African Population and Health Research Center

THE GIRL GENERATION

Learning brief

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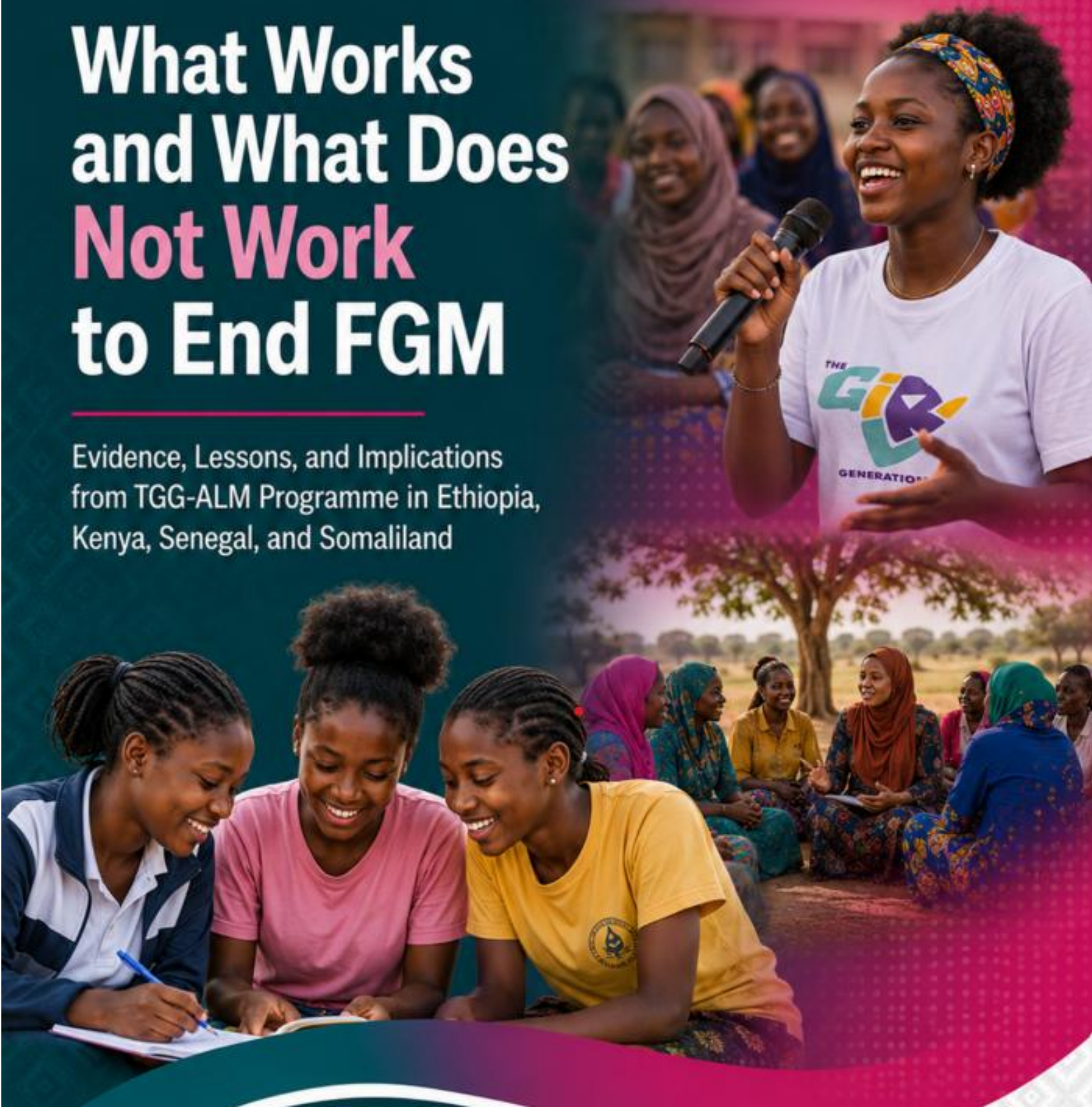
What Works and What Does Not Work to End FGM

Evidence, Lessons, and Implications from TGG-ALM Programme in Ethiopia, Kenya, Senegal, and Somaliland



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Executive Summary

This learning brief summarises evidence, lessons, and implications from the endline evaluation of The Girl Generation: Support to the Africa-led Movement to End FGM (TGG-ALM) programme across Ethiopia, Kenya, Senegal, and Somaliland.

What worked best (and why)

- **Girl-centred platforms (school and girls clubs) consistently strengthened knowledge and agency** (for example, strong gains in confidence and willingness to speak; in Senegal and Somaliland, large gains in knowledge and agency were observed alongside constraints in shifting broader attitudes).
- **Survivor leadership initiative** increased credibility and agency when paired with sustained mentoring, safe spaces, and targeted training. This initiative enabled survivor advocates to engage peers, families, and communities with confidence, drawing on their lived experience, while also providing opportunities for meaningful participation in FGM-related spaces, further strengthening their empowerment.
- **Community dialogues work when they are repeated, socially embedded, and facilitated by trusted local actors**: communities widely endorsed dialogue approaches, and quantitative and qualitative data indicate these spaces enabled public questioning of what was previously taboo and increased awareness on FGM.
- **Health system integration** strengthened sustainability by embedding prevention and response into professional practice (including pre-service training), while also providing trusted spaces for counselling and dialogue.
- **Grants mechanisms strengthened local organisations' capacity and legitimacy**, helping shift grassroots organisations from activity implementers to networked movement actors with stronger systems (safeguarding, financial management, governance).

What did not work well

1. **Awareness and agency did not consistently translate into wider norm change**, especially where social sanctions remain strong or where exposure to programme activities was concentrated among early adopters.
2. **Over-centring girls in public community engagement created safeguarding and legitimacy challenges** in some contexts, with reported pushback and fatigue among girls.
3. **Operational disruptions** (e.g., instability and school closures) reduced continuity for school-anchored approaches, highlighting the need for parallel community delivery channels.
4. **Sustainability and scale risks** persist where coalitions, media engagement, and local organisations rely on short project cycles without longer-term resourcing and institutional support (i.e. capacity building).

Implications for policy and future programming

- **Fund for diffusion and reach:** support delivery models that intentionally reach remote and conservative households, including logistics, transport, and locally legitimate conveners.
- **Balance girl-centred approaches with safeguarding and adult legitimacy:** invest in safeguarding, mentoring, and shared leadership models that pair girls with trusted adult champions (religious leaders, grandmothers, men, and providers) for community-wide engagement.
- **Invest in movement infrastructure, not only activities:** multi-year, flexible funding for local organisations, coalitions, and anchoring partners can protect gains in capacity, staff retention, and advocacy momentum.
- **Strengthen systems pathways that sustain change:** continue health-sector and policy integration to reinforce community norm change with institutional legitimacy, accountability (including against medicalisation of FGM[1]), and services.

Introduction

Programme overview and context

The Girl Generation: Support to the Africa-led Movement to End FGM programme (2021- 2026) is implemented in Ethiopia, Kenya, Senegal, and Somaliland. The mission is to reduce female genital mutilation (FGM) by 2026. The five-year programme is funded by the UK's Foreign, Commonwealth, Development Office (FCDO).

Implemented by a consortium led by Options and its partners Amref Health Africa, ActionAid, Orchid Project, and the Africa Coordination Centre for Abandonment of Female Genital Mutilation (ACCAF), the programme leverages its data and evidence arm through the Population Council's FGM Data Hub. TGG-ALM envisions a world where girls and women exercise their power and rights, have expanded choice and agency, and are free from all forms of violence.

TGG-ALM's approach was designed to move beyond traditional, top-down and fragmented approaches towards multi-layered, community-driven efforts. To accelerate positive changes in social attitudes towards ending FGM, the programme utilises the Socio-Ecological Model (SEM) to drive community-led transformation through locally led interventions at subnational (individual, household, community, and county levels) and national levels. By placing girls at the centre of the strategy, the programme ensures that these interventions are grounded in local realities and sustained across all levels of implementation.

Overview of TGG-ALM interventions

Interventions were underpinned by gender transformative principles, a "Do No Harm" framework and emphasis on learning and generating evidence.

These interventions included:

- School and girl clubs

[1] When FGM is performed by a healthcare provider.

- Community dialogues and sensitisation
- Small grants mechanism
- Integration of FGM prevention and response into the health system
- Strategic media and communications
- Global advocacy
- Evidence and learning

The Evidence Base: Endline Evaluation

Between March 2024 and January 2026, the African Population and Health Research Center (APHRC) conducted an evaluation of TGG-ALM to assess the extent to which the programme achieved its intended effects, outputs and outcomes in **Ethiopia, Kenya**, and **Senegal** and to document lessons to inform future programming. The evaluation was designed to:

1. Assess changes in knowledge, beliefs, and attitudes around FGM.
2. Understand the contribution of TGG–ALM to documented changes.
3. Document learnings from programme implementation, including what worked, what did not, and the probable sustainability of achievements.

This learning brief summarises evidence, lessons, and implications from the endline evaluation in terms of what worked and what did not work and recommendations for the future. The full endline evaluation, including summary reports and other learning briefs, are available at thegirlgeneration.org.

Evaluation approach

This learning is drawn from various data sources generated by the APHRC and the Population Council, using quantitative and qualitative approaches.

Quantitative data

The evaluation in Garissa, Ethiopia, and Senegal employed a quasi-experimental repeated cross-sectional design, through comparative Baseline and Endline household surveys across intervention and control sites with women, men, girls, and boys aged 15 years and above. Baseline data were collected between 2022 and 2023, and Endline data in 2025. Data analysis focused on comparing differences across intervention and comparison sites, as well as between exposed and unexposed participants.

In Somaliland, the evaluation used a cross-sectional design involving a large community-based survey conducted among 2,054 young and adult men and women in Sool and Sanaag regions. Participants were drawn from communities with varying levels of exposure to TGG–ALM interventions, allowing for comparison between exposed and non-exposed individuals among the same communities.

In Isiolo and Narok, the baseline data collection involved a baseline phase conducted in 2024 and an endline in 2025 among young and adult men and women. It is important to note that implementation of the intervention in both Isiolo and Narok had already commenced in 2022 and therefore, the baseline survey did not capture a true pre-intervention measurement but rather reflects outcomes after the intervention had been underway.

Data were collected with a simple opinion poll survey using a combination of direct (self-report) and indirect (vignettes) questioning methodologies to generate robust data to measure public views on FGM.

Table 1: Sample size for the quantitative data

Country	Regions	Survey Rounds	
		Baseline	Endline
Ethiopia	Amhara	802	560
Kenya	Garissa	536	554
	Narok	2,658	2,340
	Isiolo	2,201	1,728
Somaliland	Somaliland	-	2,054
Senegal	Kedougou	-	568
	Tambacounda	343	565
	Kolda	239	566
	Sédhiou	168	569

Qualitative data

To complement and deepen the quantitative endline findings, a multi-phased qualitative study was conducted across Ethiopia (Amhara), Kenya (Garissa, Narok, Isiolo), Senegal (Kedougou, Kolda, Sedhiou, Tambacounda), and Somaliland between June 2024 and January 2026.

The evaluation employed a multi-method approach to ensure data triangulation and thematic depth:

- **Primary Data Collection:** Extensive ethnographic fieldwork, In-Depth Interviews (IDIs), Focus Group Discussions (FGDs), Key Informant Interviews (KIIs)
- **Outcome Harvesting:** Applied specifically to document, verify, and substantiate significant non-linear changes attributable to the programme.
- **Case-study Development:** Qualitative data was synthesised into case studies highlighting organisational growth among grantees, the evolution of networks, and individual narratives of change and leadership.

Table 2: Sample size for the qualitative data

Endline component	Lead organisation	Date	Methodology	Respondents	Locations	Number
	APHRC		Ethnography (participant	Community members,	Kenya (Garissa County)	55

Endline ethnography		April-July 2025	observation, IDI, KII, participatory methods/FGD)	champions, leaders, programme implementers,	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
					Senegal (Kedougou and Kolda + National)	92
Endline Outcome harvesting	APHRC	November 2025	Outcome harvesting	Programmes implementers, Beneficiaries, national stakeholders	Kenya	22
Qualitative (Somaliland)	Pop Council	-	In-depth interviews	-	Somaliland	8
			Focus group discussions	Community members	Somaliland	19
		-	Key informant interviews	local administrators and program staff,	Somaliland	8

*UOP-University of Portsmouth

Stakeholder Engagement

Data was gathered from a diverse ecosystem of actors to capture a 360-degree view of impact:

- **Community Level**: Girl and boy champions, religious and traditional leaders, survivor networks and community health volunteers. The community dialogues engaged men, women, youth, and community leaders.

- **Institutional Level**: Healthcare providers, medical students, media actors, and implementing partners.
- **Systemic Level**: Regional and national policymakers, and advocacy/movement-building stakeholders.

Technical Limitations and Mitigation

The study accounts for important limitations, including:

- Potential social desirability bias and self-reported exposure to end FGM initiatives.
- Accounting for methodological differences between baseline and endline measurements, and between countries/regions where data was collection by APHRC and Population Council.

Key findings and learnings

What worked

Empowering girls to challenge norms early: School and girls clubs

Girl-centred platforms including school clubs in Kenya and Somaliland, girls' clubs in Senegal, and peer-to-peer sessions in Ethiopia were effective in equipping girls with knowledge, confidence, and skills to challenge FGM. Through sustained training, mentorship, and engagement, girls gained knowledge on FGM, its consequences, and its framing as a violation of rights.

> "*The experiences I benefited from made me an active person who cannot remain silent about the harm that FGM causes to girls and the community. I learned that my voice has value, that it is listened to, and that I can continue raising awareness and bring change even as a student*," (FGD Participant, School Club Members, Sanaag Region)

> *"Initially, I was not confident enough to say something even to my family and friends. Personally, now I am confident enough to advocate for it." Girl Champion Kenya*

Across all four countries, girls moved from passive recipients of information to active participants in awareness and dialogue. Many began engaging peers, family members, and community members in conversations about FGM, contributing to early disruption of norms and social expectations.

Pathways to Impact

This approach created safe, sustained spaces for change, enabling girls to move from silent victims to advocates. By combining knowledge with peer support and mentorship, the programme strengthened girls' self-efficacy and voice, their confidence to speak about FGM, normalised conversation about FGM among peers and with adults, and began shifting attitudes within their immediate networks. Beyond girls, the approach also contributed to building champions among boys, who gained the confidence and openness to discuss topics that were previously unthinkable. It enabled them to overcome embarrassment and engage more freely and openly in conversations. In addition, the programme produced and promoted several clubs curricula as global goods (freely available on TGG-ALM website) in local languages to support actors to implement clubs in other regions.

Evidence Summary

The impact of programme exposure on FGM knowledge, agency and beliefs opposed to FGM in the sampled population was as follows:

- **Ethiopia:** Strong gains in confidence (odds ratio (OR)[2] 2.21) and willingness to encourage others to oppose FGM (OR 6.25)
- **Senegal:** Increased agency (OR 5.22) in the opposition to FGM, but faced constraints in influencing broader community attitudes (OR 0.15).
- **Somaliland:** Exposure to interventions was strongly associated with higher levels of opposition. 74% of exposed participants completely opposed FGM compared to 30% among those not exposed.
- **Garissa, Kenya:** High levels of agency, with community members actively engaging in advocacy and dialogue (OR 4.80)
- **Isiolo, Kenya**: At endline, 78.5% of exposed participants opposed FGM compared with 61.4% of those not exposed.
- **Narok, Kenya:** At baseline, 92.5% of exposed participants were completely opposed to FGM compared with 75.4% of those not exposed ($p<0.01$). By endline, 90.6% of exposed participants remained opposed compared with 85.1% of the unexposed ($p<0.01$).
- **Cross-country:** Girl-centred approaches were among the strongest drivers of knowledge and agency gains.

Implication for policy and programming

Future programmes should strengthen grassroot collaborations and be context specific, establishing a robust monitoring system to track programme exposure, work closely with local organisations, and scale up approaches that show results. Community dialogues should include women, men, young people, and trusted leaders so they can openly question FGM and harmful gender norms. Messaging should also clearly address misinformation and reinforce zero tolerance for all forms of FGM.

Survivor leadership builds credibility and drives change

The Survivor Leadership Initiative (SLI) provided survivors with training and opportunities for engagement in FGM-related spaces, further strengthening their empowerment.

Across Ethiopia, Kenya, Senegal, and Somaliland survivors become visible advocates, strengthening their leadership, and participated more confidently in national and local advocacy spaces. Through these platforms, survivors helped translate abstract messaging on FGM into lived experience, making the consequences of FGM more visible and harder to dismiss.

[2] *In this context, an OR represents the odds of an outcome occurring in the exposed group versus the unexposed group*

Pathways to Impact

This worked because it leveraged lived experience as a source of legitimacy and influence. Survivors brought moral authority and authenticity that external actors cannot replicate, humanising the consequences of FGM and expanding who is recognised as a legitimate movement leader.

Evidence Summary

Outcome harvesting in Kenya and Senegal confirmed multiple substantiated survivor-led advocacy outcomes, including participation in media engagement, community dialogues, regional forums, and contributions to local policy processes. The Population Council report also indicates that community and couple dialogues were instrumental in engaging communities and shifting norms.

Country observations

- **Kenya:** Survivors actively engaged in media and advocacy spaces, influencing public discourse.
- **Senegal:** Survivor voices strengthened community dialogue and coalition-building efforts.
- **Ethiopia and Somaliland:** Survivors contributed to local advocacy and community-level engagement.

Implication for policy and programming: Resource survivor leadership as a core movement function (not an add-on) through sustained psychosocial support, protection, and structured roles in advocacy, media, and community dialogue.

Community dialogues and sensitisations

Sustained community dialogues and sensitisations were effective when they were socially embedded, repeated over time, and delivered by trusted local actors.

Across the four countries, the programme implemented sensitisation sessions, intergenerational dialogues, couple dialogues, and broader community forums that engaged multiple segments of the community.

- **Ethiopia:** Community leaders, *Iddir* leaders, Kebele administrators, health volunteers, and former practitioners were trained to facilitate discussions.
- **Kenya:** Chiefs, religious leaders, and former practitioners acted as community champions.
- **Senegal**: Girl champions, community health workers, religious leaders, and traditional leaders engaged mothers, fathers, grandparents, spouses, and youth.
- **Somaliland**: Champions, religious leaders, administrators, community health promoters contributed to social diffusion of end FGM messages.

These approaches created inclusive platforms where norms could be collectively examined across generations and social groups.

Pathways to Impact

This worked because:

- FGM was treated as a social norm issue, not only an individual belief. Repeated, trusted spaces allowed communities to revisit and renegotiate shared expectations over time, making it possible to question in public what had been taboo.
- The role of trusted messengers: Engagement with religious and traditional leaders emerged as one of the most effective strategies for challenging the social legitimacy of FGM. In many communities, decisions about FGM are not driven by health information alone but are shaped by what respected leaders define as morally, religiously, and culturally acceptable.
- Engagement of men and boys' champions drove shared ownership and accountability for ending FGM: Nurturing and engaging emerging champions among boys and men contributed to increased knowledge and shifts in beliefs, including greater attention to the harms of FGM and a willingness not to subject their future children to the practice. This included the formation of structures such as boys' clubs and Model Husbands' Clubs, which promoted peer influence, community advocacy, and local accountability mechanisms like monitoring and vigilance committees.

Evidence Summary

The table below shows the programme outcomes across the three countries and respondents' perspectives on community dialogues as an approach towards ending FGM.

Country	**Community dialogue endorsement as effective approach to ending FGM**	**Knowledge levels (Exposed vs. Non-Exposed)**	**Intent to perform FGM on daughters (Exposed vs. Non-Exposed)**	**Religious and traditional leaders act as effective actors**
Kenya	97%	53% (vs. 39%)	60% (vs. 33%)	95-97%
Ethiopia	91%	74% (vs. 53%)	100% (vs. 87%)	82-91%
Senegal	100%	~8x increase in knowledge	86% (vs. 72%)	97%
Somaliland	-	-	48% (vs.24%)	-

The endorsement confirms that repeated, trusted-dialogue formats were perceived as legitimate and influential mechanisms for shifting knowledge and attitudes.

The evaluation also found increased knowledge and shifting beliefs among boys and men, including a growing willingness not to subject their daughters to FGM. Some men actively advocated against the practice within their families and communities, with testimonies highlighting increased awareness of its impact on women's wellbeing and marital relationships. Work with men and boys addressed a key driver of social norms often overlooked: male expectations around marriageability, purity, and family honour**.**

> *"With God's help, my daughters will never be cut." (Father and madrasa teacher, Kenya)*

Implication for policy and programming:

1. Fund dialogue as a long-term process—plan for repeated cycles, trusted facilitators, and deliberate inclusion of decision-makers (elders, religious leaders, men and boys), not one-off sensitisation;
2. Treat male engagement as a core norm-change pathway—resource male champion structures, tailor messages to marriageability and family expectations, and link men's platforms to community dialogue and health messaging.

Small Grants Mechanism

Delivered through small, medium and anchor grants, this mechanism enabled local organisations to implement anti-FGM interventions while strengthening their internal systems and legitimacy. In Ethiopia, Kenya and Senegal, grantees were not only funded to deliver activities; they were also supported to improve safeguarding, financial management and accountability mechanisms, human resource procedures and grant administration.

The programme also applied a capacity strengthening model, combining technical support from the programme with mentorship from stronger, locally embedded anchor organisations. In several contexts, these anchor organisations supported smaller grassroots actors, strengthening coordination and peer learning.

> *"It helped to rebuild the ties between these different organisations […] It led to better synergy." (KII, Grantee organisation manager, Kedougou)*

An intentional inclusion lens further ensured meaningful participation of women with disabilities; a group often excluded from anti-FGM efforts. Their inclusion enhanced the legitimacy and representativeness of community-based organisations, contributing to strengthened trust in both the organisations and the programme. By broadening representation in advocacy spaces and providing access to grants, the programme strengthened fairness, equity, and responsiveness to diverse community needs.

Pathway to Impact

The grants mechanism shifted local organisations from implementers to movement actors. By investing in both delivery and institutional capacity, the programme strengthened the credibility, sustainability, and reach of locally embedded actors trusted by communities.

Key drivers of effectiveness included the following:

- **Local ownership**: Organisations were embedded in the communities they served.
- **Capacity and funding**: Strengthened both delivery and institutional systems.
- **Peer mentorship:** Anchor organisations supported smaller actors.
- **Inclusive participation**: Broadened representation and legitimacy through inclusion of women with disabilities.

Evidence Summary

Findings indicate that strengthened local organisations were not only implementers, but trusted and influential conduits for social norm change. By fostering ownership and collaboration, the project integrated community-rooted actors, enhancing reach and adaptation to the context. Notably, several organisations strategically repositioned themselves to address FGM. Their participatory approach improved organisational skills and long-term sustainability.

This approach helped shift local organisations from isolated implementers to connected movement actors capable of coordinated advocacy, collective action, and sustained engagement against FGM.

Implication for policy and programming: Maintain multi-year, flexible support that funds both delivery and core systems (safeguarding, finance, MEL) and use anchor partners to mentor smaller organisations for scale and quality.

Integrating FGM prevention and response within health systems strengthens sustainability, credibility, and long-term normative change

Integrating FGM prevention and response into pre-service curricula in health training institutions and service delivery improved clinical competencies and enhanced professional acumen. This included training medical students and establishing a model health facility to strengthen practical learning and service delivery (Kenya), and institutional endorsement through national technical and ministerial structures (Senegal). Health workers and medical students also played dual roles in clinical care and community outreach, while health facilities provided safe spaces for counselling and dialogue.

Collaboration with community health promoters contributed to shifts in attitudes among community members, as clinical expertise was combined with established community trust to deliver consistent messaging.

Why it worked

This moved anti-FGM work beyond short-term projects into formal health systems, embedding prevention and response within professional norms that shape future health workers. It also helped address medicalisation by framing prevention as routine health practice and filling curriculum gaps on FGM-related complications and ethics.

Implication for policy and programming: Scale up health integration by funding pre-service curriculum adoption, supervision, and practical placements, and by pairing facility-based counselling with targeted community outreach to reduce all forms of FGM including medicalisation.

Evidence Summary

Across all four countries, endorsement of health workers as effective actors was consistently high among respondents exposed in intervention sites, with for example: 97% in Kenya, 96% in Ethiopia, and 99% in Senegal. This positions health workers as one of the most trusted and influential groups for FGM prevention, validating the programme's strategy of integrating FGM content into health sector training.

Health facilities played a central role in supporting normative change. The evaluation found that participating in individual consultations and group health talks provided confidential spaces for women to share FGM experiences and seek guidance. These interactions increased knowledge, improved provider–patient relationships, and fostered trust in health services. Access to reliable information and counselling strengthened women's agency, with some reporting a greater willingness to discourage FGM within their families and social networks.

Country observations

- **Kenya:** Focus on experiential learning through training of medical students and establishment of a model health facility strengthened both service delivery and practical skills application.
- **Senegal:** Strong institutionalisation through engagement with national technical and ministerial bodies advanced the adoption and formal endorsement of curriculum tools.
- **Ethiopia:** Integration within training systems aligned with broader programme efforts, reinforcing the role of health workers as trusted influencers, and strengthening community-level engagement through outreach.

Strategic media engagement and communication amplify credible voices and drives movement coherence

Strategic communication and advocacy worked when they amplified credible local voices and were embedded within broader movement-building efforts rather than treated as stand-alone awareness activities.

Across Ethiopia, Kenya, and Senegal, the programme deliberately positioned survivors, girls, and community advocates including religious leaders, health care workers and *Badiénou Gox* (community maternal and child health promoters) at the centre of public messaging. This translated abstract information about FGM into lived reality. By training survivors and activists alongside journalists and advocates, the programme humanised the consequences of FGM, generated empathy, and made harm harder to dismiss. This approach expanded who is recognised as a legitimate movement leader.

Media engagement complemented this approach. In all three countries radio, television, social media, awareness caravans, and national and international commemorative events were used to keep FGM visible in public discourse. Journalists now frame FGM as a rights violation and a form of gender-based violence, rather than solely as a cultural practice.

> *"For me that approach (journalist training) has worked well. Starting with the training so that they understand where we are coming from because it's very easy for them to continue saying that FGM is culture. If we are saying it is not culture, what evidence then are we giving them as media professionals?" (Implementing partner)*

Pathway to Impact

These efforts worked best when media amplified credible local voices (girls, survivors, religious leaders, community-based organisations) and when communication was linked to policy and community action rather than treated as stand-alone dissemination. Overall, aligning survivor leadership, media, policy

engagement, and grassroots grant-making enabled credible local voices and supportive systems to reinforce norm change and strengthen an Africa-led movement to end FGM.

Evidence Summary

Outcome harvesting in Kenya and Senegal documented multiple survivor-led advocacy outcomes, including participation in regional forums, influencing local by-laws, and participating in media programmes. These outcomes were independently substantiated, and contributions linked in part to TGG-ALM's communication and advocacy model.

Additional outcomes included the establishment and formal registration of previously informal community organisations, which strengthened local ownership and collective action against FGM.

Community endorsement of media as an effective strategy was extremely high in exposed intervention sites (Kenya: 99%, Ethiopia: 93% and Senegal: 97%). This shows that media engagement was most effective when linked to trusted local actors and embedded within broader community processes.

Implication for policy and programming:

1. Pair journalist training with funded editorial follow-up, content pipelines, and links to community campaigns and policy moments to sustain coverage and reinforce norm change.;
2. Keep communication, advocacy, and grants tightly linked through shared plans, coordinated calendars, and feedback loops so messages and policy asks are reinforced across channels.

Global advocacy to strengthen and secure additional commitments and resources: Linking community action to systems change

Advocacy and movement-building were strengthened through sustained engagement with policy and institutional structures.

- In Kenya, TGG-ALM supported county-level planning, costed action matrices for FGM, technical working groups, child protection mechanisms, and collaboration with the Anti-FGM Board including community influencers.
- In Ethiopia, TGG-ALM partners facilitated FGM steering committees, girls' councils, and inclusive stakeholder platforms.
- In Senegal, TGG-ALM supported emerging regional coalitions (FENOPAM), survivor networks, cross-border collaboration, and alignment with national anti-FGM and gender-based violence structures.

This multi-actor approach strengthened vertical and horizontal linkages across the movement, connecting community-level action with institutional and policy spaces.

Country observations

- **Kenya:** Strong integration with policy and institutional structures, enhancing reach and legitimacy of advocacy.
- **Ethiopia:** Structured stakeholder platforms and councils strengthened coordination and dialogue.

- **Senegal:** Coalition-building (e.g., FENOPAM) enabled coordinated advocacy and alignment across regions.

Added value of the Social Ecology Model approach

TGG-ALM applied a Social Ecology Model to address FGM across individual, community, civil society, and institutional levels. By combining grassroots grants, survivor- and girl-led engagement, community dialogue, work with religious leaders, media, health systems, and policy advocacy, it reinforced norm-change messages through multiple, aligned pathways.

This approach was most effective in increasing awareness, agency, openness, and capacity in civil society, while strengthening institutional entry points. However, progress toward widespread norm change and sustained abandonment remains uneven, particularly in conservative contexts.

Overall, the model added value by driving multi-level momentum, while highlighting the need for sustained, context-specific investment to achieve lasting change.

Implication for policy and programming: Maintain a multi-level package (girls, survivors, community dialogue, grants, media, health, and policy) with explicit coordination and multi-year timelines so gains in agency translate into wider norm diffusion.

What did not work (or worked less well)

Community dialogues

- Centring girls is powerful but must be balanced with safeguarding and legitimacy

Girl-centred approaches strengthened agency, but in some contexts positioning girls as primary leads for community dialogues created safeguarding and legitimacy risks (pushback, fatigue among girls, and reduced influence in elder-led spaces). **Implication:** Keep girls as catalysts (peer and household influence) and pair them with trained adult champions (e.g., religious leaders, grandmothers, men) for community-wide dialogue, with safeguarding and mentoring embedded by design.

- **Senegal (what this signals):** Girls were respected, but other messengers carried greater influence for entrenched norms: girls' empowerment (95%) vs religious leaders (97%), elders (99%), and health workers (99%).

- Increasing awareness and agency does not necessarily change deeply held norms

Activities increased knowledge of the law and harms of FGM, but this did not consistently diffuse across the wider social environment or shift deeper expectations that sustain FGM. In some contexts, this translated into harm reduction rather than abandonment. For example, in Garissa (Kenya) and Somaliland, some respondents described shifts from Type 3 (Pharaonic) FGM to forms perceived as less harmful or religiously acceptable (e.g., 'Sunna' FGM): *"The Firauni type of circumcision was stopped... But the Sunna type I don't think it will ever be stopped."*

Implication: Pair awareness with sustained, norm-focused work that targets social sanctions and decision-makers and explicitly addresses "milder/medicalised" narratives.

- Legitimacy of messengers determines influence

Belief change was more limited where messengers were not viewed as legitimate for sensitive cross-generational conversations. Quantitative findings in Senegal show exposure was associated with higher agency (OR = 5.2) but lower odds of holding a progressive overall attitude (OR = 0.15), suggesting that who delivers the information is critical to shifting beliefs and attitudes

> **"***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". (Observation Field Notes, Sédhiou)*

Implication for policy and programming: Sequence and blend messengers—use girls and survivors to catalyse discussion, but anchor community-wide persuasion in locally legitimate authorities (elders, religious leaders, providers) to shift collective expectations.

- Norm change depends on scale, repetition, and social diffusion

Dialogue approaches worked best when repeated, widely distributed, led by trusted facilitators, and designed to diffuse beyond early adopters. In practice, reach was uneven (a "clique effect" where the same champions attended programme activities repeatedly), with elders, remote households, and more conservative families often unexposed due to distance and resource constraints.

Implication for policy and programming: Fund and manage for coverage and diffusion (targeting who is not in the room). It is not just how many sessions are held, but who the session targets.

- **Senegal:** Exposure to programme interventions was likely concentrated in more conservative pockets (non-exposed respondents held more progressive attitudes: 86% opposed continuation vs 72% of exposed), limiting apparent impact and diffusion.
- **Ethiopia:** Low and uneven exposure in remote/insecure kebeles with 22% exposed in control vs only 39% exposed in the intervention sites constrained programme reach and collective norm shifts.
- **Strategic communication:** Without follow-up support, incentives, and budgets, media training did not consistently translate into sustained anti-FGM coverage.

- Limited progress on gender-equitable beliefs and attitudes

Although exposure was associated with stronger FGM-related knowledge, greater agency, and more opposition to FGM in several settings, the evidence shows that deeper gender-equality attitudes and beliefs were much less responsive. Across countries, exposure showed no significant association with gender-inequality beliefs, suggesting that broader gender-related norms remain among the least responsive domains. This suggests that programme activities were more effective at shifting FGM-specific knowledge and behaviours than transforming the underlying gender attitudes that help sustain the practice.

Implication for policy and programming: Move beyond awareness-raising to longer-term, gender-transformative approaches that directly address entrenched gender norms, social expectations, and power relations.

School clubs: Delivery models must account for unstable contexts

School-based and other institutionally anchored approaches were effective, but conflict-related disruptions (e.g., school closures) particularly in Ethiopia, forced delivery into communities and reduced continuity.

Implication for policy and programming: In fragile settings, design parallel delivery channels from the outset (institutional + community) so programming can continue without a full model switch.

Grant mechanism: Sustainability and scale are constrained without long-term resourcing and capacity

The programme strengthened local organisations and systems, however, evaluation data in Ethiopia and Senegal show that some organisations lacked stable funding streams beyond TGG-ALM's grant cycle, raising concerns about sustainability. Several grantees reported that without continued financial support, they risked losing trained staff or scaling down community engagement activities. In Ethiopia, exposure to end FGM interventions among community respondents remained uneven (only 22% in control sites and 38.6% in intervention sites at endline), partly because smaller organisations lacked the logistical capacity to reach remote or insecure areas. Without multi-year, flexible support, the gains made through the grant's mechanism risk remaining organisational improvements rather than translating into sustained, community-wide norm change.

Implication for policy and programming: Prioritise multi-year support that protects staff retention, follow-up, and last-mile delivery capacity—especially for smaller partners.

Movement-building requires institutionalisation beyond project funding- Collaboration among grantee partners improved, but many coalitions remained fragile and dependent on project funding.

Implication for policy and programming: Institutionalise coordination (clear mandates, governance, and resourcing) so networks can maintain advocacy momentum beyond grant cycles.

Conclusion and recommendations

TGG-ALM's endline evaluation provides important and constructive lessons for future efforts to end FGM. Across Ethiopia, Kenya, Senegal, and Somaliland, the programme demonstrated that locally led, socially embedded, and multi-level approaches can generate meaningful gains in knowledge, agency, opposition to FGM, movement capacity, and institutional engagement. At the same time, the findings show that awareness and individual agency alone are not enough to transform deeply rooted social and gender norms at scale. Sustained progress requires interventions that combine girl- and survivor-centred approaches with trusted community leadership, repeated dialogue, health and systems integration, strategic communication, and long-term investment in local movement infrastructure.

Adapting approaches to specific contexts could further strengthen results and accelerate progress toward ending FGM in Africa.

This includes:

- **Move beyond awareness to norm change**: pairing knowledge creation with deeper gender-transformative dialogue that addresses power, control, social sanctions, marriageability and girls'

bodily autonomy to address the root cause of FGM and explicit messaging to counter "milder" or medicalised FGM.

- **Use the right messengers for the right conversations:** keep girls and survivors as catalysts, while anchoring community-wide persuasion in locally legitimate champions (religious and traditional leaders, grandmothers, men, and health workers), with safeguarding and mentoring built in.
- **Design for diffusion and reach:** plan and resource repeated and sustained engagement that reaches those least likely to participate (remote households, elders, conservative families) and track coverage as a measure of performance.
- **Expand the model health facility approach**: sustain it with additional staffing or ensure that there is no disruption in rotation of interns to ensure providers a balanced workload that creates enough time for effective client-centred engagement.
- **Institutionalise and resource systems pathways:** deepen integration in health, education, and protection systems (including pre-service training and supervision) to sustain prevention, address medicalisation, and ensure quality outreach.
- **Fund movement infrastructure for the long term:** provide multi-year, flexible support for local organisations and coalitions (core systems, staff retention, logistics), so gains do not erode at the end of grant cycles.

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