since I used to have stomach-ache during that time so she told me the woman will cure me of the stomach-ache and I accepted. On arriving at the woman’s, the woman told me to remove my trouser and I was wondering what was happening. There were other women present who pinned us down and the woman circumcised us there”. (IDI, Girl Champion, Garissa)*

Unintended and unanticipated changes

Change of age of girls undergoing FGM

Participants reported a reduction in the age at which girls undergo FGM, from above 10 years to below 5 years. This shift was attributed to increasing empowerment and awareness among older girls, who are now more likely to resist, refuse, or report the practice. In addition, early age is used to avoid detection by teachers due to absenteeism before, during, or during recovery after the practice.

“Before the practice, you notice the girls targeted for FGM are missing school just before the school holidays. In some cases, girls are taken from school directly by relatives; one survivor recounts being taken by her uncle and aunt during the school day for her to undergo FGM” (KII Teacher, Garissa).

Participants also noted that younger girls are perceived to heal faster and are less able to oppose the procedure, making them more vulnerable.

“Another thing that is contributing to the change in age is [they are now] realising the younger girls heal faster than the older girls”. P2: “yes, another thing is that the older girls are more empowered and enough to say no. The baby has no consent, and you can literally pin her down while the older girls can fight you. She can even report you because they don’t want it”. (FGD, Grantee Organisation, Garissa)

Change in Type of FGM practiced

Qualitative findings show a broad consensus that Pharaonic (Type III) FGM is harmful and should be eliminated. Throughout the discussions, participants tended to define FGM as *Pharaonic* FGM and to distinguish *Sunna* as separate, despite both practices constituting FGM under national and the programme zero-tolerance standards.

“I have always spoken out that Firauni is prohibited. If people insist on cutting, they should only practice Sunna... Circumcision of girls is sunnah mu’akkadah, one that individuals should not take lightly”. (KII, Religious Leader, Garissa)

The case of Imam Ibrahim serves as a poignant illustration of the complex negotiations required by community leaders (Box 1). As a primary gatekeeper of local morality, he must navigate the precarious intersection where deeply entrenched social codes meet the evolving landscape of modern human rights. In this high-stakes environment, focusing his advocacy specifically on the total abandonment of Type III FGM offers a strategic middle ground - a way to conciliate the spiritual expectations of his community with the urgent physical protections demanded by the programme.

Moreover, some girls interviewed also expressed support for retaining *Sunna*, associating it with purity, cultural identity, and religious belonging.

“Eradicating Pharaonic is necessary—no girl should suffer like that. But they shouldn’t touch Sunna. Let girls keep that part. It’s our culture, our religion, our pride”. (IDI, Girl, Garissa)

The strong value placed on cultural belonging and religious identity appeared to reinforce acceptance of *Sunna* as a compromise practice. Awareness campaigns in these communities were perceived to focus more on eliminating severe forms, with less emphasis on directly advocating for zero tolerance to all forms of FGM. Hence, most of the abandonment reported in the quantitative findings may be referring to the shift from type 3 to *Sunna* FGM.

Medicalisation

Medicalisation emerged as a strategy used by some communities to modernise the practice of FGM by reducing perceived pain and trauma. Framed as a “safer” alternative, this approach is perceived to allow families to preserve cultural beliefs while attempting to avoid legal consequences. Communities are reportedly more accepting of medicalised FGM, particularly as it is perceived to be performed by healthcare providers in sterile environments as opposed to earlier practices and limited to the ‘less severe’ *Sunna* type.

“They (community members) moved to a practice called “Kisasa” FGM. This is medicalised FGM that is being practiced. Why was it being practiced? Because as much as so much awareness had gone around FGM being a violation of the rights of women and girls, there was still that cultural attachment to it. So, they were like, okay, if we can get medical practitioners to administer anaesthesia, to use sterile tools, then just to cut a little bit, just to connect us with the culture and the ancestors, it wouldn't be bad” (KII, Advocacy manager, Kenya).

The medical students and lecturers trained by the Africa Coordinating Centre for the Abandonment of Female Genital Mutilation (ACCAF) echoed the same sentiments, indicating that healthcare professionals were now performing FGM at the health facilities

One medical lecturer noted that, prior to ACCAF's training, FGM was often viewed in the community as “modest and decent,” and concerns about harm were more commonly linked to *how* the procedure was performed rather than to the practice itself. Traditionally, the practice was carried out by respected older women, but there is now an emerging shift toward medicalisation that provides the “safe” environment and process.

“Traditionally, it was done by elderly women who were respected in the community. However, there is now a growing trend of medicalisation, where nurses, clinicians, and even doctors are involved”. (KII, Healthcare professional /lecturer, Garissa)

Other changes: organisational level, integration of FGM in health system and movement building

2.1.8.1 Integration of FGM into healthcare system in Kenya

Among the many ways of reducing FGM is the integration of FGM services in conventional health care. ACCAF was reported to be one of the organisations that trained medical students on FGM, as part of TGG-ALM, to integrate FGM prevention, identification, and management into routine clinical practice. This integrated approach was developed in response to identified gaps in healthcare services related to the management of FGM-related complications at health facilities. ACCAF trained several medical/nursing students and lecturers using a curriculum focusing on prevention and response to FGM. Beneficiaries of this training reported several changes, including their awareness on FGM, for those who were not very familiar with the concept, as reported by one student:

“Basically, to most of us we had not really heard about FGM but we didn't really know it as much, so the training basically introduced us to the whole concept of FGM from the descriptions, the types, the care that is supposed to be given to those who have undergone FGM from both medical and psychological, and also referral systems. We were also trained on the legal aspects of FGM, including the legal implications for those who perform it. And then they also introduced the concept of medicalisation of FGM, and at the end we took a - let me call it a vow - not to be part of those who engage in medicalisation of FGM”. (Medical student)

The quote reflects a clear shift from limited awareness to informed knowledge, which then led to an ethical commitment and professional responsibility as a direct result of the training. Specifically, it demonstrates that participants moved from having little or no understanding of FGM to acquiring comprehensive knowledge of its forms, health consequences, legal implications, and referral pathways. Importantly, the training also prompted a values-based change: by addressing medicalisation and its harms, including providers' potential role in perpetuating FGM, this student made an explicit commitment not to engage in the practice. Similar changes were also reported among lecturers, as highlighted:

“Despite me undergoing a training, a health-related program, undergoing a master's program and even currently a PHD (doctorate) I could not strictly say that FGM is bad I could say people do it, but let them do it in the hospital. That was my belief initially, but now that one, I

know FGM in whatever form, wherever it's done, it's not good and safe for women and girls". (KII, Lecturer, Kenya)

Access to information on how to manage FGM-related complications has led to improved techniques and skills for the medical students, enabling them to manage such complications successfully.

"Ah, we also teach the students to manage their immediate and long-term complications better, and also the most important part which was actually a problem is how to do a surgical intervention to correct type three intervention FGM which is di-infibulation. So, the skills that are most important are di-infibulation, which we normally teach our students to do, and some students have reported that they have done di-infibulation just after the training". (KII, Lecturer)

The students indicated being more conversant with such medical complications and engaging proactively to teach and train other health professionals on FGM, as one student narrates below:

"I have been able to do CMEs to my fellow nurse interns; we have Continuous Medical Education; I have been able to talk to them about FGM and the types that FGM has and the type of care that they can give in terms of management and counselling from the training that I got. I am able to pass that information to my fellow health care workers within the facility".

The medical students and lecturers benefited from the training by becoming change agents in the healthcare system. They became advocates against medicalisation, recognising that it is not about how safe the procedure is but about violating the rights of the girl/woman and therefore taking an oath to oppose the practice in totality.

Institutional level changes/impact (grantees and governmental bodies)

In Kenya, the advocacy workstream of TGG-ALM supported the development of a costed matrix for Narok County, a subnational area in Kenya that has domesticated the FGM policy. The costed matrix led to the allocation of costs for FGM activities in the county's annual development plan, a crucial component in policy implementation. In other areas, religious institutions increasingly participated in anti-FGM campaigns, with training initiatives increasing religious leaders' knowledge about FGM and its consequences and their confidence to speak against the practice in religious forums and community spaces such as chiefs' barazas (see more under sect 2.1.7 and box 1).

Participants also noted improved institutional capacity among local organisations that were awarded small grants. This included improved planning and more systematic implementation of activities such as regular awareness sessions, counselling, public barazas, engagement with local leaders, and referral systems. Through the capacity building, small community-based organisations expanded in staff capacity and development of policies, as one grantee manager reflected:

"But with TGG, they have really a capacity to build us as an organisation, and as an individual. Now, things are different; we have a lot of policies. We have board members. We never had a board member in the first place. You know, they have the capacity to build our board members. They have educated us on how to get board members. And now we have a very structured organisation in structured board members. We have policies, a lot of policies. We have the procurement policies, HR policies. We have the safeguarding policy that we didn't have in the first place. So, they have also helped our organisation grow, and they have also helped us individually ourselves also grow". (KII, Grantee manager, Garissa).

The small and medium CBOs attributed their growth to the training and grants received from the TGG program. The groups expanded their reach in campaigning against FGM due to increased staff and the financial ability to reach the remote areas. The capacity building moved beyond institutional to individual with the grantees and the grant managers indicating that the training had been beneficial for them, giving them confidence to speak about FGM and to collaborate with other community leaders. The confidence enabled the grantee organisations to fight community backlash and break some of the cultural barriers, as seen in the quote below:

“We received a lot of community backlashes. And yeah, and the fact that you're even, the fact that you are young girls was more, was even the worst issue because talking to our elders and talking to our women, telling them FGM is wrong, and they tell you, ‘How do you know it's wrong? I've given birth to 10 kids. You haven't even had one kid’... I have been using circumcised women and religious leaders in our awareness programs. So, yes, right now it's different...they have understood, okay, this organisation is really talking about something that is real, something that is there”. (KII, grantee manager, Garissa)

The evolution of Ewang'an Community-Based Organisation (CBO) illustrates how the TGG-ALM programme's investment in institutional capacity can transform fragmented grassroots advocacy into a unified, high-impact movement. By providing phased financial support and technical mentorship, the programme enabled Ewang'an to transition from a small collection of informal self-help groups into a credible, medium-level CBO with robust governance and safeguarding policies. This professionalisation allowed the organisation to move beyond "siloed" efforts and gain the community trust necessary to engage traditional power structures. Today, the organisation serves as a model of community ownership in Narok County, successfully turning former FGM practitioners into whistleblowers and silent fathers into vocal protectors, proving that strengthened local leadership is the most effective engine for the sustainable abandonment of FGM (Box 4)

Scaling grassroots impact: how institutional capacity strengthening refined Ewang'an's mission

Ewang'an Community-Based Organisation (CBO) is a grassroots organisation founded in 2019 by local self-help groups in Narok East, Narok County. The organisation focuses on human rights sensitisation, working primarily with women and young people, with a core mandate to end female genital mutilation (FGM).

Before the establishment of Ewang'an CBO, several informal self-help groups operated in silos on FGM advocacy, resulting in limited influence. Recognising this limitation, seven groups collaborated to form a community-based organisation that could more effectively represent community concerns and speak with a unified voice. As founder Dickson Kaleche observed,

"To argue as an individual, it was a bit difficult. So, we came up with an idea that we need to have a community-based organisation that is going to speak for the community."

Between 2022 and 2023, TGG-ALM began working with Ewang'an, a CBO, to provide grants and strengthen organisational capacity. From 2023 to 2025, the organisation transitioned from a small to a medium-level CBO, with improved governance, planning, monitoring, and accountability systems. With support from TGG-ALM, COVAW, Amref Health Africa, and initial start-up support from Forum Sieve, the CBO developed finance, procurement, and safeguarding policies that strengthened transparency and credibility.

The TGG-ALM programme provided phased financial support, beginning with a seed grant and later scaling up to KES 3 million. TGG also provided capacity strengthening through workshops, mentorship, and on-site support. Ewang'an CBO strengthened its operations, responsibly managed funding, and expanded its community awareness efforts among diverse community members. From a small CBO to a medium-sized organisation, Ewang'an strengthened its financial system by recruiting a finance officer and improving financial record-keeping and proposal development. It also shifted from cash-based operations to online banking systems. The organisation gained the capacity to manage larger grants and confidently engage with partners and government stakeholders within the county.

Ewang'an's new status also enabled deep community engagement across all generations. Notable shifts in social norms emerged as former FGM practitioners shifted from performing FGM to provide surveillance to prevent FGM, while a peer group of 60 secondary school girls was organised to sensitise peers and support rescues. Central to this success was the strategic engagement of men through the "Men Talk" forum. By initiating dialogues on livelihoods before transitioning to discussing FGM, the CBO disrupted long-standing power dynamics, fostering father-daughter discussions where men openly supported their daughters' decisions.

In one powerful instance of male intervention, a father discovered his daughter had been taken to a neighbouring village for FGM; he issued firm instructions to the mother to ensure the girl's safety, warning that any harm would be reported to local authorities. This involvement reduces secrecy and grants girls space to express themselves without fear. Furthermore, the Edu-Sport program for schoolboys and the inclusion of previously hesitant religious leaders created new layers of advocacy and community accountability.

Ewang'an CBO is today recognised as a trusted community institution and serves as a referral point/channel for health, family planning, and gender-based violence across five villages: *"It was easy for us to penetrate because there was a feeling that this was our organisation. There is community ownership. When people feel you belong to them, they listen."* Narok County's experience demonstrates that sustained progress against FGM is achievable by strengthening grassroots organisations and treating communities as partners rather than beneficiaries. Empowering local leadership and working with government can help translate laws into lived change—offering girls not just protection but also viable alternatives and agency over their futures.

Box 4: Scaling grassroots impact: How institutional strengthening refined Ewang'an mission

Networks and movement building

The TGG-ALM programme's movement-building approach focused on convening diverse stakeholders to employ a collective action towards the abandonment of FGM, while also fostering strategic linkages with organisations and networks working to end FGM at national, regional and global levels. Two major achievements in movement building were identified. First, the establishment of the Survivor Leadership Initiative created a structured platform for empowering FGM survivors, strengthening their leadership, visibility, and influence within advocacy spaces. Second, the formation of a national civil society organisations network in Kenya, which was launched in July 2023 and comprised 120 member organisations, enhanced coordination, policy engagement, and collective advocacy at the national level through collaboration with the Government's Anti-FGM Board.

"The SLI [Survivor Leadership Initiative] programme prioritises the well-being of the survivors, especially their mental health, because if the survivors are expected to lead, the work must start from a place of healing. Once they are trained on self-care, they are then taught on leadership. The TGG-ALM program has supported the survivors to form networks in each of the countries, and some, or all of them, have started their own organisations. They were funded by the organisation, and some of them have since received funding from other sources. For instance, a survivor in the Garissa network received funding from UNFPA". (Movement building lead)

The movement-building strategy intentionally prioritised inclusivity, making deliberate efforts to ensure the meaningful participation of persons with disabilities. This included securing their representation in national and regional forums and allocating funding to organisations led by persons with disabilities. By integrating diverse voices and lived experiences into the campaign to end FGM, this inclusive approach strengthened the coverage and sustainability of the movement.

"I attended so many training sessions which were being funded, almost all conducted by the TGG-ALM team. What I can say is that as a woman with a disability, my voice, you know, became stronger, you know. So, I was shy when I was talking to people, but what I can say is through the training that I gained knowledge that connected me with many other organisations. I have seen and met new friends. I have learned how to, you know, handle such cases like the case of the FGM or something like that. What I can say is I have learned from others through the training and cooperative funding that I gained from the TGG-ALM team." (KII participant, Grantee manager, Garissa)

Regional and local advocacy and policy implementation

Several significant advocacy-related changes were observed because of the programme's interventions. These included the reframing of FGM from a cultural or traditional harmful practice to its recognition as a form of GBV, harm, and abuse. In addition, the integration of the medicalisation of FGM in policy and normative documents as an unacceptable practice reflects a key policy-level achievement, following sustained advocacy efforts at the African Union level.

"For example, at the African Union last December, I remember we were given a chance to input into the outcome documents, I think that is one platform that we had a chance... to really say that as a program we know that medicalisation of FGM is there and it is not acceptable and there is need for it to be in policy" (KII, Programme implementation partner)

The programme also contributed to increased recognition of the interlinkages between climate change and FGM/GBV, particularly in contexts where climate-related shocks such as drought exacerbate vulnerability, leading to early and forced marriages and increased risk of FGM. This inclusion of climate change into discussions on FGM strengthened the policy discourse by positioning FGM within broader structural and environmental risk factors, rather than as an isolated cultural practice.

“So again that interlink between climate change and gender-based violence has also now again come into policy and policy are also referring to that because when there's drought

more girls get cut more girls get married...before they get married, they have to be cut so again there's a interlink between the climate change and FGM.” (KII, programme implementation partner)

A key strategy underpinning successful advocacy against FGM was the use of appropriate, and rights-based messaging. This was achieved through targeted training of key stakeholders including grantees, journalists, and FGM survivors on strategic media engagement. These capacity-building efforts were designed to strengthen consistent framing of FGM as a human rights violation and a form of gender-based violence, rather than as a cultural or traditional practice. Community-based media platforms were targeted, especially vernacular radio, given their central role in reaching local populations and shaping community discourse. As noted by one respondent:

“Radio, the vernacular radio, the importance of media engagement because these are in the communities and the grantee partners are community-based organisations that are quite central to the program. Aligning their work is quite central by strengthening their capacity in media engagement (...) because how the story of FGM is told has always been framed as culture—but it is not culture. It is a form of gender-based violence”. (Programme implementation partner)

The training also empowered survivors to confidently share their lived experiences, while equipping journalists with skills to document and translate these narratives into platforms that promote dignity, fairness, and agency. A deliberate shift was encouraged in media practice to recognise survivors not merely as storytellers, but as experts with valuable insights and solutions grounded in lived experience. This capacity-building approach contributed to more responsible media representation, strengthened survivor-centered advocacy, and supported normative change in public discourse on FGM.

“Media has in the past and continues to handle survivors as if they are not experts... but survivors are experts of their own experiences. They have the right to offer solutions because they know what they have gone through. They have a right to a decent platform”. (Programme implementation partner)

Sustainability

Interviews and observations highlighted several strategies intended to sustain changes beyond the programme period in Garissa and in Kenya in general. First, participants reported that the programme worked towards embedding the interventions in existing institutional anchors, notably school clubs supported through trained teacher-patrons, and multisectoral county coordination (e.g., technical working groups and child protection structures). This ensured that activities were institutionalised rather than stand-alone, reducing reliance on the programme timeline and increasing the likelihood that outcomes would be sustained beyond TGG-ALM lifecycle. The embedment in existing structures involved integrating the programme into the health care system through the development of an FGM-related curriculum, training of students, lecturers and providers, and the establishment of a model health facility in Narok (moving beyond the training) to create the conditions for providers and students to implement the skills learned (see Section 3.1.8).

The second strategy was the nurturing and building of champions (including women, religious leaders, chiefs, youth and former FGM practitioners, journalists) through training and support to convene dialogues (sensitisation sessions, intergenerational and couple dialogues) and act as trusted messengers (as highlighted in the section regarding individual level changes). Another key approach was the small grants mechanism. A key sustainability strategy employed was to strengthen larger community-based organisations to mentor, build the capacity of, and monitor smaller CBOs, so that organisational structures and anti-FGM advocacy could continue beyond the life of the programme. As one programme manager explained:

“The whole essence, or the whole thought behind the TGG-ALM grant was to strengthen grassroots organisations to take the lead in terms of implementation and leading advocacy in FGM, such that once the TGG-ALM grant comes to an end, we have left grassroots organisations

that can continue their work. So, we had six organisations under us, which were building capacity”. (Program manager, Grantee Organisation).

Finally, participants emphasised movement building (including support to networks such as Men4Change and survivor leadership) as an important lever of sustainability. As highlighted earlier, these approaches have proven to be effective in producing changes and shifts at the individual level and institutional level and creating a movement within Garissa and Kenya in general. When it comes to the sustainability of the gains, participants reported that the most sustainable gains are those embedded in institutions (such as the health system and schools) where school clubs and safeguarding, counselling and referral practices have been absorbed into routine activities and are likely to continue, even if activity levels reduce.

Similarly, the skills, confidence and leadership of trained champions and local organisations that benefited from the grant mechanism were cited as gains that are likely to be sustained beyond the programme.

“Yes, because after this we can get grants from other organisations to push this campaign, and even if we don’t get, we can continue with the campaigns to areas that have not been reached”. (KII, program manager, grantee organisation).

The outcomes harvesting findings show that a few organisations have already managed to secure funding (even though not directly on FGM) thanks to improvements in their structures and their leadership. They are now trusted organisations that can apply for funding or join consortiums to attract funding and continue working on FGM.

However, stakeholders emphasised the need for creating the conditions for these gains to be sustained. This includes the need for a multifaceted approach that addresses both systemic and community-level drivers to sustain progress toward the elimination of FGM. Stakeholders highlighted the need for strengthened healthcare practices, robust law enforcement and accountability mechanisms, and inclusive engagement of men, parents and other community members, and not just girls, to ensure safeguarding. As TGG-ALM’s gender lead explained:

“To achieve sustained impact, there is a need for a multifaceted approach that includes different stakeholders, including men, parents, and other people, as focusing only on girls would raise safeguarding concerns” (KII, programme implementation partner).

Additional sustainability mechanisms included strengthening multi-sectoral partnerships, establishing civil society organisation networks, and developing practical advocacy tools, such as the girl-centered framework and practical guide, and the safe space checklist, to support youth inclusion and long-term community ownership of the campaign against FGM.

“Sustainability depends on continued training, community engagement, and adequate resources. Regular monitoring and follow-up are essential”. (KII, Health Professional /Lecturer, Garissa, Kenya).

Stakeholders noted that sustainability depended on continued engagement with communities through regular follow-up meetings, movement-building activities for girls, and consistent communication with community champions, even with limited resources. These ongoing interactions were noted to provide space to assess community dynamics, address emerging challenges, and strengthen local ownership of anti-FGM efforts.

In the absence of these sustained engagement and accountability mechanisms, initial gains risk being eroded over time. The durability of behaviour change remains uncertain in contexts where FGM is deeply tied to identity, marriage prospects, and fear of social sanctions, and where enforcement is

uneven, as highlighted earlier. Moreover, where findings indicate limited shifts in underlying values that sustain FGM, and the emergence of adaptation strategies such as medicalisation or transitions from Type III to Sunna FGM, the lack of continued engagement with stakeholders and community members, as well as weak community accountability responses, may further dilute programme gains.

Summary/overview of key findings

- **Programme exposure:** This was associated with more progressive beliefs and lower support for FGM among respondents in intervention sites. Exposure to FGM-related activities in intervention sites was associated with more opposition to FGM and lower intention to practice FGM, reflecting favourable attitudes in areas where the intervention was directly implemented. Respondents exposed in intervention sites consistently showed the most progressive outcomes across beliefs, knowledge, sanctions, intentions, agency, and overall attitudes, confirming a strong exposure gradient (a clear and consistent relationship between exposure and the resulting outcomes).
- **Importance of community engagement:** Building advocacy networks, empowering survivors, and involving men, elders, and religious leaders emerged as key strategies for shifting norms and sustaining anti-FGM efforts. Champions—including religious scholars, former practitioners, teachers, and youth—played a central role in diffusing anti-FGM messages through trusted community platforms such as barazas, madrassas, schools, and health facilities.
- **Persistent social norms:** FGM remains deeply tied to social identity, marriageability, and community expectations, indicating that individual attitudes alone may not be sufficient without broader community support. In Garissa, religious interpretations and clan-based expectations continue to reinforce the practice, especially in rural and pastoralist areas.
- **Gap between attitudes and behavioural intentions:** While attitudes toward FGM were more favourable among exposed respondents, behavioural-proximal outcomes such as intention to practice FGM remained influenced by strong social pressures and fear of sanctions. This gap reflects the early-stage nature of normative transition, where personal beliefs shift faster than perceived social expectations. This gap may also have contributed to a shift from type 3 FGM to Sunna FGM, often seen as “less harmful”, instead of a real abandonment of the practice.
- **Role of knowledge:** Knowledge did not show an independent association with overall attitudes once beliefs and gender norms were considered. This suggests that factual knowledge alone is not a strong determinant of opposition to FGM in this context. However, inconsistent messaging or framing, including promotion of shifts in FGM type, can lead communities to shift from ‘severe’ to ‘milder’ forms, rather than zero tolerance to all forms of FGM. The findings highlight that knowledge must be paired with credible messengers, religious clarification, and community-level dialogue to translate into normative change.
- **Medicalisation as a challenge:** There is a growing trend of FGM being performed in medical settings, which risks legitimising the practice. The programme responded through training, monitoring, a model health facility and medical curricula development, and advocacy to reinforce that medicalised FGM still constitutes a rights violation. Health workers reported community pressure to perform “safer” procedures, underscoring the need for stronger regulatory oversight and rights-based messaging.
- **Legal gaps and enforcement issues:** Kenya has strong anti-FGM laws, but enforcement is weak. Secrecy, cross-border FGM, and FGM at a younger age are common tactics to evade the law. Families increasingly conceal FGM, travel to remote areas, or rely on informal practitioners, highlighting the need for stronger surveillance, cross-county coordination, and community-based reporting mechanisms.
- **Change is gradual, fragile and context-dependent:** Progress is slow and can be easily reversed without sustained engagement, funding, and outreach, especially in hard-to-reach or high-prevalence areas. Geographic barriers, insecurity, and limited access to remote villages

Discussion on the Garissa findings

The bivariate findings show clear differences in the distribution of FGM-related outcomes across study sites and exposure categories. Respondents in intervention sites, and especially those exposed to FGM-related activities within these sites, consistently displayed higher proportions of favourable responses across beliefs, knowledge, sanctions, intentions, agency, and overall attitudes. Non-exposed respondents showed the least favourable distributions across nearly all outcomes, forming a clear descriptive gradient between non-exposure and exposure. Some patterns among respondents exposed in control sites appeared favourable but were based on very small cell sizes, and these percentages should therefore be interpreted cautiously. A further caution is that some respondents may not consider Sunna to be FGM, meaning attitudinal responses may not fully capture support for all forms of the practice. This gradient mirrors expected early-stage norm-change processes, where exposure to credible messengers and repeated dialogue shifts beliefs and perceived sanctions before deeper social expectations change (Cislaghi & Heise, 2018).

The regression analysis reinforces and sharpens these descriptive patterns. The overall social attitude index provides the strongest evidence, with exposed respondents in intervention sites having substantially higher odds of opposing FGM at endline. Although exposure in control sites showed a positive but not statistically significant pattern at endline, the pooled baseline–endline analysis indicated a statistically significant negative association, with those exposed less likely to oppose the practice compared with those who were not exposed. This divergence underscores that exposure in intervention sites aligns with more favourable normative climates, while exposure in control/baseline sites may reflect lower-intensity or historical activities embedded in more conservative contexts. Qualitative evidence supports this interpretation: many control site respondents had only indirect or historical exposure through earlier NGO activities, religious teachings, or informal community discussions, which may not have been strong enough to shift entrenched norms.

Across individual domains, exposure in intervention sites was associated with rejecting FGM-supportive beliefs and with higher FGM-related knowledge in the bivariate analysis. However, knowledge did not stand out as a separate factor influencing overall attitude once beliefs and gender norms were considered. This pattern aligns with evidence that knowledge often shifts earlier than deeper normative constructs. In Garissa, knowledge gains were often framed through health risk messaging or religious reinterpretation, but these did not always translate into broader normative change, especially where Sunna FGM was perceived as religiously acceptable or less harmful. Opposition to social sanctions also showed strong associations with exposure, suggesting that community dialogues and mentorship activities may be influencing perceptions of the social consequences of abandonment.

Attitudinal outcomes showed some of the largest associations. Respondents exposed in intervention sites were far more likely to have encouraged someone to abandon FGM, less likely to intend to cut their daughters, and more likely to report agency to oppose the practice. These patterns indicate strong associations, not only with attitudinal change but also with personal empowerment, which are critical markers of social norm change. Qualitative accounts from champions, teachers, and religious leaders confirm that interpersonal influence—particularly through school clubs, barazas, and peer-led sensitisation—played a central role in shifting intentions and agency.

A notable and unexpected finding was the persistence of Sunna FGM as a perceived “acceptable” alternative to abandonment. The shift toward viewing *Sunna* as an alternative to full abandonment, combined with increased secrecy due to anti-FGM laws, has slowed progress in ending FGM. In response to cultural and religious pressures, some families cut girls at younger ages or sought FGM services across borders, often changing the age and location to avoid detection. Participants noted that the TGG program helped change attitudes and increased opposition to FGM. However, framing FGM as a human rights violation was not directly reflected in reported changes. There was consensus to

oppose the Pharaonic practice, commonly referred to as FGM. Religious leaders, recognised as community influencers, further emphasised these perceptions. This partial shift—rejecting Type III while tolerating Sunna—illustrates a substitution effect documented in other Somali majority contexts (Shell-Duncan et al., 2017).

Gender-inequality beliefs were the least responsive domain, with no significant associations between exposure and more gender-equal views. This aligns with global evidence that gender norms are deeply entrenched and require sustained, multi-sectoral engagement to shift. The endline model also showed that respondents holding unequal gender beliefs were much less likely to oppose FGM (OR = 0.16, $p < 0.001$), reinforcing that gender norms remain a major barrier. Qualitative evidence suggests that in Somali-majority contexts such as Garissa, FGM abandonment is often justified through religious reinterpretation, heightened awareness of health risks, or legal prohibitions rather than through shifts in gender-equality norms. As a result, individuals may oppose FGM while still endorsing traditional gender hierarchies. This partial decoupling underscores that progress on FGM abandonment does not automatically translate into broader gender-transformative change. This finding is consistent with norm-change theory, which distinguishes between personal attitudes and collective expectations, and highlights that gender norms often lag behind other domains (Mackie & LeJeune, 2009).

Another unexpected finding was that respondents with primary or secondary education had lower odds of holding an overall attitude opposed to FGM compared with those with no formal education or those with religious education. This indicates that formal schooling in this context does not necessarily translate into more progressive attitudes toward FGM. This finding has important implications for tailoring messaging and engagement strategies. It suggests that educated youth and adults may be under-targeted by current interventions, or that formal education does not adequately address religious interpretations, identity-based norms, or peer pressures that sustain FGM. The implications could include education-knowledge de-coupling and the need to strengthen school-based clubs so that increased knowledge translates into normative change.

Overall, the Garissa results show a coherent pattern: exposure, particularly in intervention sites, is strongly associated with more progressive attitudes and behaviours related to FGM. However, the presence of exposure in control sites, the different contextual backgrounds and the long-standing activity of other organisations such as Action-AID, the Anti-FGM board and the Collaborative Centre for Gender and Development (CCGD), among others, complicate attribution. The findings should therefore be interpreted as reflecting broader ecosystem effects rather than programme-specific impacts. Taken together, the evidence suggests that Garissa is in an early-to-mid stage of normative transition, where shifts in beliefs, sanctions, and interpersonal influence are visible, but deeper gender norms, religious interpretations, and substitution practices (e.g., Sunna) require sustained, context-specific engagement.

Conclusion

The Garissa findings demonstrate that exposure to end FGM-related activities is strongly and consistently associated with more progressive attitudes toward FGM abandonment. The overall social attitude index presents the clearest pattern: respondents exposed in intervention sites were substantially more likely to oppose FGM, both at endline and in the pooled analysis. Exposure in intervention sites was also strongly associated with rejecting FGM-supportive beliefs, FGM-related knowledge, greater opposition to social sanctions, and reduced support for continuation of the practice. Across both endline and pooled analyses, non-exposed respondents consistently displayed the least favourable outcomes, underscoring the central role of exposure in shaping attitudes and behaviours. These patterns reflect an expected early-stage norm-change trajectory in which beliefs, knowledge, and perceived sanctions shift before deeper social expectations fully transform.

Attitudinal outcomes, such as encouragement of abandonment, intention to cut daughters, and agency to oppose FGM, showed some of the largest effect sizes, indicating shifts in interpersonal influence and personal empowerment. In contrast, gender-inequality beliefs remained largely unchanged, underscoring the need for deeper, longer-term gender-transformative approaches. Although gender-inequality beliefs showed limited movement, and in some cases displayed counter-intuitive patterns, this reflects the reality that FGM abandonment in Garissa can advance through religious, legal, or health-based reasoning even when broader gender norms remain resistant. This partial decoupling

between FGM abandonment and gender equality norms is consistent with global evidence showing that gender norms often lag behind other domains of social change.

Differences between intervention and control/baseline sites point to distinct normative environments. As exposure also occurred in control sites and multiple actors have long operated in Garissa, these results reflect broader effects of FGM-related programming rather than impacts solely attributable to TGG. However, it is important to note that from the qualitative findings, participants specifically attributed the changes they experienced to the program. The findings suggest that community dialogues, mentorship activities, and other forms of stakeholder engagement are contributing to meaningful shifts in knowledge, attitudes, and emerging behaviours. Champions—including religious scholars, former practitioners, teachers, and youth—played a central role in diffusing anti-FGM messages through trusted community platforms, reinforcing the programme’s influence even in settings with longstanding external actors.

This evaluation shows that exposure to the TGG-ALM programme led to reduced support for FGM and intentions to cut daughters among those reached with interventions at schools, community centres, and health facilities, helping to create spaces to challenge entrenched beliefs, amplifying the programme’s impact. However, persistent barriers remain, especially in high-prevalence areas. These include persistent social pressures making behaviour change difficult despite improved attitudes. Social identity and marriageability are powerful drivers of FGM, and pro-FGM beliefs strongly predict intentions to continue the practice. The persistence of Sunna FGM as a perceived “acceptable” alternative to abandonment illustrates a substitution effect that slows progress and requires explicit zero tolerance messaging. Engaging men and boys is increasingly effective in the campaign to end FGM, suggesting a promising direction for future interventions.

Centering girls within FGM discourse may have contributed to the empowerment of girls and women by elevating their voices and strengthening their confidence to share lived experiences that can influence their communities. Through intergenerational dialogues, women of different ages have been able to engage more openly about the intergenerational trauma associated with FGM. Topics that were previously considered private or too sensitive to discuss are increasingly being addressed in public and community spaces, with champions and FGM survivors at the forefront of advocacy to end the practice. These shifts in public discourse signal early signs of normative transition, even as deeper social expectations remain contested.

Partial knowledge and limited shift in beliefs—and in some cases no shifts at all— may also drive a shift in practice, highlighting the need for comprehensive education that explains that “milder” forms of FGM and medicalised FGM are still violations. Indeed, as awareness of the severe health risks and legal consequences associated with more “extreme forms” of FGM increases, many families adapt by opting for practices perceived as “milder,” “less” harmful, or less visible, namely Sunna FGM. These adaptations are frequently rooted in the persistence of social norms and beliefs that link FGM to morality, marriageability, and religious identity, alongside a growing desire to minimise risk, protect daughters and avoid sanctions. In contexts where messaging emphasises harm reduction without clearly reinforcing that all forms of FGM (including Sunna) constitute rights violations (as highlighted in the findings), communities may interpret programme messages as tacit approval of lesser forms. This underscores the need for comprehensive education that explicitly challenges the legitimacy of all forms of FGM and addresses the normative beliefs sustaining the practice, rather than focusing solely on severity or health outcomes. Similarly, the rise in medicalisation also poses challenges requiring strong

health sector accountability, ongoing ethical training for health workers, strict enforcement of health-sector regulations, along with comprehensive education and messaging (as for Sunna FGM). Health workers reported community pressure to perform “safer” procedures, underscoring the need for rights-based messaging that clearly rejects all forms of FGM.

While Kenya has strong anti-FGM laws, enforcement is weak. Secrecy, cross-border FGM, and the shift to subjecting younger girls to FGM complicate detection and require adaptive programming. These patterns show that legislation alone is insufficient without community involvement, accessible reporting, and clear accountability mechanisms. The combination of secrecy, early-age FGM, and

cross-border mobility reflects community adaptation to legal pressure, requiring stronger surveillance and cross-county coordination.

Sustainability relies on empowering survivors as advocates, strengthening local organisations and fostering community ownership. Integrating FGM counselling into maternal health services can expand dialogue and improve awareness. Although change is gradual and fragile, increased reporting by empowered girls and the growth of survivor-led networks signal early signs of social transformation. Taken together, the evidence suggests that Garissa is in an early-to-mid stage of normative transition, where shifts in beliefs, sanctions, and interpersonal influence are visible, but deeper gender norms, religious interpretations, and substitution practices require sustained, context-specific engagement. Continued funding, outreach, and engagement remain critical to prevent backsliding and consolidate progress.

Implications of the findings

The findings show clear shifts in beliefs and attitudes toward FGM among those exposed to interventions. These positive changes, however, are accompanied by new challenges and adaptations within communities. The implications for policy and practice highlighted below reflect both the progress achieved and the evolving landscape of FGM.

1. **Support survivor-led advocacy:** Empowered survivor networks have started to disrupt norms and add legitimacy to anti-FGM efforts. Sustaining and scaling this leadership is crucial for long-term change. Survivors’ testimonies were among the most influential drivers of attitude change, suggesting the need for structured platforms, psychosocial support, and long-term investment in survivor leadership.
2. **Expand reach to underserved and nomadic communities:** Change has been most pronounced where interventions occurred, but gaps remain in hard-to-reach areas. Extending coverage is essential for wider impact. Geographic barriers, insecurity, and the concentration of activities in trading centres limited reach to pastoralist and remote settlements, underscoring the need for mobile, flexible, and locally led delivery models.
3. **Address all forms of FGM explicitly:** As some communities shift from ‘severe’ to so-called milder forms, messaging must be clear that all forms are harmful (and illegal, even if conducted by medical professionals) to prevent substitution. The persistence of Sunna FGM as a perceived “acceptable” alternative requires explicit zero-tolerance messaging and stronger religious engagement to counter misinterpretations.
4. **Strengthen enforcement and accountability:** The move to more secretive or early-age FGM highlights the need for more robust monitoring, reporting, and legal action. Cross-border mobility, FGM at younger ages, and strategic concealment reflect community adaptation to legal pressure and require stronger surveillance, community-based reporting mechanisms, and cross-county coordination.
5. **Engage men, elders, and religious leaders:** Shifts in male attitudes demonstrate the value of involving influential community members to accelerate broader norm change. Religious scholars were particularly effective in demystifying pro-FGM religious arguments, indicating the need to institutionalise their role in community dialogues and school-based programmes.

6. **Prevent medicalisation:** The trend toward medicalised FGM requires specific action within health systems, including provider accountability and ongoing training. Health workers reported community pressure to perform “safer” procedures, highlighting the need for rights-based messaging, strengthened regulatory oversight, and integration of anti-FGM content into pre-service and in-service training.
 7. **Sustain girl-centering:** Utilising platforms and providing adequate resources is required for sustained engagement, mentorship and networking of girl champions and girl council⁴ within
8. the CSO networks and other regional platforms. School clubs and peer-led dialogues were central to shifting intentions and agency; strengthening these platforms is essential to ensure that increased knowledge translates into normative and behavioural change.

Ethiopia

Background to findings

FGM remains a widespread practice in Ethiopia, with an estimated 65% of women and girls having undergone the process (EDHS 2016). There has been a marked decline in the practice, but it remains prevalent, with high numbers recorded in Ethiopia's Somali (99%), Afar (91%), and Amhara (71%) region communities. (Gebremicheal, 2018; Melese, 2020; UNICEF, 2024).

Amhara region is home to over 23 million people, making it the second-most populous region in Ethiopia. The population is predominantly Amhara (91.5%) and minority groups, including the Agaw (3.5%), Oromo (2.3%), and Qemant (1.2%). Religious life is central to the region's social fabric, with 82.5% of the population identifying as Ethiopian Orthodox Christians and 17.2% as Muslim. Most of the population (87%) resides in rural areas. The average household size in the region is 4.3 persons, though this varies between urban (3.3) and rural (4.5) settings (EDHS 2016). The regional economy is primarily dependent on subsistence agriculture, with a significant portion of the population working as farmers (CSA, 2007). Literacy rates show a significant gender gap; adult literacy for men is roughly 54%, compared to 25% for women. The primary school enrolment is about 83.9%. The infant mortality rate is high at roughly 67 to 94 deaths per 1,000 live births (Adunga, 2025). The region has some of the highest rates of harmful traditional practices (HTPs) in Ethiopia, many of which are deeply rooted in cultural and religious beliefs.

While FGM prevalence in Amhara has declined to approximately 62% (EDHS 2016), the region still accounts for the highest absolute number of girls at risk due to its large population, with the practice dominantly present in rural areas and across all religious groups. FGM practice is identified as a criminal offence under the criminal code in Ethiopia. Laws have been set up to penalise the performance of FGM practice, stipulating tougher penalties for infibulation (type 3 FGM). Challenges have been cited in implementing the law, including clear definitions of the types of cuts prohibited, limited information on medicalised and cross-border FGM practices, and low fines (Presler-Marshall, 2022). Moreover, the enforcement process is not standardised, with some cases handled outside formal processes (Abebe, 2020).

To address the widespread practice of FGM and mitigate the challenges in ending FGM in the country, more specifically in the Amhara region, The Girl Generation - Support to the Africa-led Movement to end Female Genital Mutilation (FGM) (TGG-ALM) was implemented, focusing on the woredas of Guna and Farta.

⁴ The Girl Council under TGG-ALM programme is a youth-led platform that shifts adolescent girls from passive beneficiaries to active decision-makers and peer educators. Established through participatory community consultations and intensive advocacy training, the Council serves as a formal advisory body that enables girls to lead/support community outreach (including rescuing girls at risk of FGM) and hold stakeholders accountable, ensuring interventions are culturally responsive, sustainable, and firmly rooted in girls' lived experiences.

In Ethiopia, the programme was implemented by Action-Aid Ethiopia (at different levels), Options Consultancy (for the grant mechanisms), ACCAF for the integration component, and the Options CAMB team at regional and national levels. The interventions implemented in the target region (Amhara) and at the national level included:

Individual level:

- *Peer-to-peer sessions for girls, boys, and young people:* Partners ActionAid Ethiopia and Options' grantees trained and supported volunteers to facilitate clubs at school and community levels focused on changing beliefs to end FGM. It is important to note that the initial intervention was school-based but later shifted to community-based due to conflicts leading to schools' closure in the region.

Community level:

- Partners – ActionAid, grantees – trained community leaders (religious leaders, Iddir leader, Kebele administrators), community health volunteers, and former FGM practitioners to hold various forms of community dialogues (intergenerational dialogues, model couple) and sensitisation sessions, providing them with coaching and training materials.
- Options managed a small grants mechanism to provide financial resources to expand the reach of local organisations with pre-existing work and commitment to ending FGM (or closely aligned areas), and to develop their capacity further. These funds supported a range of local activities to end FGM through community dialogues and forums.

Regional and national level:

- The Africa Coordination Centre for Abandonment of FGM (ACAAF), developed and rolled out a standardised FGM prevention and response pre-service training curriculum in health training institutions. This curriculum aims to equip health care providers with knowledge and practical skills to prevent and respond to FGM. The training covered the shift towards medicalisation of the practice.
- Anti-FGM partners (AAE, grantees and CAMB) engaged local stakeholders through a series of activities, including facilitating the setting up of FGM Steering Committees and girls' councils, Radio and TV broadcasts, social media campaigns, and celebration of key events at National level.
- Partners (AAE, ACCAF, CAMB, Options) implemented training programmes to empower survivors of FGM, FGM activists and journalists. These initiatives were specifically designed to equip participants with the skills and confidence needed to effectively amplify their voices and share their experiences.

Data sources

The data collection in Ethiopia employed mixed methods involving community-based surveys and qualitative interviews in Guna and Farta districts. Data were collected by trained research assistants with experience in quantitative or qualitative data collection and who were from the study sites.

Endline quantitative and qualitative data collection was conducted from November 22 to December 21, 2025. We also held a community sensitisation meeting with stakeholders from the zone, woreda and kebele. These included individuals from local administrations, health, education and WCSA. Data quality was ensured through a field leadership structure comprising the supervisor, team leaders and APHRC team, who conducted daily supervision, spot checks, sit-ins (where feasible), daily debrief meetings with the field teams, and review of preliminary data for consistency. The baseline data collection was conducted in February 2023 by the University of Portsmouth. The data analysis involved comparing baseline and endline, as well as intervention and control sites (see more details under section 2.3 Data management and analysis).

Table 13. Summary of sample size per data collection approach

Data collection approach	Target participants	Sample size
Endline community-based survey	Girls, boys, women and men (15-65 years)	560
In-depth and key informant interviews	Champions, Edir leaders, students, local journalists, National policy makers consortium partners (Options, ActionAid), Healthcare providers, Lecturers, grantee organisations	45
Focus group discussions (total FGDs)	Grantees Organisations, Women Watch group members and association members	6
Baseline community-based survey	Girls, boys, women and men (15-65 years)	
		802

Socio-demographic characteristics and differences in FGM-related knowledge and attitudes

The Ethiopia sample included 802 respondents at baseline and 560 at endline as shown in Table 14. Several demographic and attitudinal differences were observed between the two rounds. Women represented the majority at baseline (75%) but accounted for a smaller proportion at endline (52%), while men constituted a larger share at endline. The age profile also differed, with respondents aged 45 years and older representing 18% at baseline and 29% at endline. Educational attainment was broadly comparable across rounds, with low education reported by 37% at baseline and 42% at endline, and secondary education or above reported by 26% at baseline and 22% at endline.

Differences were also observed in FGM-related knowledge and attitudes. The proportion classified as having high FGM-related knowledge was 56% at baseline and 59% at endline. Beliefs opposed to FGM were more common at endline (81%) than at baseline (64%). Gender-inequality beliefs were reported by 75% of respondents at baseline and 84% at endline. Being in favour of social sanctions for FGM abandonment was reported at 15% at baseline and 22% at endline.

Behavioural and attitudinal indicators also varied across rounds. The proportion of respondents who had ever encouraged someone to abandon FGM was 28% at baseline and 33% at endline. Intention to subject daughters to FGM was less common at endline, with 89% opposed compared with 77% at baseline. The overall social attitude index showed 84% opposed to FGM at baseline and 77% at endline.

Table 14. Socio-demographic characteristics and difference in FGM-related knowledge and attitudes in the Amhara region, Ethiopia

Characteristic	Baseline	Endline
	N = 801 ¹	N = 560 ¹
Study site		
Baseline	801 (100%)	—
Control	—	350 (63%)
Intervention	—	210 (38%)
Exposure to FGM-related activities		
Non-exposed	612 (76%)	402 (72%)
Exposed	189 (24%)	158 (28%)
Respondent sex		
Men	200 (25%)	268 (48%)
Women	601 (75%)	292 (52%)
Marital status		
Married	179 (22%)	160 (29%)
Unmarried	622 (78%)	400 (71%)

Age group		
< 25yrs	261 (33%)	142 (25%)
25-34	213 (27%)	129 (23%)
35-44	180 (22%)	125 (22%)
≥ 45yrs	147 (18%)	164 (29%)
Education		
No formal education*	296 (37%)	235 (42%)
Primary	299 (37%)	201 (36%)
Secondary+	206 (26%)	124 (22%)
FGM-related knowledge		
Low	351 (44%)	230 (41%)
High	450 (56%)	330 (59%)
Beliefs related to FGM		
In favour	287 (36%)	107 (19%)
Opposed	514 (64%)	453 (81%)
Gender-inequality beliefs		
Unequal	599 (75%)	471 (84%)
Equal	202 (25%)	89 (16%)
Social sanction for FGM abandonment		
In favour	117 (15%)	123 (22%)
Opposed	684 (85%)	437 (78%)
Ever encouraged FGM abandonment		
Never	573 (72%)	375 (67%)
Ever encouraged	228 (28%)	185 (33%)
Agency to oppose FGM		
Can not oppose	—	466 (84%)
Can oppose	—	88 (16%)
Whether FGM should continue		
Not for continuation	—	265 (48%)
In favour of continuation	—	289 (52%)
Discrimination against girls who have not undergone FGM		
Not for discrimination	—	403 (73%)
In favour of discrimination	—	151 (27%)
Intention to subject daughters to FGM		
Opposed	619 (77%)	497 (89%)
In favour	182 (23%)	63 (11%)
Overall social attitude to FGM		
In favour	125 (16%)	127 (23%)
Opposed	676 (84%)	433 (77%)

Note: (*) No formal education refers to respondents with no schooling or those who are literate but have not attended formal education (other literates)

Exposure to FGM-related programmes

Exposure patterns varied across study sites in the Amhara region. Across the combined baseline and endline sample of 1,361 respondents, about 75% were classified as non-exposed and 25% as exposed to FGM-related activities. At baseline, 24% of respondents reported exposure, and at endline, 22% of

respondents in control sites and 39% in intervention sites reported exposure. These figures indicate that exposure was present in both types of sites, with higher proportions in intervention areas (Table 15)

Table 15. Overall exposure at baseline and endline by study site in the Amhara region, Ethiopia

Study site	Exposure to the intervention		Total
	Non-exposed	Exposed	
Baseline	612 (76%)	189 (24%)	801 (100%)
Control	273 (78%)	77 (22 %)	350 (100%)
Intervention	129 (61%)	81 (39%)	210 (100%)
Total	1,014 (75%)	347 (25%)	1,361 (100%)

Qualitative findings show different levels of exposure in the programme activities in the intervention's districts. Individuals involved in the programme activities through training and dialogues were exposed to the programme. This is also the same for communities living in intervention areas, or neighbourhoods where dialogues or sensitisation sessions are held.

Qualitative data show that exposure was rarely accidental; it was facilitated through embedded community channels such as school clubs, peer-to-peer sessions, community dialogues, and sensitisation sessions, among others. For the adolescents and young people, the school was initially the primary point of contact. Programs were not just extracurricular; they were integrated into "Safe Space" dialogues and gender clubs. After the closure of school because of conflict in the area, community-based peer-to-peer sessions took over as a channel for exposure of adolescents and young people.

Adult community members such as men and mothers were exposed to the programme through the sensitisation sessions and dialogues organised by trained champions such as religious and community leaders. Some participants explained that "Fathers of the God" (religious leaders) are the community's highest authority. Therefore, their invitation to training or dialogues was seen as a mandatory call.

Other community members, such as pregnant women and mothers, were exposed through pre and postnatal or outreach activities led by Health extension workers. One Community health worker explained that they often used mandatory vaccination and "Kiba Kidus" (religious baptism) schedules to identify families with newborn girls, using these moments to expose parents to anti-FGM education. Mass mobilisation events also appeared as channels for exposure. The use of "Montarbo" (mobile loudspeakers) and public dramas during National Women's Day or religious festivals provided broad-spectrum exposure to those who had not yet been reached by direct training and dialogues. Beyond direct participants, the program influenced families and neighbours through a "ripple effect" led by community champions. Armed with a deeper understanding of the harms of FGM and reformed perspectives, these champions actively sensitised their social circles, fostering broader community awareness.

The qualitative findings also provided information on reasons why certain segments of the community remained unexposed or resistant to the programme. The most cited reason for non-exposure was the sheer physical distance between villages and the selective nature of the intervention sites. Some participants explained that people living in neighbouring or remote sub-kebeles remained non-exposed to the programme, as compared to kebeles where trained champions and grantees were physically present and those easily accessible where activities were intensively implemented.

“The main challenge is that not all kebeles have received the same education. Our kebele is fully free... but neighbouring kebeles still practice it. When we interact during religious celebrations... ideas mix”. (KII, Religious Leader)

In addition to distance, participants also cited conflict and insecurity as one of the factors leading to some community members’ non-exposure to the programme. Ongoing regional instability physically

prevented facilitators from reaching rural areas, leaving those populations without exposure to the interventions.

“Intervention is limited to the town due to security issues... it is challenging to work easily because FGM is mostly practiced in rural areas, and there is insecurity there”. (FGD, Grantee member)

Some participants explained that non-exposure or involvement in the programme was driven by economic or professional interests. Some participants, such as FGM practitioners, did not participate in the programme because they feared losing a livelihood. Some of them viewed FGM as their primary source of income (charging up to 800–1,600 birr per child, which is equivalent to 10 to 12 USD) and would therefore avoid the programme to escape moral or legal pressure to stop FGM.

“The reason why some circumcisers are not willing to participate in the training is that they earn money from the practice... they consider it a source of income”. (IDI, Girl champion)

Lastly, some community members refuse to participate in the programme due to deep-seated beliefs that acted as a "mental block" preventing them from attending the programme activities. In addition, some considered that advocates and champions were only speaking against FGM because they were being paid by NGOs. Therefore, they would refuse to join sensitisation sessions or dialogues.

Association between Exposure and FGM-related outcomes at Endline

Bivariate analysis

Table 16 presents the endline bivariate associations between study site, exposure category, and FGM-related outcomes in the Amhara region. Across study sites, the distributions of several outcomes are similar between control and intervention areas. For beliefs related to FGM, the proportions of respondents opposed to the practice are nearly identical (81% in both control and intervention sites), with no statistically significant difference. For gender-inequality beliefs, intervention sites have a higher proportion of respondents classified as holding “equal” beliefs (88%) compared with control sites (82%), and this difference is statistically significant. Intervention sites also show a higher proportion of respondents with high FGM-related knowledge (65% vs. 55% in control sites). For other outcomes, including social sanctions, discrimination against girls who have not undergone FGM, agency, and overall social attitude, the proportions are comparable across study sites, with non-significant p-values.

When outcomes are examined by exposure category, clearer differences emerge. Respondents exposed in intervention sites have the highest proportions of favourable responses across multiple indicators. For example:

- 90% opposed FGM-supportive beliefs, compared with 78% among the non-exposed.
- 94% held equal gender beliefs, compared with 82% among the non-exposed.
- 74% had high FGM-related knowledge, compared with 55% among the non-exposed.
- 91% opposed social sanctions for FGM abandonment, compared with 76% among the non-exposed.
- None of the respondents exposed in intervention sites supported continuation of FGM (0%), compared with 9% among the non-exposed.
- 68% had ever encouraged abandonment, compared with 25% among the non-exposed.
- 100% opposed subjecting daughters to FGM, compared with 87% among the non-exposed.

- 91% held a progressive overall social attitude, compared with 75% among the non-exposed.

These bivariate differences may partly reflect selection effects, as individuals already supportive of FGM abandonment may have been more likely to participate in programme activities. Because exposure was not randomly assigned, these descriptive patterns should be interpreted as associations rather than as programme effects.

Respondents exposed in control sites often show intermediate distributions, such as 90% opposing FGM-supportive beliefs, 73% having high knowledge, and 55% having ever encouraged abandonment. These differences across exposure categories are statistically significant for most indicators, except for discrimination against girls who have not undergone FGM and agency, where proportions are similar, and p-values are not significant.

Table 16. Bivariate association of study sites and study-site related exposure by outcome variables at endline in the Amhara region, Ethiopia

Characteristic	Overall	Study sites		p-value ²	Study site related Exposure			p-value ²
		Control	Intervention		Non-exposed	Exposed	Exposed	
		N = 350 ¹	N = 210 ¹		all sites N = 439 ¹	control site N = 40 ¹	intervention site N = 81 ¹	
Beliefs related to FGM				0.803				0.015
In favour	107 (19%)	68 (19%)	39 (19%)		95 (22%)	4 (10%)	8 (9.9%)	
Opposed	453 (81%)	282 (81%)	171 (81%)		344 (78%)	36 (90%)	73 (90%)	
Gender-inequality beliefs				0.046				0.014
Equal	471 (84%)	286 (82%)	185 (88%)		359 (82%)	36 (90%)	76 (94%)	
Unequal	89 (16%)	64 (18%)	25 (12%)		80 (18%)	4 (10%)	5 (6.2%)	
FGM-related knowledge				0.03				0.001
Low	230 (41%)	156 (45%)	74 (35%)		198 (45%)	11 (28%)	21 (26%)	
High	330 (59%)	194 (55%)	136 (65%)		241 (55%)	29 (73%)	60 (74%)	
Social sanction for FGM abandonment				0.51				0.007
In favour	123 (22%)	80 (23%)	43 (20%)		107 (24%)	9 (23%)	7 (8.6%)	
Opposed	437 (78%)	270 (77%)	167 (80%)		332 (76%)	31 (78%)	74 (91%)	
Discrimination against uncut girls				0.257				0.457
Not for discrimination	531 (95%)	329 (94%)	202 (96%)		413 (94%)	39 (98%)	79 (98%)	
In favour of discrimination	29 (5.2%)	21 (6.0%)	8 (3.8%)		26 (5.9%)	1 (2.5%)	2 (2.5%)	
Opinion about FGM continuation				0.01				0.004
Not for continuation	518 (93%)	316 (90%)	202 (96%)		401 (91%)	36 (90%)	81 (100%)	
In favour of continuation	42 (7.5%)	34 (9.7%)	8 (3.8%)		38 (8.7%)	4 (10%)	0 (0%)	
Ever encouraged FGM abandonment				<0.001				<0.001
Never	375 (67%)	260 (74%)	115 (55%)		331 (75%)	18 (45%)	26 (32%)	
Ever encouraged	185 (33%)	90 (26%)	95 (45%)		108 (25%)	22 (55%)	55 (68%)	
Intention to perform FGM on daughters				0.017				<0.001

Opposed	497 (89%)	302 (86%)	195 (93%)	382 (87%)	34 (85%)	81 (100%)	
In favour	63 (11%)	48 (14%)	15 (7.1%)	57 (13%)	6 (15%)	0 (0%)	
Agency to oppose FGM				0.206			0.077
Can't oppose	450 (80%)	287 (82%)	163 (78%)	361 (82%)	31 (78%)	58 (72%)	
Can opposed	110 (20%)	63 (18%)	47 (22%)	78 (18%)	9 (23%)	23 (28%)	0.005
Overall social attitude to FGM				0.335			
In favour	127 (23%)	84 (24%)	43 (20%)	110 (25%)	10 (25%)	7 (8.6%)	
Opposed	433 (77%)	266 (76%)	167 (80%)	329 (75%)	30 (75%)	74 (91%)	

¹ n (%)

² Pearson's Chi-squared test; Fisher's exact test

Multivariable analysis-endline

The endline analysis examined how reconstructed exposure categories were associated with a range of FGM-related outcomes in the Amhara region. Table 17 presents adjusted odds ratios comparing respondents exposed in intervention sites, exposed in control sites, and non-exposed respondents across nine key behavioural and attitudinal indicators adjusted for age, sex and educational status

Beliefs opposed to FGM and unequal gender-related beliefs

Respondents exposed in intervention sites had higher odds of holding beliefs opposed to FGM (OR = 2.5; $p = 0.002$) and lower odds of holding unequal gender-related beliefs (OR = 0.32; $p = 0.017$) compared with non-exposed respondents. Exposure in control sites was not significantly associated with either holding beliefs opposing FGM or holding unequal gender beliefs. Differences between intervention and control sites were not statistically significant for either outcome.

High FGM-related knowledge

Respondents exposed in intervention sites had 2.21 times higher odds of possessing high FGM-related knowledge compared with non-exposed respondents ($p = 0.005$). At the site level, respondents in intervention sites were also more likely to have high knowledge than those in control sites (OR = 1.5; $p = 0.028$).

Endline attitudinal outcomes variables

Regarding social sanctions, respondents exposed in intervention sites were 3.17 times more likely to oppose sanctions for FGM abandonment than non-exposed respondents ($p = 0.006$). No significant differences were observed between intervention and control sites, nor between exposed and non-exposed respondents within control sites. Support for FGM continuation was lower in intervention sites compared with control sites (OR = 0.38; $p = 0.0017$). Exposure in control sites was not significantly associated with support for FGM continuation, and data for exposure in intervention sites were too sparse to estimate an effect.

Moreover, respondents exposed in intervention sites were 6.47 times more likely to have ever encouraged someone to abandon FGM compared with non-exposed respondents ($p < 0.001$). This was also true for those exposed in control sites compared with those who had not been exposed to any FGM-related activities (OR = 4.25; $p < 0.001$). The analysis by study site showed that respondents in intervention sites had significantly higher odds of encouragement than those in control sites (OR = 2.39; $p\text{-value} < 0.001$).

Furthermore, respondents in intervention sites had lower odds of intending to perform FGM on their daughters compared to those in control sites (OR = 0.51; $p = 0.032$). By exposure status, the model could not estimate an effect in intervention sites due to sparse data. For agency outcome, respondents exposed in intervention sites were 2.56 times more likely to report agency to oppose FGM compared to

non-exposed respondents ($p = 0.015$). Differences between intervention and control sites were not statistically significant.

Table 17. Adjusted Odd ratios associated with study site and exposure by outcome variables in endline in the Amhara region, Ethiopia

Models	Intervention			Exposed in control site			Exposed in intervention site		
	VS			VS			VS		
	Control			Non-exposed both sites			Non-exposed both sites		
	OR	95% CI	p-value	OR	95% CI	p-value	OR	95% CI	p-value
Holding beliefs opposed to FGM	1.03	0.66, 1.61	>0.9	2.59	0.99, 8.93	0.083	2.50	1.22, 5.83	0.020
Holding unequal gender related beliefs	0.63	0.37, 1.04	0.078	0.47	0.14, 1.27	0.2	0.32	0.11, 0.74	0.017
Having high FGM-related knowledge	1.51	1.05, 2.19	0.028	1.95	0.95, 4.26	0.077	2.21	1.30, 3.90	0.005
Being opposed to social sanctions for FGM-abandonment	1.11	0.73, 1.72	0.6	1.02	0.48, 2.40	>0.9	3.17	1.49, 7.82	0.006
Being in favour of discrimination against uncut girls	0.61	0.25, 1.37	0.3	0.43	0.02, 2.12	0.4	0.43	0.07, 1.48	0.3
Being in favour of FGM continuation	0.38	0.16, 0.80	0.017	1.17	0.33, 3.18	0.8	—		
Having ever encouraged anyone to abandon FGM	2.39	1.65, 3.46	<0.001	4.25	2.16, 8.48	<0.001	6.47	3.86, 11.1	<0.001
Intention to undergo FGM on daughters	0.51	0.27, 0.92	0.032	1.16	0.42, 2.77	0.8	—		
Agency to oppose FGM	1.69	0.94, 3.09	0.082	0.67	0.23, 1.84	0.4	2.56	1.19, 5.50	0.015

Abbreviations: CI = Confidence Interval, OR = Odds Ratio * both sites refer to the control and intervention sites.

Overall social attitude at endline

Regarding the overall social attitude toward FGM (Table 18), our findings indicate that respondents exposed in intervention sites had 2.56 times higher odds of holding an attitude opposed to FGM compared with non-exposed respondents ($p = 0.032$). In contrast, exposure in control sites was not significantly associated with overall attitude ($OR = 0.64$; $p = 0.3$). Respondents holding beliefs opposed to FGM had 5.07 times higher odds of holding an overall attitude opposed to the practice ($p < 0.001$). Conversely, those with unequal gender-related beliefs had 55% lower odds of opposing social attitude toward FGM ($OR = 0.45$; $p = 0.004$).

With respect to the sociodemographic characteristics, respondents with primary education were twice as likely to oppose FGM compared with those with no formal education ($OR = 2.16$; $p = 0.007$). Those with secondary or higher education were 2.60 times more likely to oppose the practice ($p = 0.015$). In this model, marital status, sex, age group, and FGM-related knowledge were not significantly associated with overall social attitudes.

Table 18. Endline exposure to intervention and associated adjusted Odd-ratio to social attitude against FGM practice in endline in the Amhara region, Ethiopia

Characteristic	Holding overall social attitude opposed to FGM		
	OR	95% CI	p-value
Exposure			
Non-exposed all sites (ref)	—	—	
Exposed in control site	0.64	0.29, 1.49	0.3
Exposed in intervention site	2.56	1.15, 6.55	0.032
Marital status			
No (ref)	—	—	
Yes	0.69	0.38, 1.22	0.2
Sex			
Men (ref)	—	—	
Women	0.86	0.54, 1.36	0.5
Age group			
≥ 45yrs (ref)	—	—	
35-44	0.92	0.51, 1.67	0.8
25-34	1.13	0.57, 2.28	0.7
< 25yrs	0.78	0.36, 1.67	0.5
Education			
No formal education* (ref)	—	—	
Primary	2.16	1.25, 3.81	0.007
Secondary+	2.6	1.22, 5.74	0.015
FGM-related knowledge			
Low (ref)	—	—	
High	1.16	0.73, 1.85	0.5
Beliefs related to FGM			
In favour (ref)	—	—	
Opposed	5.07	3.11, 8.34	<0.001
Gender-inequality beliefs			
Equal (ref)	—	—	
Unequal	0.45	0.26, 0.78	0.004

Abbreviations: CI = Confidence Interval, OR = Odds Ratio

Note: (*) No formal education refers to respondents with no schooling or those who are literate but have not attended formal education (other literates)

(**) borderline significance

Association between Exposure and FGM-related outcomes from the pooled Baseline-Endline data

Bivariate analysis

Table 19 presents the pooled baseline–endline bivariate associations between exposure categories and FGM-related outcomes in the Amhara region. Across the three exposure groups, non-exposed, exposed in control/baseline sites, and exposed in intervention sites, the distribution of outcomes differs for most indicators.

For beliefs related to FGM, respondents exposed in intervention sites have the highest proportion opposed to the practice (90%), followed by those exposed in control/baseline sites (77%), while non-exposed respondents have the lowest (68%). A similar gradient appears for gender-inequality beliefs: 94% of respondents exposed in intervention sites hold equal gender beliefs, compared with 81% among those exposed in control/baseline sites and 77% among the non-exposed. These differences are statistically significant.

For FGM-related knowledge, respondents exposed in intervention sites (74%) and those exposed in control/baseline sites (70%) have higher proportions with high knowledge compared with non-exposed respondents (53%). Differences across exposure categories are also statistically significant for social sanctions: 91% of respondents exposed in intervention sites oppose sanctions, compared with 87% among those exposed in control/baseline sites and 80% among the non-exposed.

Behaviour-proximal outcomes show marked variation across exposure groups. Respondents exposed in intervention sites have the highest proportion reporting that they have ever encouraged someone to abandon FGM (68%), followed by those exposed in control/baseline sites (53%), while non-exposed

respondents have the lowest (21%). A similar pattern is observed for intention to cut daughters: 100% of respondents exposed in intervention sites oppose FGM, compared with 86% among those exposed in control/baseline sites and 79% among the non-exposed. None of the respondents exposed in intervention sites report an intention to cut.

For the overall social attitude index, respondents exposed in intervention sites have the highest proportion opposed to FGM (91%), followed by those exposed in control/baseline sites (86%), while non-exposed respondents have the lowest (79%). These differences are statistically significant.

Overall, the findings show clear differences across exposure categories in the pooled baseline–endline data. Respondents exposed in intervention sites consistently display the most favourable distributions across beliefs, gender norms, knowledge, sanctions, encouragement, intentions, and overall attitudes, while non-exposed respondents show the least favourable patterns.

Table 19. Bivariate association of study-site related exposure by outcome variables using baseline-endline pooled data in the Amhara region, Ethiopia

Characteristic	Overall N = 1,361 ¹	Study site related Exposure			p-value ²
		Non-exposed all sites N = 1,014 ¹	Exposed Control and baseline N = 266 ¹	Exposed Intervention site N = 81 ¹	
Beliefs related to FGM					<0.001
In favour	394 (29%)	324 (32%)	62 (23%)	8 (10%)	
Opposed	967 (71%)	690 (68%)	204 (77%)	73 (90%)	
Gender-inequality beliefs					<0.001
Equal	1,070 (79%)	778 (77%)	216 (81%)	76 (94%)	
Unequal	291 (21%)	236 (23%)	50 (19%)	5 (6.2%)	
FGM-related knowledge					<0.001
Low	581 (43%)	481 (47%)	79 (30%)	21 (26%)	
High	780 (57%)	533 (53%)	187 (70%)	60 (74%)	
Social sanction for FGM abandonment					0.005
In favour	240 (18%)	198 (20%)	35 (13%)	7 (9%)	
Opposed	1,121 (82%)	816 (80%)	231 (87%)	74 (91%)	
Ever encouraged FGM abandonment					<0.001
Never	948 (70%)	796 (79%)	126 (47%)	26 (32%)	
Ever encouraged	413 (30%)	218 (21%)	140 (53%)	55 (68%)	
Intention to perform FGM on daughters					<0.001
Opposed	1,116 (82%)	805 (79%)	230 (86%)	81 (100%)	
In favour	245 (18%)	209 (21%)	36 (14%)	0 (0%)	

Overall social attitude to FGM

0.003

In favour	252 (19%)	208 (21%)	37 (14%)	7 (9%)
Opposed	1,109 (81%)	806 (79%)	229 (86%)	74 (91%)

¹ n (%)

² Pearson's Chi-squared test; Fisher's exact test

Multivariable analysis from pooled baseline-endline data

Table 20 presents the pooled adjusted associations from the logistic regression between exposure status and six outcome variables after controlling for sex, age, and education. In each case, the model examines

whether exposure can explain differences in key FGM-related outcomes. As a reminder, the exposure variable in that case is categorised into three groups: non-exposed from any site (intervention, control, and baseline), exposed respondents in intervention sites, and those from non-intervention sites (baseline and control).

High FGM-related knowledge

Respondents exposed in intervention sites had 2.49 times higher odds of having high FGM-related knowledge compared with non-exposed respondents ($p < 0.001$). Additionally, those exposed in control or baseline sites had 2.35 times higher odds of possessing higher FGM-related knowledge ($p < 0.001$).

The qualitative findings show that the primary change in the knowledge of FGM began with the transition from traditional hearsay to evidence-based health awareness. Participants moved from a state of not knowing to a detailed understanding of the physical and medical implications of FGM. Trained individuals, including girl and boy champions, survivors, and former practitioners, now recognise FGM as a physical injury rather than a mandatory rite to ensure a girl is marriageable.

This [new] knowledge base specifically highlights the biological mechanics of the harm, such as the loss of "elasticity" in reproductive tissue, and the direct link between FGM and traumatic childbirth. This is reported by two of the participants:

"In the training, we have seen that it is very harmful. We didn't know it previously... I understand that many couples have divorced due to it. Because FGM leads to pain during intercourse, a scar on the vagina, and loss of sexual pleasure". (FGD, member, grantee organisation)

Similarly, survivors reported reinterpreting their own reproductive health experiences through this new knowledge:

"I am circumcised, and when I delivered my first daughter, I was delivered using an operation. After I received training, I understand that my operation during my delivery was due to my circumcision". (FGD, survivor, grantee organisation)

With the skills and confidence gained through the training, survivors also contributed to sharing their experiences, hence contributing to the increased awareness of the harm of FGM.

Beliefs opposed to FGM

Respondents exposed in intervention sites had 3.98 times higher odds of holding beliefs opposed to FGM compared with non-exposed respondents ($p < 0.001$). Those exposed in control or baseline sites also showed 1.54 times higher odds ($p = 0.009$). Regarding unequal gender related beliefs, respondents in intervention sites had significantly lower odds of holding these beliefs compared with non-exposed respondents ($OR = 0.23$; $p = 0.002$). However, exposure at control or baseline sites was not significantly associated with unequal beliefs.

The qualitative findings demonstrate how the shift in knowledge effectively neutralised long-standing cultural beliefs, dismantling the myths that once anchored FGM in the community, especially among

individuals actively involved in the programme. According to participants, the pervasive idea that girls who have not undergone FGM were "rocks" or destined to break household tools was debunked by the shared experiences of those in the programme. For many, this translated into a realisation that FGM was a root cause of marital discord and divorce rather than a guarantor of fidelity.

"The community understood that those aged more than 40 are getting divorced in their marriages, and when people ask them the reason for their divorce, they say that they have no feeling during sexual intercourse because they were circumcised and the sensitive part of their vagina was cut and thrown away. Currently, the community understands the hidden truth about FGM, and as a result, everybody believes the practice needs to stop". (FGD, member, grantee organisation Amhara region)

The perceived religious necessity of the practice was replaced by the belief that FGM is a sin or a harmful tradition without spiritual merit or religious obligation.

"Our problem is only cultural. It has no religious meaning. It is an awareness problem, not religious. The belief is that if a girl is not circumcised, she will not marry, will not build a home, and will become promiscuous. There is nothing religious about it". (IDI, Male champion, Amhara region)

Qualitative findings also provide insight into the observed reduction in unequal gender-related beliefs among exposed participants. Boys, for instance, became agents of change. While the programme was not initially designed to involve them as the primary target, some of them, after being exposed and attending training sessions, became advocates in their neighbourhood. One of the boys got involved in the programme after seeing girls in his school attending training sessions. He approached the facilitators and requested to join. The training contributed to increasing his knowledge and shifting his beliefs regarding FGM. As a result, he started engaging with mothers in his community against FGM, as he reports:

"In our village, there was one mother who gave birth. Then I went there, and I told her not to perform FGM on her daughter, if you are going to do it, I said I will report to women's watch groups. And even when you told us about it, we were not surprised; we know it. Then she thanked me for my activity. (...) I may not speak at ceremonies and churches, but, at school, I am advocating about it by preparing the lesson in the form of a poem". (IDI, boy champion)

Attitudinal outcomes variables

Likewise, respondents exposed in intervention sites had 2.52 times higher odds of opposing social sanctions compared to non-exposed respondents ($p = 0.024$). Those exposed in control or baseline sites also showed significantly higher odds ($OR = 3.95$, $p < 0.001$). Similarly, respondents exposed at intervention sites had 7.43 times higher odds of encouraging someone to abandon FGM compared to non-exposed respondents ($p < 0.001$). The intention to subject their daughters to FGM was significantly lower among exposed respondents in the control and baseline sites compared to non-exposed respondents ($OR = 0.61$, $p = 0.013$). Sparse data prevented estimating the effect of exposure in intervention and non-intervention sites.

Table 20. Baseline-endline adjusted odd-ratios associated study site and exposure by outcome variables in the Amhara region, Ethiopia

Models	Exposed Control and Baseline VS Non-exposed all site			Exposed Intervention site VS Non-exposed all sites		
	OR	95% CI	p-value	OR	95% CI	p-value
Holding beliefs opposed to FGM	1.54	1.12, 2.13	0.009	3.98	2.00, 9.10	<0.001

Holding unequal gender related beliefs	0.76	0.53, 1.07	0.12	0.23	0.08, 0.53	0.002
Having high FGM-related knowledge	2.35	1.75, 3.20	<0.001	2.49	1.49, 4.31	<0.001
Being opposed to social sanctions for FGM-abandonment	1.60	1.09, 2.40	0.020	2.52	1.21, 6.15	0.024
Having ever encouraged anyone to abandon FGM	3.95	2.96, 5.27	<0.001	7.43	4.56, 12.4	<0.001
Intention to subject daughter to FGM	0.61	0.41, 0.89	0.013	—		

Abbreviations: CI = Confidence Interval, OR = Odds Ratio

Overall social attitude outcome from the pooled baseline-endline analysis

Table 21 depicts a model comparing pooled exposed respondents from the control/baseline and the intervention site with all pooled non-exposed respondents from the three categories (intervention, control, and baseline) in association with the overall opposing social attitude. In the intervention sites, those respondents exposed had 1.65 times higher odds of holding an attitude opposed to FGM compared to non-exposed respondents, though this was not statistically significant ($p = 0.20$). Similarly, sites in the control group had 1.32 times higher odds of opposition ($p = 0.20$), which was also not statistically significant. Respondents with beliefs opposed to FGM had 4.04 times higher odds of holding an overall negative attitude toward the practice ($p < 0.001$). Whereas those with unequal gender-related beliefs were 55% less likely to oppose FGM ($p < 0.001$). Demographic factors also played a significant role. Women had odds of opposing FGM approximately two times higher than men ($p = 0.002$). A strong positive gradient was observed related to education: respondents with primary education ($p = 0.008$) and those with secondary or higher education ($p = 0.005$) had significantly higher odds of opposition than those with lower education levels. No significant association was observed between an overall opposing social attitude and FGM-related knowledge ($p = 0.11$) or age categories (p -values ranged from 0.40 to 0.90).

Table 21. Baseline-endline exposure to intervention and associated adjusted odds-ratio to attitude against FGM practice in the Amhara region, Ethiopia

Characteristic	Holding overall social attitude opposed to FGM		
	OR	95% CI	p-value
Exposure			
Non-exposed all sites (ref)	—	—	
Exposed Control and baseline	1.32	0.88, 2.01	0.2
Exposed Intervention site	1.65	0.76, 4.16	0.2
Sex			
Men (ref)	—	—	
Women	1.69	1.22, 2.33	0.002
Age group			
≥ 45yrs	—	—	
35-44	1.2	0.79, 1.82	0.4
25-34	1.21	0.75, 1.94	0.4
< 25yrs	1.04	0.63, 1.73	0.9
Education			
Low education* (ref)	—	—	
Primary	1.7	1.15, 2.53	0.008
Secondary+	2.23	1.28, 3.94	0.005
FGM-related knowledge			
Low (ref)	—	—	
High	1.3	0.95, 1.78	0.11

Beliefs related to FGM			
In favour (ref)	—	—	
Opposed	4.04	2.95, 5.56	<0.001
Gender-inequality beliefs			
Equal (ref)	—	—	
Unequal	0.46	0.33, 0.64	<0.001

Abbreviations: CI = Confidence Interval, OR = Odds Ratio

Note: (*) No formal education refers to respondents with no schooling or those who are literate but have not attended formal education (other literates)

(**) borderline significance

The findings in Amhara (endline and pooled baseline-endline) show modest differences by study site and more pronounced differences across exposure categories. Respondents exposed to FGM-related

activities, particularly in intervention sites, consistently showed a higher likelihood of attitudes aligned with opposition to FGM compared with non-exposed respondents, even where associations were not statistically significant. Those exposed in non-intervention settings (control or baseline) showed weaker and less consistent patterns. Overall, the quantitative evidence indicates stable directional associations between exposure and more progressive attitudes toward FGM in Amhara.

Qualitative findings help explain these interconnected outcomes by illustrating how exposure influences resistance to social sanctions, increases active encouragement of abandonment, and shapes intentions to perform or practice at the household level. Participants increasingly questioned community enforcement mechanisms that sustain FGM, including resistance to social pressure and punishment. Through training and dialogue, individuals gained confidence to take concrete steps, including resisting pressures to perform the practice, advocating for abandonment, intervening within families, and leveraging social and administrative authority (including Kebele administrators leveraging their position and power to convene meetings, or using routinely happening platforms like when people gather to collect fertilisers and seed distributions to talk about FGM). As highlighted by participants, consistent interactions with family and broader community members contributed to changing their knowledge, especially on the harmful effects of FGM and the legal sanctions that are involved in the country.

“Currently, the community’s attitude toward FGM has changed. I remember going to Debre Tabor town for a training. When I returned, my family members and neighbours asked me why I had gone there. I explained that the training was about FGM, focusing on its harmful consequences, complications, and the existing laws against the practice. After this discussion, their attitudes and practices began to change. Later, they asked me again, “So, is FGM really a harmful practice?” and I confirmed that it is.” (boy champion, student, Amhara region)

At the same time, qualitative data highlight that sanctions are still actively used in some contexts, though increasingly contested. One participant described community-imposed punishment for performing FGM:

“In one kebele, we discovered that after delivery, mothers are given a chemically impregnated bed net. One mother had performed FGM on her daughter, and as a form of community sanction, the local Iddir leader prevented her from receiving the bed net as punishment for her action”. (KII, Grantee member, Amhara region)

This suggests that while formal and informal sanctions remain in place, exposure contributes to increasing resistance to such enforcement mechanisms. Moreover, some of these strategies to address FGM may have unintended negative consequences; for example, depriving a mother of a bed net could expose both her and her baby to malaria.

Qualitative findings further show how increased knowledge and a shift in beliefs translated into active advocacy, even beyond the people directly involved in the programme implementation. Changes were

also reported among community members who were directly in contact with the champions or trained community members, and those who repeatedly participated in sensitisation sessions.

“As I understand, I have a change in knowledge. I am circumcised, and when I delivered my first daughter, I delivered through an operation. After I received training, I understood that my operation during my delivery was due to my circumcision. My father was a cutter, and he asked me to carry out FGM. I resisted, and I directed him to receive training about the consequences of FGM by our organisation. Currently, he is not doing it due to the knowledge he obtained from the training. So, we have a change in knowledge and attitude in myself and in my family” (FGD, member, grantee organisation, Amhara region)

Trained individuals also reported increased confidence and agency to speak out. Participants reported that the repeated training has contributed to empowering them and finding the confidence to advocate against FGM in their community.

“Initially, I was not confident enough to say something even to my family and friends. Personally, I am confident enough to advocate for it”. (Girl champion, Amhara region)

Like FGM practitioners, trained community leaders also reported integrating advocacy and awareness creation into their daily engagement with their communities and administrative duties. As a Kebele administrator, one participant leveraged his authority to institutionalise FGM advocacy. The training turned routine administrative gatherings (like fertiliser distribution) into platforms for social change.

“What I did was facilitate the campaign as kebele administrator. I teach the community during different gatherings. Like, when there is a collection of farmers to take fertiliser”. (KII, Kebele administrator and farmer, Amhara region)

Similarly, the program also had an impact among journalists directly involved in the program through training. Trained journalists reported a shift in their knowledge and professional perspective around FGM. The training helped them frame FGM not as a cultural necessity, but as a physical injury with no scientific or religious backing, moving them toward a "rights-based" or "health-based" understanding in their way of dealing with FGM in their day-to-day activities. This change in knowledge and beliefs triggered a sense of responsibility to act. One participant described the training as a catalyst that "stimulated" his professional duty:

“After the training, we had a fresh mind; the training about it stimulated us to do something, and we did 2-3 programs. We invited FGM survivors to share their experiences... the training we received at that time really motivated us to carry out the activities”. (IDI, Male, journalist, Amhara region)

The qualitative findings provide important contextual insight into how exposure shapes intentions not to subject daughters to FGM at household level (i.e., daughters or female relatives). Participants reported increasing intentions not to subject daughters (and female relatives) to FGM, often linked to improved knowledge and changing beliefs. One survivor and member of a Women's Watch Group expressed,

“After the training, I understand everything, and I am a survivor. So, I do not need my little sisters to suffer. As a result of the training, I have a positive change in my knowledge, attitude, and practice” (KII, survivor, grantee member, Amhara region).

Reasons for lack or limited changes in attitudes and beliefs.

While TGG-ALM program achieved significant success among those directly involved, the qualitative data also reveal that deep-seated resistance persists within "nearly half of the community" (according to some participants). This lack of change in beliefs and attitudes is primarily rooted in a combination of social fear, cultural inertia, and entrenched economic interests that create barriers to full abandonment.

A primary driver for continued adherence to FGM is the overwhelming fear of social implications and the perceived "betrayal" of ancestral heritage. Many mothers express a sense of obligation to maintain consistency across their children, fearing that leaving a younger daughter without FGM would be an act of harm rather than protection. Findings also show that this sentiment among mothers is often fuelled by a fear of future resentment, where parents worry their daughters will blame them for being "different" or socially marginalised as they grow older. One mother confided in a grantee member:

"I have circumcised all my daughters. So why should I leave the youngest one uncircumcised? I would be harming her. Later, when she grows up, she would resent me" (FGD, member, grantee organisation, Amhara region)

These beliefs are most rigid among elderly women who serve as the gatekeepers of tradition, viewing the abandonment of FGM as a threat to the social identity they have spent decades upholding.

Resistance is further compounded by a profound lack of trust in the messengers of the programme. In many unreached or resistant kebeles, some champions reported that the community views the advocacy of health professionals and NGOs with cynicism, suspecting that the anti-FGM message is merely a vehicle for personal gain. One participant observed:

"The community perceives that they [healthcare professionals] are teaching them for their per diem allowance purpose" (FGD, member, grantee organisation, Amhara region).

This scepticism undermines the medical evidence presented, as the community dismisses scientific facts as "bought" propaganda intended to undermine their culture for profit. When the message is perceived as an external imposition rather than a community-led shift, the natural response is a defensive retreat into traditional practices to "protect" their heritage from outsiders.

Finally, the sustainability of FGM is reinforced by the economic reality of the practitioners. For many FGM practitioners, FGM is not just a cultural rite but a livelihood that provides social recognition and material support. Even when they understand the health risks, the lack of alternative income makes the "benefits" - which include "money, coffee, food, and local beer" - difficult to abandon. In kebeles where the program has not established a permanent presence, FGM practitioners continue to operate secretly, banking on the community's shared silence. Until the economic and social rewards of the practice are replaced by equally powerful deterrents or alternatives, a significant portion of the community remains caught between the emerging health awareness and the old, familiar security of tradition.

Unintended/unanticipated changes and outcomes

The qualitative findings show that the programme's implementation triggered several unintended outcomes that altered the social and operational landscape of the intervention areas. One concerning trend was the emergence of secret cross-border migration to conduct FGM. As intervention kebeles became increasingly "hostile" environments for FGM due to the vigilant oversight of community leaders and youth champions, families who remained unconvinced by the training began crossing administrative boundaries. As explained by these participants:

"As per the information we have, it is being done secretly" (KII, community leader, Amhara region)

“A woman from our catchment kebele may go to the unreached kebeles, may be influenced by the untrained community members, and may practice it due to pressure”. (FGD, member, grantee organisation, Amhara region)

As highlighted in the quotes, some community members continue to reach out to practitioners in "unreached" kebeles where the program had no presence, primarily to evade the strict social sanctions, such as the loss of Iddir⁵ benefits, imposed in their home villages. Consequently, addressing FGM becomes significantly more difficult, as the practice is much easier to combat when it is publicly visible than when it is driven underground and performed in secret.

Another unexpected change is related to the financial advantages associated with the programme. The intensive nature of the program also inadvertently created a lens of "per diem motivation" through which some community members viewed external advice. Because of the programme's scale and

frequency, a segment of the community began to perceive health and social interventions as being primarily driven by financial incentives for the facilitators. This scepticism occasionally undermined the core message, as resistant elders argued that advocates were only speaking against FGM for personal gain.

Qualitative data highlighted one unintended negative outcome, namely the potential harm caused by certain sanctions imposed by community leaders on families that continue to practice FGM. The findings highlight instances in which Iddir leaders denied mothers access to chemically treated bed nets as punishment for having subjected their newborns to FGM. While such punitive measures are intended to deter the practice, they can inadvertently undermine maternal and child health. By withholding a standard postnatal health intervention, the sanction shifts the consequences from the act of FGM to the well-being of the mother and infant, increasing their vulnerability to preventable diseases such as malaria. This example underscores a critical risk of enforcement approaches that rely on the deprivation of essential health resources, as they may cause collateral harm to mothers and newborns and contradict broader public health objectives.

One positive unintended change was the reduction in abduction (for rape and forced marriage). The programme's focus on dismantling harmful gender norms led to a significant, albeit indirect, perceived reduction in sexual violence and abduction cases within the intervention areas. By educating boys and men on the inherent value and human rights of women, the initiative moved beyond FGM to address broader patterns of systemic abuse. This shift was largely driven by the work of Voluntary Community Facilitators (VCFs) and Women's Watch Groups, who utilised a "relational empathy" approach to reframe how males viewed their female peers. As one student and boy champion observed:

“Boys younger than and older than me were participating in rape and abduction. Nowadays, due to the training, boys and men have an attitudinal change. VCFs and Women Watch groups teach them by saying, 'girls and females are your sisters, your mothers, your children. So why don't you abuse them violently? After this, there is a change among males” (Boy Champion).

⁵ Iddir is a traditional Ethiopian self-help association that serves as a significant example of social capital by providing essential financial, emotional, and practical support to its members, particularly during times of bereavement.

Institutional level changes/impact (Grantee organisations)

The qualitative findings demonstrate that TGG-ALM program significantly strengthened the operational and strategic landscape of grantee organisations. Beyond providing financial resources, the program acted as a catalyst for professionalisation and institutional constructive collaboration among Civil Society Organisations (CSOs).

Before the program, many CSOs operated in isolation with limited resources, often generated solely from member contributions. This financial scarcity restricted their interventions to sporadic activities, making it difficult to address FGM, a deeply rooted practice requiring sustained, repeated engagement to achieve attitudinal change. The transition from financial scarcity to strategic empowerment was a definitive turning point for these organisations. As one participant noted:

“Initially, our organisation had no budget, which severely limited our ability to work on FGM. After receiving funding from Options Consultancy, we were able to overcome these financial constraints. The funding allowed us to identify and bring together key target groups... and provide intensive training” (FGD, member, grantee organisation, Amhara region).

With the financial support from the program, they were able to design context-specific activities and sustainably engage with their community. The availability of funding made it possible to conduct repeated and structured interventions, which contributed to gradual attitudinal and behavioural change.

Another change reported by participants is the integration of FGM as a core topic in local CSOs' activities in the region. The program expanded the regional capacity to tackle FGM by enabling local organisations, previously focused on other broader women-related issues, to integrate FGM prevention into their core activities. For instance, one of the small grantee organisations, which work used to focus on advocacy for laws or enforcement of laws protecting domestic workers and preventing sexual violence, has now included FGM in its activities, thanks to the funding they received from the programme. This focus on FGM was accompanied by substantial training that provided the organisations and their members with the skills needed to meaningfully implement FGM-related activities. One of the meaningful approaches is the strategic shift in advocacy methodology. Grantees reported moving away from failed top-down legal threats toward a "community-buy-in" model. One participant from a grantee organisation noted that while many previous projects tried to enforce laws and warn the community, the approach ultimately failed because community members did not respect punitive measures. He explained that if the only punishment is a fine, people will simply pay it. Consequently, his organisation now prioritises approaching the community in a friendly, "sisterly and brotherly" way, reserving police reports only for those who refuse advice and continue the practice.

This sentiment was echoed by another participant from another organisation who observed a noticeable change in impact when moving away from the government's historical focus on law enforcement:

“Let me respond first. There has been a noticeable change. Previously, the government attempted to stop FGM mainly through law enforcement, but this approach did not bring meaningful change. After our organisation entered the community, we used a different approach. We did not focus on punishing practitioners. Instead, we explained the harmful consequences of FGM to build knowledge and bring about attitudinal change”. (FGD, member, Grantee organisation, Amhara region)

By explaining the harmful consequences of FGM rather than focusing on punishment, the organisation was able to build the knowledge necessary to foster genuine attitudinal change.

Beyond programmatic implementation, the TGG-ALM program significantly improved the institutional capacity of these CSOs. Receiving funds was contingent upon and accompanied by rigorous training in organisational governance. Grantees developed essential frameworks, including Standard Operating

Procedures (SOPs), Safeguarding Guidelines, Human Resources (HR) Manuals, Grant management and financial reporting systems. This is explained by one of the participants:

“The TGG-ALM program opened our eyes. It gave us the knowledge and the framework to work effectively. We learned how to handle reports and manage the project professionally”. (KII, Local CSO Leader, Amhara region)

By adopting these international standards, small local groups have improved their credibility and elevated their positions to the level of renowned CSOs in the region. According to them, this professionalisation ensures they are not only more effective in their current FGM work but also more competitive for future global funding opportunities.

“I know TGG-ALM a lot. The program first created awareness among the committee members, including us. Stakeholders such as religious fathers, community figures, and the Rama Youth Association participated. After the training, we received a contract and made commitments for future work. The program shaped us and provided policy documents to guide us. I want to thank you for the program, because before this, we were volunteers. When TGG-ALM began supporting us, we received small budgets and grew from being a small group to a small guarantee and then a medium guarantee. TGG-ALM did all of this. They mainly work to reduce and stop FGM” (KII, Grantee manager, Amhara).

Networks and movement building

Another impact highlighted in the qualitative findings is the creation of networks that strengthen the movements to end FGM in the programme region. Participants explained that the TGG-ALM program functioned as a connective tissue, transforming isolated anti-FGM efforts into a synchronised social movement. One of the most significant achievements cited was the creation of a multi-layered constructive collaboration between traditional social structures and formal institutional networks. Rather than operating as a standalone project, TGG-ALM bonded disparate actors - religious leaders, Kebele administrators, health extension workers, and Idir leaders - into a unified community front. Overall, participants feel the program contributed to creating a cohesive community front, with different categories of actors joining hands at various levels to act against FGM.

This constructive collaboration was particularly evident among the Civil Society Organisations (CSOs) in the region, especially among grantee organisations. While a lack of collaboration was a concern during earlier phases and documented in the POC, the endline study highlights a shift in operational collaboration. This included anchor organisations providing intensive mentorship to smaller entities. One participant noted:

“Mahibere Hiwot is doing with us. It is an anchor, but we are small. So, it was helping and supporting us” (KII, member, grantee organisation, Amhara region).

“This collaboration extended to joint strategic planning to maximise reach and avoid the duplication of efforts. As another participant explained, “We even discussed with all the 6 civic organisations in the South Gondar zone to not overlap the kebeles addressed by one civic society. We invite you to provide training for our catchment area”. (KII, Grantee organisation).

The movement-building aspect was further characterised by the institutionalisation of youth agency through the establishment of Girls' Councils. As one girl champion stated:

“This project facilitates the establishment of the girls’ council and gets recognition at the regional level. So, this institution will continue doing so”. (IDI, girl champion, Amhara region).

These serve as permanent, formally recognised institutions at the regional level, designed to ensure the advocacy continues regardless of external funding cycles.

Integration of FGM in the health system

Medical professionals, teachers and students reported significant impact of the training received through the programme on their awareness and attitudes towards FGM. The training contributed to raising their awareness about FGM and its presence in their country and the region as well. One intern commented:

“Before the training, we weren’t aware of it.... I know FGM is practiced in Ethiopia. However, I was not aware of its prevalence, and I didn’t expect its existence at this time. But now the training makes one conscious and awakens me to consider its existence. It makes me approach patients who may have FGM”. (IDI, Medical Student, Amhara region)

Moreover, some participants reported that the training played a critical role in addressing internal biases within the medical community, specifically the belief among some professionals that minor forms of FGM (Type 1) are harmless.

“I encounter some medical professionals who argue with type 1 FGM. They believe that Type 1 FGM has no serious harm. I realise this [is a problem]”. (IDI, Medical Student)

The most significant impact of this "clinical awareness and awakening" is a transition from theoretical knowledge to clinical vigilance. According to one of the medical students interviewed, before the training, FGM was a "neglected" consideration during physical examinations. However, the programme served as a catalyst for active screening and engagement of patients to address their needs.

They also shifted their self-perception from a passive observer to an active agent of change capable of contributing to the "zero FGM" goal.

“Previously we did not think that we could bring positive impacts. But, after the training, we understand that we can have an impact to end FGM (...) We have seen classifications of FGM, complications... and we have also discussed the prevention strategies to make it zero”. (IDI, Medical Student)

Sustainability of the programme's achievements

The endline evaluation provides a nuanced perspective on the sustainability of the TGG-ALM program, revealing a landscape of community-level commitment balanced against significant external threats.

Evidence of likely sustainability

Participants cited different signs of sustainability of the programme. This includes the high level of personal commitment from program champions, many of whom serve on a volunteer basis. These individuals have indicated a firm intention to maintain their advocacy regardless of external support. As one participant noted, *"We are volunteer workers. Even if donors stop funding us, we will continue our efforts to stop FGM using our own regular savings"* (KII, Grantee organisation).

At the organisational level, grantees reported that the professionalisation of their Standard Operating Procedures (SOPs) and fund management has positioned them to attract future financing. This institutional maturity is coupled with deep integration into local social structures. Grantees are working closely with religious leaders, *Iddir* leaders, and health extension workers who live within the

community. *"Particularly this year, we have been actively discussing sustainability with Options Consultancy... to ensure sustainability, we are working closely with key target groups within the community... these individuals live within the community, so they will continue advocating"* (Grantee organisation). Furthermore, organisations are proactively seeking new donors to expand their reach across different kebeles.

Another key structural achievement that contributes to the sustainability of the programme is the formal recognition of "Girl Council" at the regional level. By transitioning youth agency into such a permanent institutional fixture, the programme ensured that the movement has a legal and recognised voice that survives funding cycles. This is reinforced by Kebele administrators who have institutionalised advocacy by incorporating FGM education into routine government gatherings, such as agricultural resource distribution. One 67-year-old Kebele administrator and farmer from Guna described this: *"What I did was facilitate the campaign as kebele administrator. I teach the community during different gatherings. Like, when there is a collection of farmers to take fertiliser"*. This ensured that anti-FGM messaging was integrated into the community's daily governance.

Risks and barriers to sustained impact

Despite these positive signs, several risks threaten the long-term success of the positive changes catalysed by the programme. The most pressing external threat is the current conflict in the Amhara region. The conflict has shifted public and administrative priorities, causing FGM to become once again

a "neglected issue." As one journalist explained, *"The training stimulated us... and then things were not good due to the current issue... the current priority problem is the conflict, not FGM."* This environment silences advocates and religious leaders, potentially neutralising the capacity built during the program.

Sustainability of media engagement is also hampered by inconsistent engagement that prevents changes from lasting. Some beneficiaries were trained once and because of the lack of follow up, this did not translate into action: A journalist (content creator) from Ethiopia for instance, was trained in 2022, and during the interview, he could barely recall what he learnt during the training and confessed that he has not done much on FGM since the training: *"We do not have a program specifically dedicated to FGM. One reason is that our primary audience is the Bahir Dar town and its surrounding areas, where, based on the information I have, FGM is not commonly practiced. In addition, our radio signal does not adequately reach rural communities, and FGM may not be a major concern for our current audience."* (KII, Journalist).

In the contrary of this beneficiary, the training had an immediate effect on some beneficiaries. Some participants explained that the training sparked immediate actions, such as dedicated radio shows where they invited survivors to share their lived experiences. However, the impact was not sustained. The lack of financial support, follow-up, and formal structure led to a cessation of activities.

"Programs need budgets. We don't have that. After the 2-3 programs, we ceased to do... we didn't establish it... After the training, we did not receive any additional budget... we did not receive any follow-up or feedback on the programs we implemented". (KII, Journalist, Amhara region)

Summary /overview of key findings

The key findings from the evaluation study highlight the importance of consistent and persistent advocacy to sustain change towards ending FGM, alongside persistent challenges and several

unexpected dynamics that require attention. Overall, the evidence points to a context where exposure to TGG-ALM activities is strongly associated with positive shifts, but where resistance, uneven reach, and emerging unintended effects continue to shape the landscape of change.

1. **Programme exposure and reach:** The TGG-ALM programme in Ethiopia reached diverse groups: adolescents, men, elders, mothers, and FGM practitioners via schools, health facilities, religious gatherings, and community champions. Exposure was uneven, with remote and insecure areas receiving fewer interventions. Champions and organised groups were more consistently reached than the general population, creating pockets of high exposure alongside areas with minimal programme presence.
2. **Knowledge and attitude change:** Among exposed individuals, a significant shift occurred from traditional/cultural beliefs to evidence-based understanding of FGM harms. Champions, survivors, and practitioners reported increased confidence, willingness, and motivation to advocate against FGM. Quantitative findings show that exposure is strongly associated with higher FGM-related knowledge and more progressive attitudes, although the magnitude of change varies by region and demographic group.
3. **Effect of knowledge:** High FGM-related knowledge and education levels were strongly associated with lower support for FGM, reduced intention to cut daughters, and aligned with more progressive attitudes. Younger respondents, however, showed higher odds of supporting FGM in some analyses, suggesting generational ambivalence and the need for deeper youth-focused engagement.
4. **Community ripple effect:** Trained individuals influenced their families and wider communities, resulting in attitude and practice changes extending beyond direct participants. This diffusion effect was particularly strong where champions, religious leaders, and health workers collaborated, and where community dialogues were frequent and inclusive.
5. **Institutional and movement-building impacts:** The programme strengthened grassroots organisations, fostered operational synergies among civil society organisations, and institutionalised advocacy via structures such as Girls' Councils and integration of FGM training within the health system. These institutional gains contributed to sustained momentum, improved coordination, and increased legitimacy of anti-FGM efforts.
6. **Barriers to change:** Resistance remains among unexposed groups due to distance, insecurity, practitioners' economic interests, and entrenched cultural beliefs. Scepticism toward external messengers like NGOs and health workers also hindered efforts. In some areas, religious misinterpretations and pressure from elders continued to reinforce FGM as a marker of identity, purity, or marriageability.
7. **Unintended effects:** The programme had positive and negative side effects, including secret cross-border FGM (FGM tourism), financial scepticism toward facilitators related to perceived financial motives, strategic concealment of FGM, and perceptions of reduced abductions and sexual violence linked to broader gender norm changes. These dynamics highlight the need for adaptive programming and stronger cross-border coordination.

Discussion for the Amhara findings

The Amhara findings show a consistent pattern of more progressive attitudes toward FGM among respondents exposed to FGM-related activities in intervention sites. The bivariate results (Tables 16 and 19) show a clear descriptive gradient, with non-exposed respondents consistently displaying the least favourable distributions across beliefs, knowledge, sanctions, encouragement, intentions, and overall attitudes, and respondents exposed in intervention sites showing the most favourable

distributions. The clearest evidence comes from the overall social attitude index, which integrates intention, sanctions, and encouragement. At endline, respondents exposed in intervention sites had 2.56 times higher odds of holding an overall attitude opposed to FGM compared with non-exposed respondents. Although the pooled baseline–endline model did not yield statistically significant associations for exposure categories, the direction of effects remained positive for both intervention and control/baseline exposure. This suggests that exposure, particularly in intervention sites, is aligned with more favourable normative environments despite limited statistical precision due to low numbers in some of the comparative categories.

Exposure patterns did not align neatly with study site classification. Respondents in control sites reported exposure to FGM-related activities, while some in intervention sites reported no exposure. This may reflect the effect of long-standing community-based initiatives and the sustained effect of other actors working in the area before this intervention. These dynamics reinforce the need to interpret the results as associations, not programme-specific effects. They also suggest that diffusion of information and historical programming may have blurred the distinction between intervention and control areas, a pattern consistent with norm-change ecosystems where multiple actors operate simultaneously.

Across individual domains, exposure in intervention sites was consistently associated with more progressive beliefs and attitudes. Respondents exposed in intervention sites had higher odds of holding beliefs opposed to FGM, demonstrating high FGM-related knowledge, and rejecting social sanctions for abandonment. These domains are typically the earliest to shift in social norm change processes, and the Amhara results reflect this expected pattern. This alignment between knowledge, beliefs, and sanctions is consistent with established social norms theory, which posits that informational and

belief-based shifts often precede changes in perceived social expectations (Cislaghi & Heise 2018; Mackie & LeJeune 2009).

Behaviour-proximal outcomes also showed strong associations with exposure in intervention sites. Respondents exposed in intervention sites were 6.47 times more likely to have encouraged someone to abandon FGM and 2.56 times more likely to report agency to oppose the practice. They were also less likely to intend to undergo FGM on their daughters. This can be interpreted as emerging interpersonal influence and behavioural intention, key markers of normative transition. These findings mirror qualitative accounts in which champions, religious leaders, and health workers described increased confidence and willingness to speak publicly against FGM, indicating that interpersonal influence is beginning to diffuse beyond programme participants.

Exposure in control sites showed mixed patterns. In some cases, such as beliefs opposed to FGM and encouragement of abandonment, exposure in control sites was associated with more progressive attitudes, though often with marginal significance or wider confidence intervals. In other domains, such as social sanctions and intention to cut daughters, exposure in control sites showed no meaningful association. These patterns likely reflect lower-intensity engagement, historical exposure, or diffusion of information rather than recent programme reach. Sparse data in some models also limited estimation, particularly for outcomes with low prevalence. Qualitative findings support this interpretation, noting that some control areas had prior exposure to anti-FGM initiatives, while others remained harder to reach due to insecurity or geographic isolation.

Gender-inequality beliefs were among the more progressive outcome domains compared to the other countries. Exposure in intervention sites was associated with lower odds of unequal gender beliefs at endline (OR 0.32), this association was consistently observed across models. Those with unequal gender beliefs were less likely to oppose social attitude (OR 0.46), enforcing the need to apply gender transformative and multisector approaches to shift and sustain the resistant Gender-unequal beliefs in order to positively change social attitude towards FGM. Qualitative data also highlighted persistent

patriarchal expectations and the influence of elders and religious authorities, suggesting that gender transformative change remains a longer-term endeavour.

The endline model also revealed a notable pattern: respondents with primary or secondary education had higher odds of holding an overall attitude opposed to FGM compared with those with low education. This contrasts with the Kenya findings and suggests that in Amhara, higher educational attainment may reinforce more progressive attitudes toward FGM. This has important implications for tailoring messaging and engagement strategies. It also aligns with qualitative accounts in which teachers, students, and educated youth described greater openness to questioning traditional practices and adopting evidence-based perspectives.

An unexpected finding in Amhara was the higher odds of supporting FGM among younger respondents in some models. This contrasts with typical generational patterns observed in other settings and may reflect the influence of peer norms, local identity dynamics, or limited programme reach among adolescents in certain areas. This warrants further exploration, as it suggests that youth-focused strategies may need strengthening to prevent generational stagnation or reversal.

Overall, the Amhara results show a coherent pattern: exposure, particularly in intervention sites, is associated with more progressive beliefs, knowledge, and behaviours related to FGM. It is also possible that individuals already predisposed to oppose FGM were more likely to participate in, or recall exposure to, programme activities, meaning that some of the observed associations may partly reflect self-selection rather than programme influence. However, the presence of exposure in control sites, the involvement of multiple actors, and the limitations of sparse data complicate attribution. The findings should therefore be interpreted as reflecting broader ecosystem effects and the cumulative influence of FGM-related programming in the region. Taken together, the evidence suggests that Amhara is in an early-to-mid stage of normative transition, where knowledge, beliefs, and interpersonal influence are

shifting, but deeper gender norms and pockets of youth resistance require sustained, targeted engagement.

Conclusion

The Amhara findings indicate that exposure to end FGM-related activities is strongly associated with more progressive attitudes toward FGM abandonment. The overall social attitude index shows that respondents exposed in intervention sites were significantly more likely to oppose FGM at endline, and the direction of effects remained positive in the pooled analysis, despite limited statistical significance. Individual domains, including beliefs opposed to FGM, high FGM-related knowledge, and opposition to social sanctions, also showed strong associations with exposure in intervention sites. Across both endline and pooled bivariate analyses, non-exposed respondents consistently displayed the least favourable outcomes, underscoring the central role of exposure in shaping attitudes and behaviours in the region. These patterns reflect an expected early-stage norm-change trajectory in which knowledge, beliefs, and sanctions shift before deeper social expectations fully transform.

Behaviour-proximal outcomes, such as encouragement of abandonment, intention to cut daughters, and agency to oppose FGM, displayed some of the largest effect sizes, indicating emerging shifts in interpersonal influence and personal empowerment. Gender-inequality beliefs also showed progressive positive responsiveness, though there was a percentage of those still holding unequal-gender beliefs, indicating the need to sustain deeper, longer-term gender-transformative approaches. This mirrors broader evidence that gender norms are among the most resistant domains and the progressive change should be sustained, through multisectoral engagement.

The presence of exposure in control sites and the involvement of multiple actors across the region mean that results cannot be attributed to TGG specifically. Instead, the findings reflect broader ecosystem effects and the cumulative influence of FGM-related programming in Amhara. While quantitative data cannot confirm programme-level attribution at the community scale, observed changes among directly engaged individuals point to meaningful programme contributions. Indeed, qualitative evidence indicates that individuals who were actively engaged - such as trained champions - experienced positive shifts that are plausibly linked to programme activities. Beyond individual change, the programme also contributed to strengthened organisational capacity and leadership. Overall, the positive associations observed across multiple domains suggest that community engagement, dialogue, and awareness-raising activities are contributing to shifts in knowledge, attitudes, and emerging behaviours. Its multi-channel approach, engaging schools, health facilities, religious leaders, and community champions, fostered individual change and broader community dialogue. Trained champions, survivors, and former practitioners became advocates, amplifying reach through peer influence and role modelling, demonstrating the programme's contribution to diffusion of anti-FGM norms within communities.

Taken together, the Amhara results highlight the importance of sustained, context-specific approaches that reinforce community-level norm change while addressing persistent gender inequality norms and tailoring strategies to local socio-cultural dynamics. The findings suggest that Amhara is in an early-to-mid stage of normative transition, where shifts in knowledge, beliefs, and interpersonal influence are visible, but deeper social expectations and gender norms require continued investment.

However, challenges remain. Geographic location, insecurity, practitioners' economic interests, and entrenched social norms limited reach, especially in hard-to-access areas. Resistance was strongest where FGM was linked to social identity, marriage prospects, or economic benefit. Scepticism toward external actors hindered trust and uptake. An unexpected pattern - higher support for FGM among some younger respondents - highlights the need for more targeted, age-appropriate engagement to prevent generational stagnation or reversal. Unintended consequences such as increased secrecy, cross-border

FGM, and scepticism about advocates' motives reflect community adaptation and require ongoing vigilance. These dynamics underscore the importance of adaptive programming, stronger cross-border coordination, and continuous monitoring of unintended effects.

Despite these obstacles, the programme achieved notable institutional and movement-building outcomes. Grassroots organisations were strengthened, movement against FGM was integrated into the region's Girls' Councils, and anti-FGM education was integrated into health and governance systems, all of which contribute to the sustainability and resilience of community-led efforts. These institutional gains position Amhara to sustain progress and deepen normative change over time.

Implications for Policy and Practice

1. **Expand coverage and sustain community-led advocacy:** Such interventions/engagements must extend to remote, insecure, and resistant communities by leveraging trusted local champions and adopting innovative, context-sensitive approaches. Sustaining survivor- and youth-led networks beyond the project lifecycle is critical for long-term impact. Given the strong exposure gradient observed in Amhara, expanding reach to unexposed groups is essential to prevent stagnation in communities where norms remain entrenched.
2. **Institutionalise multi-sectoral approaches:** Embedding anti-FGM messaging and response mechanisms into health, education, and local governance systems will anchor progress and ensure continuity beyond donor funding cycles. The integration of FGM content into Girls' Councils and health training institutions demonstrates the value of institutional pathways for sustaining normative change.

3. **Integrate with broader gender norm initiatives:** Linking anti-FGM efforts with wider gender equality and women's empowerment programmes can amplify impact and address the root causes of FGM. Given the limited responsiveness of gender-inequality beliefs in Amhara, deeper gender-transformative approaches are needed to shift the structural norms that sustain FGM.
 4. **Build trust and combat misinformation:** Using respected community members and peer advocates as messengers enhances credibility, counters scepticism, and fosters local ownership of anti-FGM initiatives. Qualitative findings highlight that scepticism toward external actors—especially NGOs and health workers—can undermine uptake, making trusted local intermediaries essential.
 5. **Monitor and adapt to evolving challenges:** Regularly monitor unintended effects such as secretive or cross-border FGM. Programmes must stay adaptive and respond swiftly to emerging trends and community strategies. In Amhara, increased secrecy, strategic concealment, and cross-border FGM (“FGM tourism”) require stronger surveillance, cross-border coordination, and community-level dialogue to prevent displacement of the practice.
 6. **Proactively address medicalisation of FGM:** While medicalisation has not emerged as a concern, the focus on health arguments as an advocacy approach and a reason to abandonment of FGM may present a risk of medicalisation in the future as a coping mechanism. Therefore, future programmes should ensure that health messaging is complemented by broader rights and zero tolerance messaging. This is particularly important in contexts where health workers are key messengers and may inadvertently legitimise “safer” forms of FGM.
 7. **Strengthen age-appropriate and youth-focused strategies:** The unexpected finding that some younger respondents showed higher support for FGM highlights the need for tailored youth engagement. Programmes should invest in adolescent-specific platforms, peer-led dialogues, and school-based interventions to prevent generational stagnation or reversal.
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8. **Leverage champions to accelerate diffusion:** Champions, survivors, and former practitioners demonstrated strong interpersonal influence and helped diffuse anti-FGM norms beyond direct programme participants. Strengthening their capacity, visibility, and support systems can accelerate communitywide norm change.
 9. **Tailor strategies to local socio-cultural dynamics:** Norms varied across communities, with resistance strongest where FGM is tied to identity, marriageability, or religious interpretation. Localised, culturally grounded approaches - co-designed with elders, religious leaders, and women's groups - are essential for shifting deeply embedded expectations.

Senegal

Background to findings

In Senegal, cases of FGM among women aged 15 to 49 in Senegal have remained constant (around 27.5%) in recent years. However, the prevalence among women living in urban and rural areas is estimated at around 23.4% and 27.8%, respectively. (Niemi & Cete, 2012). The capital city of Dakar is home to 49% of the country's urban population, and the prevalence of FGM/C is 20.1%. The regions with the highest percentage of FGM/C are in the south and east: Kedougou (92%), Matam (87.2%), Sedhiou (86.3%), Tambacounda (85.3%), and Kolda (84.8%). The regions with the fewest cases are in the west: Diourbel (0.5%), Thies (3.5%), Louga (3.8% each), Kaolack (5.6%), and Fatick (7.3%) (Taniguchi, 2014). These regional differences have complex roots that go beyond ethnicity and are partly due to historical, political, economic, and colonial influences.

In addition, among women aged 15 to 49 who have undergone FGM, 9.9% have undergone type I FGM, 52.7% have undergone type II FGM, 13.8% underwent type III FGM, and 23.6% did not know or data were missing (Andre and Demostat, 2009). Regarding those who practice FGM, traditional FGM practitioners are most often used (91.4%), followed by “other traditional methods” (7.6%) and traditional midwives/birth attendants (1%). Very few medical FGM procedures are reported in the country.

Senegal criminalised FGM in 1999 following an amendment to the penal code. The National Reproduction Program has also been in place since 1997 to support efforts to eliminate the practice. Reports show that awareness of the law is high (PBS News Hour, 2014). A study on FGM was launched in 2000 under the leadership of the Ministry of Family and National Solidarity. The government also adopted an action plan in 2005 and a second one in 2009 in collaboration with the UNFPA-UNICEF Joint Program for the Elimination of Female Genital Mutilation with the goal of eradicating the practice by 2015. More specifically, the regions of Tambacounda, Sedhiou, Kedougou, and Kolda represent the areas of Senegal most heavily impacted by Female Genital Mutilation (FGM), with prevalence rates frequently exceeding 80% and reaching as high as 98% among specific ethnic groups. In Tambacounda, the practice affects 83% of Mandinka and 80% of Puular women, while Sedhiou sees rates of 98% among the Mandingo/Soces and 80% among the Fulani. Kedougou reports a prevalence exceeding 90% among women aged 15 to 49, with the practice deeply embedded in the initiation rites of the Malinke, Peul, and Bassari communities, though organisations like Action Aid are now collaborating with local leaders to promote abandonment. Similarly, Kolda maintains an extremely high rate of 94%, where FGM – including the most severe form, infibulation – is socially framed as a marker of purity.

The broader socio-economic landscape of Kedougou, Kolda, Tambacounda, and Sedhiou is shaped by geographic isolation and a persistent reliance on traditional social structures. Data from Senegal's National Agency of Statistics and Demography (ANSD, 2024) indicate that although regional capitals exhibit relatively balanced sex ratios, several rural departments - most notably Bakel (Tambacounda), Medina Yoro Foulah (Kolda), and Salemata (Kedougou) - experience pronounced demographic imbalances driven by high levels of male labour migration. These regions constitute a rich ethnic mosaic, predominantly composed of Peul (Pulaar), Mandingue (Malinke), and Soninke populations.

Sedhiou is additionally characterised by the presence of Balante and Diola communities, while Kedougou is home to distinctive Bassari and Bedik minority groups. Islam is the dominant religion across the four regions. Economically, livelihoods are largely based on subsistence agriculture, livestock rearing, and fishing, with Kedougou increasingly influenced by both artisanal and industrial gold mining activities. Despite this endowment of natural resources, these regions remain among the poorest in Senegal, as documented by World Bank assessments for 2022. The limited reach of formal economic and institutional infrastructure reinforces dependence on customary law and traditional authority systems. Education levels in these regions remain well below the national average, posing a major barrier to social change. ANSD and UNICEF data show that while primary enrolment has improved, secondary school completion drops sharply—particularly for girls. In Kolda and Kedougou, multidimensional child poverty affects approximately 79–82% of children, with educational deprivation identified as a key driver (UNICEF, 2025).

Across these four regions, isolation, limited access to social services, and the weight of intergenerational cultural norms necessitate targeted, multi-level interventions like the TGG/ALM program to transform long-standing social and gender expectations

The TGG/ALM programme in Senegal was designed as a connected set of interventions that worked from the level of individual girls up to national systems, rather than as isolated activities:

Individual level:

- Amref Health Africa and ActionAid Senegal (AAS) implemented girls' clubs for both in-school and out-of-school girls. These clubs focused on strengthening capacity and supporting girls in planning their own activities. A key feature is the role of trained girl champions, who did not remain only within the club setting but also helped facilitate broader engagement. Girls were

therefore positioned as active contributors to change, not only as beneficiaries. Their leadership was intentionally supported and structured, which reflected the programme's girl-centered and gender-transformative orientation in practical terms.

Community level:

- Capacity building: Amref, ActionAid Senegal (AAS), and various grantees provided specialised training for community champions. These champions included religious leaders, community health workers, and former FGM practitioners, equipping them to lead the shift in social norms from within.
- Sensitisation and community dialogues: Facilitated by girl champions—who are supported by older mentors such as healthcare providers and traditional leaders—these sessions engaged a broad spectrum of stakeholders. By targeting mothers, fathers, grandparents, spouses, and youth, the program fostered a multi-generational consensus to end the practice.
- Grants' mechanism: Managed by Options, this mechanism provided vital financial resources, coaching, and capacity building to local organisations. By empowering grassroots groups with established commitments to ending FGM, the program expanded its reach through diverse channels such as media, arts, schools, community dialogues or sensitisation sessions, survivor forums, and policy advocacy.

Regional level:

- Advocacy, stakeholders' engagement and movement building: partners jointly engaged stakeholders through meetings, mass awareness caravans, social media campaigns, celebration of national events (such 16 Days of Activism against gender-based violence, cultural days in the regions, International Day for Zero Tolerance to FGM). These engagements also involved training and capacity strengthening, convening of regional government actors (such as the Departmental Committee for Child Protection (CDPE)), to create a movement towards ending
- FGM, and enforcing existing policies and laws. This regional dynamic has been reinforced in Kolda and Sedhiou, where Amref and grantees have worked with other partners to establish regional coalitions. One of the main objectives was to strengthen cross-border collaboration with neighbouring countries to better promote the abandonment of FGM. These coalitions were then linked to the National Federation for the Promotion of the Abandonment of FGM.

National level:

- Programme partners jointly implement policy advocacy towards the enforcement of existing laws and policies and foster the inclusion of the programme in existing end FGM and GBV efforts. In addition, a national Survivors Leadership Initiative (SLI) training course was organised in 2023, which helped to strengthen the capacities of female survivor champions and launch a network of survivors.
- In parallel, the program has bolstered civil society by supporting the creation of a dedicated network of organisations (the National Federation for the Promotion of the Abandonment of FGM) and the development of a comprehensive national action plan.
- The Africa Coordination Centre for Abandonment of FGM (ACAAF) engaged health training institutions to adopt a standardised pre-service curriculum on FGM prevention and response, training lecturers who then train health students. These tools were submitted to the National Technical Committee for the Promotion of the Abandonment of FGM and then to the Ministry of Family and Solidarity, supporting the institutionalisation of FGM prevention within national systems. Together, these elements make the programme not only community-focused but also system-oriented and movement-building in nature.

Data sources

Table 22 summarises the data sources that informed the Senegal section of the report. Baseline data were collected in early 2023 and endline data between April 2025 and January 2026 by the University of Portsmouth. The data analysis involved comparing baseline and endline, as well as intervention and control sites (see more details under section 2.3 Data management and analysis).

Table 22. Summary of sample size per each data collection approach in Senegal

Evaluation phase	Target population	Sites	Sample size
Baseline survey	Girls, boys, women and men (15-65 years)	Kolda, Sedhiou and Tambacounda	812
Endline community-based survey	Girls, boys, women and men (15-65 years)	Kedougou, Kolda, Sedhiou and Tambacounda	2268
Endline qualitative study (IDIs, KIIs and FGD)	IDIs: Girls, boys, women and men, Girls' and boys' champions	Kedougou, Kolda, Sedhiou and Tambacounda	33
	KIIs: Civil society organisations, survivor networks, youth and community champions, media actors, consortium partners, and government and policy stakeholders.		55
	FGD: Grantee organisation members		6
Ethnographic study	Community members, champions, leaders, programme implementers	Sedhiou and Tambacounda	90
Outcome harvesting	Key stakeholders and beneficiaries (including substantiation from Tambacounda and Sedhiou), Implementing partners	Kedougou, Kolda, Sedhiou and Tambacounda	77

Socio-demographic information and differences in FGM-related knowledge and attitudes

The Senegal sample included 812 respondents at baseline and 2,268 at endline, as shown in Table 23. At endline, respondents were drawn from both control and intervention sites, with 65% from control areas and 35% from intervention areas.

Several demographic distinctions are observed between the two rounds. Women represented 75% of respondents at baseline and 57% at endline, while men accounted for 25% at baseline and 43% at endline. Respondents aged 45 years and above constituted 21% at baseline and 30% at endline, with the remaining age groups distributed more evenly across rounds. Educational attainment also differed: 54% of baseline respondents reported no formal education, compared with 45% at endline, and secondary education or above was reported by 26% at baseline and 34% at endline.

Differences were also noted in FGM-related knowledge and attitudes. The proportion classified as having high FGM-related knowledge was 64% at baseline and 55% at endline. Beliefs opposed to FGM were reported by 47% of respondents at baseline and 61% at endline. Gender-inequality beliefs were reported by 56% at baseline and 87% at endline.

Patterns related to social norms and behaviours also varied across rounds. Opposition to social sanctions for FGM abandonment was reported by 65% at baseline and 88% at endline. The proportion who had ever encouraged someone to abandon FGM was 69% at baseline and 15% at endline. At endline, 47% of respondents reported agency to oppose FGM, and 12% reported being in favour of FGM continuation.

Indicators related to intention and overall attitude also differed between rounds. At baseline, 72% of respondents opposed performing FGM on daughters, compared with 86% at endline. Similarly, the overall social attitude index showed 65% opposed to FGM at baseline and 88% at endline.

Table 23. Sample description by characteristics in the four study regions of Senegal

Characteristic	Baseline*	Endline
	N = 750 ^l	N = 2,268 ^l
Study site		
Baseline	750 (100%)	—
Control	—	1,467 (65%)
Intervention	—	801 (35%)
Exposure to FGM-related activities		
Non-exposed	368 (49%)	1,580 (70%)
Exposed	382 (51%)	688 (30%)
Respondent sex		
Men	184 (25%)	970 (43%)
Women	566 (75%)	1,298 (57%)
Marital status		
No	82 (11%)	564 (25%)
Yes	481 (64%)	1,704 (75%)
NA (missing data)	187 (25%)	—
Age group		
< 25yrs	238 (32%)	474 (21%)
25-34	200 (27%)	615 (27%)
35-44	155 (21%)	503 (22%)
≥ 45yrs	157 (21%)	676 (30%)
Ethnicity		
Pulaar	312 (42%)	1,129 (50%)
Soninké	106 (14%)	282 (12%)
Mandingue	225 (30%)	411 (18%)
Wolof	38 (5%)	129 (6%)
Others	69 (9%)	317 (14%)
Religion		
Christian	13 (2%)	86 (4%)
Muslim	737 (98%)	2,182 (96%)
Education		
No formal education**	404 (54%)	1,013 (45%)
Primary	151 (20%)	479 (21%)
Secondary+	195 (26%)	776 (34%)
Region		
Kedougou	—	568 (25%)
Kolda	239 (32%)	566 (25%)
Sedhiou	168 (22%)	569 (25%)
Tambacounda	343 (46%)	565 (25%)
FGM-related knowledge		
Low	269 (36%)	1,011 (45%)
High	481 (64%)	1,257 (55%)
Beliefs related to FGM		
In favour	401 (53%)	877 (39%)
Opposed	349 (47%)	1,391 (61%)
Gender-inequality beliefs		
unequal	422 (56%)	1,974 (87%)
equal	328 (44%)	294 (13%)
Social sanction for FGM abandonment		
In favour	264 (35%)	265 (12%)
Opposed	486 (65%)	2,003 (88%)
Ever encouraged FGM abandonment		
Never	231 (31%)	1,935 (85%)
Ever encouraged	519 (69%)	333 (15%)

Agency to oppose FGM		
Can't oppose	—	1209 (53%)
Can oppose	—	1059 (47%)
Whether FGM should continue		
Not for continuation	—	2003 (88%)
In favour of continuation	—	265 (12%)
Discrimination against girls who have not undergone FGM		
Not for discrimination	—	2082 (92%)
In favour of discrimination	—	186 (8%)
Intention to undergo FGM on daughters		
Opposed	540 (72%)	1,950 (86%)
In favour	210 (28%)	318 (14%)
Overall social attitude to FGM		
In favour	266 (35%)	265 (12%)
Opposed	484 (65%)	2,003 (88%)

Note: (*) Baseline data do not include Kedougou

(**) No formal education refers to respondents with no schooling or those who are literate but have not attended formal education (other literates)

Exposure to FGM-related interventions

Table 24 summarises exposure to community-based activities related to FGM abandonment across baseline and endline sites in the three regions included in both rounds. Over the 3,018 respondents, 35% reported having been exposed to such activities.

At baseline, 51% of respondents stated that they had been exposed to community-based activities related to FGM abandonment. In the endline control sites, 27% of respondents reported exposure, while in the endline intervention sites, 37% reported exposure. Exposure was therefore observed across all sites at endline, with higher proportions in intervention areas, yet lower than those observed at baseline.

As Kedougou was not intended to be part of the baseline sample, 60 baseline observations from this region were removed. For consistency, 568 endline observations from Kedougou were also excluded from the pooled baseline–endline dataset, resulting in a consolidated analytic sample of 2,450 respondents for the pooled analysis.

Table 24. Overall exposure in baseline and endline by study site in Kolda, Sedhiou and Tambacounda regions in Senegal

Study site	Exposure to the intervention		Total
	Non-exposed	Exposed	
Baseline	368 (49%)	382 (51%)	750 (100%)
Control	1,075 (73%)	392 (27%)	1,467 (100%)
Intervention	505 (63%)	296 (37%)	801 (100%)
Total	1,948 (64%)	1,070 (35%)	3,018 (100%)

The qualitative findings provided insights into the programme implementation and how exposure occurred (or did not). Data indicate the programme has raised awareness and engagement locally. Some accounts suggest engagement extends beyond the initially targeted groups, as shown in the following quote from a "champion" interviewed for this evaluation:

"Everyone is talking about it now; even former circumcisers participate in the activities and recognise that excision is not a good practice. What I liked most about these activities is that

they allow us to call on adults in front of everyone, girls, boys, parents to talk about it openly". (IDI, Girl Champion, Tambacounda)

This quote highlights two key points. First, former FGM practitioners now participate in the programme and openly acknowledge the harm of FGM. This is significant because these women traditionally upheld the practice. Their involvement indicates the programme has engaged individuals who were once part of the problem. Second, the participant noted that the programme facilitated open dialogue among individuals of various ages and genders, including girls, boys, and parents. These discussions are essential for influencing and transforming harmful social norms.

Another quote that sheds light on the programme's reach comes from a boy champion who describes his direct experience with one of the community awareness sessions organised by the programme. His account adds a different perspective to the discussion, as it comes from a male community member who was exposed to the programme's activities and chose to engage with them actively:

"I once participated in the talk that was organised by the girls, and I even spoke to share my feelings and explain how our ideas are starting to change thanks to everything they said and did." (IDI, Boy champion, Sedhiou)

This quote highlights two key points. Firstly, the programme's activities successfully engaged male members of the community, which is important because shifting attitudes about FGM involves both men and women. The young man's participation in a girls-only session and his willingness to speak out publicly demonstrate genuine engagement with the programme's messages. Secondly, he uses the term "our" when discussing changing ideas, indicating that the shift in thinking is not solely personal but shared with others, potentially signalling an early stage of broader community norm change.

However, this account should be viewed cautiously. As a boy champion, the respondent is part of the programme, so his experience might not represent that of the typical male community member with limited or no direct exposure to TGG/ALM activities.

While the testimonies presented above suggest that the TGG/ALM programme has achieved some level of community reach in the areas where it operates, it is also important to examine the factors that have limited the exposure to the programme in certain contexts. Indeed, findings demonstrate that the program's reach was uneven across different demographics and geographies. Urban centres and the immediate neighbourhoods of community champions reported significantly higher levels of exposure. A similar trend was observed in the border areas across all four regions, a pattern previously noted during the proof-of-concept assessment phase. In contrast, rural and remote settings often experienced limited direct engagement, with fewer opportunities to participate in core program activities such as community dialogues or youth clubs. Regarding the reasons, participants frequently cited practical difficulties that prevent activities from reaching remote or less accessible areas. Far from being mere operational inconveniences, these constraints directly hindered the program's mission, particularly in rural areas, where weak transportation infrastructure and the significant distances between villages pose formidable obstacles. The following testimony from a girl champion clearly illustrates these challenges:

"We are not sufficiently equipped; there are things that need to be improved for field activities. Because, for example, if we want to go to the surrounding villages to carry out activities with the other champions, we will have problems getting there. Problems like transportation, access to other villages, so we need to be equipped so that we can continue the fight". (IDI, Girl champion, Tambacounda)

This testimony directly identifies the material and logistical gaps that are limiting the programme's reach on the ground. Similar concerns were also raised by other participants, including among the grantees. Together, these factors create barriers that prevent the programme from expanding beyond some areas or communities. Moreover, the girl champion's choice of the word "fight" is particularly telling; it underscores a deep sense of personal commitment and resilience. Her tone suggests frustration

rather than defeat; she possesses the drive to effect change but lacks the necessary tools to facilitate it. This indicates that the primary bottleneck is not a lack of community will or motivation, but rather a deficit in the practical resources and structural support required to sustain and scale their efforts. From an analytical perspective, this testimony raises critical questions regarding the program's design and resource allocation. Outreach models that rely on community volunteers or peer educators to disseminate messages beyond a central hub must account for the tangible costs and mobility challenges inherent in rural settings. The respondent's explicit request for better equipment suggests that these practical requirements may not have been fully integrated into the implementation phase.

Regarding the difference in exposure of the demographics in the intervention areas, some participants explained how individuals such as the champions were overly exposed compared to the general community members, as described in this quote:

“Since the programme began, I have noticed that it’s always the same activities and training sessions taking place, and they benefit the same people” (CCA members, champion girls, peer educators, girls’ clubs, and Badiénou Gox)⁶. “It seems to me like a clique, and that’s why I have reduced my involvement. Not only is there nothing new, but it’s always the same faces showing up. Aside from these people, I can say that there isn’t a single member of the community who knows about the ALM program”. (Male community members, Tambacounda)

This quote shows a critical bottleneck in the TGG-ALM programme’s reach, suggesting that the initiative may be suffering from "elite capture" where participation has become concentrated within a closed circle of insiders. If the programme intentionally chose to repeatedly engage the same specific groups such as CCA members, girl champions, religious leaders, or the Badiénou Gox, it has inadvertently fostered the perception of an exclusive "clique,"⁷ which may have alienated the broader community and discouraged new people from joining the initiative. This sense of exclusion is compounded by a perceived lack of innovation; the participant notes that the repetition of the "same activities" and "same faces" leads to participation fatigue, eventually causing even motivated individuals to reduce their involvement (like for this participant). Crucially, the testimony highlights a failure in the diffusion of information, asserting that outside of this core group of champions, the public remains largely unaware of the programme’s existence. This suggests that the community engagement model, while effective at training a dedicated cadre of champions, struggled to move beyond these organised structures to achieve the wide-scale community saturation necessary for a true social movement.

Association between exposure and FGM-related outcomes at Endline

Endline bivariate analysis

Table 25 presents the endline bivariate associations between study site, exposure category, and FGM-related outcomes across the four study regions in Senegal. Across study sites, several outcomes show similar distributions between control and intervention areas, while others display modest differences. For beliefs related to FGM, intervention sites have a slightly higher proportion of respondents opposed to the practice (64%) compared with control sites (60%), and this difference is statistically significant. For gender-inequality beliefs, the proportions holding “equal” beliefs are nearly identical across study sites (87% in both), with no significant difference. FGM-related knowledge shows a clearer distinction: 64% of respondents in intervention sites have high knowledge compared with 51% in control sites. For other outcomes, including social sanctions, discrimination against uncut girls, opinion about continuation, and overall social attitude, the proportions across study sites are broadly similar, with non-significant p-values.

⁶ Badiénou Gox are respected community women in Senegal who act as local advisors and health promoters, supporting families on issues like maternal health, family planning, and social well-being.

⁷ A “clique” means a small, exclusive group of people who spend time together and don’t easily include others.

When outcomes are examined by exposure category, a distinct and counter-intuitive gradient emerges. Across multiple indicators - including beliefs, sanctions, discrimination, intention, and overall attitude - non-exposed respondents consistently show the most favourable distributions. Respondents exposed in control sites show the least favourable patterns, while those exposed in intervention sites fall between these two groups. This pattern contrasts with Kenya and Ethiopia and suggests that exposure in Senegal occurred disproportionately in communities or sub-groups where norms remain strongly supportive of FGM.

For beliefs related to FGM, 63% of respondents exposed in control sites are in favour of the practice, compared with 41% among those exposed in intervention sites and 35% among the non-exposed. For FGM-related knowledge, the gradient reverses: high knowledge is lowest among non-exposed respondents (47%) and highest among those exposed in intervention sites (88%), with those exposed in control sites falling in between (79%). Social sanctions and discrimination against uncut girls also show clear differences: 95% of non-exposed respondents oppose sanctions, compared with 60% among those exposed in control sites and 70% among those exposed in intervention sites. A similar pattern appears for discrimination, where 94% of non-exposed respondents reject discriminatory attitudes, compared with 79% among those exposed in control sites and 86% among those exposed in intervention sites.

Behavior

ur-proximal outcomes also vary across exposure groups. Respondents exposed in intervention sites have the highest proportion reporting that they have ever encouraged someone to abandon FGM (30%), followed by those exposed in control sites (18%), while non-exposed respondents have the lowest (12%). For intention to cut daughters, 91% of respondents exposed in intervention sites oppose FGM, compared with 84% among those exposed in control sites and 85% among the non-exposed. For agency to oppose FGM, respondents exposed in both control and intervention sites show substantially higher proportions reporting that they can oppose the practice (80% and 76%, respectively) compared with non-exposed respondents (38%).

Table 25. Bivariate association of study sites and study-site related exposure by outcome variables at endline in the in the four study regions of Senegal

Characteristic	Overall	Study site		p-value ²	Study site related Exposure			p-value ²
		Control	Intervention		Non-exposed all sites	Exposed control site	Exposed intervention site	
		N = 1,467 ¹	N = 801 ¹		N = 1,753 ¹	N = 219 ¹	N = 296 ¹	
Beliefs related to FGM				0.032				<0.001
In favour	877 (39%)	591 (40%)	286 (36%)		616 (35%)	139 (63%)	122 (41%)	
Opposed	1,391 (61%)	876 (60%)	515 (64%)		1,137 (65%)	80 (37%)	174 (59%)	
Gender-inequality beliefs				0.711				0.606
Equal	1,974 (87%)	1,274 (87%)	700 (87%)		1,524 (87%)	195 (89%)	255 (86%)	
Unequal	294 (13%)	193 (13%)	101 (13%)		229 (13%)	24 (11%)	41 (14%)	
FGM-related knowledge				<0.001				<0.001
Low	1,011 (45%)	723 (49%)	288 (36%)		927 (53%)	47 (21%)	37 (13%)	
High	1,257 (55%)	744 (51%)	513 (64%)		826 (47%)	172 (79%)	259 (88%)	
Social sanction for FGM abandonment				0.641				<0.001
In favour	265 (12%)	168 (11%)	97 (12%)		88 (5.0%)	88 (40%)	89 (30%)	
Opposed	2,003 (88%)	1,299 (89%)	704 (88%)		1,665 (95%)	131 (60%)	207 (70%)	
Discrimination against uncut girls				0.362				<0.001
Not for discrimination	2,082 (92%)	1,341 (91%)	741 (93%)		1,655 (94%)	172 (79%)	255 (86%)	
In favour of discrimination	186 (8%)	126 (9%)	60 (7%)		98 (5.6%)	47 (21%)	41 (14%)	

				0.003			0.046
Opinion about FGM continuation							
Not for continuation	2,003 (88%)	1,274 (87%)	729 (91%)		1,539 (88%)	190 (87%)	274 (93%)
In favour of continuation	265 (12%)	193 (13%)	72 (9%)		214 (12%)	29 (13%)	22 (7.4%)
Ever encouraged FGM abandonment				0.002			<0.001
Never	1,935 (85%)	1,276 (87%)	659 (82%)		1,549 (88%)	179 (82%)	207 (70%)
Ever encouraged	333 (15%)	191 (13%)	142 (18%)		204 (12%)	40 (18%)	89 (30%)
Intention to perform FGM on daughters				0.015			0.025
Opposed	1,950 (86%)	1,242 (85%)	708 (88%)		1,498 (85%)	183 (84%)	269 (91%)
In favour	318 (14%)	225 (15%)	93 (12%)		255 (15%)	36 (16%)	27 (9%)
Agency to oppose FGM				0.001			<0.001
Can't oppose	1,209 (53%)	819 (56%)	390 (49%)		1,095 (62%)	44 (20%)	70 (24%)
Can oppose	1,059 (47%)	648 (44%)	411 (51%)		658 (38%)	175 (80%)	226 (76%)
Overall social attitude to FGM				0.547			<0.001
In favour	265 (12%)	167 (11%)	98 (12%)		88 (5.0%)	88 (40%)	89 (30%)
Opposed	2,003 (88%)	1,300 (89%)	703 (88%)		1,665 (95%)	131 (60%)	207 (70%)

¹ n (%)

² Pearson's Chi-squared test; Fisher's exact test

Endline multivariate analysis

Table 26 examines how study site and exposure categories relate to nine FGM-related outcomes at endline across the four study regions of Senegal. All models are adjusted for sex, age, education, marital status, ethnicity, religion, and region. The results show distinct patterns across outcomes, with several statistically significant associations for exposure categories, particularly among respondents exposed in intervention sites.

Beliefs opposed to FGM

The comparison between intervention and control sites showed no statistically significant difference in the odds of holding beliefs opposed to FGM (OR = 1.14, $p = 0.2$). When exposure is considered, respondents exposed in intervention sites had lower odds of holding beliefs opposed to FGM compared with non-exposed respondents (OR = 0.78), although this association was not statistically significant ($p = 0.073$). Respondents exposed in control sites also had lower odds of holding opposing beliefs compared with non-exposed respondents (OR = 0.37, $p < 0.001$). Regarding unequal gender-related beliefs, none of the site-level or exposure-related comparisons showed statistically significant associations.

High FGM-related knowledge

Our analysis shows that respondents living in intervention sites had 1.68 times higher odds of reporting high FGM-related knowledge compared with those in control sites ($p < 0.001$). When exposure is considered, the associations are substantially stronger: respondents exposed in intervention sites had 8.09 times higher odds of reporting high knowledge compared with non-exposed respondents ($p < 0.001$), and those exposed in control sites had 5.11 times higher odds ($p < 0.001$).

Detailed attitudinal outcomes

Across attitudinal outcomes, the comparison between intervention and control sites generally showed few statistically significant differences, with odds ratios close to 1 (ranging from 0.76 to 1.46). In contrast, exposure -whether occurring in intervention or control sites - showed clearer and often stronger

associations. Exposure in intervention sites was associated with substantially lower odds for several attitudes supportive of FGM, including support for social sanctions, support for continuation, and intention to cut daughters (with ORs ranging from 0.09 to 0.48), and higher odds for attitudes aligned with abandonment, such as encouraging others (OR = 3.00) and reporting agency to oppose FGM (OR = 5.22). Exposure in control sites showed a similar pattern, including lower support for sanctions (OR = 0.06), lower intention to cut daughters (OR = 0.60), and markedly higher reported agency (OR = 7.32). The main exception was support for discrimination against uncut girls, where exposure in both intervention and control sites was associated with higher odds (OR = 2.72 and OR = 2.91), contrasting with the broader pattern observed across other attitudinal measures.

Table 26. Adjusted Odds ratios of the association between study site and exposure by outcome variables in endline in the four study regions of Senegal

Outcomes	Intervention VS Control			Exposed in control site VS Non-exposed all site			Exposed in intervention site VS Non-exposed all sites		
	OR	95% CI	p-value	OR	95% CI	p-value	OR	95% CI	p-value
Holding beliefs opposed to FGM	1.14	0.94, 1.38	0.2	0.37	0.27, 0.51	<0.001	0.78	0.59, 1.02	0.073
Holding unequal gender related beliefs	1.05	0.80, 1.37	0.7	0.69	0.43, 1.09	0.13	1.06	0.72, 1.52	0.8
Having high FGM-related knowledge	1.68	1.39, 2.03	<0.001	5.11	3.57, 7.46	<0.001	8.09	5.64, 11.9	<0.001
Being opposed to social sanctions for FGM-abandonment	0.94	0.70, 1.25	0.7	0.06	0.04, 0.10	<0.001	0.09	0.06, 0.13	<0.001
Being in favour of discrimination against uncut girls	0.96	0.68, 1.34	0.8	2.91	1.90, 4.39	<0.001	2.72	1.77, 4.12	<0.001
Being in favour of FGM continuation	0.76	0.55, 1.02	0.075	0.65	0.40, 1.01	0.063	0.48	0.29, 0.77	0.003
Having ever encouraged anyone to abandon FGM	1.46	1.13, 1.88	0.003	1.48	0.98, 2.19	0.054*	3.00	2.20, 4.09	<0.001
Intention to perform FGM on daughters	0.86	0.64, 1.15	0.3	0.60	0.39, 0.92	0.023	0.48	0.30, 0.74	0.001
Agency to oppose FGM	1.28	1.07, 1.54	0.007	7.32	5.13, 10.7	<0.001	5.22	3.90, 7.06	<0.001

Abbreviations: CI = Confidence Interval, OR = Odds Ratio

(*) Borderline significance

Overall social attitude outcome

In the endline comparison of overall social attitude opposed to FGM (Table 27), respondents exposed in intervention sites had lower odds of holding an overall attitude opposed to FGM compared with non-exposed respondents (OR = 0.15, $p < 0.001$). A similar association was observed for respondents exposed in control sites (OR = 0.15, $p < 0.001$).

Beliefs opposed to FGM showed the strongest association in the model: respondents who held beliefs opposed to FGM had 26.4 times higher odds of reporting an overall attitude opposed to the practice ($p < 0.001$). High FGM-related knowledge was associated with lower odds of opposing FGM (OR = 0.17, $p < 0.001$). This pattern contrasts with formal education, which showed no significant association with overall attitude, indicating that higher knowledge and higher schooling do not align in their associations with opposition to FGM in this setting.

Regional differences were pronounced. Compared with respondents in Kedougou, those in Kolda (OR = 0.03, $p < 0.001$), Sedhiou (OR = 0.15, $p < 0.001$), and Tambacounda (OR = 0.27, $p = 0.026$) had lower odds of holding an attitude opposed to FGM. Mandingue ethnicity showed a borderline association (OR = 0.59, $p = 0.056$).

Other sociodemographic characteristics were not significantly associated with overall attitude. Marital status (OR = 0.81, $p = 0.4$), sex (OR = 1.33, $p = 0.15$), and age (ORs ranging from 0.87 to 1.21, p values between 0.5 and 0.8) showed no significant differences. Education, as noted above, likewise showed no association with overall attitude. Religion (OR = 2.71, $p = 0.1$) and gender-inequality beliefs (OR = 0.91, $p = 0.8$) were also not significantly associated.

Table 27. Endline exposure to intervention and associated adjusted Odd-ratio to attitude against FGM practice in endline in the four study regions of Senegal

Characteristic	Holding an overall social attitude opposed to FGM		
	OR	95% CI	p-value
Exposure			
Non-exposed all sites (ref)	—	—	
Exposed in control site	0.15	0.09, 0.24	<0.001
Exposed in intervention site	0.15	0.09, 0.25	<0.001
Marital status			
No (ref)	—	—	
Yes	0.81	0.49, 1.31	0.4
Sex			
Men (ref)	—	—	
Women	1.33	0.90, 1.96	0.15
Age group			
≥ 45yrs (ref)	—	—	
35-44	1.21	0.70, 2.11	0.5
25-34	1.07	0.63, 1.84	0.8
< 25yrs	0.87	0.46, 1.64	0.7
Ethnicity			
Pulaar (ref)	—	—	
Soninké	0.98	0.39, 2.55	>0.9
Mandingue	0.59	0.34, 1.01	0.056*
Wolof	1.72	0.75, 4.06	0.2
Others	0.62	0.30, 1.29	0.2
Religion			
Christian (ref)	—	—	
Muslim	2.71	0.81, 8.52	0.1
Education			
No formal education* (ref)	—	—	
Primary	1.18	0.68, 2.06	0.6
Secondary+	0.81	0.49, 1.32	0.4
Region			
Kedougou (ref)	—	—	
Kolda	0.03	0.01, 0.08	<0.001
Sedhiou	0.15	0.05, 0.38	<0.001
Tambacounda	0.27	0.08, 0.81	0.026
FGM-related knowledge			
Low (ref)	—	—	
High	0.17	0.11, 0.27	<0.001
Beliefs related to FGM			
In favour (ref)	—	—	
Opposed	26.4	15.9, 46.0	<0.001

Gender-inequality beliefs

Equal (ref)

Unequal

0.91

0.51, 1.69

0.8

Abbreviations: CI = Confidence Interval, OR = Odds Ratio

Note: (*) No formal education refers to respondents with no schooling or those who are literate but have not attended formal education (other literates)

(**) borderline significance

Association between exposure and FGM-related outcomes from the pooled Baseline-Endline data

Baseline-endline bivariate analysis

Table 28 presents the pooled baseline–endline bivariate associations between exposure categories and FGM-related outcomes across the three Senegal regions included in both rounds of data collection (Kedougou is excluded because it was not part of the baseline survey). Across the three exposure groups, non-exposed, exposed in control/baseline sites, and exposed in intervention sites, the distribution of outcomes varies substantially for most indicators.

For beliefs related to FGM, respondents exposed in control/baseline sites have the highest proportion in favour of the practice (59%), while non-exposed respondents have the lowest (40%), indicating the most progressive pattern. Respondents exposed in intervention sites fall between these two groups (49% in favour). Gender-inequality beliefs show a similar gradient: 85% of respondents exposed in intervention sites hold equal gender beliefs, compared with 78% among the non-exposed and 73% among those exposed in control/baseline sites.

FGM-related knowledge displays a strong and expected gradient. High knowledge is lowest among non-exposed respondents (47%), higher among those exposed in control/baseline sites (73%), and highest among those exposed in intervention sites (88%). These differences are statistically significant.

For social sanctions, the pattern reverses. Respondents exposed in control/baseline sites have the highest proportion in favour of sanctions (41%), while non-exposed respondents have the lowest (9%), indicating the most favourable normative position. Respondents exposed in intervention sites again fall between these two groups (37% in favour). A similar pattern is observed for the overall social attitude index: 91% of non-exposed respondents oppose FGM, compared with 59% among those exposed in control/baseline sites and 63% among those exposed in intervention sites.

Behaviour-proximal outcomes also differ across exposure groups. Respondents exposed in control/baseline sites have the highest proportion reporting that they have ever encouraged someone to abandon FGM (55%), followed by those exposed in intervention sites (32%), while non-exposed respondents have the lowest (19%). For intention to cut daughters, respondents exposed in intervention sites show the highest proportion opposed to FGM (89%), compared with 80% among those exposed in control/baseline sites and 77% among the non-exposed. These differences are statistically significant.

Table 28. Bivariate association of study-site related exposure by outcome variables using baseline-endline pooled data in the four study regions of Senegal

Characteristic	Overall N = 2,450 ¹	Study site related exposure			P- value ²
		Non-exposed all sites	Exposed Control and baseline	Exposed Intervention site	
		N = 1,498 ¹	N = 714 ¹	N = 238 ¹	
Beliefs related to FGM					<0.001
In favour	1,145 (47%)	605 (40%)	424 (59%)	116 (49%)	
Opposed	1,305 (53%)	893 (60%)	290 (41%)	122 (51%)	
Gender-inequality beliefs					<0.001

Equal	1,892 (77%)	1,169 (78%)	521 (73%)	202 (85%)	
Unequal	558 (23%)	329 (22%)	193 (27%)	36 (15%)	
FGM-related knowledge					<0.001
Low	1,017 (42%)	797 (53%)	192 (27%)	28 (12%)	
High	1,433 (58%)	701 (47%)	522 (73%)	210 (88%)	
Social sanction for FGM abandonment					<0.001
In favour	523 (21%)	140 (9%)	295 (41%)	88 (37%)	
Opposed	1,927 (79%)	1,358 (91%)	419 (59%)	150 (63%)	
Ever encouraged FGM abandonment					<0.001
Never	1,690 (69%)	1,208 (81%)	321 (45%)	161 (68%)	
Ever encouraged	760 (31%)	290 (19%)	393 (55%)	77 (32%)	
Intention to perform FGM on daughters					<0.001
Opposed	1,933 (79%)	1,148 (77%)	574 (80%)	211 (89%)	
In favour	517 (21%)	350 (23%)	140 (20%)	27 (11%)	
Overall social attitude to FGM					<0.001
In favour	526 (21%)	142 (9%)	296 (41%)	88 (37%)	
Opposed	1,924 (79%)	1,356 (91%)	418 (59%)	150 (63%)	

¹ n (%)

² Pearson's Chi-squared test; Fisher's exact test

Baseline-endline multivariate analysis

Table 29 presents the baseline–endline regression-related associations between exposure and six FGM-related outcomes across the three regions included in both survey rounds.

High FGM-related knowledge

Strong associations were observed for both exposure categories. Respondents exposed in intervention sites had 8.91 times higher odds of reporting high FGM-related knowledge compared with non-exposed respondents ($p < 0.001$). Those exposed in control or baseline sites also had higher odds of reporting high knowledge (OR = 3.20, $p < 0.001$).

Table 29. Baseline-endline adjusted Odd-ratios associated study site and exposure by outcome variables in in Kolda, Sedhiou and Tambacounda, Senegal

Outcomes	Exposed Control and Baseline			Exposed Intervention site		
	VS			VS		
	Non-exposed all site			Non-exposed all sites		
	OR	95% CI	p-value	OR	95% CI	p-value
Holding beliefs opposed to FGM	0.43	0.36, 0.52	<0.001	0.64	0.48, 0.86	0.003
Holding unequal gender related beliefs	1.31	1.06, 1.63	0.013	0.74	0.50, 1.08	0.13
Having high FGM-related knowledge	3.20	2.61, 3.94	<0.001	8.91	5.92, 13.9	<0.001
Being opposed to social sanctions for FGM-abandonment	0.13	0.10, 0.17	<0.001	0.14	0.10, 0.20	<0.001

Having ever encouraged anyone to abandon FGM	5.32	4.34, 6.54	<0.001	2.14	1.56, 2.94	<0.001
Intention to undergo FGM on daughters	0.79	0.62, 0.99	0.043	0.43	0.27, 0.65	<0.001

Abbreviations: CI = Confidence Interval, OR = Odds Ratio

During immersion in the communities where the TGG-ALM program was implemented, informal conversations and interviews revealed how the program helped raise community members' awareness on the consequences of FGM. In Sedhiou, for example, the presence of community radio stations and frequent awareness-raising and dialogue initiatives allowed residents to hear public health messages about the consequences of FGM on multiple occasions. The dissemination of information among young people was also highlighted, with teenage girls discussing what they had learned among themselves and trying to convince their friends. For example, girls in school clubs were able to list risks such as haemorrhage, infections, complications during childbirth, and even psychological impacts such as fear or trauma.

“Even before joining the TGG-ALM program, I was already afraid of FGM because I knew some of its consequences. I underwent the procedure myself twice: once when I was five years old, and then again around the age of ten. I still remember the pain very clearly. Today, I still suffer from its aftereffects. I regularly suffer from stomach aches, and, having been infibulated, I live in constant fear of getting married one day”. (IDI, Girl champion, Sedhiou)

The experiences of the girl champions also played a key role in bringing about change. As illustrated by the body mapping exercise, the champion girls used their personal experiences of pain, fear, trauma, blood, or loss of self-esteem to raise awareness among mothers and adults about what girls go through when subjected to FGM and to elicit their empathy. This is also illustrated in the following field notes:

“I asked her if she thought there had been a real change. She replied that she was convinced of it, especially among mothers. When they hear their daughters' testimonies, they feel guilt and regret, acknowledging that if they could do it over, they wouldn't do it again. Many have come to understand that this practice, which they once viewed as noble and justified on religious or cultural grounds, is in fact harmful” (Field notes, Goudomp, Sedhiou).

This made real the experiences of girls and led to some mothers feeling ashamed and acknowledging the consequences of FGM.

Beliefs opposed to FGM and unequal gender-related beliefs

As per Table 29 above, respondents exposed in intervention sites had lower odds of holding beliefs opposed to FGM compared with non-exposed respondents (OR = 0.64, $p = 0.003$). Those exposed in non-intervention areas (baseline and control) also had lower odds of opposing FGM (OR = 0.43, $p < 0.001$). For gender-inequality beliefs, respondents exposed in intervention sites were less likely to hold unequal gender-related beliefs compared with non-exposed respondents, although this association was not statistically significant (OR = 0.74, $p = 0.13$). In contrast, respondents exposed in non-intervention areas (baseline and control) had higher odds of holding unequal gender-related beliefs compared with non-exposed respondents (OR = 1.31, $p = 0.013$).

Qualitative findings illustrate that there were some changes among those intensively involved in the programme - even if this did not translate into consistent population-level change. Interviews and observations show that changes in knowledge have influenced individual beliefs, especially girls' champions and other individuals who were extensively engaged in the programme implementation. Before the program began, FGM was socially accepted; in some cases, it was even considered a “profession” or a source of income for certain women. The program helped dismantle these perceptions by empowering participants to understand that the practice is neither beneficial nor necessary.

“Before the program arrived, it was a profession for some women in the village, a way to make a living. But it was also a mindset because it’s something we inherited from our ancestors, and no one saw the negative side of it”. (KII, Woman, Tambacounda)

In all four regions, discussions and interviews with these champions revealed a change in how they perceive the value of FGM. This change among champions is illustrated by the case of Mariama, in the region of Tambacounda (Box 5). By bridging the gap between ancestral customs (*“finatawa”*) and modern human rights, her story of change illustrates how individual-level change in belief can drive community-level changes.

The Voice of Salikenié: Mariama journey from “finatawa” to global advocacy

In the vibrant, dusty commune of Salikenié, nestled near the border where Senegal meets Guinea-Bissau, a profound transformation is unfolding through the life of a young woman named Mariama. Though she was subjected to FGM while an infant by her own aunt, Mariama grew up in a world where the scars of the past were silenced by the rigid expectations of the present. In her community, the roles of boys and girls were as strictly demarcated as the border lines on a map, with education often viewed as a luxury for young women. Yet, even as a child, Mariama possessed a quiet defiance. From her earliest years in school through her graduation, she consistently stepped into leadership roles, proving to herself and her peers that a girl’s voice can carry a natural, undeniable authority.

As she matured, Mariama began to look at the traditions of her elders with a critical, analytical eye. She was told that FGM was a sacred shield designed to protect a girl’s virtue, yet she saw the reality of the world around her: girls who survived FGM still faced early pregnancies and the same social vulnerabilities as anyone else. These contradictions sparked a fire within her. She realised that the justifications for these practices were not based on medical or spiritual truths, but on a cycle of misinformation and harmful beliefs that needed to be broken.

Her journey toward becoming a "Champion Girl" was not without its hurdles. Her initial attempts to join local advocacy clubs were met with resistance from her mother, who feared the social repercussions of such a public stance. After a period spent in Dakar, Mariama returned to Salikenié in 2021, and a simple encounter with a group of young advocates visiting her home became the spark that reignited her purpose. Determined to do more than just follow, Mariama approached the local Mayor with a vision to lead. Armed with nothing but a notebook and a pen, she recruited students at the local high school to form a new club that quickly became the most dynamic force in the community. However, it was the arrival of the TGG-ALM programme and AMREF that fundamentally transformed her grassroots passion into a sophisticated, evidence-based leadership style. The programme provided her with the critical "ammunition" she lacked: clinical data on long-term health risks and human rights frameworks that allowed her to challenge traditional narratives without disrespecting her heritage. This professional mentorship gave her the confidence to move from a curious sceptic to a vocal, strategic advocate.

Today, Mariama is a bridge between her old and new “culture”. Her influence is so deeply felt that the Mayor of Salikenié does not hold a single meeting regarding women’s rights without her presence at the table. Even within her own family, the shift has been monumental; despite her aunt’s history as an FGM practitioner, Mariama now operates with the full blessing of her parents. Through intergenerational dialogues facilitated by the programme, she has helped bring imams, village elders, and "Badjenou Gox" into the conversation, effectively lifting the veil of silence that once shrouded the topic of FGM. Her engagement has scaled from the village paths of Salikenié to international platforms in Nairobi, proving that when the TGG-ALM programme provides the right tools, a survivor can become the architect of a new, safer cultural legacy.

Box 5: The Voice of Salikenié: Mariama journey from “finatawa” to global advocacy

During the free-listing exercise with community members, responses to questions such as “A woman who has undergone FGM is...” included statements like “half a woman,” or “violented”, “oppressed”. This reflects a move away from earlier perceptions that associated FGM with purity, reduced sexual desire, respect for elders and husbands, or protection against infidelity as result of the TGG-ALM programme effect. Indeed, findings show that dialogues, sensitisation sessions and day-to-day

interactions of champions with their relatives and people around them contributed to shifting beliefs and perceptions about FGM value. Fatou is one of the young women who experienced changes thanks to the TGG-ALM programme. The transformation of Fatou, a 28-year-old woman from Goudomp, serves as a poignant testament to the profound ripple effects of the TGG-ALM programme in the intervention's regions (box 6).

Deconstructing the "Honor": Fatou's journey of physical and mental awakening

Our first encounter with her was fortuitous, occurring behind an improvised stall selling "fatayas"* along the national road. While Fatou initially appeared as a welcoming and simple presence, her internal world was a complex battlefield of long-held cultural beliefs and unrecognised trauma. As a member of the Diakhanké community, Fatou's early life was governed by a belief system that viewed FGM not as a violation, but as a non-negotiable badge of honour. To her, FGM was the essential gateway to being seen as a "true woman," and she had once looked upon her own rite of passage with a sense of pride and conformity, unaware that this very "honour" would eventually derail her academic future and lead to a forced marriage she was forced to flee.

For over a decade, Fatou lived in a state of cognitive dissonance, suffering from chronic intimate infections and lacerating physical pain that she accepted as the "natural" burden of being female. Her shift in perception was not an overnight event, but a gradual deconstruction of these deep-seated myths facilitated by the TGG-ALM programme's presence in her household. Though Fatou was not an official participant, the programme's influence entered her home through her younger sisters, one of whom was a "Champion Girl." As her sisters shared the clinical and human rights frameworks they learned in the club, the rigid architecture of Fatou's beliefs began to crumble. The programme provided the scientific vocabulary to replace her cultural euphemisms; she realised that the physical discomfort she had carried in secret was not a "natural" feminine condition, but the direct, documented consequence of the mutilation she had once defended.

This newfound knowledge acted as a catalyst for a radical ideological shift. The TGG-ALM programme did more than just provide health facts; it empowered Fatou to re-evaluate her own history through a lens of bodily autonomy rather than traditional obligation. She began to see the link between the ritual she had accepted and the subsequent "theft" of her education and freedom. This intellectual awakening transformed her from a passive observer of tradition into a firm opponent of it. The programme's success lay in its ability to turn the family dinner table into a space for intergenerational dialogue, allowing Fatou to reconcile her past with a vision for a safer future for her younger sisters.

Today, Fatou's perception of FGM has been entirely rewritten. She no longer views the practice as a source of prestige, but as a form of cultural violence that serves no medical or moral purpose. Her engagement is now fuelled by a desire to ensure that no other girl in Goudomp mistakes a harmful practice for a rite of honour. By integrating the messages of the TGG-ALM programme into her daily life, Fatou has reclaimed her narrative. She uses her voice at her roadside stall and in community circles to pull back the veil on the "secret" sufferings of women, proving that when the light of information reaches the heart of a home, even the most entrenched beliefs can be transformed into a powerful commitment to change.

Box 6: Deconstructing the "Honor": Fatou's journey of physical and mental awakening

*Fataya (from Wolof) refers to small, deep-fried pastries that are very popular in Senegal and across West Africa.

The programme's activities also contributed to shifts in religious beliefs. One of the most significant impacts of The Girl Generation initiative was the transformation of participants' understanding of the religious justifications traditionally used to defend the practice. Testimonies indicate that, prior to the programme, many girls and community members believed FGM to be a religious obligation mandated by the Qur'an, as reported by one of the girl champions:

There have been many changes, because I used to think it was written in the Quran. Now I know it's not written in the Quran, that it's a custom, a tradition. I also know more about the consequences, such as internal bleeding, deaths during childbirth, and illnesses during

childbirth, like fistulas. I learned all of that there. I know that FGM can cause all of that” (IDI, Girl champion, Kedougou)

This perception placed the practice beyond scrutiny, making it difficult for them to question or challenge it. The involvement of religious leaders played a critical role in clarifying the link between religion and FGM, as explained by one religious leader in Sedhiou:

“My role is to educate people about what they don’t know regarding religion and its connection to female genital mutilation. Because at first, people didn’t know; they said it was a Sunnah of the Prophet and that he was the one who recommended we do it. We really need to tell people that today we must distinguish between religious obligations that come from God and the Prophet’s recommendations. Because even the Prophet found these practices within his community. It is a practice that dates back a very long time, to the earliest prophets”. (KII, Religious leader, Sedhiou)

Through training and their active engagement, religious leaders held sermons and joined dialogues to clarify Islam’s stance regarding FGM. Their involvement helped dismantle longstanding misconceptions and opened space for dialogue and critical reflection on the practice. The subsequent distinction between religion and custom represented a fundamental cognitive shift that paved the way for critical thinking. Once it became clear that this practice is a human tradition rather than a divine commandment, individuals could question and reject it without feeling that they were violating religious norms.

The program thus gave girls and some community members the intellectual tools needed to counter the religious argument often used to defend FGM. Furthermore, acquiring accurate medical knowledge allows them to move from vague opposition to a concrete understanding of the dangers. The specific mention of haemorrhages, obstetric complications, and fistulas shows that the participants have absorbed detailed information about the harmful mechanisms at play. This dual shift, both religious and health-related, equipped the young advocates with solid arguments for their awareness-raising activities and profoundly changed their own attitude toward a practice they previously accepted as an unquestionable norm (as highlighted in Boxes 5 and 6).

However, the difference in opinions among religious leaders was highlighted by some participants as something that contributed to undermining the programme's effectiveness in tackling beliefs. Indeed, while beliefs promoting FGM are gradually reducing, participants’ observations and interviews with community members show persistence of beliefs (see section on reasons of lack of change)

Detailed attitudinal outcomes from the pooled baseline-endline data

Referring to Table 29 above, exposure in intervention sites was associated with more progressive attitudes for two of the three outcomes examined. Compared with non-exposed respondents, those exposed in intervention sites were more likely to have encouraged someone to abandon FGM (OR = 2.14, $p < 0.001$) and were less likely to intend to cut their daughters (OR = 0.43, $p < 0.001$). Similar patterns were observed among respondents exposed in non-intervention areas, who were even more likely than non-exposed respondents to have encouraged others to abandon the practice (OR = 5.32, $p < 0.001$) and were also less likely to intend to cut their daughters (OR = 0.79, $p = 0.043$). However, exposure was not associated with more favourable views on social sanctions: compared with non-exposed respondents, those exposed in intervention sites (OR = 0.14, $p < 0.001$) and in non-intervention areas (OR = 0.13, $p < 0.001$) were less likely to oppose punitive sanctions against individuals or families who abandon FGM. Taken together, exposure to programme activities was associated with greater interpersonal action to discourage FGM and lower intention to continue the practice in the next generation, but not with increased opposition to punitive sanctions.

Overall social attitude outcome

As shown in Table 30, results from the pooled baseline-endline data reveal that exposure to programme activities - whether in intervention or non-intervention areas - was associated with a lower likelihood of holding an overall attitude opposed to FGM when compared with non-exposed respondents. People exposed in intervention sites were 80% less likely to oppose FGM (OR = 0.20, $p < 0.001$), and a similar pattern was observed among those exposed in non-intervention areas (OR = 0.20, $p < 0.001$).

Belief systems remained the strongest predictors of overall attitude. Respondents who already held beliefs opposed to FGM were over nine times more likely than those with favourable beliefs to report an overall opposing attitude (OR = 9.28, $p < 0.001$). In contrast, higher FGM-related knowledge did not translate into stronger opposition: respondents with high knowledge were 70% less likely to oppose FGM than those with low knowledge (OR = 0.30, $p < 0.001$). This points to a complex link between information and attitude change. People who held unequal gender-related beliefs were also less likely to oppose the practice (OR = 0.49, $p < 0.001$).

Geographic and ethnic differences were pronounced. Compared with respondents in Kolda, those in Sedhiou were more than three times as likely to oppose FGM (OR = 3.26, $p < 0.001$), and those in Tambacounda were nearly twice as likely (OR = 1.82, $p < 0.001$). Ethnic patterns also varied: Soninke respondents were almost twice as likely to oppose FGM (OR = 1.93, $p = 0.007$), while Mandingue (OR = 0.53, $p < 0.001$) and other groups (OR = 0.58, $p = 0.027$) were significantly less likely to do so.

Taken together, these findings show that overall attitudes toward FGM are shaped by a combination of programme exposure, underlying beliefs, gender norms, and broader social and cultural contexts - including region and ethnicity.

Table 30. Baseline-endline exposure to intervention and associated adjusted Odd-ratio to attitude against FGM practice in Kolda, Sedhiou and Tambacounda in Senegal

Characteristic	Holding an overall social attitude opposed to FGM		
	OR	95% CI	p-value
Exposure			
Non-exposed all sites (ref)	—	—	
Exposed Control and baseline	0.2	0.15, 0.26	<0.001
Exposed Intervention site	0.2	0.13, 0.30	<0.001
Sex			
Men (ref)	—	—	
Women	1.2	0.92, 1.55	0.2
Age group			
≥ 45yrs (ref)	—	—	
35-44	1.21	0.84, 1.74	0.3
25-34	0.97	0.68, 1.37	0.9
< 25yrs	0.65	0.45, 0.94	0.023
Ethnicity			
Pulaar (ref)	—	—	
Soninké	1.93	1.21, 3.14	0.007
Mandingue	0.53	0.38, 0.74	<0.001
Wolof	1.46	0.83, 2.62	0.2
Others	0.58	0.36, 0.94	0.027
Religion			
Christian (ref)	—	—	
Muslim	2.06	0.87, 4.77	0.094
Education			
No formal education* (ref)	—	—	
Primary	1.36	0.97, 1.91	0.078
Secondary+	1.21	0.88, 1.67	0.2

Region			
Kolda (ref)	—	—	
Sedhiou	3.26	2.26, 4.74	<0.001
Tambacounda	1.82	1.31, 2.52	<0.001
FGM-related knowledge			
Low (ref)	—	—	
High	0.3	0.23, 0.40	<0.001
Beliefs related to FGM			
In favour (ref)	—	—	
Opposed	9.28	7.03, 12.4	<0.001
Gender-inequality beliefs			
Equal (ref)	—	—	
Unequal	0.49	0.37, 0.64	<0.001

Abbreviations: CI = Confidence Interval, OR = Odds Ratio

Note: (*) No formal education refers to respondents with no schooling or those who are literate but have not attended formal education (other literates)

(**) borderline significance

Across both endline and pooled analyses, and in both bivariate and multivariate models, study site differences were modest, but exposure differences were substantial and consistently non-linear. Exposure - whether in intervention or control/baseline sites - was associated with more progressive attitudes on several behaviour-proximal outcomes, including higher encouragement of abandonment, lower intention to cut daughters, and higher reported agency to oppose FGM. However, for core normative outcomes such as beliefs, social sanctions, discrimination, and overall attitude, non-exposed respondents consistently showed the most favourable distributions, while respondents exposed in control/baseline sites showed the least favourable patterns, with those exposed in intervention sites falling in between. This recurring gradient across rounds and models suggests that exposure in Senegal was concentrated in more conservative normative environments, shaping the unexpected associations observed across rounds.

According to the various categories of participants interviewed in the qualitative studies, the programme has contributed to shifting attitudes in the intervention areas and among people who were exposed to the programme. These changes in attitudes were reported across different categories of actors. One of these actors are girl champions. The discussions with girls show a transformation that goes beyond simply acquiring knowledge about the dangers of this practice. The young champions describe a genuine process of personal reconstruction, as described in Mariama's case (box 5). Before the program, many girls and young women lived trapped by the weight of their experience, unable to make sense of what they had been through. The program created a space where they could transform this painful experience into a force for action. This evolution represents a fundamental change in their identity: they are moving from being silent victims to becoming activists committed to protecting other young girls from FGM.

Personal development is another essential dimension of the transformation brought about by the programme. Girl champions reported how they have now become resilient when faced with obstacles and discouragement in their awareness-raising activities. Before the training, even a cold or hostile reception could easily dissuade them and cause them to abandon their efforts. Through the programme, however, they have cultivated perseverance and self-confidence that enable them to navigate difficult situations with patience, composure, and determination.

“Personally, I’ve gained a lot of knowledge. Yes, it’s true, I was already familiar with the topic of FGM, but I struggled to get the message across. Thanks to this program, everything has changed. I have learned communication techniques, how to talk to people without offending them, and so on. That has changed. My personal development has too. Before, you could see

someone, but the way they received you was discouraging, and you didn't even want to continue. But with this project and the personal development training, none of that bothers me anymore. Since I'm the one who needs you, I'll wait until you've finished everything you have to do, just as you do with me (laughs). So, I'll wait. All of this is the experience I have gained". (IDI, Girl champion, Kolda)

According to girls, this psychological transformation is essential for a lasting commitment to the fight against FGM, as it enables them to face the inevitable resistance they encounter in their communities as girl champions. Therefore, this personal resilience appeared to them as a long-term investment in young women's ability to sustain their activism despite the challenges

This transformation was also accompanied by concrete changes in family dynamics. The commitment of the young champions created complex situations within their homes, where they must negotiate between traditional expectations and their new convictions. Their testimonies reveal how their participation in the program initially creates tensions, particularly with family members who question their priorities and repeated absences. However, when the young girls find the courage to explain the reasons for their commitment, they often succeed in influencing the attitudes of their loved ones (see Mariama's case in Box 5). These intra-family dialogues become decisive moments when the knowledge transmitted by the program spreads beyond the direct participants and reaches other family members, particularly those who have decision-making power over the younger generations. One of the girl champions in Kedougou recounts her experience:

I: Now, has your way of thinking about FGM changed with the arrival of the program?

R: Since the program started, my way of thinking has changed because before, when I thought about what I had been through, it caused me problems and I shut myself off. But now, since the project started, I have found courage, and I know that I have already overcome this ordeal. And that I must leave my past behind and commit myself to saving other young girls."

I: How does your family feel about your involvement in a program like this?

R: I can say that they are happier, because it is true that I don't live with my father and mother; I was alone in the house. Sometimes I didn't cook dinner so I could participate in the activities, and one day my big brother asked me why I was leaving and not cooking dinner so I could go to the awareness sessions. I sat down, and my older sister told me not to be ashamed of her and to explain why I was doing this. I explained it to her, and she understood and even cried. She told me that it was okay, so if I wanted to go to the program, I could go. Thanks to that, none of my older siblings had their daughters circumcised. However, in the house where we live, everyone brought their daughters during the holidays to be circumcised, and my older sister said that these children would not go. When asked why, she said that it was because her little sister was involved in a program and had explained all the consequences to her, and that her daughter would not undergo this. Now, when I greet the old woman, she doesn't answer me. That's the problem between her and me: the fact that I raised my sister's awareness and she refused to bring her daughter. That's what caused a problem between us.

I: So, the program gave you the courage to speak up?

R: Yes, it gave us courage, and wherever we go, we can raise awareness about FGM without any problems." (IDI, Girl champion, Kedougou)

This testimony highlights several key dimensions of the programme's influence on attitudes and beliefs. The older sister's emotional response - "she cries as she listens to the explanations" - signals a moment of painful awareness that prompts her to break with the intergenerational transmission of the practice. Her choice to protect her daughters, even in the face of strong collective pressure during the holiday season, illustrates how a young champion's shift in attitude can produce tangible protective effects for

the next generation. Yet, departing from community norms carries social costs, reflected in the hostility and silence of the “old woman,” likely a figure of traditional authority. Such silence operates as a form of social sanction, revealing the subtle mechanisms through which communities enforce conformity. Despite these tensions, the young girl reports gaining the confidence to speak publicly about FGM, shifting from “I” to “we” to signal her identification with a collective that legitimises and strengthens her voice. This progression demonstrates that the programme has fostered not only knowledge but also the courage required to navigate social conflict and sustain commitment in the face of resistance.

Beyond girls, the programme also brought change among boys. Participants reported that the awareness campaigns and training have fostered a spirit of solidarity among boys - some began participating alongside their sisters in community activities, while others, previously unaware of the practice or its implications for girls, learned about it for the first time. Through the programme’s activities, they gained an understanding of the reality of FGM and its consequences:

“...there are young people who tell you they didn’t know these practices existed among girls, and that they weren’t even aware of them. It was through these activities that they learned girls undergo this kind of practice, and they committed to supporting their sisters to help them with awareness-raising activities, as well as community mobilisation...” (IDI, girl champion. Sedhiou)

As a result, in Sedhiou and Kolda, stakeholders reported during the outcome harvesting exercise that after participating in the intergenerational dialogues, boys shifted their views on female genital mutilation and went on to form boys’ clubs to defend girls’ rights in the communities.

Beyond boys, changes were also reported among men in the communities. Once perceived as “a women’s issue,” the matter is now the subject of active male engagement through the promotion of positive masculinity. Men are thus becoming allies, playing a role in raising awareness and advocating for change, which strengthens the social legitimacy of the discourse in favour of abandoning FGM.

The interviews also reveal a significant shift among former FGM practitioners. Initially uninformed about the harmful effects of FGM, they gained new knowledge through discussions and awareness-raising activities.

“Through ALM, we’ve learned a lot about this. They invited us to a talk once and taught us a lot, and it’s thanks to them that we became aware of all this. They showed us videos and images, and that really helped us a lot. ALM really raised our awareness about all of this”. (KII, Former FGM practitioner, Kedougou)

The programme contributed significantly to shifting practitioners’ understanding of the consequences of FGM. As a result, some have publicly renounced the practice and now participate in community dialogues to share their testimonies. The programme also transformed the nature of practitioners’ relationships with FGM-related initiatives. The disappearance of fear - whether of stigma or arrest - alongside a growing willingness to speak out to “protect other girls” reflects a profound shift in perception and a redefinition of their social role. Women who once stood at the centre of the practice are now emerging as agents of community change. Mama Aminata is one such example of this transformation among former FGM practitioners. (Box 7)

The blade laid down: Mama Aminata's journey beyond tradition

In the historic neighbourhood of Kedougou - where the red earth meets a mosaic of ethnic traditions—56-year-old Mama Aminata once stood as a custodian of ancestral heritage. For decades, she was not only a respected member of her women's collective; she held the blade that defined womanhood in her community. As a high-profile FGM practitioner, she viewed FGM not as a violation but as a sacred obligation inherited from her grandparents. In her eyes, FGM was a pathway to purity, social belonging, and cultural identity. She recalls the grand festivities of earlier years, when 14-year-old girls eagerly joined the practice to avoid the stigma of being considered “incomplete.” Convinced she possessed spiritual powers, Mama Aminata saw no reason to question the health implications of her actions.

A profound shift began in 2023, triggered by the strategic intervention of the TGG-ALM programme, implemented through KEOH and ActionAid. What Mama Aminata encountered was not simply new information - it was a transformation that enabled her to dismantle more than fifty years of deeply rooted belief. Through high-impact visual advocacy, the programme exposed her to the physical and psychological consequences of FGM, stripping away the ritualistic glamour she had long associated with the practice. For the first time, she understood the extent of the harm she had helped to perpetuate.

Equally important was the programme's decision to integrate her fully into its workshops and dialogues. Treated as a stakeholder rather than a pariah, she gained the confidence and communication skills needed to articulate her evolving views and engage constructively with community members. This respectful inclusion laid the groundwork for a profound shift in her social identity. With support from TGG-ALM's networking initiatives - connecting her with religious leaders, girl champions, and advocacy organisations – Mama Aminata transitioned from practitioner to “Voice Bearer.” Instead of organising FGM ceremonies, she now leads causeries (community discussions), using her unique authority as a former practitioner to advocate passionately for abandonment: *“this is no longer good.”*

The depth of Mama Aminata's transformation is reflected in her own words: *“They integrated us so that we could show it is no longer good... to be able to better discuss with people.”* Today, she speaks with renewed purpose. She observes with pride that the girls who were once the “objects” of her blade are now active agents of their own protection, refusing the practice and shielding their younger sisters. Through targeted capacity-building, empathetic engagement, and respectful inclusion, the TGG-ALM programme transformed a guardian of a harmful tradition into one of the community's most credible and influential advocates for its abandonment.

Box 7: The blade laid down: Mama Aminata's journey beyond tradition

The interviews also highlight a gradual lifting of the taboo. Female genital mutilation, once a “highly taboo” subject, is now openly discussed within communities. Young people, adults, community leaders, and imams now participate in these discussions, and the involvement of community and religious leaders who were previously reluctant represents a major step forward, with some even helping to propose solutions. Participants reported agency and confidence among girls and young women, who now publicly engage in advocacy and address these issues within their families.

“Another fact is that through our activities, we have met with cutters, people who used to perform FGM who have openly stated that they have stopped the practice. These are changes we have observed on the ground. But also, girls who are speaking up and openly declaring that they will participate in advocacy. Girls who sit down with their parents and discuss these topics. These are topics that were not previously discussed within families”. (IDI, Girl champion, Kedougou).

The fact that girls can now discuss FGM with their parents marks a major shift, as these topics were previously absent from family discussions. Some have even convinced their parents not to subject their sisters to FGM, reflecting a tangible shift in intra-family decision-making.

“They've managed to convince their parents not to circumcise their sisters.” (IDI, Former FGM practitioner, Kedougou)

As a result of these changes in attitudes, participants report a noticeable decline in practice in the intervention areas, although it has not been completely eradicated.

Reasons for lack or limited changes in attitudes and beliefs

An analysis of interviews and field notes reveals that, despite awareness-raising efforts and an apparent shift in public discourse, changes in attitudes and beliefs regarding FGM remain limited and fragile. The data show that the continuation of the practice now relies less on explicit religious arguments than on deeply rooted cultural and identity-based foundations. One participant stated during an informal conversation in Sedhiou that “*our ancestors did it and they never got sick*”, thereby invoking legitimisation through tradition and historical experience. The lack of formal recognition of complications is interpreted as proof of safety. The practice is perceived as a transmitted heritage, which it would be risky, even symbolically dangerous, to abandon.

While the religious argument has been gradually deconstructed in public discourse, the cultural dimension remains central. For certain ethnic groups, FGM determines group membership: it is a marker of collective identity. Abandoning the practice is thus experienced not only as a change in behaviour, but as a break with one’s community of origin. This dimension explains the persistent resistance, even when health or legal arguments are known.

“Religious and cultural considerations. Because culturally, it’s important. Some ethnic groups, to this day, believe it is an imperative that this practice is maintained so that a person can be considered as a member of that group. So, for them, it’s a matter of ethnicity”. (KII, Grantee organisation, Kolda)

“Now, this cycle must be broken for the practice to be abandoned. We think it’s a matter of religion. But we also know that the religious argument no longer holds up. Because we’ve had to demonstrate that. Now they know that religion doesn’t permit it. What remains is culture. And culture is what makes people cling to this practice. Sometimes, it’s difficult to get rid of it”. (KII, Lawyer, Tambacounda)

Indeed, while the lived experiences of girl champions were key in driving changes among mothers, for instance, our findings also show instances where participants of sensitisation sessions would vehemently contest arguments about FGM consequences by girl champions, as highlighted in the field notes below:

Our encounter with Mama Hadi took place in a setting that was both collective and symbolic: a mother-daughter dialogue organised by the young female champions of the program, aimed at raising awareness about the issue of FGM. This intergenerational exchange was designed as a space for discussion, but also as an opportunity to question the knowledge passed down from generation to generation.

It was in this context that Mama Hadi stood out. Among all the participants, her intervention caught our attention, to the point of becoming a catalyst for the rest of our work. While the young girls presented the causes and consequences of female genital mutilation, emphasising the health, psychological, and social risks involved in the practice, Mother Hadi stood up with confidence and authority. Her speech was forceful and radical: she categorically rejected all the arguments put forward by the young girls, stating with conviction that, in her opinion, nothing they described corresponded to her experience or that of other women of her generation. For mama Hadi, the voices of these young girls seemed disconnected from the lived experience of those who had undergone FGM in the past. She stated bluntly that, despite having been subjected to FGM herself and having performed the procedure on her own daughters, neither she nor her relatives had ever experienced the diseases or complications mentioned. This head-on opposition, expressed publicly, made a strong impression on the audience. While some of

the women present may have shared her convictions, few had the courage to express them aloud. For us, as researchers and observers, this intervention revealed the depth of the generational divide, but also the complexity of resistance to change. (Field notes, Goudomp, Sedhiou)

Participants like Mama Hadi were consistently present, especially when the dialogues were facilitated by girl champions. They countered arguments on FGM consequences using their own experiences. Some of them would hold such positions despite having attended several sensitisation or dialogue sessions. One participant we had a conversation with further explained that FGM is harmless, and the complications raised are due to “bad practices” such as the fact of practicing FGM on babies, or practitioners that are not skilled enough. Findings also show that men are often less informed than women, although in villages close to major roads, awareness-raising has begun to reach more of them.

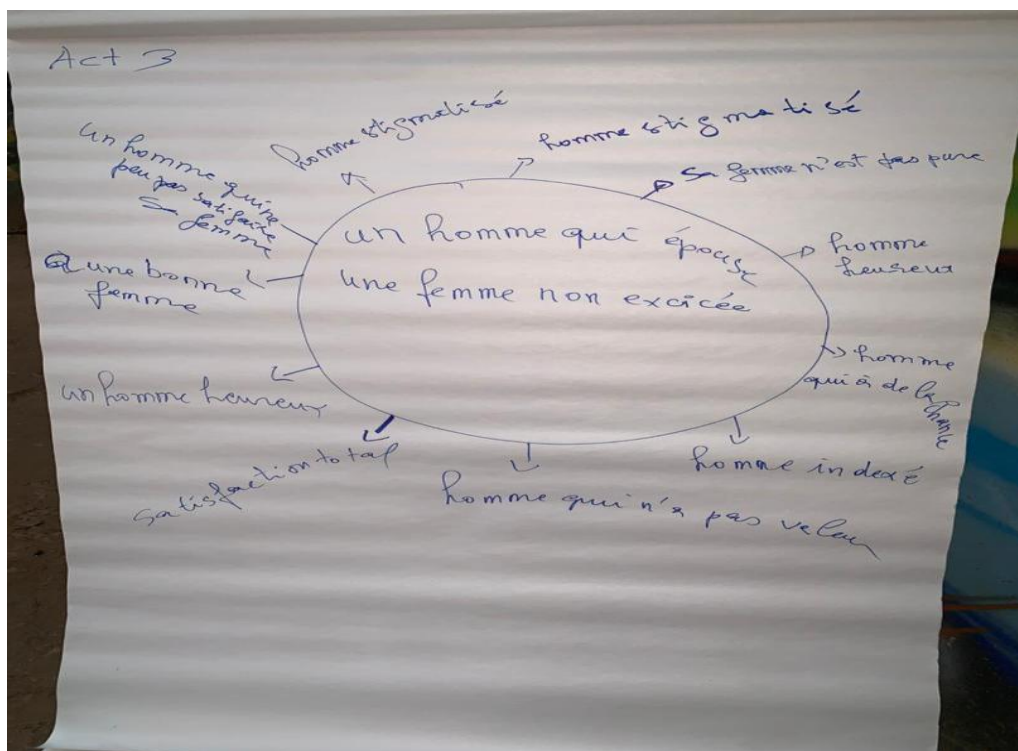
Their strong opinions were also driven by the ideas that girls were sent by foreigners *and “white people and relayed by a generation of young people who want to live like them, to the detriment of local traditions”*. However, we noticed less resistance when the dialogue in the same areas was being facilitated by people such as matrons or health care providers invited by the girl champions.

Our observations and interviews show that many women (especially mothers and grandmothers, including some who were exposed to the programme), and men still believe that FGM “purifies” the young girl and that a woman who has not undergone FGM cannot be considered as a respectable wife. They still see FGM as recommended by religion and tradition:

“They say that a girl who is not circumcised is not clean, she is not pure. It's as if you had seen your period and you had to do the “big wash”. You are not healthy. It's as if you prayed without doing your ablutions”. (IDI, Girl champion, Tambacounda)

“From what I have heard, it's a tradition. A tradition which, according to our grandparents, if you don't do it, you are not a clean girl. If you cook, no one will eat it because you are impure. Moreover, if you serve water, no one will drink it either. So, you must be mutilated. Well, that is what I have heard”. (IDI, Girl champion, Tambacounda)

In addition to purifying the women, FGM is also viewed as ensuring virginity, reducing promiscuity, and making a girl a good woman. Therefore, mothers and grandmothers hold on to FGM to deal with the *“fear that their daughter brings them shame, that they hang around with boys, get pregnant and ruin their reputation”*. Likewise, free listing with men also showed persistent negative views about men marrying women who have not undergone FGM. During one of the FGDs with men, responses to the question *“a man who marries a woman who has not undergone FGM is...”* brought answers such as a stigmatised man, his wife is not pure, a man who cannot satisfy his wife, a man without value. The few positive responses were *a happy man, a lucky man, or a satisfied man*.



Free listing with Men participants in Tambacounda

Back to the case of Mama Hadi described above, we got the opportunity to follow her up and build trust to document more her perspective on FGM. We were able to find out through our regular conversations how the sessions were not enough to change her beliefs towards FGM:

As she recounts her childhood, she nostalgically describes the rituals of the past. Back then, in her native region of Ziguinchor, female genital mutilation was not performed secretly in homes, but in the bush, in a ritualistic and festive manner. They used to organise a ritual called Kouyamba, a big initiation ceremony where young girls, usually aged 8 to 10, would undergo FGM and then be educated collectively. It was not just a physical operation, but a moment of moral and social education, where girls were taught the values of resistance, respect, and dignity.

She opposes this era to the current situation, where FGM is often performed on noticeably young girls, even babies, in unhygienic conditions and without ritual accompaniment. For her, this shift largely explains the criticism that FGM faces today: medical complications and suffering are not inherent to the practice but linked to its deviation.

She also insists on the expertise of the past FGM practitioners, known as NgaMano. According to her, these women had their own prevention and care techniques. They would boil the blades in water before using them on several girls, then apply leaves from trees known for their healing properties, serving as a natural substitute for tetanus. According to her, this traditional expertise ensured relative health safety and prevented the spread of disease. Today, she regrets, these practices have been lost, replaced by modern solutions such as industrial ointments which, instead of protecting girls, aggravate their condition.

Listening to her story, we understood that her attachment to FGM is based on her belief driven by cultural norms and practices that provide a strong meaning to FGM. She sees FGM as a continuity between past and present, a transmission of values, but also a ritual for social integration. For her, rejecting this practice is like breaking with an entire system of meanings and erasing part of the collective identity.

Due to such strong beliefs, dialogues and sensitisation sessions that we attended were often heated. During some sessions, opponents to FGM abandonment like Mama Hadi were very vocal, claiming that

it is “*the only way to properly raise a girl.*”, while those who were anti-FGM participants or facilitators were claiming the contrary, using the health consequences as arguments.

The interviews reveal that awareness of health risks does not necessarily lead to abandonment, but rather to an adaptation of the practice. In our conversation with one community member, she simply suggested “changing the blade” or performing the procedure at a hospital. This reaction reflects a logic of medicalisation or safety rather than a rejection of the very principle of FGM.

“She told me about their current practice, specifically that they now perform the procedure on babies. I then mentioned a few points about the potential diseases associated with unsterilised tools, such as HIV. She said that we simply need to raise awareness among the practitioners to change the blade or perform the procedure at the hospital. I noted mentally their resistance to abandoning the practice, but also a slight openness to dialogue”. (Field notes, Sedhiou)

Furthermore, the practice is shifting toward younger age groups: “*they now perform FGM on babies.*” This shift remains a circumvention strategy aimed at maintaining the social norm. The change is therefore partial: it concerns the methods, not the normative foundation. The results also indicate a cautious but non-committal openness in discourse, with the statements of religious and traditional leaders in the program’s intervention areas illustrating an intermediate stance. This does not automatically translate into an actual change in practices.

*“The village chief speaks up. His voice is deep and slow. He says:
‘We are listening to you. Our daughters have always been important. If what you say helps them live better, then we must consider it.’
Then comes the imam, whose words are eagerly awaited. He simply says:
‘God does not want us to cause suffering. If this causes harm, then we must discuss it, calmly.’
It is not a clear yes, but it is not a refusal either. It is a door left ajar, an implicit social permission.” (field notes, Tambacounda)*

Even when the practice appears to be declining in certain localities, the data show that it is shifting to peripheral or cross-border areas. The influence of neighbouring countries such as Mauritania, Mali, and Guinea helps maintain a normative environment conducive to the continuation of the practice. Thus, the apparent decline in cases in certain localities does not necessarily signify a profound shift in beliefs, but rather a spatial reconfiguration and a more discreet practice, as illustrated in the field notes below:

“However, DD offered an important caveat, highlighting the persistent complexity of the issue: ‘except that people go to the surrounding villages, and also due to the influence of Mauritania and Mali, people still go there to carry out the practice.’” This observation is crucial for understanding the remaining challenges. Even if the practice is declining in Bakel, it may shift to more remote or cross-border areas, where legislation is less strictly enforced or attitudes are less open”. (field notes, Tambacounda)

Several stakeholders emphasise the “highly sensitive” and “deeply rooted” nature of FGM. According to one community member we interacted with in an informal conversation, using the terminology “fight against” seems aggressive or stigmatising. She suggests prioritising language focused on “raising awareness of the risks” to reduce resistance. She also emphasises that the legitimacy of those involved is crucial: not being from the area can limit the effectiveness of campaigns. This highlights the importance of social capital and community belonging in transforming norms.

“During that same discussion with the woman, she told me that to succeed in this fight, we need to rethink the messages conveyed during awareness-raising and communication with the public; we shouldn’t use expressions or terms like ‘fight against,’ but rather ‘raising awareness about the risks associated with female genital mutilation.’” She also noted that the region is complex due to its socio-cultural realities, meaning that if you are not from the area, you cannot effectively lead these awareness campaigns within the communities. The woman tells us that for an effective campaign, we must challenge the religious beliefs people hold regarding FGM because, in her view, people believe that religion is what recommends the practice”. (Field notes, Sedhiou)

Financial, institutional, and legal challenges also hinder the expansion and consolidation of change. Organisations working in these border areas have limited resources and do not cover all villages. This is compounded by weak law enforcement, which primarily results in warnings rather than effective sanctions. This partial enforcement reduces the deterrent effect of the legal framework and may reinforce the idea that social norms take precedence over legal norms.

“I think it’s a financial issue because our area of operation does not cover the entire region, and we know that this is a border area; there are many villages along the borders, and our scope of operation isn’t broad enough. I think these are financial challenges, and people need access to other financial resources to expand. As I mentioned earlier, in the villages where we operate, there are cases that have been addressed.” (FGD, Grantee organisation member, Kedougou)

“This is something that wasn’t put in place very early on, but the law hasn’t been enforced yet, so it’s in the form of a warning”. (FGD, Grantee organisation member, Kedougou)

Finally, the qualitative findings also underscored the role of social sanctions as a central barrier to abandonment of FGM in the intervention areas. According to some participants, the programme has progressively contributed to reducing social sanctions, especially among people exposed (as described in the quantitative findings). This is explained by one participant:

“She was considered impure. If she prepared food, no one wanted to eat her food. In society, she was rejected, marginalised. Even for marriage, boys weren’t interested in an uncircumcised girl. They were called Bilakoro, meaning uncircumcised girls. But today, this perception is changing; it’s not like before”. (IDI, Girl champion, Tambacounda)

In Sedhiou for example, participants reported a reduced discrimination in areas where champions are active. Families who choose to stop FGM sometimes receive discreet support from other parents, which helps them stick to their decision. Villages that have made a public declaration of abandonment have seen a decrease in insults, a sign that the social norms are beginning to shift.

Among individuals not exposed to the programme, the fear of social sanctions was consistently present. During one of the FGDs in Tambacounda, some mothers reported that their mothers-in-law threaten them with family conflict if they refuse to have their girls undergo FGM. Therefore, the risk of them giving into these threats and subjecting their daughters to FGM was still high and acknowledged.

The fear of social sanctions impeded individuals’ capacity to report FGM cases. Participants often feared being excluded by neighbours or being attacked through magic if they report FGM cases. Therefore, participants explained that they would keep quiet about cases of FGM they witnessed or heard about within their family or in their neighbourhood, including some girls being forced by their family to remain silent and avoid perpetrators of FGM being arrested and bearing (including their family) the shame and repercussions.

Unintended/unanticipated outcomes

The testimonies gathered indicate changes in practices and social norms related to FGM, including the visibility of the practice, particularly in its public visibility. Many participants reported that heightened attention to FGM in programme areas, combined with fear of legal sanctions, has led to adaptive strategies among families who continue to practice FGM. It has driven the practice out of public spaces and into greater secrecy. This includes a relocation of the practice to isolated and border areas, particularly to villages near the Guinean border. In some cases, families cross the border to practice FGM on their daughters in secret.

“... In speaking with the family, I learned that the girl had stayed in Guinea, and that is where she underwent female genital mutilation. So, the practice was not performed here, but in another country. This shows that FGM continues to exist elsewhere, particularly in neighbouring countries like Guinea, where some families still strongly adhere to the tradition”. (KII, Midwife, Tambacounda)

“You could say they have changed their minds; here in Kedougou, it's decreasing, but most of them are taking their children to villages near the borders”. (KII, MEL officer, Kedougou)

This reveals a perverse effect of the fight: the visible decrease in the practice does not necessarily mean its complete abandonment, but rather its geographical displacement.

“Regarding the change, I would say that here in Kedougou, it has become very rare. We are told that those who do it here are foreigners, perhaps Guineans. They often they cross the border to do it secretly in villages bordering Guinea. So, they no longer do it in the area, but those who persist in doing it are forced to cross the border. And that is a battle we have started to win more and more”. (KII, Midwife, Kedougou)

Furthermore, some testimonies, without formal confirmation, report an evolution in the methods of the practice, with rumours of FGM being performed at an early age, sometimes on newborns. This trend is thought to be linked to bans and sanctions, with families seeking to avoid inspections and denunciations.

“Well, according to rumours, I have not really verified the information, because some people are now doing it in the cradle, according to the rumours. But it's like I have not had the certification, but I hear when people say it's now being done in the cradle. Even now, in the cradle, it's because there have been bans about it. (KII, Grantee organisation member, Kedougou)

Institutional level changes

From an institutional perspective, the results indicate a significant strengthening of the local organisational landscape. The project fostered a dynamic of structuring, ownership, and collaboration among local organisations. By integrating these actors—often deeply rooted in their communities—the programme enhanced both the territorial reach of interventions and their ability to adapt to local contexts.

“Since last year, the project has recruited organisations at the regional level to carry out activities within this framework. There are also two other small to medium-sized organisations and two other small organisations working on mass awareness-raising activities”. (KII, Grantee organisation member, Kedougou)

The results reveal a strategic reorientation of some organisations which, although initially not involved in FGM, have gradually repositioned themselves; there is also a participatory approach which promotes the development of organisational skills, the empowerment of local actors and a better sustainability of actions.

“There were some organisations that were not working on it, but today they have completely reoriented themselves towards the issue of gender-based violence, more specifically the issue of female genital mutilation. Relying on local organisations and giving them the opportunity to design their projects, submit them, and receive funding allows them to act autonomously” (KII, Grantee organisation manager, Kedougou)

Finally, the results highlight a significant improvement in coordination and inter-organisational collaboration. The project helped to rebuild ties between organisations that previously knew each other but had little collaboration, thus promoting the sharing of experiences, the complementarity of interventions, and the development of collective actions.

“It helped to rebuild the ties between these different organisations, which knew each other before but did not really work together. It led to better collaboration”. (KII, Grantee organisation manager, Kedougou)

The qualitative findings show that beyond the primary beneficiaries such as grantees and individuals, the programme has contributed to empowering government bodies towards tackling FGM. The training and activities carried out have enabled the local government bodies (i.e., Departmental Committee for Child Protection - CDPE - Adolescent counselling centre - CCA) to make considerable progress in the fight against FGM. Thanks to these results, the southern region (Kolda and Sedhiou) has become a laboratory for the rest of the country. As a result, all activities related to FGM, CCAs, girl champions, and other services are invited to share their success stories and inform country-wide FGM programming

Development of networks and movements

The results show that the creation of movements relies on a combination of youth mobilisation, structuring into clubs and coalitions, and a national strategic vision. The program has thus contributed to transforming the fight against FGM from a collection of individual or ad hoc initiatives into a more inclusive and credible social movement, capable of driving change at various levels (individual, community, and institutional).

“With the support of TGG-ALM through ActionAid/AMREF, we were able to establish four coalitions: Tambacounda, Kedougou, Sedhiou, and Kolda. At the beginning of this year, we plan to establish coalitions in Matam and Ziguinchor to cover more of the high-prevalence areas. We will also be adding a coalition in Dakar. The Kolda coalition has been the most active”. (KII, Implementing partner)

Examples of the programme successes in creating networks include the survivor’s leadership initiatives, the collaboration between local CSOs and the formation of FENOPAM (Box 8). This inclusive and participatory approach is a determining factor for the sustainability of commitments and the embedding of the movement within local social norms. The impact of the TGG/ALM program is also reflected in the establishment of youth clubs, which have emerged as a central lever for the creation of movements.

“Many discussions have taken place regarding female genital mutilation (FGM), which was not the case before. This is due to the creation of the boys' clubs, especially because, through their awareness-raising efforts, they manage to convince other young people that FGM is not a good practice. They even go as far as to say that they will not marry girls who have undergone FGM, and they have connected with the cause of the boys' clubs. I am certain that if they have children,

their daughters will not be cut, and they, in turn, discuss the issue with other boys to truly fight against FGM". (KII, Medical student, Kolda)

These clubs, active in both school and community settings, conduct various awareness-raising activities aimed at strengthening young people's understanding of the health, social and psychological consequences of female genital mutilation.

"And so, more and more youth clubs are being set up. And these youth clubs do indeed carry out many activities, and things in schools and in the community, to help young people become more aware of all the consequences that can result from the practice of female genital mutilation". (IDI, Boy champion, Sedhiou)

TGG/ALM was described by participants as a strategic tool for building social movements, aiming to unite diverse actors around a common cause. The interviews highlight that the observed movements are a direct and deliberate manifestation of this approach, confirming its relevance in strengthening collective action.

Decentralising Power: How FENOPAM became the backbone of Senegal's anti-FGM movement

For decades, efforts to end Female Genital Mutilation (FGM) in Senegal were largely centralised - led by a handful of major actors and often disconnected from the realities of high-prevalence border regions such as Matam, Kanel, Tambacounda, and Kedougou. In these areas, porous borders with Guinea, Mali, and Gambia enabled cross-border FGM, while limited media coverage and deeply embedded social norms kept the practice shielded from public scrutiny.

Between 2023 and 2025, the TGG-ALM programme catalysed a structural shift that transformed this landscape. Through targeted support, civil society and community-based organisations united to form the National Federation for the Promotion of the Abandonment of FGM (FENOPAM). What emerged was a decentralised, community-driven movement capable of mobilising local actors, adapting strategies to regional contexts, and bridging the longstanding gap between national policy and local realities.

Under TG- ALM's guidance, FENOPAM rapidly expanded into four active regional coalitions - Tambacounda, Kedougou, Kolda, and Sedhiou - each rooted in community leadership rather than Dakar-based coordination. This shift empowered coalitions to engage directly with local authorities, religious leaders, youth champions, and media actors, cultivating a multi-level advocacy ecosystem. Parliamentarians and the National Assembly's Social Affairs Commission were also brought into dialogue, strengthening calls for rigorous implementation of Law 99-05.

A pivotal aspect of this transformation was the elevation of local voices. Through capacity-building workshops, journalists learned to report ethically and sensitively on FGM, shifting from brief "faits divers" (breaking news) to survivor-centered narratives that humanised the issue and sparked wider public debate. Girl and boy champions - once passive subjects of protection - became vocal advocates working alongside community radios and print media to address the practice openly. This "liberation of speech" helped dismantle the culture of silence surrounding FGM in regions where it had long been taboo.

Today, FENOPAM stands as a leading actor in national and regional advocacy. Its decentralised structure enables real-time engagement, while its emerging cross-border collaborations aim to address FGM practices that transcend national boundaries. As one coalition member put it, the movement is now "in full flight," propelled not by external directives but by the collective strength and ownership of the communities it serves. This evolution marks a significant step toward sustainability: the protection of girls is no longer a project - it is becoming a permanent community mandate.

Box 8: Decentralising Power: How FENOPAM became the backbone of Senegal's anti-FGM movement

Integration of FGM into health system

The results from the interviews show progress in the institutional integration of the topic of female genital mutilation (FGM) within the training programs for healthcare professionals, particularly at the African Institute of Health Sciences (ASSMDB) and the National School of Health and Social Development (ENDSS). The training received through the program has enabled trainers to sustainably strengthen their skills.

“A lot, really. A lot. Because it really allowed me to maintain and solidify my knowledge of genital mutilation. And I know that I now have the ability to replicate this training with any target audience”. (KII, Lecturer, National)

Some trained midwives and nurses emphasise that this capacity building has allowed them to consolidate their knowledge of FGM, especially since the modules on FGM were not as comprehensive during their initial training. With this program training, they felt capable of replicating the training content with different target groups, including colleagues.

“We put this knowledge into practice because upon our return, we conducted awareness campaigns. We carried out several awareness-raising activities, such as discussions. And we saw that it was effective”. (KII, nurse station manager, Sedhiou)

“These training courses allowed us to gain more knowledge on the subject. We can’t claim to know everything. When we were trained to be midwives, we talked about female genital mutilation, but that was all. Furthermore, we were only given a portion of the information. We discussed it, but there isn’t a module specifically dedicated to FGM. However, in obstetric care, we listed the types of genital mutilation and their consequences. We focused heavily on the types of mutilation that exist and their health consequences. That’s what we briefly covered. We were fortunate to receive training, specifically on this topic. It allowed us to gain more knowledge”. (KII, Midwife, Kedougou)

At the level of healthcare training schools, the integration of FGM-related content occurred through several stages. Following the initial training, nearly 200 second-year undergraduate students (nurses and midwives) were trained; even though a course on FGM already existed, it was considered insufficiently comprehensive. The program thus contributed to a revision and enrichment of the content, with the implementation of a specific component dedicated to FGM, primarily intended for third-year midwifery students. This strategic choice aims to ensure that future healthcare professionals complete their studies with solid skills in the prevention, detection, and management of FGM.

“We took the modules, integrated them into our courses, and trained our midwives and students. Then, we took our modules and trained our students. That was an internal process because we had the opportunity to receive this training.” And unfortunately, there were modules in the training that were not part of the curriculum, that were not included in our modules”. (KII, Lecturer, national)

Furthermore, the results reveal a ripple effect at the regional level. With a view to eradicating FGM, service providers unanimously emphasised the importance of the cross-border dimension surrounding FGM. The skills acquired within the program have thus enabled some trainers to position themselves as resource persons in the development of midwifery training programs in neighbouring countries, incorporating a specific component on FGM.

“The ability to talk with people, to inform them. And recently, I went to Mauritania, so I explained to them that there is a package on female genital mutilation because in Mauritania, they also have this problem of genital mutilation. So, they are ready to see how to support them so that this

module can be integrated into their training. So, it's a course that really interests them." So, they are ready to see how to support them in integrating this course into their training". (KII, Lecturer, National)

These insights illustrate the program's ability to influence training curricula beyond the national framework and to strengthen the role of beneficiaries as regional partners in the fight against FGM. Overall, the integration of FGM content into the IASSMDB and ENDSS marks a key step toward the sustainable institutionalisation of the fight against FGM in the initial training of healthcare professionals.

Sustainability of the program achievements

Participants' testimonies demonstrate a clear awareness of the need to sustain gains beyond the programme's implementation period. This concern for sustainability goes beyond abstract intentions and is reflected in concrete organisational and structuring initiatives. In particular, young champions expressed a strong desire to institutionalise their engagement through the creation of local associations capable of continuing awareness-raising activities independently of external support. This emphasis on community ownership is a positive indicator of sustainability, as it shows that participants do not view themselves merely as passive recipients of a time-bound intervention, but as autonomous actors with the capacity to drive social change over the long term.

Beyond organisational structures, the participants also express a transformation in the social perception of FGM within their communities. The shift from a taboo subject to an open and legitimate topic of discussion constitutes a profound cultural change that carries within it the seeds of its own sustainability. When the norms of silence are broken and speaking about FGM becomes socially acceptable, it becomes difficult to reverse the trend. This normalisation of dialogue around FGM creates the conditions for lasting change, as it allows new generations to grow up in an environment where questioning this practice is no longer transgressive but part of ordinary community discussions.

M: Now, we are going to talk about making these changes sustainable. Do you think these changes will last in the future?

R: "Yes. These changes will last because, as I mentioned, we created an association. Even after the program ends, we will continue the fight. I think FGM will no longer be a taboo subject in Kedougou." (IDI, Girl champion, Kedougou)

This testimony encapsulates two key dimensions of sustainability. First, the decision by young champions to establish their own association reflects an elevated level of ownership over the change process. This locally driven initiative indicates that participants have developed not only knowledge and skills, but also a strategic vision for continuing their engagement beyond the programme's lifespan. The assertion, 'Even at the end of the programme, we will continue the fight,' signals a deep personal commitment that is not dependent on external incentives or project funding. Such empowerment represents a core objective of development interventions: the emergence of self-sustaining local dynamics capable of carrying change forward. Beyond these signs of viability of the programme achievements, discussions with community stakeholders and local organisations point to several factors suggesting that the program's effects may be sustainable. These factors are evident at various levels and reflect dynamics that could extend the changes beyond the program's duration.

- At the community level, the sustainability of observed gains appears linked to the gradual internalisation of awareness-raising messages by community members, particularly young

- girls. Multiple accounts indicate that girls affected by the practice are increasingly able to openly oppose FGM and actively protect their sisters. This growing capacity for resistance and mobilisation is a strong indicator of an ongoing normative shift with the potential to endure over time. The emergence of such agency among young girls suggests that key messages have not only been received but appropriated by the beneficiaries themselves, thereby strengthening the prospects for sustaining change.
- At the level of community structures and local organisations, sustainability is largely dependent on their continued commitment and engagement. Several organisations reported their intention to pursue awareness-raising activities even in the absence of external financial support, drawing on the capacities developed within communities. In this regard, the training of young people - particularly girl champions - has emerged as a critical lever for sustainability. Embedded within their communities, these young leaders have been organised into emerging structures capable of mobilising resources and carrying out sensitisation activities. This emphasis on strengthening local capacities contributes to the institutionalisation of anti-FGM actions within existing community dynamics.

Summary of key findings

- **Exposure patterns were complex:** While exposure was linked to more progressive attitudes such as encouraging abandonment, opposing FGM of daughters, and feeling able to speak out - non-exposed respondents consistently showed the most favourable normative attitudes overall. Those exposed in control/baseline sites showed the least favourable patterns, with respondents exposed in intervention sites falling in between.
- **Exposure occurred in more conservative environments:** The counter-intuitive patterns across beliefs, sanctions, discrimination, and overall attitudes suggest that programme activities in Senegal were concentrated in communities with stronger pro-FGM norms, shaping the associations observed in both endline and pooled analyses.
- **Awareness and engagement increased:** The program encouraged more community conversations about FGM and involved a wide range of people, such as girls, boys, men, and former FGM practitioners.
- **Uneven reach across communities:** Even though many people got involved, the program mostly reached urban areas, border regions, and places with many champions. Remote rural areas were harder to reach due to logistical challenges.
- **Powerful drivers of change:** In the communities that took part, stories from girl champions and support from religious leaders played a key role in changing what people knew and believed.
- **Deep cultural norms limit change:** Even with these strong influences and more awareness, deep cultural identity, traditions, and social pressures keep FGM going and make people resist change.
- **Adaptation and System Strengthening:** Some communities changed how they practice FGM in secret, such as doing it at younger ages, across borders, or in medical settings. At the same time, the program helped strengthen local organisations, youth groups, and the health sector.

Discussion for the Senegal study regions

Overall, the most compelling finding in the Senegal results is that exposure was associated with less opposition to FGM, an unexpected pattern, which diverges from Kenya and Ethiopia findings. At endline, respondents exposed in both control and intervention sites had substantially lower odds of holding an overall attitude opposed to FGM compared with non-exposed respondents (OR = 0.15 for both categories). As the report notes, “respondents exposed in control sites had lower odds of holding

an overall attitude opposed to FGM compared with non-exposed respondents (OR = 0.15, $p < 0.001$). A similar association was observed for those exposed in intervention sites (OR = 0.15, $p < 0.001$).” In the pooled baseline–endline model, this pattern persists: exposure in both control/baseline and intervention sites is associated with lower odds of opposing FGM (OR = 0.20 for both).

The updated bivariate results reinforce this pattern. Across both endline and pooled analyses, non-exposed respondents consistently display the most favourable distributions across beliefs, sanctions, discrimination, intentions, and overall attitudes, while respondents exposed in control/baseline sites often show the least favourable distributions. Those exposed in intervention sites fall between these two groups. Taken together, these findings indicate that exposure, as captured in the survey, is not translating into more favourable overall attitudes and may instead be occurring in communities or sub-groups where norms remain strongly supportive of FGM. This interpretation is consistent with evidence that programmes often reach communities where norms are most entrenched, and where early engagement may surface resistance rather than immediate normative change (UNICEF Innocenti; Mackie & LeJeune 2009). This interpretation is reinforced by the fact that exposure patterns do not align neatly with study-site classification and appear concentrated in more conservative pockets of certain regions, dampening or reversing expected associations at aggregate level.

A complementary explanation relates to how programme exposure occurred. While survey respondents were randomly selected, participation in programme activities was not. Selective participation in norm-change interventions—where individuals with stronger adherence to prevailing norms engage more actively in early programme spaces—has been documented in the social norms literature (Cislaghi & Heise 2017; Mackie et al. 2015). FGM-specific studies similarly show that conservative actors may attend community dialogues to monitor discussions or defend the practice, particularly in settings where FGM remains tied to identity and social belonging (Shell-Duncan et al. 2010; Hernlund & Shell-Duncan 2007). This dynamic may help explain why exposure groups, especially in control/baseline sites, display less favourable normative attitudes despite higher levels of programme contact.

Despite these counter-intuitive exposure patterns, the underlying determinants of overall attitude behave in a more expected and internally coherent way. Across models, respondents who hold beliefs opposed to FGM and those with more gender-equal views are much more likely to have an overall attitude opposed to the practice. For example, “respondents who held beliefs opposed to FGM had 26.4 times higher odds of having an overall attitude opposed to the practice,” and in the pooled model “respondents who held beliefs opposed to FGM had 9.28 times higher odds of holding an overall attitude opposed to the practice.” Gender-inequality beliefs are also strongly linked: those with unequal beliefs have lower odds of opposing FGM (OR = 0.49 in the pooled model). This coherence between underlying beliefs and the composite attitude index reinforces the validity of the overall attitude measure, even as its association with exposure remains counter-intuitive.

Knowledge and some immediate outcomes move in a more “expected” direction, but their relationship with overall attitude is paradoxical. Exposure, especially in intervention sites, is very strongly associated with high FGM-related knowledge (endline OR = 8.09; pooled OR = 8.91 for intervention exposure) and with lower intention to cut daughters (endline OR = 0.48; pooled OR = 0.43 for intervention exposure). Yet in both endline and pooled models, high knowledge is associated with lower odds of holding an overall attitude opposed to FGM (OR = 0.17 at endline; OR = 0.30 in the pooled model). The text notes that “high FGM-related knowledge was also associated with lower odds of opposing FGM (OR = 0.30, $p < 0.001$).” This suggests that knowledge gains may be occurring in settings where social expectations remain strongly pro-FGM, limiting the translation of information into broader normative positioning. The divergence between intention and overall attitude reflects the fact that these constructs respond to different normative pressures. Intention is more behaviour-proximal and can shift when individuals privately reconsider cutting or feel empowered to act differently, even if they still perceive strong community expectations in favour of FGM. In contrast, the overall attitude index captures broader normative positioning -including perceived sanctions and encouragement - which remains strongly shaped by community-level expectations. As a result,

respondents may report lower intention to cut daughters while still expressing attitudes aligned with prevailing social norms. It may also reflect messaging that increases awareness of health risks without fully challenging the social legitimacy of the practice.

This counter-intuitive association aligns with early-stage norm-change theory, which shows that when new added information challenges long-standing cultural expectations, communities may initially resist or defensively reaffirm existing norms (Mackie & LeJeune 2009; Cislighi & Heise 2018). Qualitative research on FGM in Senegal and other practising contexts similarly finds that increased awareness of health risks does not automatically translate into opposition to the practice; instead, it may coexist with continued support where FGM remains tied to identity, marriageability, and moral expectations (Shell-Duncan et al. 2010; Shell-Duncan et al. 2018). This dynamic - sometimes described as an early-stage “backlash” effect - suggests that information alone is insufficient to shift attitudes when underlying social expectations and sanctions remain intact.

In contrast to these normative outcomes, several behaviour-proximal indicators show clearer and more positive associations with exposure. Respondents exposed in intervention sites are more likely to have ever encouraged someone to abandon FGM (endline OR = 3.00; pooled OR = 2.14) and to report agency to oppose FGM (endline OR = 5.22). Exposure is also associated with lower intention to cut daughters in both control/baseline and intervention sites. These patterns indicate that exposure is linked to some concrete shifts in interpersonal influence and intentions, even as broader social attitudes remain less favourable. The coexistence of positive behavioural shifts with less progressive overall attitudes underscores the complexity of norm change in Senegal: individuals may privately oppose FGM or act against it while still perceiving community norms as supportive. This divergence between private attitudes and perceived social expectations is well documented in social norms theory (Bicchieri 2016) and has been observed in FGM-practising contexts where individuals change behaviour before norms visibly shift (UNFPA-UNICEF Joint Programme 2017).

A further unexpected finding is that exposure in both intervention and control/baseline sites is associated with higher odds of supporting discrimination against uncut girls. This contrasts with the broader pattern of behaviour-proximal improvements and suggests that some normative dimensions—particularly those tied to stigma, identity, and social sanctions—remain resistant to change or may even harden in response to programme activities. Similar patterns have been documented in settings where abandonment efforts inadvertently heighten anxiety around social belonging, leading to increased policing of conformity (Shell-Duncan et al. 2010; Boyle 2002). This reinforces the need to understand how messages are interpreted in conservative environments and whether they inadvertently trigger defensive reactions.

Regional and ethnic heterogeneity further complicate the picture. The models show strong regional contrasts: compared with Kedougou at endline, respondents in Kolda, Sedhiou, and Tambacounda have lower odds of opposing FGM, while in the pooled model respondents in Sedhiou and Tambacounda have higher odds than those in Kolda. Ethnic differences are also pronounced, with Soninke respondents more likely and Mandingue and “other” groups less likely to oppose FGM. Exploratory checks suggest that the negative association between exposure and overall attitude may be driven by more conservative sub-regions where exposure is concentrated, masking positive effects elsewhere. These patterns, combined with diffuse exposure across control and intervention sites, point to a highly heterogeneous ecosystem where multiple actors, histories, and norms intersect. Qualitative findings also highlight uneven programme reach, with remote rural areas - often the most conservative - being harder to access, which may further shape the observed quantitative patterns.

Taken together, the Senegal findings suggest three key implications:

- First, overall social attitude, the key outcome, does not improve with exposure as currently measured, despite strong positive associations between exposure and knowledge and some behavioural indicators. This raises important questions about the content, framing, and targeting of FGM-related activities, including the possibility of backlash or selective participation by

more conservative groups. The unexpected increase in support for discrimination among exposed groups further underscores the need to examine how messages are received and whether they inadvertently reinforce certain norms.

- Second, the strong, consistent role of beliefs related to FGM and gender inequality in shaping overall attitude highlights the need to move beyond information-heavy approaches toward deeper, gender-transformative work that explicitly challenges the social and moral justifications for FGM. Interventions must address not only health risks but also the identity-based and moral dimensions that sustain the practice.
- Third, pronounced regional and ethnic differences, combined with diffuse exposure across sites, underscore the importance of tailoring strategies to local normative landscapes and strengthening coordination among actors to avoid fragmented or contradictory messaging. Understanding where exposure is concentrated, and whether it aligns with communities most ready for change, is essential for interpreting these patterns. Improved targeting and deeper engagement in high-normativity areas may help avoid the counter-intuitive patterns observed.

Conclusion

In Senegal, the central outcome, overall social attitude opposed to FGM, shows a pattern that is not aligned with the more straightforward positive associations seen in Kenya and Ethiopia. At both endline and in the pooled baseline–endline analysis, exposure (in control/baseline and intervention sites) is associated with lower odds of holding an overall attitude opposed to FGM, even though exposure is strongly linked to higher FGM-related knowledge, lower intention to cut daughters, greater agency to oppose FGM, and more frequent encouragement of abandonment. The bivariate results reinforce this pattern: non-exposed respondents consistently display the most favourable distributions across beliefs, sanctions, discrimination, intentions, and overall attitudes, while exposed groups, particularly those in control/baseline sites, show the least favourable distributions. This combination of positive shifts in some domains and less favourable overall attitudes suggests that norm-change processes in Senegal are contested, uneven, and strongly shaped by local context. The pattern is consistent with exposure occurring disproportionately in more conservative communities or sub-groups, where perceived social expectations remain strongly pro-FGM and where knowledge gains do not readily translate into normative change.

In addition, participation in programme activities was not random. Qualitative evidence shows that certain groups - such as champions, CCA members, and other organised actors - were repeatedly exposed, while broader community members, especially in rural and remote areas, had limited access. This selective participation, documented in social norms literature, may have concentrated exposure among individuals embedded in more conservative networks, thereby shaping the counter-intuitive associations observed.

The findings also highlight two unexpected dynamics: first, high FGM-related knowledge is associated with lower odds of opposing FGM, consistent with early-stage backlash effects described in norm-change theory; and second, exposure is associated with higher support for discrimination against uncut girls, suggesting that some identity-based norms may harden when challenged. These patterns underscore that information alone is insufficient to shift attitudes when underlying social expectations, sanctions, and identity markers remain intact.

These findings imply that simply expanding exposure to FGM-related activities is unlikely to be sufficient. Programmes need to interrogate *how* messages are framed, *who* is reached and empowered, and *which* norms are being reinforced or challenged. Priority should be given to:

- designing interventions that explicitly link knowledge gains to clear moral and social arguments against FGM,
- embedding robust gender-transformative components that tackle unequal gender norms alongside FGM, and

- tailoring strategies to regional and ethnic contexts, with stronger coordination among actors to ensure coherent, mutually reinforcing messaging. This includes addressing uneven programme reach and ensuring that exposure extends beyond organised groups to the wider community. Understanding where exposure is concentrated, and whether it aligns with communities most ready for change, will be essential for strengthening programme effectiveness.

Overall, the Senegal results point to an ecosystem where FGM-related programming is active and knowledge is high, but where social attitudes remain ambivalent or resistant in key groups. Future efforts should focus on deepening normative change, rather than only broadening exposure, so that gains in knowledge and individual agency translate into sustained, community-level opposition to FGM. Achieving this will require more deliberate engagement with the social norms' environment - including the actors, networks, and expectations that shape how information is interpreted and acted upon - and strategies that anticipate and mitigate early-stage resistance or backlash.

Implications of the findings in Senegal

The Senegal findings reveal a complex landscape where exposure increases knowledge, agency, and some behaviour-proximal actions, yet does not translate into more favourable overall attitudes toward FGM. Instead, exposure is concentrated in conservative pockets, sometimes reinforcing stigma or triggering early-stage resistance. The implications below reflect the need for deeper, more targeted, and more norm-transformative approaches.

1. **Expand reach beyond organised groups:** Exposure was concentrated among champions and structured groups, leaving many community members—especially in rural and remote areas—unreached. Broadening outreach is essential for shifting norms beyond a small circle of repeatedly engaged actors.
2. **Target conservative and high-normativity pockets:** Counter-intuitive patterns emerged where exposure occurred in communities with deeply entrenched norms. Tailored strategies are needed for these sub-regions and ethnic groups, where identity and belonging strongly shape FGM attitudes.
3. **Anticipate and mitigate early-stage backlash:** High knowledge was associated with *lower* opposition to FGM, signalling early-stage resistance. Programmes should incorporate approaches that address defensive reactions, identity concerns, and social expectations—not only health risks.
4. **Address stigma and discrimination against uncut girls:** Exposure was linked to *higher* support for discrimination, indicating that some norms may harden when challenged. Interventions must explicitly address stigma, inclusion, and the rights and dignity of uncut girls.
5. **Strengthen gender-transformative components:** Gender-inequality beliefs were among the strongest predictors of overall attitude. Deepening work on gender norms, masculinity, and power relations is essential for shifting the social foundations that sustain FGM.
6. **Improve coordination to ensure coherent messaging:** Diffuse exposure across control and intervention sites suggests overlapping actors and inconsistent messages. Stronger coordination among NGOs, religious leaders, youth groups, and government actors is needed to reinforce shared narratives.
7. **Support champions while preventing elite capture:** Champions remain powerful drivers of change, but repeated engagement with the same individuals created perceptions of exclusivity. Sustaining girl-centered leadership while diversifying participation will strengthen community ownership.

8. **Address logistical barriers to rural outreach:** Transport and access constraints limited programme reach in remote areas - often the most conservative. Investing in mobility, decentralised delivery, and field resources is critical for equitable coverage.
9. **Link knowledge to moral and social arguments:** Knowledge gains alone did not shift attitudes and sometimes hardened them. Messaging must connect information to moral reasoning, social belonging, and collective identity to support deeper normative change.
10. **Monitor and respond to unintended consequences:** Senegal's findings show that exposure can produce both positive and negative effects. Systems for detecting backlash, stigma, or norm hardening are essential for adaptive, responsive programming.

Overall Limitations

The evaluation faced several methodological and operational limitations that should be considered when interpreting the findings.

Baseline–endline comparability

Although the evaluation included two rounds of data collection, the design is best characterised as a repeated cross-section rather than a longitudinal study, as the baseline and endline samples were not drawn from the same respondents and endline included a larger set of villages than baseline. While the two rounds remain broadly comparable at the population level, differences in village coverage, sample composition, and the structuring of some survey questions limit the extent to which baseline–endline differences can be interpreted as true change over time. In addition, baseline data were collected approximately one year after programme activities had already begun, which further reduces the validity of using baseline as a counterfactual. For these reasons, descriptive comparisons across rounds were interpreted cautiously, and the primary analysis relied on endline-only models and pooled exposure-based contrasts rather than baseline–endline change.

The evaluation was initially designed to compare intervention and control sites; however, this structure could not be maintained. As documented in the methodology, exposure to FGM-related activities occurred across both intervention and control areas, delivered by multiple actors including TGG grantees and other organisations. This diffusion meant that “exposure no longer aligned with site classification,” undermining the original quasi-experimental counterfactual. As a result, the evaluation appropriately shifted to an exposure-based analytic framework, and all quantitative findings should be interpreted as associations rather than causal programme effects.

Limitations of the reconstructed exposure variable

The exposure measure relied on self-reported engagement in FGM-related activities and could not distinguish whether activities were delivered by TGG-ALM or other actors, nor when exposure occurred. Respondents may also have reported historical exposure predating the programme. While the reconstructed exposure variable provides a more accurate representation of who was reached, it introduces uncertainty and limits attribution. In addition, the timing, frequency, and intensity of exposure could not be captured, limiting the ability to differentiate between light touch and sustained engagement.

Operational delays and sampling challenges

The evaluation experienced delays due to the time required to obtain ethical approvals in Kenya, Ethiopia, and Senegal. In addition, obtaining complete and timely information on intervention villages affected the sampling process and contributed to inconsistencies between baseline and endline sampling frames. These operational constraints also reduced the time available for fieldwork in some settings, which may have affected sample composition and the depth of qualitative engagement.

Potential for social desirability bias

Given the sensitivity of FGM, respondents may have provided socially acceptable or legally “safe” answers, particularly regarding intention to cut daughters or attitudes toward the practice. Fear of stigma or prosecution may have influenced responses. While triangulation with ethnographic data, qualitative interviews, and Outcome Harvesting helped mitigate this risk, some degree of social desirability bias cannot be ruled out. This risk may have been heightened in areas with strong legal enforcement or where champions and local leaders were visibly associated with the programme.

Contextual and security constraints

In some settings, security concerns, mobility restrictions, or local political dynamics may have influenced access to certain communities or respondents. These contextual factors may have shaped who was available to participate and the depth of information shared. In remote or insecure areas, limited access may have resulted in under-representation of more conservative communities, potentially biasing estimates toward more favourable attitudes.

Ecosystem effects and prior interventions

In several evaluation areas, anti-FGM activities had been implemented by government agencies, NGOs, religious institutions, or community groups prior to the start of TGG-ALM. These historical efforts may have shaped baseline attitudes and contributed to existing awareness or resistance. Although some organisations continued limited activities during the evaluation period, the extent of concurrent programming could not be systematically documented. As a result, it is difficult to fully isolate the contribution of TGG-ALM from broader, pre-existing community influences, and the findings should be interpreted within this wider ecosystem context.

Overall cross-country discussion

This section synthesises the internal consistency of results across the nine secondary outcomes and the overall social attitude index within each country. The aim is not to restate country-specific findings, but to examine how outcomes align with one another and what this reveals about the nature of change in each context.

The synthesis shows three distinct patterns. Kenya exhibits high internal coherence, with exposure consistently associated with progressive outcomes across domains, despite persistent resistance in gender-inequality beliefs and the continued acceptability of Sunna FGM. In Garissa, partial substitution toward Sunna FGM illustrates how normative change can advance unevenly across domains. Ethiopia shows moderate to high coherence, with exposure-based effects stronger than site-level contrasts, though sparse data and unexpected youth conservatism temper some associations. Senegal shows low coherence, with strong gains in knowledge and agency but mixed or negative associations for attitudes, sanctions and discrimination, reflecting contested norms, uneven readiness for change and selective exposure in more conservative environments.

The updated bivariate patterns mirror these contrasts. In Kenya and Ethiopia, the most favourable distributions consistently appear among respondents exposed in intervention sites, while non-exposed respondents cluster at the least favourable end of the distributions. In Senegal, the pattern reverses: non-exposed respondents consistently show the most favourable distributions across beliefs, sanctions, discrimination, intentions, and overall attitudes, while those reached through activities, particularly in control/baseline sites, cluster in less favourable normative positions. This reversal underscores that exposure in Senegal is occurring disproportionately in communities or sub-groups where norms remain strongly supportive of FGM.

Table 31. Consistency across secondary outcomes and overall social attitude within each country

Country	Pattern across secondary outcome variables	Pattern for overall social attitude	Cross-outcome pattern (Interpretation)
Kenya (Garissa)	- δ Strong and consistent progressive associations for 8 of 9 secondary outcomes. - δ Only unequal gender beliefs remained non-significant across all comparisons. - δ Exposure-based effects were consistently stronger than site-level effects.	δ Strongly progressive and aligned with exposure.	High internal consistency: Exposure reliably predicts more progressive attitudes and behaviours. Gender norms remain resistant.
Ethiopia (Amhara)	- δ Mixed site-level significance (4/9 significant), but exposure-based effects were strong and consistent for most outcomes. - δ Only discrimination was non-significant across all comparisons. - δ Some models not estimable due to sparse data.	δ Moderately progressive and aligned with exposure.	Moderate to high internal consistency: Exposure is a better predictor than study site assignment. Gender norms show partial responsiveness.
Senegal (Kedougou, Kolda, Sedhiou, Tambacounda)	- δ Strong knowledge and agency effects, - δ but mixed or negative associations for beliefs, sanctions, and discrimination. - δ Site-level effects weak. - δ Exposure sometimes associated with <i>less</i> progressive attitudes.	δ Negative association: exposure linked to <i>lower</i> odds of a progressive overall attitude.	Low internal consistency: Knowledge gains do not translate into attitude change. Norms are contested; exposure occurs in conservative environments.

Taken together, these patterns highlight that the relationship between exposure and social norm change is highly context-dependent. In settings where norms are already shifting or where exposure aligns with broader community readiness (as in Garissa and parts of Amhara), engagement tends to reinforce and accelerate progressive attitudes across multiple domains. In both settings, gender inequality beliefs remain among the least responsive domains, consistent with global evidence that gender norms shift more slowly than other normative constructs.

In contrast, in settings where norms remain deeply entrenched or where exposure is concentrated among more conservative groups (as in Kolda and Sedhiou), increases in knowledge do not necessarily translate into attitudinal change. In Senegal, exposure is associated with higher knowledge, greater agency, and lower intention to cut daughters, yet also with lower odds of holding a progressive overall attitude and higher support for discrimination against uncut girls. In addition, behaviour-proximal outcomes such as encouragement and agency improve even as broader attitudes remain less favourable, underscoring a divergence between private actions and perceived social expectations. This divergence reflects early-stage resistance and selective participation rather than programme-specific backlash and underscores the importance of understanding who is reached and under what normative conditions.

Across all three countries, ecosystem effects - long-standing programming, multiple actors, and diffusion of information - blur the distinction between intervention and control sites and reinforce the need to interpret exposure-based associations as reflecting broader normative environments rather than programme-specific impacts.

Overall, the degree of internal consistency appears to reflect the broader normative landscape: where norms are already shifting (Garissa, parts of Amhara), exposure aligns with progressive attitudes; where norms remain deeply rooted (parts of Senegal), exposure interacts with existing conservatism in ways that limit or even reverse attitudinal change.

Overall cross-country conclusion

Across Kenya (Garissa), Ethiopia (Amhara), and Senegal (Kedougou, Kolda, Sedhiou, Tambacounda), the quantitative findings reveal a complex but instructive picture of how exposure to FGM-related activities relates to attitudes, beliefs, and behaviours. The clearest insights come from the overall social attitude index, which integrates intention, sanctions, and encouragement and therefore provides the strongest signal of normative positioning.

Across countries, the bivariate evidence highlights a clear divergence in how exposure aligns with outcomes: in Kenya and Ethiopia, progressive patterns emerge most strongly among those reached by activities, supported by consistent associations across beliefs, knowledge, sanctions, and behaviour-proximal outcomes. These patterns suggest that community dialogues, mentorship activities, and awareness-raising efforts, whether delivered by TGG grantees or other actors, are contributing to shifts in both attitudes and emerging behaviours.

In Senegal, however, the pattern diverges. Exposure, whether in control or intervention sites, is associated with lower odds of holding an overall attitude opposed to FGM, despite strong positive associations with knowledge and some behaviour-proximal indicators. The most favourable attitudinal profiles are found among non-exposed respondents, indicating that exposure may be occurring disproportionately in more conservative communities or sub-groups where knowledge gains do not readily translate into shifts in perceived social expectations. In addition, behaviour-proximal outcomes such as encouragement and agency improve even as broader attitudes remain less favourable, underscoring a divergence between private actions and perceived social expectations. Regional and ethnic heterogeneity further shape these dynamics, suggesting that norm-change processes are more contested and uneven.

Across all three countries, three domains show the strongest and most consistent associations with exposure:

- Beliefs opposed to FGM
- FGM-related knowledge
- Opposition to social sanctions for abandonment

These domains typically shift earlier in social norm change processes, and the results suggest that community engagement is influencing how individuals understand and evaluate FGM.

Behaviour-proximal outcomes, encouraging someone to abandon FGM, intention to undergo FGM on daughters, and agency to oppose FGM, also show positive associations with exposure, though with stronger and more consistent effects in Kenya and Amhara than in Senegal. These differences reflect contextual factors such as the intensity of programming, the presence of multiple actors, and the diversity of normative environments. They also mirror the cross-outcome patterns observed in each country: high coherence in Kenya, moderate coherence in Amhara, and low coherence in Senegal.

Gender-inequality beliefs remain the least responsive domain in Kenya and Senegal, underscoring the need for deeper, longer-term gender-transformative approaches.

A cross-cutting finding is that exposure in control sites often shows associations, sometimes positive, sometimes negative, reflecting the presence of other actors, historical programming, and diffusion of

information. This reinforces that the results reflect ecosystem-level effects, not programme-specific impacts.

Taken together, the cross-country findings suggest that community-level engagement is contributing to shifts in knowledge, beliefs, and some behaviours, but the direction and magnitude of change vary substantially by context. The uneven exposure patterns, contamination across sites, and the involvement of multiple actors mean that all results must be interpreted as associative rather than causal. Future efforts should focus on deepening normative change, particularly in settings where exposure reaches more conservative groups, so that gains in knowledge and individual agency translate into sustained, community-level opposition to FGM.

Cross-country recommendations

The cross-country results show that engagement with FGM-related activities does not operate uniformly across settings. In some contexts, exposure aligns with broad shifts in knowledge, beliefs, and emerging behaviours, while in others it intersects with more resistant normative environments and produces mixed or counter-intuitive patterns. These variations reflect differences in community readiness, the distribution of exposure, the wider ecosystem of actors and the quality or appropriateness of programming. The recommendations below translate these contextual insights into practical priorities for strengthening programming across the three countries and other countries with populations affected by FGM.

1. Strengthen exposure measurement and monitoring

- Develop exposure indicators that distinguish between programme-specific and ecosystem-level activities.
- Track intensity, frequency, and type of engagement to understand dose–response patterns.
- Strengthen monitoring systems to capture who is reached, how often, and through which channels.
- Integrate simple, standardised exposure questions across partners to improve comparability.

ð **Justification:** Exposure did not align with site assignment in any country, and control sites frequently showed substantial exposure, indicating ecosystem-level rather than programme-specific reach. Cross-country differences in how exposure aligns with outcomes highlight the importance of tracking not only reach but also the normative environments in which engagement occurs.

2. Improve coordination across actors to ensure coherent messaging

- Map all organisations working on FGM abandonment in intervention and control areas.
- Strengthen coordination platforms to align messaging and reduce contradictory or fragmented approaches.
- Use shared monitoring tools to track exposure across actors and regions.
- Establish periodic joint reviews to harmonise content and identify gaps in coverage.

ð **Justification:** Multiple actors were active across all countries, contributing to diffuse exposure patterns and inconsistent associations, especially in Senegal.

3. Prioritise domains that consistently respond to engagement

- Scale up interventions that strengthen FGM-related knowledge, challenge beliefs supporting FGM, and reduce perceived social sanctions.
- Reinforce community dialogues, mentorship programmes, and awareness-raising activities that show consistent associations with progressive outcomes.
- Invest in formats that have demonstrated reach and resonance across countries, such as facilitated group discussions and youth mentorship.

ð **Justification:** Beliefs opposed to FGM, knowledge, and opposition to sanctions showed the strongest and most consistent positive associations with the overall social attitude across all three countries.

4. Address domains that remain resistant, especially gender inequality norms

- Integrate gender-transformative approaches across all programme components.
- Engage men, elders, and religious leaders more systematically to address deeply rooted gender norms.
- Link FGM programming with broader gender-equality initiatives (education, livelihoods, rights awareness).
- Support long-term, multi-sectoral strategies that address the structural drivers of unequal gender norms.

ð **Justification:** Gender-inequality beliefs were the least responsive domain in all countries, with no significant associations in Kenya and **inconsistent effects** in Ethiopia and Senegal.

5. Deepen work on immediate behavioural outcomes

- Strengthen interventions that build agency, confidence, and interpersonal influence, especially among youth.
- Expand peer-to-peer and intergenerational dialogue models that encourage active opposition to FGM.
- Support community champions and role models who can influence behaviour change.
- Prioritise approaches that translate individual conviction into collective action.

ð **Justification:** Encouragement of abandonment, intention not to practice FGM on daughters, and agency showed strong associations with exposure to FGM-related activities in Kenya and Ethiopia, and mixed but positive associations in Senegal.

6. Tailor programming to regional and cultural contexts

- Adapt interventions to reflect local variations in FGM prevalence, ethnic norms, and community structures.
- Use region-specific messaging and delivery channels to enhance relevance and uptake.
- In contexts like Senegal, prioritise approaches that explicitly address contested norms and potential backlash.
- Ensure programme design is informed by local readiness for change, not only by prevalence levels.

ð **Justification:** Senegal showed strong regional and ethnic heterogeneity, and Ethiopia showed subgroup variation and sparse data; exposure effects varied sharply by context. Cross-country contrasts in exposure–outcome patterns point to the need for strategies that are sensitive to local norms and levels of readiness for change.

Country-Specific recommendations

Kenya (Garissa)

- Strengthen engagement in control-site communities to ensure consistent messaging and reduce misinformation.
- Deepen work on immediate behavioural outcomes, building on strong associations with encouragement of abandonment and agency.
- Address persistent gender inequality norms through targeted gender-transformative programming, including male engagement and community leadership dialogues.
- Leverage strong shifts in knowledge and beliefs by expanding mentorship clubs and community dialogues.
- Consolidate partnerships with local leaders to sustain normative gains.

ð **Justification:** Kenya showed the strongest internal consistency, with exposure predicting progressive outcomes across nearly all domains.

Ethiopia (Amhara)

- Consolidate and scale interventions that show strong associations, particularly those influencing knowledge, beliefs, and social sanctions.
- Strengthen behaviour-change components, building on strong associations with encouragement of abandonment and agency.
- Address gender inequality norms through long-term, multi-sectoral approaches that engage elders, religious leaders, and youth.
- Strengthen youth-focused engagement to address pockets of conservatism among younger respondents.
- Improve exposure tracking given the presence of multiple actors and the likelihood of contamination across sites.
- Prioritise interventions that align with existing community readiness and momentum.

ð **Justification:** Exposure-based effects were strong and consistent across beliefs, knowledge, sanctions, and behaviour-proximal outcomes.

Senegal

- Tailor interventions to regional and ethnic diversity, recognising that social norms and FGM prevalence vary widely.
- Prioritise deeper normative work, given that exposure is associated with *lower* odds of progressive overall attitudes.
- Strengthen behaviour-change components, ensuring that knowledge gains translate into shifts in broader social attitudes.
- Address discriminatory norms toward uncut girls, which remain resistant and, in some cases, intensify among exposed groups.
- Enhance coordination among actors to ensure coherent, mutually reinforcing messaging.
- Reassess the framing and content of FGM-related activities to address potential backlash, selective participation, or contested norms.
- Focus on identifying and engaging communities where readiness for change is emerging, rather than concentrating exposure in more conservative areas.

ð **Justification:** Senegal showed low internal consistency, with exposure associated with higher knowledge and agency but lower odds of progressive overall attitudes.

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