End Term Evaluation in Female Genital Mutilation Elimination Project

Evaluation Conducted in Selected Six Wards of Serengeti District – Mara Region

Disclaimer: This evaluation report has been developed by an independent evaluation team. The analysis presented in this report reflects the views of the authors and may not necessarily represent those of Amref Health Africa, its partners or the UN Trust Fund.”

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Evaluation Commissioned by: Amref Health Africa
End Term Evaluation of the Female Genital Mutilation Elimination Project

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Lastly, the evaluation team would like to thank and express gratitude to the Amref and project partner, the United Nations Trust Fund to End Violence against Women, without whose support implementation of the project and its evaluation would not be possible.
## List of Acronyms and Abbreviations

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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<tbody>
<tr>
<td>Amref</td>
<td>Amref Health Africa</td>
</tr>
<tr>
<td>ARP</td>
<td>Alternative Rites of Passage</td>
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<tr>
<td>CBO</td>
<td>Community-Based Organization</td>
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<td>CCHPs</td>
<td>Comprehensive Council Health Plans</td>
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<td>CDO</td>
<td>Community Development Officer</td>
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<tr>
<td>CEDAW</td>
<td>Convention on the Elimination of all forms of Discrimination Against Women</td>
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<td>CHAC</td>
<td>Council HIV and AIDS Coordinator</td>
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<td>CHW</td>
<td>Community Health Worker</td>
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<td>CM</td>
<td>Child Marriage</td>
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<td>CSO</td>
<td>Civil Society Organization</td>
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<tr>
<td>DAS</td>
<td>District Administrative Secretary</td>
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<tr>
<td>DC</td>
<td>District Council</td>
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<td>DED</td>
<td>District Executive Director</td>
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<tr>
<td>DEO</td>
<td>District Education Officer</td>
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<tr>
<td>DMO</td>
<td>District Medical Officer</td>
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<tr>
<td>DNA</td>
<td>deoxyribonucleic acid</td>
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<tr>
<td>DPLO</td>
<td>District Planning and Logistics Officer</td>
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<tr>
<td>DRCHCO</td>
<td>District Reproductive and Child Health Coordinator</td>
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<tr>
<td>DSO</td>
<td>District Security Officer</td>
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<tr>
<td>DSWO</td>
<td>District Social Officer</td>
</tr>
<tr>
<td>EQUIP</td>
<td>Education Quality Improvement Programme</td>
</tr>
<tr>
<td>EVAW/G</td>
<td>Ending violence against Women/Girls</td>
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<tr>
<td>FBO</td>
<td>Faith-Based Organization</td>
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<tr>
<td>FGC</td>
<td>Female Genital Cutting</td>
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<tr>
<td>FGD</td>
<td>Focus Group Discussion</td>
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<tr>
<td>FGM</td>
<td>Female Genital Mutilation</td>
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<tr>
<td>FGM/C</td>
<td>Female Genital Mutilation/Cutting</td>
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<tr>
<td>GBV</td>
<td>Gender Based Violence</td>
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<tr>
<td>GNA</td>
<td>Gender Needs Assessment</td>
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<tr>
<td>HCP</td>
<td>Health Care Professional</td>
</tr>
<tr>
<td>HRC</td>
<td>Human Rights Council</td>
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<tr>
<td>IEC</td>
<td>Information, Education and Communication</td>
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<tr>
<td>KII</td>
<td>Key Informant Interview</td>
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<tr>
<td>LGAs</td>
<td>Local Government Authorities</td>
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<tr>
<td>LHRC</td>
<td>Legal and Human Rights Centre</td>
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<tr>
<td>M &amp; E</td>
<td>Monitoring and Evaluation</td>
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<tr>
<td>Acronym</td>
<td>Description</td>
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<tr>
<td>MEL</td>
<td>Monitoring, Evaluation and Learning</td>
</tr>
<tr>
<td>MIS</td>
<td>Management Information System</td>
</tr>
<tr>
<td>MKUE-T</td>
<td>Mpango wa Kuinua Ubora wa Elimu nchini</td>
</tr>
<tr>
<td>MoHCDEC</td>
<td>Ministry of Health, Community Development, Gender Elderly and Children</td>
</tr>
<tr>
<td>MoU</td>
<td>Memorandum of Understanding</td>
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<tr>
<td>MP</td>
<td>Member of Parliament</td>
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<tr>
<td>NDDH</td>
<td>Nyerere District Designated Hospital</td>
</tr>
<tr>
<td>NGO</td>
<td>Non-Governmental Organization</td>
</tr>
<tr>
<td>NHPC</td>
<td>National Housing Population Census</td>
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<tr>
<td>NPA-EVAWC</td>
<td>National Plan of Action to End Violence Against Women and Children</td>
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<tr>
<td>OCD</td>
<td>Officer Commanding District</td>
</tr>
<tr>
<td>PF3</td>
<td>Police Form 3</td>
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<tr>
<td>PMU</td>
<td>Programme Management Unit</td>
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<tr>
<td>RC</td>
<td>Regional Commissioner</td>
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<tr>
<td>SADC</td>
<td>Southern Africa Development Community</td>
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<tr>
<td>SDC</td>
<td>Serengeti District Council</td>
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<td>SDGs</td>
<td>Sustainable Development Goals</td>
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<tr>
<td>SMS</td>
<td>Short Message Service</td>
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<tr>
<td>SPSS</td>
<td>Statistical Package for the Social Sciences</td>
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<tr>
<td>SRHC</td>
<td>Sexual and Reproductive Health Commodities</td>
</tr>
<tr>
<td>SWO</td>
<td>Social Welfare Officer</td>
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<tr>
<td>TDHS</td>
<td>Tanzania Demographic and Health Survey</td>
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<tr>
<td>ToT</td>
<td>Training of Trainers</td>
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<tr>
<td>UN</td>
<td>United Nations</td>
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<tr>
<td>UNEG</td>
<td>United Nations Ethical Guidelines for Evaluation</td>
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<tr>
<td>URT</td>
<td>United Republic of Tanzania</td>
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<tr>
<td>VAC</td>
<td>Violence Against Children</td>
</tr>
<tr>
<td>VAW</td>
<td>Violence Against Women</td>
</tr>
<tr>
<td>VEO</td>
<td>Village Executive Officer</td>
</tr>
<tr>
<td>WASHEHABISE</td>
<td>Wasaidizi wa Sheria na Haki za Binadamu Serengeti</td>
</tr>
<tr>
<td>WEO</td>
<td>Ward Executive Officer</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
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Executive Summary

Introduction

Tokomeza Ukeketaji Serengeti Project was implemented by Amref Health Africa and Legal and Human Rights Centre (LHRC) from 2016 to 2018 in Serengeti District, Mara Region. The 3-year project targeted a total of 29,383 primary beneficiaries and 10,972 secondary beneficiaries. Primary beneficiaries were women and girls in the district, while secondary beneficiaries included local CBOs, the general public, the police force, judicial system, circumcisers, teachers, traditional healers, health workers, boys and men, parents and caregivers, health workers and community peer educators. The overall goal of the project was to see that girls and young women in Serengeti District are free from the FGM practice and have more opportunities to exercise their legal and social rights by the year 2018. Specifically, the project sought to empower girls, women and community in Serengeti District to abandon FGM/C practice; build the capacity of health and legal personnel in Serengeti District to deliver effective services in combatting and handling cases of gender based violence including FGM; and strengthen the capacity of community based organizations to carry out policy and law advocacy on elimination of FGM/GBV practices.

One of the key activities under the project was to conduct an end term evaluation, which done in January 2019. The end term evaluation study conducted in 6 wards of Serengeti District sought to evaluate the project against effectiveness, relevance, efficiency, sustainability, gender equality and human rights criteria, as well as recording some key lessons and best practices and then provide recommendations for future project implementation. The data is thus expected to be used to inform and shape future interventions and implementation strategies.

The main objective of the final evaluation was to measure progress towards the project goal, outcomes, outputs and achievements against set outcome indicators. The evaluation further sought to record lessons learnt (challenges and opportunities), best practices and provide recommendations for future project implementation. As systematically and objectively as possible, the evaluation aimed at determining the relevance, value for money (efficiency and effectiveness), impact, results, innovations and sustainability of the project. It also sought to identify significant factors that hindered/contributed to achievement of the outcomes and outputs.

The study was conducted in selected six (6) wards of Serengeti District, namely: Machochwe; Nyansusura, Mbalibali, Issenye, Ikoma and Nagusi. A total of twelve (12) villages were reached, namely: Machochwe, Nyansusrura, Mbalimbali, Nyiberekera, Park Nyigoti, Iharara, Nyamakendo, Kitarungu, Kitunguruma, Nyamisingisi, Robanda and Singisi.
Methodology

The evaluation targeted a total of 660 respondents, but reached 679 respondents – 19 more than the targeted number. These respondents participated in focus group discussions (FGDs) and interviews, including key informant interviews (KIIIs), while some of them responded to a questionnaire. Among them were women, girls, FGM survivors, former circumcisers, traditional leaders, religious leaders, district authorities, teachers, parents, police, healthcare workers, judicial officers, paralegals, CBO representatives and project staff.

Key Findings

Effectiveness

The project has effectively and significantly increased awareness of health effects and human rights aspect of FGM among girls and young women, as demonstrated by increased knowledge levels and women and girls taking a stand against FGM.

→ A total of 15,747 out of 24,533 (64%) of women and girls living in Serengeti DC have been reached and sensitized by the project; this has been possible through different methods such as cinema shows, public meetings and training at schools and at the community level.

→ Increased awareness and knowledge on health effects of FGM and human rights aspect of the practice has enable girls and young women in Serengeti to abandon FGM, as evidenced by decline of FGM. It was revealed during KIIIs that the rate of FGM decline in study areas stands at an average of 80%.

→ 94% of questionnaire respondents said that they believe FGM in Serengeti has declined, while 96% believe the project has brought about changes in Serengeti, as a consequence of increased awareness of FGM and human rights aspect of the practice among primary and secondary project beneficiaries.

→ Fewer cases of FGM reported also attest to project effectiveness, with more than 621 girls aged 8-17 years managing to escape FGM. Girls are also better positioned to escape the practice by fleeing to the police gender desk and safe house for help and refuge respectively.

→ A drop in the number of girls registered to undergo FGM in Serengeti DC in the course of project implementation also points out to project effectiveness in terms of strategies employed to increase awareness about FGM and its effects. Project records show that the number of girls registered to undergo FGM in the district fell from 5621 in 2016 to 726 in 2018, dropping by 87%.

→ Evaluation estimates project achievement rate at 80%, largely contributed by effective strategies employed in increasing awareness of health effects of FGM and its human rights aspect among all project beneficiaries.
The project has significantly contributed to increased awareness on health effects and human rights aspect of FGM among parents/caregiver, traditional leaders, boys, men and circumcisers. This has created an environment for these groups to discourage FGM.

→ Majority of respondents of quantitative (80%) were of the view that generally the community does not support continuation of FGM, while 84% and 87% of the respondents said that generally majority of men and women in the district respectively are not in favour of continuation of FGM. This points to project effectiveness and is an improvement on the baseline data, which shows that over 70% of men, boys and girls do not support the practice to continue.

→ More than 90% of participants of FGDs with men and girls indicate that the project has helped to change men’s attitude and mindset regarding FGM.

The project has effectively established the ARP model and engaged traditional leaders, circumcisers and young women and girls to abandon FGM practices using the model.

→ Successful introduction of Alternative Rites of Passage (ARP) has been one of the key highlights of the project and largely contributed to project effectiveness by encouraging passage into adulthood for girls without having to undergo FGM.

→ Project records show that 359 out of 1500 girls participated in ARP and graduated in the year 2018. KIIs in Issenye Ward also confirmed that 234 girls had passed graduated through ARP in 2018.

→ Effective engagement of traditional leaders and circumcisers has also contributed to abandonment of FGM practice. Project intervention enabled 78% of traditional leaders engaged by the project to sign anti-FGM petition/declaration, committing themselves to abandon the practice and advocate for its abandonment in the community. Circumcisers were also engaged and empowered to seek alternative sources of income to good effect, as some of them downed their tools and were even at the latter stages of the project used in implementing project activities, including facilitating trainings and raising awareness.

Through trainings for healthcare workers and mothers attending clinics, the project has significantly improved their knowledge on avoiding effects of FGM.

→ Healthcare workers and mothers were effectively engaged and trained on health effects of FGM, which contributed to enabling them to avoid such effects and thus contribute to overall goal of the project, which includes enabling women to be free from FGM and its effects so that they can freely enjoy their rights.

The project effectively engaged and trained 30 police gender desks officers, paralegals and judicial officers to improve their legal knowledge to effectively respond to FGM cases and ensure perpetrators are brought to justice. Consequently, there is improved access to and quality of legal services. The project also effectively trained 178 healthcare workers and 104 community health workers to improve their knowledge on managing health complications of FGM and enable them to provide comprehensive SRHR and psychosocial support to girls and women.
Building the capacity of legal and health professionals on FGM and its effects as well as handling and responding to FGM cases was a key strategy that significantly contributed to project effectiveness. Improved knowledge of these professionals translates into improved legal and health services they deliver, as attested by a majority of respondents, who claimed increased efficiency of legal and health professionals as a result of project intervention.

Over 70% of the respondents expressed that the efficiency of the healthcare workers FGM-related services has increased, while over 50% attested to increased efficiency on the part of police officers and judicial officers. 80% of FGD participants and 85% of key informants also attested to the increased efficiency of healthcare workers in provision of health services to survivors of FGM, child marriage and other forms of GBV.

The project successfully created forums to advocate for enforcement of GBV-related and policies in order to safeguard rights of women and girls.

The project encouraged formation of CBOs and built capacity of existing CBOs to ensure they advocate for rights of women and against FGM.

The project managed to engage, sensitize and build the capacity of local government authorities to ensure increased allocation of budget for GBV/FGM in annual budget. However, no budget was allocated for GBV/FGM until the final year of project implementation, which was itself not substantial.

Despite the various achievements of the project highlighted above, project effectiveness was found to have been affected by several factors. Key among these factors is the threat posed by neighbouring districts, such as Bunda and Tarime, where FGM is practiced with impunity. Other factors including corruption allegations within the police force, shortage of legal and health professionals, lack of political will (especially among Members of Parliament) and complaints about some of the traditional leaders sabotaging anti-FGM efforts.

Relevance

The project goal, outcomes and outputs were found to be relevant to the needs of women and girls in Serengeti, owing to the gaps in knowledge among them and other members of the community, including legal and health professionals, and existence of gender inequalities in the district.

To a large extent, the project responded to anti-FGM and GBV agenda contained in key national plans such as the National Plan of Action to End Violence against Women and Children in Tanzania 2017/18 – 2021/22 and the Tanzania Development Vision 2025.

Tanzania policy framework and political commitment to end FGM/GBV are critical factors for the relevance of the project in Serengeti and the neighbouring districts. The challenge remains on adoption and translating these policy statements into resource allocations, particularly at District Council Budget level.
The evaluation revealed that the project is relevant in terms of the national plans and priorities as it is meant to complement government efforts under the National Plan of Action to End Violence against Women and Children in Tanzania 2017/18 – 2021/22 and the Tanzania Vision 2025, among others.

The project is also relevant and continues to be relevant to the needs of women and girls. Asked whether the project has been relevant to community needs, 94% of questionnaire respondents said Yes, while 80% of the same respondents indicated that they would like for the project to be scaled up horizontally (to neighborhood Tarime and Bunda districts which remains critically challenging in ending FGM and vertically (to cover the remaining project target including the 76% of girls to be graduated). Moreover, 70% of all respondents demonstrated their willingness to spread the anti-FGM messages. All these factors point to the relevance of the project.

Moreover, 81.7% of the community members reported that families are forced into debt to cater for the circumcision ceremonies of their daughters.

The project was also relevant in terms of ensuring increased availability, accessibility and quality of legal aid and health services provided by police gender desks and health facilities. Community needs quality and accessible legal and health services to address FGM and other forms of GBV.

### Efficiency

The project was generally characterized by timely delivery of activities and all activities were implemented in line with project work plan and budget. Only a few activities were not delivered on time but valid reasons for the delays were given and they were eventually effectively implemented.

For instance, study visits for traditional leaders and young girls scheduled for 2016 in Kilindi District had to be postponed until June 2017 due to the anti-FGM ceremony being shifted to that period instead of 2016.

The project employed participatory and holistic approaches in designing, managing and implementing the project to good effect and engaged external experts when needed in order to effectively and efficiently implement the project.

The project collaborated with all key stakeholders in implementing project activities, including the district authorities who sometimes played a coordination role and traditional leaders and former circumcisers, who sometimes played a facilitation role during trainings. Peer educators were also used to reach out to women and girls, as well as other members of the community to provide FGM and GBV education, facilitated by the project with bicycles to ease movements.

The project employed effective strategies and approaches to empower and build the capacity of targeted beneficiaries.

The evaluation team generally found that the approaches and mechanisms utilized by project implementers were largely innovative and cost-effective. Most of the interventions were made through trainings, seminars, campaigns, school platforms.
→ Project efficiency was also guaranteed through strengthening capacity of duty bearers in response to FGM and increased engagement with women and girls.

**Challenges affecting project efficiency**

The project was faced with a number of challenges, which impacted on its efficiency. One such challenge was a clash between project management and the Serengeti District Council over who should take lead in bringing about change in the project, despite efforts made to enhance the holistic approach. In some circumstances, the district council felt that it should have been more directly involved in implementation of project activities, with some of the authorities who were interviewed even insisting that the district council should receive some of the project funds to implement activities.

KIIs with community health workers also revealed that although the project facilitated them with bicycles to reach out to community members and educate them about FGM and its effects, they were limited in their scope of operation due to lack of allowance to sustain themselves while moving from one area to another to conduct community sensitization. In study areas, KIIs also mentioned that most computers that were intended for police posts and health centres were not distributed. For instance, the project disbursed 7 computers for Robanda, Majimoto, Mto Mara and Machochwe police stations/posts. However, 5 of these were not distributed, rather remained at district level, due to gaps in computer knowledge among police officers. In some areas identified for the computers/laptops, there was not power – making it a challenge to use the equipment.

**Sustainability**

**Effective strategies and approaches employed by the project have helped to institutionalize the anti-FGM project and agenda in Serengeti and build capacity of key stakeholders in order to sustain achieved results. The participatory and holistic approaches were key in institutionalizing the project, as were strategies such as engaging the traditional leaders and circumcisers to effectively participate in implementation of project activities and establishment of anti-FGM/GBV clubs in schools and local human rights CBOs.**

→ Sustainability of this project was considered right from its conceptual design, and was linked with the identified activities per objectives.

→ It was expected that after the strengthening of community structures, there will be improved capacities of the CHWs and children protection committees that have institutionalized the project outcomes into the government health delivery systems. During the course of implementation through advocacy, law and policy influences, favourable political environment has been created to support the smooth integration of FGM and GBV into the respective district plans, thus winning support from the district leadership after the project period ending. Through the Tokomeza Ukeketaji project, Amref and LHRC, have established strong working relationships with the district authorities and partners for shared FGM and GBV responsibilities.

→ Establishment of forums such as anti-FGM/GBV clubs in schools and establishment of local human rights CBOs as well as close collaboration with district authorities have
been key to ensure project sustainability, in addition to effective engagement of traditional leaders, religious leaders and circumcisers.

Impact

*The project has largely contributed to project goal through empowering women and girls to ensure they are free from FGM and GBV, which in has enabled them to enjoy more freedom to exercise their legal and social rights.*

*The project has significantly contributed to women and girls taking a stand against FGM and committing to abandon it.*

- Women and girls have gained increase knowledge on where they get help when forced to undergo FGM; and are now enjoying more freedom in realizing their rights, including right to education.
- The project also had unintended impact in that it contributed in boosting school attendance for girls, as claimed by respondents during KII and FGDs. 60% of FGD participants expressed that decline of FGM has also resulted improvement in girls' school attendance.

*Increased knowledge on FGM and its effects among project beneficiaries has resulted into change in mindset and attitude towards FGM.*

- The project has helped to change community perception about the FGM, whereby 90% of respondents revealed that the interventions made under the project have brought about positive changes in the community. Among the changes brought is decline in FGM and increased willingly of community members to abandon the practice. The project has helped to change the mindset and attitude, including amongst traditional leaders and circumcisers, some of whom have committed to abandoning the practice.
- Majority of KII and FGD participants also indicated that project interventions have helped to significantly reduce discrimination and stigmatization of girls and women who have not undergone FGM in the district.

*Project intervention to ensure increased commitment to abandoning FGM practice has contributed to a decline in FGM in Serengeti.*

*Project intervention has also contributed to increased number of FGM cases sent to court.*

- Tokomeza Ukeketaji project in Serengeti has put a remarkable history, being the first district in the country where prosecutions and arrests involving FGM have been reported. This is the result of the holistic approaches used by the project by involving police gender desks officers, paralegals and judicial officers, who were trained and oriented for improved legal knowledge to effectively respond to cases of FGM and ensure perpetrators are brought to justice. The project has been strategically holding different forums mainly to bring attention to the public in Serengeti as part of movement to improve women and girls awareness on their human rights. This move has
formulated a ground breaking for community action against FGM arguing that, all perpetrators should be reported for action. The Tokomeza project has been critical in Serengeti for building anti-FGM platforms; hence, the need to ensure these efforts continue for a sustainable achievement in a long run. These efforts in Serengeti have enforced community based anti-FGM move, whereas, the leaders have set different fines in their own localities that apply to practitioners and to anyone who knows it is happening and does not report it.

The project has ensured improved and friendlier services due to increased efficiency of health and legal professionals.

The project has largely contributed to long-term positive effect on health of young girls and women in Serengeti through increased knowledge about FGM and its effects and improving their access to friendlier FGM and GBV services due to training and capacity building of legal and health professionals in the district.

The project has successfully advocated for inclusion of GBV/FGM budget in district council annual budget.

Gender Equality and Human Rights

In terms of gender equality and human rights, the Tokomeza Ukeketaji Project was able to employ key human rights and gender equality principles, chief of which were the principles of participation and non-discrimination. Gender needs assessment was conducted to identify the needs and priorities of women and girls and all human rights concerns were taken into consideration in the course of implementing the project.

Throughout the evaluation process the team came to realize that the project has been fully aligned to international human rights and gender equality norms and standards as well as gender responsive approaches, incorporated throughout the project implementations, The project has also observed principles of participation and social inclusion

Knowledge Generation

Among the key lessons that emerged during the evaluation study are:

- There was a confusion among some of the community members over role of Amref with regard to policing of FGM
- Education is key in eliminating FGM in the long term
- Involving men in anti-FGM initiatives is key in achieving anti-FGM results
- Traditional leaders are very crucial in the fight against FGM as they hold a big influence over other community members
- Continuous monitoring and evaluation is key for sustained anti-FGM efforts
- Ability to adapt to changing circumstances was one of the key highlights of the project
• The role played by Serengeti District Council Authority and Project Management unit was instrumental addressing FGM
• Political will is key in the fight against FGM

The evaluation team was able to identify the following promising or good practices:

• Employment of holistic and participatory approaches in project implementation
• Engagement of traditional leaders, religious leaders and circumcisers: Promotion of alternative rites of passage (ARP)
• Education and awareness-raising as key weapons in achieving project objectives
• Use of peer educators to reach out to wider section of the community
• Establishment and empowerment of local CBOs to increase protection and ensure availability of support services for women and girls in Serengeti after project completion

Involvement of women and girls who have undergone FGM in project implementation

Key Recommendations

**The Government and Parliament**

• Although Tanzania is doing well in addressing FGM and other forms of VAW/VAC through implementation of the plan of action to protect women and children from violence, which incorporate strategies to end FGM and contributed in reduction of prevalence rate from 15% in 2010 to 10% in 2015, these initiatives need to be complimented by enactment of FGM/GBV **Specific Legislation** which will fully ensure prevention and abandonment of the practice and create a sustained mechanism for legal redress. The necessity of improving dissemination of the meaning and content of laws requires close collaboration with both civil society and the media and dissemination of information through user-friendly languages.

• The plan of action and budget requires commitment to budgeting for and providing adequate funds for their implementation at the national and district levels.

• In regards to government responsibilities, the Human Rights Council (HRC), during its 38th Session in July 2018, called upon states in **Recommendation 3** to: develop and implement, with the participation of the relevant stakeholders — including girls, women, religious and traditional leaders, community leaders, health- care providers, civil society, human rights groups, men and boys and youth organizations — integrated, comprehensive and coordinated strategies and policies to prevent and eliminate all forms of female genital mutilation.

• Further, in **Recommendation 10** the HRC called upon states to: provide assistance to women and girls who are victims of female genital mutilation, including through appropriate support services for treatment of the physical, physiological and psychological consequences such as One Stop centres be established at the District level.

• We suggest an emphasis be put on the further engagement of the traditional leaders’ council, which has the power to make culturally-binding decisions.
• Government authorities have a responsibility to ensure that the media plays a full and productive role in the dissemination of information on the law and FGM and does not face restrictions and threats for contributing to national plans to end FGM.
  ▪ Increased use of all the media, including social media, would help raise public awareness on FGM/GBV, effects and related laws.
  ▪ Increased support from the local governments for the role of media would boost dissemination of information about FGM, its effects and its human rights aspect.
  ▪ Tribunals and quasi-judicial bodies should be encouraged to ensure any cases and prosecutions relating to FGM are clearly reported through appropriate media channels.

**Serengeti District Council**

SDC needs to develop and implement up-to-date national strategies and action plans to tackle FGM and meet their commitments under international treaties and the SDGs. District strategies should include:

• Funding commitments and set out budget lines and adequate funding to support the work to end FGM in line with the National Plan to End Violence Against Women and Children and directives from the National Annual Guideline for Preparation of Plan and Budget;

• Training around FGM and anti-FGM laws and prevention mechanisms for all members of the police and judiciary (from local police officers through to Community health Workers and border control district) and all those in positions of authority, including medical professionals, social workers, teachers and faith and community leaders;

• Develop behaviour change communication materials which also need to be made accessible to all members of society and drafted in friendly languages to be locally understood;

• Where they are currently unavailable and a need is identified, appropriate protection measures (such as emergency telephone hotlines or safe spaces) should be put in place for women and girls at risk of FGM; and

• Adequate monitoring and reporting of FGM cases to improve efficiency and inform policy makers, the judiciary, the police, civil society and all those working to implement and enforce the law as well as allocating resources.

**PMU/AMREF/Donor**

As discussed in the report, the neighbouring districts such as Butiama, Bunda and Tarime pose a threat to project sustainability. It is understandable that, anti-FGM campaigns take long to yield results, and have to be part of a larger process of social change. Hence, the evaluation recommends existence of sustainable efforts to address FGM in the neighbouring districts, where those who continue to embrace FGM flock to in search of FGM services.

Generally the evaluation team observed that Amref stands a better position to provide the best practises and strategic framework with evidence-based knowledge and tools enable both
policy-makers and in-country anti-FGM campaigners to be successful and make a sustainable change to end FGM as a result of project achievements. However, should the scale up or extension happen the evaluation recommends for the following to be considered in order to realise the maximum potentiality of the investments:

**Need to engage in joint advocacy for Government disbursement of funds for GBV/FGM**

Financial resources of Government came up as a constraint under a number of conclusion areas. Although the Government has shown policy commitment through National Plan of Action to End Violence Against Women and Children and the National Guideline for preparations of Plans and Budget, and funds are minimally budgeted and allocated, the necessary funds are frequently not disbursed or timely disbursed. To address this, the Amref needs to expand their involvement with the government under other key actors in developing an advocacy strategy, which will ensure timely and adequate budget allocation and disbursement at the LGA level. The evaluation has noted the Gender Responsive Budgeting training to LGA Council Management Team but this was conducted towards the end of the project, the outcomes which need to be realised at the next level of the project.

- Whilst this is something that Amref and its partners will not be able to do alone, it is important to form strategic alliances within and outside the project scope, to jointly advocate with the Government to disburse the funds even from the District own source, necessary to improve the impact of the project.

**Address the Economic Empowerment for Women and Girls**

It is important to expand efforts of economically empowering women and girls as a key initiative to ensure abandonment of FGM. It is critical to consider and facilitate alternative sources of income for circumcisers and traditional leaders. Moreover, based on economic deprivation of women and girls, strategic approaches need to be addressed for women’ economic empowerment, such as investing on entrepreneurship skills to Income generating Groups and linking them with the Government Development Fund at the local Level. Investing the limited resources in this area may deliver more results at the local and national level.

**Need to use a more structured approach on evidence gathering and knowledge management, including by involving academia and ensuring essential human resources for M&E framework in place**

The evaluation has found that the project has done its best in capturing results from the ground through Community health workers in particular, and other key actors. However, the major gaps has been a systemic result framework and data base in capturing gender disaggregated data which has resulted in unreliable and inconsistent data during the field work. Moreover, it does not have a sufficiently structural approach to gathering evidence on results and impact and using it for influencing policy, visibility and making decisions.

The project should develop a strategy for evidence gathering, and start with addressing the knowledge gaps and making those the priority for data collection, analysis and use for decision-
making. Moreover, the project must make better use of its interventions and gather data through its partners or by involving staff or experts along with developing a Comprehensive management Information System (MIS)

In order to gather good quality information, the project may contemplate partnering with an academic institution/resource people with relevant skills and experience on gender disaggregated data collection as well as recruiting senior M&E specialist and gender expert staff as soon as possible.

**Need for better structured approach**

Better structured approach is critical for strengthening the structural mechanism through rebuilding family and community structures and support systems in dealing with FGM/GBV for early warning and or supporting survivors by:

- Establishing at least One STOP CENTRE (pilot). This will facilitate in addressing the roots and indicators not the effects
- Gender Desks at least in all critical wards with higher prevalence rates of GBV/FGM
- Paralegal units in every ward to compliment efforts of CHW
- Psycho social support desks in schools for children’s victims of violence perpetuated at home and other areas within a particular community
- Community based knowledge centers where traditional leaders and CHW may provide counseling and teaching. This was commented by almost 75% of respondents particularly elderly in rural setting and that will be effective for the sustainability of the project. Amref may partner with and/or seek experience from Local NGOs, which have success stories in community based-knowledge centers.
- There is a need to have a Safe House owned by the District Council. This may have considered as an intermediary interventions as the current safe house is owned by a church administration’s
- Establish Social accountability monitoring for perpetrators and budgeting for FGM/GBV and also to ensure that FGM/GBV should be one of the cross cutting agenda in all meetings within the district.
- Closely monitor and document the effectiveness of the established 100 child protection committees in every ward as directed by National Plan of Action to End Violence Against Women and Children.
- Establish a gender-sensitive macro working/technical group in the district to monitor and document gender mainstreaming approaches and strategies in the district
- Amref needs to conduct a baseline survey on the current situation of GBV/FGM in Bunda, Tarime and Butiama to determine socio-cultural norms and barriers potential threats to Serengeti District in ending FGM before considering scaling up.

**Civil Society**

The evaluation team is of the view that local CSOs and mostly Legal Aid Providers (Paralegals), working alongside local police and the judiciary, are best placed to provide education on laws
and raise awareness of the effects of FGM, but they need robust legislation in place to start with, the ongoing support of the government and adequate funds to maximize the impact of their work in future.

- Increased funding and empowerment of local activists is needed to ensure greater promotion of anti-FGM laws in their advocacy work.
- Civil society has a vital role to play in disseminating information on the law and FGM. Moving forwards, LGA and government authorities need to work in close partnership with these organisations to ensure that the content of the law is easy to understand (simplified materials) and available to all members of society.
- The development of NGO coalitions that can share knowledge and best practice is welcomed and should be encouraged by all governments as part of their annual plans.
- Civil society, in partnership with government authorities and the media, can provide access to communities at a grassroots level to supply vital awareness-training on FGM/GBV and related laws.
- Other NGOs with gender and children protection and rights focus may be encouraged to incorporate anti-FGM initiatives in their plans.
Chapter 1: Introduction

1.1. Context and Description of the Project

1.1.1. Context

Female Genital Mutilation (FGM) is defined by the World Health Organization (WHO) as comprising ‘all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons.’\(^1\) It is also called female genital cutting (FGC) and female genital mutilation/cutting (FGM/C).\(^2\) It is usually carried out using special knives, scissors and razors. This is a global phenomenon, with more than 200 million women and girls in regions such as Africa, the Middle East and Asia, having undergone the cut.\(^3\)

The practice of FGM has no known health benefits.\(^4\) On the contrary, it is known to be harmful to girls and women. As well as severe pain suffered during cutting, the removal of, or damage to, healthy, normal genital tissue interferes with the natural functioning of the body. Immediate and long-term health consequences of FGM include severe bleeding, infections, retention of urine, and later, potential complications during childbirth that can lead to maternal and newborn deaths. In Tanzania, this practice is prevalent in various communities, with more than 7.9 million women and girls estimated to have undergone FGM.\(^5\)

Several steps have been taken in Tanzania to address FGM, by both government and non-government actors. These include legal reforms to prohibit and criminalize the practice, particularly through the Penal Code and the Law of the Child Act of 2009, as well as adopting different action plans to address the problem, the most recent being the National Plan of Action to End Violence Against Women and Children (NPA-VAWC 2017/18-2021/22), which was adopted in December 2016. This plan consolidates 8 previous action plans that addressed violence against women and children, with the view of eradicating such violence in line with Tanzania’s commitments under the Agenda 2030 SDGs and African Union Commission’s Agenda 2063: The Africa We Want. These domestic efforts are in line with Tanzania’s obligations under regional and international conventions and commitments to combat FGM, including the Convention on the Elimination of all forms of Discrimination Against Women (CEDAW) and the Maputo Protocol and the SADC Protocol on Gender and Development.

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\(^2\) Ibid


\(^5\) the National Plan of Action to End Violence Against Women and Children in Tanzania 2017/18 – 2021/22, p. 3
Anti-FGM interventions saw the prevalence of the practice dropping slightly from 18% in 1996 to 15% in 2010. Further action and interventions saw further reduction of FGM among women of age 15-49 by 5%. However, the practice is still widely practiced in some parts of Tanzania, including Serengeti District, where an estimated 75% of women among the dominant Kurya tribe have undergone FGM to-date.

![Percentage of women age 15-49 who are circumcised](chart)

**Figure 1: FGM trends in Tanzania (1996-2016)**  
*Source: TDHS-MIS 2015-16*

### 1.1.2. Project Description

Recognizing gaps in anti-FGM interventions, Amref secured about 1,000,000 United States Dollar (US$) from the UN Trust Fund to End Violence against Women to implement a three-year project (from 01.01.2016 to 31.12.2018) that sought to contribute towards the elimination of the FGM practice among girls and young women in Serengeti District. The project also sought to ensure that girls and women, boys and men, parents, traditional leaders, circumcisers are aware of the health effects of FGM and commit to abandon the practice. Further, the survivors of Gender Based Violence (GBV) and FGM would have access to effective health, legal and social services. Lessons from the project were intended to be used to influence policy and legal reforms focusing on addressing FGM practice in Serengeti District and other parts of Tanzania.

Primary beneficiaries of the project were women and girls in general who are vulnerable to and/or victims/survivors of FGM. Secondary beneficiaries are: CBOs, the general public, the police force, judicial system, circumcisers, teachers, traditional healers, health workers, boys and men, parents and caregivers, health workers and community peer educators, FBOs and

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6 See Tanzania Demographic and Health Survey (TDHS) 1996; Tanzania Demographic and Health Survey (TDHS)2010  
7 Tanzania Demographic and Health Survey (TDHS) 2015-16
district authorities. The project targeted 29,383 primary beneficiaries and 10,972 secondary beneficiaries.\(^8\)

The project was implemented by Amref Health Africa and Legal and Human Rights Centre (LHRC) from 2016 to 2018 in Serengeti District, Mara Region. The following partners were also involved in the project under different capacities, including advisory role:

- Ministry of Health, Community Development, Gender, Elderly and Children;
- Local Government Authorities (District Council);
- District Executive Director’s office (District Medical Officers’ office, District Community Development officer’s office, District Educational officer’s office-primary and secondary, District Commissioner’s office); and
- Anglican Church Diocese of Mara-Serengeti Safe House.

**Goal and Objectives**

The overall goal of the project was to see that girls and young women in Serengeti District are free from the FGM practice and have more opportunities to exercise their legal and social rights by the year 2018. The objectives of the project were:

- To empower girls, women and community in Serengeti District to abandon FGM/C practice;
- To build the capacity of health and legal personnel in Serengeti District to deliver effective services in combatting and handling cases of gender based violence including FGM; and
- To strengthen the capacity of community based organizations to carry out policy and law advocacy on elimination of FGM/GBV practices.

**Theory of change**

The project was guided by a holistic theory of change, whereby Amref and LHRC believed that the reduction of new cases of FGM to 10% by 2018 and provision of quality health care and legal aid for the girls and women who are FGM survivors, requires political commitments, availability of resources, community participation and commitment to abandon FGM and change agents. IF the project empowers girls and women to voice out their rights, and change a marriage, empower cutters and parents with knowledge on adverse health effects of FGM and related laws to commit abandonment of FGM and strengthen existing community systems through innovative capacity building approaches and advocacy forums, then it would reduce the new cases of FGM to 10% in Serengeti District by 2018. There would be a multiplier effect associated with empowerment of the communities since the approaches for awareness creation, capacity building and advocacy would use community resource persons. In addition, the drivers of mutilations, primarily the cutters, would be trained on entrepreneurship skills, supported with startup capital, facilitated to join or form socio-economic groups and coached on the best way to do business. In turn, the same cutters would be used as future trainers and

\(^8\) For a detailed description of beneficiaries see annex 3 below.
change agents. This would ensure that there is continuity of the project interventions even after the project phases out. The community would be capacitated to carry out Alternative Rites of Passage (ARP) without Amref support in the future.

**Project Outcomes, Outputs and Activities**

**Outcome 1:** Traditional leaders, caregivers, parents, circumcisers, women and girls have increased commitment to abandoning FGM practices

**Output 1.1:** Girls and young women are aware of the health effects and human rights aspect of FGM as part of the broader sexual reproductive health and rights

**Activities**
- Sensitize 23858 Girls/young women in general on the health effects and human rights aspect of FGM using SMS texts and Age specific forums
- Support 28 communities to conduct ARP ceremony to 1500 girls to abandon FGM/C
- Conduct awareness forum with 84 Indigenous women on health effects of FGM and laws related to GBV
- Facilitate dialogue and non-judgmental discussion forum to 140 women with disability on health effects of FGM and laws related to GBV
- Identify and Train 184 Peer Educators on how to conduct training during ARP, FGM/GBV and health effects of FGM

**Output 1.2:** Parents/caregivers, traditional leaders, boys, men and circumcisers are aware on health effects and human rights aspect of FGM and ready to discourage FGM Practices

**Activities**
- Sensitize 21851 parents on the health effects and human rights aspect of FGM using SMS texts, Home visits, awareness campaigns with cultural dances, and community radio
- Facilitate dialogue forum with 153 traditional leaders on understanding health effects of FGM and laws related to GBV/FGM
- Facilitate age and gender specific dialogue fora with 5912 boys and men on health effects of FGM and laws related to GBV
- Facilitate 184 Peer Educators with bicycles to assist in home visit for anti FGM/GBV education

**Output 1.3:** Traditional leaders, circumcisers, caregivers and young women/ girls are aware of the value of abandoning FGM practices using ARP model

**Activities**
- Facilitate a study visit of 60 traditional leaders and 62 circumcisers to learn on best practices from Kilindi district
- Conduct sensitization Forums to 10245 parents using role models/peer educators/ parents who abandoned FGM as a result of ARP approach on health effects of FGM
End Term Evaluation in Female Genital Mutilation Elimination Project, March, 2019

Outcome 2: Health and legal systems have improved skills to provide quality health care and legal services to FGM survivors

Output 2.1: Mothers and caregivers have improved knowledge on avoiding effects of FGM as they are attending antenatal, postnatal, family planning and well-baby clinics

Activities
- Train 65 Health care workers using Kolb model, eLearning and mLearning approaches on how to provide anti FGM education during antenatal and post-natal care
- Train 1023 women during prenatal care clinic on FGM and GBV education
- Train 1023 women during post-natal care clinic on FGM and GBV education
- Facilitate the development of training manual on anti FGM/GBV education provided during antenatal and post-natal care
- Train 100 school teachers on FGM/C recognition of girls at risk and how to discuss FGM/C related issues in teaching sessions

Output 2.2: Police gender desk officers, paralegals and judicial officers have improved legal knowledge to effectively respond to cases of FGM and ensure perpetrators are brought to justice;

Activities
- Train 30 police gender desk officers using blended approach of face to face(Kolb Model), eLearning and mLearning approaches on how to handle FGM issues
- Train 30 paralegal officers using face to face Kolb model blended with eLearning to effectively respond to cases of FGM and ensure perpetrators are brought to justice;
- Train 28 judicial officers using face to face Kolb model blended with eLearning to effectively respond to cases of FGM and ensure perpetrators are brought to justice;
- Produce 500 CDs for judicial officers, paralegals and police officers
- Procure 50 desktop computers for trainees to be used for eLearning sessions and writing reports on FGM cases

Output 2.3: Health care workers have greater knowledge to manage health complications of FGM and provide comprehensive SRHR and psychosocial support to girls and women;

Activities
- Train 140 health care workers using Kolb model, eLearning and mLearning approaches on managing health complications of FGM to girls and women
- Train 175 health care workers using Kolb model, eLearning and mLearning approaches on provision of psycho social support to girls and women victims of FGM/GBV
• Train 100 Community Health Workers using face to face /Kolb model on provision of home based FGM health care, Monitoring and FGM/GBV Education

Output 2.4: Referral and feedback mechanism exists to improve health and legal aid services for FGM survivors

Activities
• Facilitate establishment of Village gender desks/Police gender desks/ help desk using SMS text, Call system and complaints box for legal referral and complaint services
• Facilitate establishment of Village Health help desk/ Health Facility Help desk using SMS text, Call system and complaints box for health referral and complaint services
• Orient 23 health workers and 23 police officers on analysis of complaint data raised on FGM/GBV for decision making
• Sensitize community members on the use of FGM/GBV complaints and referral services using IEC materials and community radio

Outcome 3:
Community Based Organizations effectively advocate against FGM practices leading to increased commitment from authorities and resources allocation for anti GBV activities

Output 3.1: Advocacy for GBV related laws and policy enforcement is undertaken to safeguard the right of women and girls and to meet the international human rights standards

Activities
• Facilitate district dialogue forum on anti FGM and GBV related law and policies affecting girls and women
• Facilitate village based dialogue forums on anti FGM/GBV laws and policies
• Facilitate school clubs dialogue forums on anti FGM/GBV policies and laws
• Conduct Kick Off meeting with stakeholders
• Train 21 spiritual leaders of 3 FBOs on strategies to abandon FGM /GBV and related effects

Output 3.2: Local organizations are well coordinated and engaged to take lead of advocacy against FGM practices to contribute to the reduction of FGM cases

Activities
• Sensitize the community to form local CBOs on human rights issues and anti FGM
• Build the capacity of 64 local CBOs on policy advocacy and human rights monitoring
• Build the capacity of 64 local CBOs dealing with health and human right issues on leadership, management and governance
• Facilitate formation and strengthening of 60 school clubs on anti FGM/GBV
• Strengthen 65 Most Vulnerable Children Committees at the village and ward level to protect and support girls fleeing from FGM.

Output 3.3: Local Governments Authorities are sensitized, capacitated and eager to take lead to allocate enough resource for anti GBV/FGM activities on yearly basis in their budget.
Activities

- Facilitate discussion forum with district authority to advocate for prioritizing anti GBV activities in their annual Medium Term Expenditure Framework
- Train 65 district staff on gender based budgeting and GBV related laws and policies
- Facilitate the FGM/GBV need assessment at district level for budgeting purposes using Opportunities and Obstacles to Development approach

1.2. FGM Legal Framework and Gaps

Global Context

Concern about FGM at the international level dates from 1990, when the UN Convention on the Elimination of Discrimination Against Women adopted General Recommendation No. 14 calling on states ‘to take appropriate and effective measures with a view to eradicating the practice of female circumcision.

Subsequent recommendations and statements have been issued by CEDAW and the Office of the UN High Commissioner for Human Rights, reminding member governments of their obligations to eliminate FGM and other harmful practices. In 2014 signatory states to CEDAW and the Convention on the Rights of the Child passed a Joint General Recommendation on Harmful Practices confirming their obligations ‘to ensure full compliance in order to eliminate harmful practices. In 2016 the UN Human Rights Council (HRC) adopted a resolution recognising FGM as an act of violence against women and girls. It urged countries to put in place national legislation prohibiting FGM and develop strategies for its enforcement.

In March 2018 the UN Commission on the Status of Women, at its meeting to discuss ‘Challenges and opportunities in achieving gender equality and the empowerment of rural women and girls’, agreed to:

In July 2018, the HRC, at its 38th Session, passed Resolution No. 38/615, which affirmed all previous international treaties and commitments to the elimination of FGM.

In addition to the formal international treaties, the globally accepted Sustainable Development Goals (SDGs) that were put in place for 2015–2030 make specific reference to the elimination of FGM at Goal 5.3. It is hoped that this will strengthen the hands of governments, NGOs and multi-lateral organisations when implementing anti-FGM policies and legislation to adopt, implement, harmonize and enforce laws and policies to prevent and put an end to female genital mutilation, protect those at risk and support women and girls who have been subjected to the practice.

Regional Context
Legal systems vary widely across countries in Africa: some are based upon the former colonial system (for example, English common law or the French Civil Code); others upon Islamic religious law (Sharia); others upon customary or tribal law. Most countries have a mixture of two or more of these systems. Among the 22 countries that criminalise the act of FGM, there is a mix of those that have a specific national law against FGM and those that refer to FGM and/or harmful traditional practices within their criminal or penal codes and/or address the practice through other forms of legislation, such as laws covering the rights and welfare of children, violence against women, reproductive health or domestic violence (see Table 3 below).

On a regional level, the African Union (AU) has been calling on member states to eliminate FGM since 1990, when it adopted the African Charter on the Rights and Welfare of the Child. In 2003 the AU adopted the Maputo Protocol, in which Article 5 specifically requires members to prohibit ‘by legislative measures backed by sanctions all forms of female genital mutilation, scarification, medicalisation and para-medicalisation of female genital mutilation and all other practices in order to eradicate them.

In addition, the AU has declared the years 2010 to 2020 to be the African Women’s Decade. Again, it is hoped that this declaration will assist in promoting gender equality and the eradication of FGM and other forms of violence against women and girls.

Tanzania and Uganda enacted the East African Community Prohibition of Female Genital Mutilation Act (EAC Act) to promote cooperation in the prosecution of perpetrators of FGM through harmonisation of laws, policies and strategies to end FGM across the region. The EAC Act aims to raise awareness about the dangers of FGMs and provide for the sharing of information, research and data.

**Country Policy and Legal Context**

Although the Constitution of Tanzania (1977 does not directly reference harmful practices or FGM, Article 9 imposes an obligation on the State to respect and preserve human dignity and rights, to accord men and women equal rights and to eradicate all forms of discrimination. Article 13 addresses equality further and states that ‘all persons are equal before the law and are entitled, without any discrimination, to protection and equality before the law’ and charges the State to implement procedures that take into account that ‘no person shall be subjected to torture or inhuman or degrading punishment or treatment.’ Article 16 also states, ‘Every person is entitled to respect and protection of his person’ and ‘privacy of his own person’. The main law criminalizing FGM in Tanzania is the Sexual Offences Special Provisions Act 1998 (SOSPA), which amended Section 169 of the Penal Code and prohibits FGM on girls under the age of 18 years.

**Relevant Government Authorities and Strategies**
The Ministry of Health, Community Development, Gender, Elderly and Children is responsible for issues relating to violence against women and girls in Tanzania. The strategy to tackle harmful practices, such as FGM and child marriage, is set out in The National Plan of Action to End Violence against Women and Children 2017–2022. It sets out the measures to be taken to end FGM, including the development of a communication strategy and advocacy campaigns involving religious and influential leaders and policy-makers ‘to promote positive norms and values and address gender inequalities’ through community dialogue, data collection and training across ten regions. Regarding the law, the Plan aims to engage police forces and local government authorities to respond sensitively and appropriately to cases of FGM.

The Guideline for Preparations of Plans and Budget (2017/2018 and 2019/2020) directs all Accounting Officers to allocate budget for the National Plan of Action to End Violence Against Women and Children⁹. This provides an opportunity and entry point for the project and stakeholders to fully engage on advocacy for this commitments

**Gaps in Tanzania Legal Context**

**Narrow definitions of FGM and age limits**

Although a clear definition of all relevant types of FGM should be a fundamental feature of a national legislative framework upon reference to the internationally recognised definitions set out by the World Health Organization.

Article 21 of SOSPA, which inserted Section 169A into the Penal Code, criminalises and punishes the performance and procurement of FGM on girls under 18 years of age by anyone who has custody, charge or care of the girl. It does not, however, give a clear definition of FGM, nor explicitly address medicalised FGM, cross-border FGM or the failure to report FGM.

The law only defines FGM referring only to *Anyone who procures FGM leaving those who are aiding and abetting FGM as enshrined by international Instruments discussed above.*

The actual practitioners of FGM, other perpetrators need to be addressed by laws, including:

- **Those responsible for requesting and arranging (procuring)** the act of FGM. These may be family members of the victims or others in the community such as local community or religious leaders.

- **Those who assist, aid and abet** the practice. The practitioner who performs the FGM is often accompanied by one or more assistants or younger trainees who may be family members or members of the local community (their actions often include holding down the victim of FGM during the procedure). Members of the wider community may also take actions that fall into this category.

In the absence of clear definitions of these terms, there is a danger of such terminology being used as a loophole to justify FGM.

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Tanzania only prohibit the performance of FGM on girls under 18 years of age and therefore not providing adequate protection for adult women.

The definition is also very narrow unlike Kenya and Uganda which extends to ‘Anyone procuring, aiding and abetting FGM’. While in Tanzania is limited to ‘Anyone who procures FGM’.

Consent and the Punishment of Victims of FGM

- The challenges of consent and culture/custom/tradition/religion being used as defences for the crime of FGM are not generally addressed in current laws. There is an underlying implication that, if consent is given by a woman or girl herself, FGM is not a criminal offence (as she has ‘chosen’ to be cut). This is a weakness and should be tackled, as should the use of culture/custom/tradition or religion as reasons for disregarding the law. Women and girls are put under considerable societal pressure to undergo FGM by their families, friends and communities. Consent and choice should never be permitted as a defence for FGM.
- Anyone who is involved in the performance or procurement of FGM should be punished regardless of consent (or assumed consent where the girl is unable to give consent; for example, because she is a minor). Both Kenya and Uganda clearly address these points in their anti-FGM laws.

Reporting FGM

Many of the countries that do not specifically criminalise the failure to report FGM do set out punishments in other legislation (often their Penal or Criminal Codes) for failing to report any crime. While, in theory, this ought to cover FGM, in practice there are no identifiable cases of these general clauses being used to prosecute those who fail to report the practice in the following recommended approaches

- **Collective responsibility** – the general responsibility of a community to protect women and girls and report if they are at risk. Those who know that an act of FGM has taken place, is taking place or is planned may include a woman’s or girl’s family, friends and other members of her community.
- **Positional responsibility** – the specific responsibility of those in positions of authority, including those who carry a duty of care such as health professionals, social workers, teachers, youth workers, and community and religious leaders.

Those working in the health sector may be presented with cases of FGM, either because the woman or girl needs treatment following the practice, or because a survivor is having ongoing health problems as a result of the practice or is expecting a baby, which would require maternal healthcare services (and, in some cases, de-infibulation to give birth).

The law should include provisions to prosecute all those who fail to report FGM that has taken place, is currently taking place or is planned.
District Border Crossing ad lack of legal enforcements

The movement of families and traditional practitioners across project district borders for the purpose of FGM remains a complex challenge for the campaign to end the practice, and women and girls living in border communities can be particularly vulnerable.

The variable existence and enforcement of by-laws against FGM across the practising district particularly Bunda, Butiama and Tarime has encouraged supporters of the practice to move women and girls between countries to avoid prosecution.

While the project have attempted to address the challenge of cross-border FGM, with police, judiciary and NGOs from districts liaising wherever possible, the lack of specific reference to this aspect of the practice in the majority of legislative frameworks continues to undermine efforts of government authorities and civil society to tackle the problem and thus may jeopardize the achievements and sustainability of this project.

This call for a need of by-laws in order to effectively combat the cross-border practice of female genital mutilation, including by strengthening transnational police and judicial cooperation in the exchange of information on victims and perpetrators of female genital mutilation, in accordance with international human rights law. This can also address the lacuna in the penal code by enacting specific FGM Act.

This evaluation has found that the remaining challenge, is that Serengeti legal frameworks are keen in enforcing the laws that ban the practice, while, some people tend to practice the same underground by crossing to the neighboring districts due to fear of social punishment from the traditional leaders and that from the legal frameworks. The progress on the legislative approach in the project area, has been possible due to human rights educational programmes, and community forums mainly to foster a consensus on the abandonment of the FGM practices. Again, the project ensured that, the legal frameworks work along with the other units, particularly the health facilities, whereby; healthcare professionals closely supported by CHWs have been remarkable in implementation of health educational programmes and detection of the same. It this group that enabled 56 young girls and women not to be subjected to FGM in the reporting period; by ensuring that are lodged at safe house for further measures including supporting the police.

The evaluation further, found that during the cut season in December,2016, it was observed that, the practice halted in Serengeti district, but was openly carried out in the neighboring districts of Tarime, Rorya and some parts of Bunda and Butiama districts. Namely, most of the parents who had their daughters cut, crossed in these neighboring districts during mid nights.
Thus, the project, proposes for a cost extension to have its scope broadened to those neighboring districts for cascading a sustainable impact in the region.

There are other key features of the law that may provide important protection for women and girls at risk of FGM. This study suggests that the following should be considered for inclusion in all legislation against FGM:

- Criminalising the use of abusive language such as ‘Msagane’ (uncircumcised woman) and threatening behaviour towards uncut women and girls and their families;

The Ugandan FGM Act 2010 expands this further under Sections 11 and 12, setting out penalties for behaviour that excludes an uncut woman and her family from wider activities:

A person who discriminates against or stigmatizes a female who has not undergone female genital mutilation from engaging or participating in any economic, social, political or other activities in the community commits an offence and is liable on conviction to imprisonment not exceeding five years.

A person who discriminates against or stigmatizes another person whose wife, daughter or relative has not undergone female genital mutilation from engaging or participating in any economic, political, social or other activities in the community commits an offence and is liable on conviction to imprisonment not exceeding five years.

Conclusion

The main drivers behind passing legislation that criminalises FGM, or improving legislation that already exists, should be to use it as a deterrent, to utilise its content to protect women and girls at risk and to prevent all forms of FGM from taking place.

Even though Laws alone cannot end FGM; they need to be applied alongside education on the rights of women and girls and form part of the community engagement around changing cultural and social norms

The main drivers behind passing legislation that criminalises FGM, or improving legislation that already exists, should be to use it as a deterrent, to utilise its content to protect women and girls at risk and to prevent all forms of FGM from taking place—OCD Serengeti.

Enacting a specific legislation to end FGM in Tanzania is not an options but rather a requirement which, along other measures, will guarantee the zero tolerance and end of FGM in Tanzania. The enactment of this law should be coupled with effective implementation and enforcements to address challenges which were found with this evaluation. Some of
these challenges are systemic; for example, there are often few police or other government officials in remote rural areas, where FGM is most prevalent, and those who are in these areas may have limited knowledge or understanding of the law. There are also cultural challenges and conflicts of interest where police and local political and community leaders continue to support the practice (for reasons of ‘tradition’, status and/or financial gain).

Delays of cases and execution also need to be addressed. The evaluation found that as of July to December, 2017, 2 cutters who have been sentenced to imprisonment for 8 years each as a result of being found guilty by practicing the cut in the season of 2016. These are out of 20 FGM cases reported by 2016, and 8 were filed for ruling, out of which now 4 are ruled.

The primary purpose of a national law should not be to prosecute; ultimately, it should be a tool for the prevention of FGM.

Working together, government authorities, civil society and the media can achieve successful implementation of anti-FGM laws.

1.3. Purpose of the Evaluation

The main objective of the final evaluation was to measure progress towards the project goal, outcomes and outputs. The evaluation further sought to record lessons learnt (challenges and opportunities), best practices and provide recommendations for future project implementation. As systematically and objectively as possible, the evaluation aimed at determining the relevance, value for money (efficiency and effectiveness), impact, results, innovations and sustainability of the project. It also sought to identify significant factors that hindered/contributed to achievement of the outcomes and outputs.

1.4. Objectives and Scope of the Evaluation

1.4.1. Objectives

The main objectives of the evaluation study were:

- To evaluate the entire project (two to three years, from 2016 to 2018), against the effectiveness, relevance, efficiency, sustainability and impact criteria, as well as the cross-cutting gender equality and human rights criteria;
  - How much the project has contributed to the reduction of FGM/C and Child Marriage practices in Serengeti district
  - Measure the current levels of knowledge, attitudes and practice towards FGM/C and Child Marriage practices in each of the targeted communities (including traditional leaders, young girls, women, parents, district officials, boys and etc
  - Measure the current level of knowledge; attitude and practice of judicial officers, paralegals and police officers towards provision of legal services to FGM and child marriage victims
- Measure the current level of knowledge; attitude and practice of health care workers and community health workers towards provision of health services to FGM and child marriage victims
- Determine the capacity of the district legal and health systems (including police gender desks and health gender desks) to provide legal and health services
- Establish the opportunities that exist for institutionalization and sustainability of anti-FGM initiatives among the stakeholders and the communities in Serengeti
- Assess budgetary allocations and expenditure trends for FGM/C and GBV at districts level
- Assess the implementation of gender sensitive programming for improved Anti-FGM programming in the district through gender mainstreaming in the project activities
- To identify key lessons and promising or emerging good practices in the field of ending violence against women and girls, for learning purposes; and
- Provide recommendations for future interventions.

1.4.2. Scope of work

The evaluation study covered six (6) selected wards of Serengeti District, namely: Machochwe, Nyansurura, Ikoma, Nagusi, Issenyi and Mbalibali. A total of 12 villages were reached, these include Machochwe, Nyamakendo, Kitarungu, Parkinyigoti, Robanda, Iharara, Singisi, Mbalibali and Kitunguruma. Selection of these areas was mainly based on availability of direct beneficiaries and prevalence of FGM.

1.5. Evaluation Team

The team that undertook the assignment was composed of the lead consultant, who had the overall responsibility of coordinating the study and ensuring quality assurance. The lead consultant was assisted by a co-consultant, who is an MEL specialist; a statistician; a research and data expert; a senior evaluation specialist; and five research assistants. The evaluation study team consisted of experts and research assistants who have ample experience in undertaking evaluation assignments – including experience in collecting and analyzing data related to FGM and GBV for local NGOs like LHRC and Tanzania Gender Networking Programme (TGNP) Mtandao.

<table>
<thead>
<tr>
<th>Team Member &amp; Role</th>
<th>Key Responsibilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr. Geoffrey Chambua</td>
<td>Dr. Chambua had an overall responsibility and accountability for management and conduct of the assignment, including coordination of all consultants, quality assurance, and oversight regarding the evaluation process and deliverables. He will be responsible for regular client liaison and making presentations and debriefings to the client and other stakeholders as required.</td>
</tr>
</tbody>
</table>
Paul provided our team with expert advice on MEL, in particular FGM/C issues, throughout the course of this assignment. He supported the team during the design phase in relation to designing the methodology for data collection at all levels. Paul also participated in data analysis, formulation of overarching findings, and compilation of the final evaluation report. He also supported the team leader in providing quality control for all deliverables.

He was instrumental in all data issues, including data processing and analysis and also participated and provided guidance in report writing.

Gratiana supported the team leader in overseeing and conducting data collection and analysis. She led the field work as well as data analysis and writing of the related case study report. She participated in the process of overall data analysis, formulation of preliminary findings, and preparation of the draft and final evaluation reports.

They assisted the team leader and the senior evaluation specialist in providing expert advice in evaluation throughout the course of this assignment as needed. They were actively involved in the design phase, in particular in the finalization of the evaluation methodology and tools and more importantly in gathering field data.

1.6. Evaluation Criteria and Questions

The evaluation of Tokomeza Ukeketaji Project was conducted based on the criteria and questions below.

Effectiveness

• Question 1: To what extent were the intended project goal, outcomes and outputs (project results) achieved and how? To what extent did the project reach the targeted beneficiaries at the outcome and Output levels?

Relevance

• Question 2: To what extent do the achieved results (project goal, outcomes and outputs) continue to be relevant to the needs of women and girls?
• Question 3: To what extent does the project respond to anti-FGM and GBV priority issues?

Efficiency

• Question 4: To what extent was the project efficiently and cost-effectively implemented?

Sustainability

• Question 5: To what extent will the achieved results, especially any positive changes in the lives of women and girls (project goal level), be sustained after this project ends?
Impact

• Question 6: To what extent has the project contributed to ending violence against women, gender equality and/or women’s empowerment (both intended and unintended impact)?/To what extent has the projected contributed to the project goal?
• Question 7: To what extent is the project contributed to a long-term positive (and negative) effect on health of young girls and women in Serengeti?

Knowledge generation

• Question 8: To what extent has the project generated knowledge, promising or emerging practices in the field of EVAW/G that should be documented and shared with other practitioners?

Gender Equality and Human Rights

• Question 9: To what extent did the project incorporate human rights-based and gender responsive approaches throughout the project?

1.7. Organization of the Report

This report is divided into four chapters, each chapter consisting of several sub-chapters. Chapter One introduces the project context and description, as well as highlighting the purpose and objectives of the evaluation, evaluation team and evaluation questions. Chapter Two is on evaluation design and methodology, explaining the study sites, sources of data, methods of data collection, sampling, data quality, ethical considerations, data analysis and limitations. Chapter Three presents the evaluation findings and discussion for each objective, while Chapter Four provides a summary of findings, conclusions and recommendations for different actors, government and non-government. List of references and tools used in the preparation of this report are contained in the Annexes section.
Chapter 2: Evaluation Design and Methodology

2.1. Description of the Overall Design

The evaluation study conducted in Serengeti District was a cross-sectional study that employed both quantitative and qualitative approaches to determine the effectiveness, efficiency, relevance, gender equality and human rights consideration, knowledge generation, impact and sustainability of the anti-FGM project implemented by Amref and its partners in the district. The evaluation team employed a pre and posttest evaluation design without comparison group to determine the impact and effectiveness of the anti-FGM intervention in the district. Both qualitative and quantitative data collection techniques were employed, including key informant interviews, focus group discussion and community questionnaire survey.

The study was designed to collect evidence-based data relating to the project implementation and FGM practices in the Serengeti, covering 6 wards – semi-urban and remote areas. The table below shows the wards and villages that were studied.

<table>
<thead>
<tr>
<th>Ward</th>
<th>Village Semi-urban</th>
<th>Village Remote</th>
</tr>
</thead>
<tbody>
<tr>
<td>Machochwe</td>
<td>Machochwe</td>
<td>Nyamakendo</td>
</tr>
<tr>
<td>Nyansurura</td>
<td>Nyansurura</td>
<td>Kitarungu</td>
</tr>
<tr>
<td>Mbalibali</td>
<td>Mbalibali</td>
<td>Kitunguruma</td>
</tr>
<tr>
<td>Issenye</td>
<td>Nyiberekera</td>
<td>Nyamisingisi</td>
</tr>
<tr>
<td>Ikoma</td>
<td>Parkinyigoti</td>
<td>Robanda</td>
</tr>
<tr>
<td>Nagusi</td>
<td>Iharara</td>
<td>Singisi</td>
</tr>
<tr>
<td>6</td>
<td>6</td>
<td>6</td>
</tr>
</tbody>
</table>

Cluster and random sampling techniques were employed to choose the six (6) wards to represent the thirty (30) wards of Serengeti District, including both semi-urban and urban areas. The evaluation team randomly picked two villages in each ward, bringing the total number of villages reached to twelve (12). The wards and villages were picked based on high prevalence of FGM and GBV, guided by desk review and engagement with project management.

2.2. Sources of Data

The evaluation study employed both primary and secondary sources of data. Primary data was obtained through the fieldwork in selected six wards of Serengeti District, utilizing data collection tools developed by the evaluation team. Desk research was conducted to obtain secondary data, which included review of project documents, relevant laws and policies, reports and articles on FGM in Tanzania, relevant action plans. Key documents reviewed include National Plan Of Action To End Violence Against Women (2017/18 – 2021/22), Demographic Health Survey Report (2015/2016), National Housing and Population Census (2012), Serengeti District Strategic Plan (2016/17 – 2020/21), Guidelines for the Preparation of Plans and Budget

2.3. Data Collection Methods and Tools

In the course of conducting the evaluation study, the team employed mixed-methods of data collection, both qualitative and quantitative. The methods that were used were: document review (desk research), Key Informant Interviews (KIIs), Focus Group Discussions (FGDs), questionnaire survey and checklists (including school checklist, health facility checklist, police gender and children desk checklist). Utilization of mixed methods served to ensure triangulation of data to guarantee quality assurance. Document review helped to generate secondary data, while KIIs, FGDs, questionnaires and checklist produced primary data.

An Inception report was drafted, shared, discussed and validated with Amref staff and experts on how the evaluation process would ensure the participation of stakeholders at all stages, the sampling framework, approaches, methodology and tools for the evaluation.

2.3.1. Document Review

The evaluation team conducted a document review, which included obtaining and analyzing all Amref documents relating to the anti-FGM project that was implemented in Serengeti District, including various project reports such as annual and progress reports. The team also reviewed other documents, including reports, policies, action plans and laws, relating to FGM in Tanzania. This review helped to provide secondary data and enabled the team to conduct an analysis in triangulation with field data. The document review also informed formulation of study tools.

2.3.2. Key Informant Interviews

KIIs were used to obtained detailed information relating to FGM practice and the anti-FGM project from key stakeholders in Serengeti District. KIIs were conducted with project staff, district authorities, local government authorities, local CSOs, religious leaders, police, judicial officers and health professionals. Interviews were conducted with policy makers, policy actors and influencing partners at different levels. These respondents provided their professional views on the FGM practice and implementation of the anti-FGM project in the district. A total of 80 key informants were interviewed by the evaluation team, whereby 62 interviewed at ward level while 18 reached at district level. The table below indicates key informants that were reached at ward level by the evaluation study team.

<table>
<thead>
<tr>
<th>Ward</th>
<th>Respondents</th>
<th>% against actual target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Machochwe</td>
<td>10</td>
<td>100%</td>
</tr>
<tr>
<td>Nyansurura</td>
<td>12</td>
<td>120%</td>
</tr>
<tr>
<td>Mbalibali</td>
<td>11</td>
<td>110%</td>
</tr>
<tr>
<td>Issenye</td>
<td>9</td>
<td>90%</td>
</tr>
</tbody>
</table>
2.3.3. Focus Group Discussions

FDGs were conducted with men, women and girls in all studied wards, who were purposively selected to be discussants. Women and girls were engaged as primary beneficiaries of the project and survivors of FGM, while men were engaged as secondary beneficiaries and key drivers of change. FGDs for these groups served to create open discussions key FGM-related issues affecting women and girls in Serengeti District. Through the FGDs, the evaluation team was able to assess knowledge, attitudes, perceptions and personal experiences of FGM.

FDGs were conducted in groups of about 8 to 12 participants each, bringing the total of participants to 188. Preparations for FGDs took into consideration issues of gender and cultural sensitivity. The facilitator of each FGD was guided by FGD guide and was of the same sex as the participants; and had a note taker with them. This method was used to generate detailed information pertinent to project implementation and attitude, practice and knowledge about FGM and its effects, which was used to triangulate with data obtained through other methods. A total of 18 FGDs were conducted, involving 188 respondents across the studied wards.

2.3.4. Questionnaire

Questionnaires were provided to male and female beneficiaries of the project. A total of 429 respondents participated in the questionnaire survey, after giving their informed consent. The questionnaire sought to generate quantitative information pertinent to FGM knowledge, attitude and practice in Serengeti District, as well as impact, effectiveness and sustainability of the anti-FGM project. Table no. 4 below highlights respondents of questionnaire survey in each of the studied wards.

<table>
<thead>
<tr>
<th>No.</th>
<th>Ward</th>
<th>Village</th>
<th>Questionnaire</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Male</td>
<td>Female</td>
</tr>
<tr>
<td>1</td>
<td>Machochwe</td>
<td>Machochwe Nyamakendo</td>
<td>34</td>
<td>39</td>
</tr>
<tr>
<td>2</td>
<td>Nyansusura</td>
<td>Nyansusura Kitarungu</td>
<td>33</td>
<td>44</td>
</tr>
<tr>
<td>3</td>
<td>Mbalibali</td>
<td>Mbalibali Kitunguruma</td>
<td>28</td>
<td>43</td>
</tr>
<tr>
<td>4</td>
<td>Issenye</td>
<td>Nyibekera Nyamisingisi</td>
<td>28</td>
<td>41</td>
</tr>
<tr>
<td>5</td>
<td>Ikoma</td>
<td>Parkinyigoti Robanda</td>
<td>34</td>
<td>42</td>
</tr>
<tr>
<td>6</td>
<td>Nagusi</td>
<td>Iharara</td>
<td>27</td>
<td>36</td>
</tr>
</tbody>
</table>

Source: Field Data, January 2019
2.3.5. Checklists

Three types of checklist were developed and employed in the evaluation study. These are: health facility checklist; school checklist and police gender desk checklist. School checklist was employed in 9 villages of the 6 wards that were studied. These villages are: Nyansurura, Kitarungu, Nyiberekera, Machochwe, Nyamakendo, Mbalibali, Kitunguruma, Robanda and Iharara. Police gender checklist was conducted at Mugumu Police Station in Serengeti District while the health facility checklist was employed at the District Hospital and at Issaco health center and Machochwe, Issenye, Park-nyigoti, Robanda, Singisi and Mbalibali dispensaries.

2.4. Population and Sampling

Population involved in the study included project beneficiaries and community members of the selected wards and villages of Serengeti District. These included FGM survivors, women, girls, parents, traditional leaders and religious leaders; legal and health services providers; regional, district and local government authorities; and other relevant stakeholders for the evaluation.

Through a balanced document and stakeholder selection in consultation with Amref at the project site, the evaluation team reached stakeholders with different backgrounds. All key evaluation criteria received similar attention.

Both probability and non-probability sampling techniques were utilized in the course of conducting this evaluation study. The study respondents were randomly and purposively sampled, at district, ward and village levels. A total of 660 respondents were targeted for the evaluation study. The evaluation team was able to reach a total of 679 respondents. A total of 62 (women and 65 (girls) were reached through FGD, while 245 (women) were reached through a questionnaire. A total of 61 men were reached through FGD and 184 men were reached through a questionnaire. Participants of key informant interviews were purposively sampled – based on their expertise or deep knowledge about FGM and GBV in Serengeti District or their involvement in the project, including legal and health professionals, Social Welfare Officers (SWOs), Community Development officers (CDOs) and judicial officers. Participants for FGD and questionnaires (men, women and girls) were purposively picked amongst the project beneficiaries. The total sample size was 679 respondents, an average of about 100 per ward. Table no. 5 below indicates the distribution of evaluation study participants in Serengeti District.

<table>
<thead>
<tr>
<th>No.</th>
<th>Ward</th>
<th>Village</th>
<th>KII</th>
<th>FGD</th>
<th>Questionnaire</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Women</td>
<td>Male</td>
<td>Female</td>
</tr>
<tr>
<td>1</td>
<td>Machochwe</td>
<td>Machochwe</td>
<td>10</td>
<td>0</td>
<td>34</td>
<td>39</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Nyamakendo</td>
<td>10</td>
<td>0</td>
<td>33</td>
<td>44</td>
</tr>
<tr>
<td>2</td>
<td>Nyansusura</td>
<td>Nyansusura</td>
<td>12</td>
<td>0</td>
<td>33</td>
<td>44</td>
</tr>
</tbody>
</table>

Table 5: Study participants at ward and village levels

Source: Field Data, 2019
Sampling for the community questionnaire survey was calculated using the Raosoft Sample Estimator formula. The population size is 24,533. The recommended standard minimum sample size provide figures with 95% confidence intervals of not more than +/−, while margin of error is 5% and response distribution 50%. This sample was increased by 10% to account for non-response. The sample per district was determined based on the proportion to size ratio. Using the formula, for the estimated population size of 24,533, the sample size was 377, while the 10% of this sample is 38 respondents. The total sample size was therefore 415, which was rounded to 420 to make it 70 respondents for each ward. Questionnaire method was mainly employed for women and girls, including FGM survivors.

A total of 8 to 12 respondents were purposively picked for KII in each ward. This brings the total of KII respondents to 62. KIIs were used for secondary beneficiaries and project partners.

A total of 18 FGDs were conducted in studied wards, 3 in each ward. Each FGD involved 8-12 respondents, hence the total of 188 respondents across the Serengeti District. FGDs were conducted with women, men and girls in selected wards of Serengeti District. Interviews were conducted with 10 randomly selected project staff members as well as key government authorities at district level.

**Figure 2: %Distribution of study participants by method of data collection**
2.5. Data Quality

The consultant trained the research assistants on research ethics and study protocols to ensure deep understanding and mastery of data collection tools, ensuring that they are all well trained ahead of the task ahead and enabling them to collect accurate and reliable data. Experienced supervisors, including the consultant, were deployed to supervise the field assistants, responsible for ensuring the data are collected in line with the prepared tools and protocols and providing relevant assistance during field work. The supervisors reviewed and checked all questionnaires at each enumeration area, to ensure completeness, coherence and consistency; while, maintaining close communication with Amref focal person. All collected data were properly cleaned by the supervisors before analysis was conducted. The supervisors also participated in data collected, particularly interviewing key informants at district and ward levels. The team based their approach on existing evaluation guidelines from UN Trust Fund Guideline for Final External Project Evaluations by also incorporating gender and human rights. The evaluations have also applied a gender responsive approach to the assessment of the contribution development effectiveness. The team has identified expected and unexpected changes in target and affected groups.

During the first two days of the evaluation period, the team had a participatory and comprehensive induction session and conducted a data piloting in Stand Kuu Ward (Bomani and Mapinduzi Hamlets), the objective being to ensure the approach is streamlined and equally understood by all team members. Thereafter, the team used the opportunity to split and conduct interviews on a parallel trial, to cover as many interviewees as possible within the short time available.

All study tools were prepared in English and then translated into Swahili to facilitate easy understanding of the questions by the respondents. The tools were pre-tested and thereafter fine-tuned and finalized in order to ensure respondents do not face difficulties in understanding the questions, which were both open and close-ended, and improve the flow. All teams were briefed before embarking on field work and each supervisor compiled summaries of data collected and conducted a short daily review of how the whole exercise was conducted. The supervisors oversaw quality control at all stages of the assignment, from inception to report writing, communicating with research assistants daily for briefings. They ensured that all data were prospered managed and stored.

2.6. Ethical Considerations and Protocols

Ethical considerations means that research participants are treated with dignity and respect through the research process. The main guiding principles of ethical human research are respect, benefit and justice. These principles influenced the general behavior of research assistants and consultants as they carried out the evaluation study task.

The evaluation team lead worked closely with Amref to obtain clearance from relevant authorities, as well as permit at district and ward levels. All research assistants received
guidance in research ethics before embarking upon fieldwork. Ethical considerations of respondents were of utmost priority in determining the most appropriate methods and their implementation. Use was made of the UNEG Ethical Guidelines for Evaluation.

Participants took part in the study on a voluntary basis as no one was forced or coerced to participate in the study and each participant was free to discontinue their participation in the study (withdrawal) at any point in time. The participants were informed about this ethical consideration, as well as the benefits and risks involved; and informed consent was sought from them before engaging in the study, whereby each participant signed a consent form provided by research assistants. For children respondents, consent was obtained from their parents or guardians, as well as themselves, before engaging them to participate in the study. In line with the principle of benefit, the evaluation study team ensured that no harm or injury befell the respondents, either through action or omission. This included ensuring privacy and confidentiality when discussing sensitive issues related to the study. All collected data was stored in safe place and has not been shared with any third party.

All information collected from interviews has been treated as confidential, source protection was promised and respondents were informed about the confidentiality at the onset of each interview. Information was used solely for facilitation of the analysis. Respondents were not quoted in the report without their permission.

UNICEF emphasizes that self-reported data on FGM ‘needs to be treated with caution’ since women ‘may be unwilling to disclose having undergone the procedure because of the sensitivity of the topic or the illegal status of the practice. Women may also be unaware that they have been cut, or the extent to which they have been cut, especially if FGM was carried out at a young age. In light of this caution, the following were taken into considerations during the field work:

- Extra sensitivity was considered in taking photos, whereby informed and waiver consent were deployed for public use of photos.
- Participants were informed that there were minimal or no risk to their participation in the study, that participation was voluntary, and that they could withdraw their participation anytime during the interview.
- Gender sensitivity was considered throughout the data gathering as female enumerators interviewed and discussed with female respondents as well as male enumerators who interviewed male counterparts respectively. The intention was to encourage transparency and openness as well as to create confidence.
- Maintain transparency with all consultations and resulting decisions, taking care to minimize any unequal power hierarchies between the research team, community members, and participants.
- Processes and criteria for participant recruitment were carefully considered to avoid excluding women who may not initially disclose experience of violence.

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11 see detailed safety and security protocol annexed
• Other strategies to increase disclosure;
  o asking questions in multiple ways (e.g. both directly and indirectly)
  o asking questions multiple times during the screening questionnaire
• Measuring and monitoring harm related to the research was key and incorporated into safety protocols. Researchers have an ethical obligation to monitor and measure harms or threats of harm that may occur during the conduct of a study and determine what, if any, experiences result from research participation. All respondents were given contacts of the lead and local evaluators for follow up and reporting.

2.7. Data Analysis

The evaluation team employed a number of methods of analysis, namely: content analysis, descriptive analysis, comparative analysis and quantitative/statistical analysis. Descriptive analysis was used to understand a particular context in which the project has evolved and describe various types of interventions, while content analysis was used to review documents and qualitative data to identify common trends and themes. Comparative analysis was used to examine findings and cross-tabulating data gathered to identify best practices, innovative approaches and lessons learnt. All quantitative data were analyzed using the using Statistical Package for Social Sciences (SPSS) quantitative data analysis software. A statistician developed a coding frame, ensured analysis was done in line with evaluation objectives, and oversaw entry of data into SPSS. The questionnaires were reviewed for inconsistencies, errors and missing data and cleaned by the supervisors and consultants before being entered into SPSS. Analysis using this software was mainly descriptive, seeking frequencies and cross-tabulation findings.

Data obtained through KII's and FGDs were translated and then analysed thematically using qualitative data software, Microsoft Excel and manually to identify themes and sub-themes.

2.8. Limitations

• Demand for allowance: Many respondents demanded allowance for participating in the interviews and discussions, even after prior communication that there will not be any attached benefits to their participation. This made some targeted respondents to be rude and even withdrew their participation.
• Cultural norms, patriarchal nature around gender violence, coupled with shame and discomfort of discussing GBV difficulties for some, especially in rural areas: For instance, in Nyansurura and Kitunguruma Villages in Nyansurura and Machochwe Wards respectively, some women were not comfortable discussing GBV issues because they were afraid of being beaten by their husbands. To mitigate this, some of the project team were selected basing on their familiarity with the evaluation area. Participants were informed to report to the authorities any kind of violation due to their participation in the evaluation process.
• Assessing attribution and partners’ support to overall changes in the project results was complicated, because many different actors and circumstances contributed to these changes.

• Moreover, interviewees did not always avail of extensive information or demonstrated knowledge limited to output level or to a specific area. The evaluation team thus had to adopt and change the line of questioning to extract more information from the respondents.

• Reliability of statements in interviews may at times have been sub-optimal, since interviewees tended to give socially-acceptable or convenient replies, or provided unreliable. The evaluation team thus had to mitigate this challenge by seeking similar information from other sources and re-ask questions to see if the respondents provide similar answers.

• Using multiple sources of information from various backgrounds and triangulation has minimalized the consequences of such issues.

• Availability of all required stakeholders could not be guaranteed from the evaluation team’s side. However, maximum efforts were undertaken to ensure relevant contacts through phone conversations when meetings in person could not be arranged on the spot.

• Although the data collection tools were translated into Swahili, some respondents were not fluent in Swahili and required a translator in a local dialect. This could have potentially misrepresented some of the questions in the tool(s). However, the team recruited two local researchers (male and female) to address this challenge.
Chapter 3: Evaluation Findings and Analysis

3.1. Socio-demographic characteristics of respondents

Age of Respondents
The evaluation study interviewed 429 respondents of different ages using questionnaires, where majority of the respondents interviewed belonged in the age category of 26-34 (28.9%), followed by those who fell in the age category of 18-25 and 35-44 (22.85%). In general, youth constituted the majority of the respondents. The table below provides a summary of age of respondents that were involved in the evaluation study in Serengeti District.

Table 5: Age of evaluation study respondents

<table>
<thead>
<tr>
<th>Age Category</th>
<th># Respondents</th>
<th>% Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>18 -25</td>
<td>98</td>
<td>22.8</td>
</tr>
<tr>
<td>26 - 34</td>
<td>124</td>
<td>28.9</td>
</tr>
<tr>
<td>35 – 44</td>
<td>98</td>
<td>22.8</td>
</tr>
<tr>
<td>45 – 54</td>
<td>61</td>
<td>14.2</td>
</tr>
<tr>
<td>55+</td>
<td>48</td>
<td>11.2</td>
</tr>
<tr>
<td>TOTAL</td>
<td>429</td>
<td>100</td>
</tr>
</tbody>
</table>

Source: Field Data 2019

Sex of Respondents
Given the nature of the project and the fact that women and girls are the primary victims of FGM, majority of the respondents participated in face to face interview (questionnaire) were female. As the figure below shows, 57.1% of the respondents were female (women and girls), while 42.9% were male.

Table 6: Sex of evaluation study respondents

<table>
<thead>
<tr>
<th>Sex</th>
<th># Respondents</th>
<th>% Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>184</td>
<td>42.9</td>
</tr>
<tr>
<td>Female</td>
<td>245</td>
<td>57.1</td>
</tr>
<tr>
<td>TOTAL</td>
<td>429</td>
<td>100</td>
</tr>
</tbody>
</table>

Source: Field Data 2019

Occupation of Respondents
The respondents of the evaluation study interviewed by questionnaires included teachers, farmers, pupils, students, entrepreneurs and others including community health workers, tailors, barbers, carpenters, hair dressers, bodaboda drivers, retired officers, miners, shopkeepers, shoe makers, religious leaders, restaurant servers and pastoralists. The table below presents the different categories of respondents, based on their occupation, that were involved in the evaluation study.

Table 7: % Distribution of respondents involved in the study based on their occupation

<table>
<thead>
<tr>
<th>Occupation</th>
<th>% Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Teachers</td>
<td>8.4</td>
</tr>
</tbody>
</table>
Apart from questionnaires, the evaluation covered other participants as follows: FGDs constituted of 62 women with age range 25 – 55+, 65 girls with age range 13 – 24 and 61 men with age range 18 – 55+. Moreover, 80 Key Informants interviewed in both district and ward levels. The selection of Key informants was not based on their age but according to their positions and responsibilities within the society.

### 3.2. Effectiveness

**Question 1: To what extent were the intended project goal, outcomes and outputs (project results) achieved and how? To what extent did the project reach the targeted beneficiaries at the outcome and Output levels?**

Through effective engagement of primary and secondary beneficiaries such as women, girls, traditional leaders, circumcisers, parents, healthcare workers, legal professionals, police gender desks and CBOs, the project has significantly contributed to women in Serengeti District being free from effects of FGM practice and having more opportunity to exercise their legal and social rights. This has been achieved through effective engagement of project beneficiaries, including women, girls, traditional leaders and circumcisers, to ensure they have increased FGM knowledge and commit to abandoning FGM practices; building the capacity of legal and health professionals so as to increase their knowledge and improve their capacity to provide quality legal and health services related to FGM and GBV to women and girls in Serengeti District; and empowering local CBOs to help out with advocacy on women and girls’ rights and providing legal services to FGM and GBV survivors as well as other women and girls.

**Outcome 1: Traditional leaders, caregivers, parents, circumcisers, women and girls have increased commitment to abandoning FGM practices**

The project has been largely successful in ensuring commitment of traditional leaders, caregivers, parents, circumcisers, women and girls in Serengeti District. This has been achieved through effective engagement of these groups through collaborative efforts with project partners, including district authorities, local government authorities and village authorities. The highlight of project was the successful pilot of the alternative rites of passage (ARP) ceremony, which brought about a new hope for girls to be pass into adulthood without having to undergo FGM.

According to project report (January – December 2018), a total of 359 girls out of 1500 graduated, which is equal to 23.9% of the initial target. During KII in Issenyi Ward, it was revealed that about 234 girls passed into adulthood without having to undergo FGM in 2018.\(^{12}\)

\(^{12}\) Field Data 2019 – KII Issenyi Ward.
At outcome level, the project was able to been to reach all its intended beneficiaries (traditional leaders, caregivers, parents, circumcisers, women and girls) in a bid to increase their commitment to abandon FGM in Serengeti.

1. The project has effectively and significantly increased awareness of health effects and human rights aspect of FGM among girls and young women, as demonstrated by increased knowledge levels and women and girls taking a stand against FGM. A total of 15,747 out of 24,533 (64%) of women and girls were reached by the project.

A key strategy employed by the project to increase awareness of health effects and human rights aspect of FGM was sensitize 24,533 girls and young women in Serengeti District through SMS texts and age-specific forms. A total of 15,747 out of 24,533 (64%) of women and girls were reached by the project. These were reached through different forums, including community meetings and ARP ceremonies. The project also planned to support 28 communities to conduct alternative rites of passage (ARP) ceremony to 1500 girls to abandon FGM, which was successfully conducted in 2018, but managed to get only 359 girls (23.9%) to graduate in the course of project implementation.12 Moreover, the project managed to train and sensitize 132 indigenous women, 48 more than it had planned, on the health effects of FGM and GBV-related laws, focusing on wards with high FGM prevalence.

Furthermore, the project engaged 39 women with disability out of 140 it had planned to engage to sensitize them on health effects of FGM and GBV-related laws in 2017 and, in collaboration with district authorities, identified and trained 184 peer educators on how to conducting trainings during ARP ceremonies and on health effects of FGM in 2016.
In 2017, the project managed to organize endorsement of traditional leaders’ anti-FGM Serengeti declaration, whereby 78 traditional elders signed the declaration, in addition to 98 who had signed previously.\textsuperscript{14}

Field findings revealed that an increase in awareness of health effects and human rights aspect of FGM among girls and young women, has prompted them to be more confident to say no to FGM and seek assistance from local authorities and organizations when they are put under pressure to undergo the practice, reporting the matter to local police and/or seek refuge at safe houses. For instance, in 2016, sensitization efforts led to 762 girls (13%), who had been prepared to undergo the cut, escaping the practice and managing to flee to safe houses and openly denouncing FGM.

\begin{quote}
“In November 2018, a girl ran from the cut, managing to avoid FGM attempt. She then ran to the police station to report and seek help; and was later sent to a safe house.”
\textit{Interview with a parent, Field Report – January 2019}
\end{quote}

\begin{quote}
“My daughter, (names her), is at a safe house in Mugumu. She ran because her fellow girls at school were laughing at her because she had not undergone the cut. I support her decision (not to undergo FGM).”
\textit{A mother in Machochwe Village – Machochwe Ward}
\end{quote}

Increased awareness on effects of FGM has also contributed in change of attitude among women. Quantitative findings show that majority of women Serengeti do not support FGM practice to continue. Asked whether women in their community generally want FGM to continue, 375 respondents (88%) said No, while only 8% said Yes, as indicated in figure 3 below.

\textsuperscript{14} Tokomeza Ukeketaji Project Annual Report 2017.
Moreover, increased awareness is also believed to have contributed to decline in FGM in Serengeti District. It was revealed during KII s that the rate of FGM decline in study areas stands at an average of 80%. This could have a positive bearing on other project areas.

However, even though the project’s activities contributed to significant knowledge gains, the integration of gender knowledge in activities by the stakeholders and particularly in the District Council was observed to be limited. Moreover, the shape and focus of gender mainstreaming efforts are still evolving. It is clear that gender mainstreaming requires more time and resources to be effective. Additionally, although FGM/C and child marriage knowledge is high, a significant number of respondents demonstrated limited knowledge about availability and services offered by the police gender desks, judiciary and paralegals, particular those in remote villages/areas.

2. The project has significantly contributed to increased awareness on health effects and human rights aspect of FGM among parents/caregiver, traditional leaders, boys, men and circumcisers. This has created an environment for these groups to discourage FGM.

Strategies employed by the project to ensure increased awareness on health effects and human rights aspect of FGM were sensitization program for parents; dialogue with traditional leaders; age and gender-specific dialogue with men and boys; and supporting peer educators with bicycles to enable them to make home visits and provide FGM and GBV education. The project managed to reach 16,743 parents out of the 21,851 it had planned to reach (76.6%) through home visits, text messages, awareness campaigns and community radios. The project also planned to reach 153 traditional leaders and managed to reach 156 (101%).

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Regarding age and gender specific dialogue fora, the project 2,713 boys and men out of 5,912 it had planned to reach, which is equal to 45.8% of the target. The project also successfully procured and provided 84 bicycles to 84 out of 184 peer educators/community health workers.

Implementation of these activities has contributed to increased awareness on health effects and human rights aspect of FGM among the beneficiaries. Most FGD participants demonstrated a good understanding of FGM and its consequences. Moreover, all key informants, including district officials, parents, ward and village leaders, religious leaders and other influential people who were interviewed, expressed knowledge about FGM/C, child marriage and other forms of GBV. They claimed to know about these issues, including those who have passed away due to severe bleeding during FGM/C. Some of them shared examples of those passed away and also mentioned areas with high rates of FGM/C practice compared with those with low rate or zero FGM/C practices.

Interviews with district authorities, including the District Commissioner (DC), District Administrative Secretary (DAS), District Executive Director (DED) and District Social Officer (DSO), yielded similar results, as they all attested to increased knowledge and awareness about not only FGM but also other forms of GBV. They pointed out that during the cutting seasons some girls run away from home to escape FGM and acknowledged that currently the girls and young women know where to obtain FGM-related services.

Increased awareness on health effects and human rights aspect of FGM, has in turn led to change of mindsets and attitude regarding FGM among parents/caregivers, traditional leaders, boys, men and circumcisers. Quantitative study findings show that the community in Serengeti is generally not in favour of continuation of FGM. Asked whether they the community generally supports continuation of FGM, majority of respondents of quantitative survey (80%) responded No, while only 15% indicated that it is the case and 5% did not know, as indicated in figure 5 below.

![Figure 4: Community support for FGM (N=429)](source: Field Data, January 2019)
Quantitative data also show that attitude among women has generally changed. Asked whether men in their community generally want FGM to continue, majority of respondents (84%) indicated that generally men in their community are not in favour of FGM practice to continue, while 13% said Yes and 3% said No. Baseline data shows 74.5% of men and 72% of women were not in favour of continuation of FGM.

[Image: Figure 5: Responses on whether men want FGM to continue (N=429)
Source: Field Data, January 2019]

Qualitative findings mirrored quantitative findings in that attitude of men towards FGM has generally changed for the better. For instance, during FGDs with girls majority of participants indicated that the project has helped to change men’s attitude and mindset regarding FGM, such that most of them are now ready to marry a woman even if she has not undergone the cut, which was not the case before. This demonstrates increased awareness about FGM and its effects, which has helped men to abandon a false belief that a woman who has not undergone the cut is not fit for marriage. FGDs with men also yielded similar results, with participants generally confirming that men are not generally okay with marrying a woman who is uncircumcised, although they acknowledged that there are some few families and men who are still embracing FGM and will not marry a woman who is not circumcised.

KIIIs also revealed that project intervention has helped to change attitude of traditional leaders and circumcisers. Effective engagement of traditional leaders has helped to turn some of them into champions, speaking against and discouraging FGM in Serengeti. Effective engagement of circumcisers through FGM education and economic empowerment has seen some of them down their tools and seeking alternative source of income.

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16 Field Data 2019 – FGDs with girls in Robanda Village, Ikoma Ward.
“I think the activities implemented under the Tokomeza Ukeketaji Project have largely responded to project goal and outcomes because the clans have slowly been abandoning the practice and allowing girls to be initiated into adulthood without having to undergo FGM. Traditional leaders have also been active in speaking against and discouraging FGM and child marriage; and equipment used by circumcisers (Ngaribas) have been destroyed in public. Some of the former circumcisers have formed a socio-economic group, engaging in savings and credit schemes.”

KII with a local organization executive director – Issenyi Ward

However, some of the respondents questioned the will of some of the traditional leaders who were engaged in project activities to end FGM in Serengeti. For instance, in Machochwe and Mbalibali Wards it was revealed that some of the traditional leaders have been pretending to support the project but do the complete opposite when they return to their villages, warning villagers and circumcisers about possible government and project interventions. For instance, it was stated that information had reached police and other anti-FGM stakeholders that around November and December 2018 an FGM ceremony was planned to be conducted in Machochwe Ward, but the organizers apparently received word about possible police ambush and moved the ceremony back to September 2018. A health worker at Machochwe Dispensary revealed during a KII that participation of traditional leaders in ending FGM in the ward was not satisfactory. Similar concerns with traditional leaders were raised during KIIs and FGDs in Robanda Village, Ikoma Ward and Kitunguruma Village in Mbalibali Ward, whereby it was stated that traditional leaders and some circumcisers still pose a threat to project sustainability despite participating in anti-FGM activities under the project. During FGDs with women in Nyamisingisi, Singisi, Park Nyigoti and Machochwe Villages, similar sentiments were also expressed, with participants claiming that some traditional leaders still support FGM practices continue because it is their key cultural identity. They also remarked that men who oppose the project in their villages believe that a girl child who undergoes FGM brings some good luck in the family and attracts higher dowry (sometimes up to 12 cows). Consequently, some families continue with the tradition of FGM, with ceremonies now taking place at night and involving a smaller audience.

KII findings also revealed concerns of over some of the former circumcisers who complained about not being effectively assisted to find an alternative source of income. However, such shortcomings are expected in project implementation and the issue was not raised by a majority of respondents.

There are complaints about circumcisers and traditional elders who had agreed to abandon FGM not being economically empowered to find alternative sources of income. Most circumcisers depend on the practice as only source of income, so when they lay down their tools they find it difficult to engage in another income generating activity. On the other hand, elders benefit from FGM ceremonies because they are able to sell their cattle to be used for the occasions. This has created a negative perception amongst some of the community members.

KII, Issenyi
3. The project has effectively established the ARP model and engaged traditional leaders, circumcisers and young women and girls to abandon FGM practices using the model.

The project successfully facilitated a study visit of 60 traditional leaders and 62 circumcisers to learn best practices in Kilindi District-Tanga Region in June 2017. This was pivotal in ensuring they denounce FGM and commit to hold first ARP in December 2018. Through peer educators, the project also managed to facilitate sensitization forums on health effects of FGM for a total of 2,346 parents out of 10,245 it had planned to sensitize (22.8%). In June 2017, the project managed to facilitate a study visit in Kilindi District and training of trainers (ToT) for 80 uncircumcised girls from Serengeti District. Furthermore, the project had planned to reach 1772 girls and raise their awareness on health effects of FGM and GBV-related laws using peer educators and girls who had undergone training to become trainers, but instead managed to reach a total of 7951 girls at schools and within communities, which is more than 4 times of the targeted number. Additionally, the project had planned to train 170 circumcisers on entrepreneurship skills and support them with startup funds and instead managed to train 180 circumcisers, 10 more than the targeted number. As a result, the project managed to guide them establish their own 11 CBOs and expose them to alternative sources of income.

Introduction of ARP, which has been successfully piloted, has largely contributed to project effectiveness. Through the project, ARP was introduced to targeted groups, especially traditional leaders, youth and women. The project helped these groups forming local ARP committees, which

Key Achievement
The project, in collaboration with the traditional leaders union, organized a the community-based endorsement of the traditional leaders’ anti-FGM Serengeti declaration MoU. All the clans were involved, including: Inchugu, Inchage, Ngoreme, Walenchoka, Tatoga and Wakenye, whereby a total of 80 (78%) traditional elders signed the petition out of 103 elders, whereby 23 (22%) refused to sign. The elders and other community members also discussed the alternative rites of passage in the Kuryan context, and agreed on the proposed ARP model.

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19 Amref and LHRC’s Annual Project Report, Year 2, 01/01/2017 - 31/12/2017.
promote initiation without FGM among all six clans - Tatoga, Ngoreme, Inchugu, Inchage, Warenchoka and Wakenye. The evaluation team found ARP to be instrumental in advocating for attitude and behaviour change in the community.

Figure 6: Status of signing of anti-FGM petition to end FGM by traditional elders

Gender needs assessment report and field findings indicate that at the start of the project 25 circumcisers were active. However, by December 2018, three of them had downed their tools and 9 had passed away.

Table 8: Status of circumcisers among the 6 clans in Serengeti District

<table>
<thead>
<tr>
<th>Clan</th>
<th>Still Practicing</th>
<th>Abandoned</th>
<th>Died</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Ngoreme</td>
<td>3</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>2. Inchugu</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>3. Warenchoka</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>4. Watatoga</td>
<td>3</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>5. Inchage</td>
<td>2</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>6. Wakenye</td>
<td>2</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>13</strong></td>
<td><strong>3</strong></td>
<td><strong>9</strong></td>
</tr>
</tbody>
</table>

Source: Data shared by traditional elders’ secretaries- November 2018

Outcome 2: Health and legal systems have improved skills to provide quality health care and legal services to FGM survivors

Trainings and workshops conducted for healthcare workers and legal professionals in Serengeti District effectively improved the quality of health and legal services provided.

4. **Through trainings for healthcare workers and mothers attending clinics, the project has significantly improved their knowledge on avoiding effects of FGM**

The project had planned to train 65 healthcare workers on how to provision of anti-FGM education during antenatal and post-natal care and managed to train all of them, using kolb model, e-learning and m-learning approaches. It had also planned to train 1,023 women on

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Ibid.
FGM and GBV during prenatal care clinic, but managed to train 1,215, who are 192 more than the target. Moreover, the project successfully trained more than 1632 women on FGM and GBV during post-natal care clinic, compared to 1023 it had planned to train. In collaboration with the district authorities and other stakeholders, the project also developed some training notes on FGM and GBV education, geared towards increase knowledge on effects of FGM and how to avoid them.

5. The project effectively engaged and trained 30 police gender desks officers, paralegals and judicial officers to improve their legal knowledge to effectively respond to FGM cases and ensure perpetrators are brought to justice. Consequently, there is improved access to and quality of legal services

In order to improve response to FGM cases, the project conducted trainings on how to respond to and handle FGM cases to police gender desk officers, paralegals and judicial officers in Serengeti District. It also produced CDs for judicial officers, paralegals and police officers and procured desktop computers for trainees to be used for eLearning sessions and writing reports on FGM cases.

The project planned to train 30 police gender desk officers, 30 paralegals and 28 judicial officers, managing to train all 30 police gender desk officers, 34 paralegals and 29 judicial officers. It also produce 600 CDs for judicial officers, paralegals and police officers, 100 more than the target; and procured all targeted 50 computers, which were distributed to key stakeholders under the project.

KII and FGD findings indicate an increase in knowledge about FGM and other forms of GBV among police officers, paralegals and judicial officers in responding to FGM cases. All key informants that were reached were of the view that the knowledge of these groups has increased compared to the situation before the project interventions. The Officer Commanding District (OCD) in Serengeti also acknowledged that the project has increased knowledge of police officers on FGM and its effects, as well as how to hand FGM cases, as they previously had limited knowledge. Police officers themselves who were interviewed also expressed that trainings conducted by the project helped to increase their knowledge and shaped the way they handle FGM cases.

Trainings for the police, paralegals and legal professionals effectively contributed to improved capacity of these groups to respond to FGM cases. Field findings point to increased efficiency of police gender desks officers, paralegals and judicial officers. As indicated in figure 9 below, more than 50% of the questionnaire respondents believe efficiency of these groups has increased following the interventions made by the project in Serengeti.
The police force in the district was said to have a significant contribution in addressing FGM and ensuring perpetrators are brought to justice, through working closely with the project. Majority of questionnaire respondents (58%) indicated that police major contribution was in effecting arrest of perpetrators of FGM. However, some of the villagers/community members have also complained about preference of use of force by police to apprehend those are implicated in FGM practice, rather than providing more education and conducting more awareness-raising sessions to prompt or trigger behavior change. It was reported that in some areas this action caused some of the community elders and members to oppose the project and even tearing down the project anti-FGM banners.

Moreover, while training of police gender desk officers has helped to boost their ability to hand FGM and GBV cases and general provide better legal services to survivors, access to such services was found to be a challenge in some areas due to the proximity of police gender desks. For instance, the Officer Commanding District (OCD) in Serengeti informed the evaluation team that there are only 2 police gender desks in the district, one at Mugumu Police Station and another at Issenyi Police Post. The gender desk in Mugumu was found to be the most reliable in that it was found to be fully operational and characterized by an environment that promotes comfortability among survivors seeking its services, including the officers not wearing uniforms and ensuring privacy and confidentiality, as well as safely storing information in a computer. Moreover, the desk was found to have in place Standard Operating Procedures (left) and Guidelines for establishment of police gender desks, as shown in picture 6 below.
On the other hand, the police gender desk in Mugumu was said to face a number of challenges, including lack of free telephone services for survivors and to enable close follow up of cases. One room for attending clients/survivors was said to be not enough, considering the desk was relied upon by most wards in the Serengeti. Lack of sufficient budget for day to day running of the desk was also raised as a concern during interviews with police gender desk officers. Inability to conduct a DNA test in Serengeti was said to be a challenge that sometimes leads to acquittal of FGM/GBV perpetrators by a court of law.

Proximity of the Mugumu police gender desk poses a great challenge, considering also the roughness of the roads. For instance, interviews with village officials in Mbalibali Village revealed that FGM/GBV survivors sometimes decide against seeking services provided at Mugumu gender and children desk due to the long distance to the Mugumu Police Station where the desk is located. They also mentioned that some residents are not aware of the availability and services offered, while others fear police interviews and interrogations.

““One woman found out that her underage daughter was pregnant, her teacher being the man responsible. She reported the matter to the Regional Commissioner and later the case was sent to court. However, the court set the accused person free because the mother and her daughter failed to provide evidence of DNA.”

KII – Mugumu police gender and children desk

“The police gender and children is very far from our village, located in Mugumu. Many people are not aware of the existence of the desk and services provided; and most people tend to fear police interviews, thus they would rather turn to social welfare officers for assistance.”

KII – Mbalibali Village
The project effectively trained 178 healthcare workers and 104 community health workers to improve their knowledge on managing health complications of FGM and enable them to provide comprehensive SRHS and psychosocial support to girls and women.

While the project had planned to train 140 healthcare workers on managing health complications of FGM to girls and women, 175 healthcare workers provision of psycho social support to girls and women victims of FGM/GBV and 100 community health workers on provision of home based FGM health care, monitoring and FGM/GBV education, it managed to exceed these targets by 16, 3 and 4 respectively.²¹

Trainings for healthcare workers and community health workers, have had a positive impact on their knowledge on managing health complications of FGM and enabled them to provide improved SRHR and psychosocial support services to girls and women in Serengeti District.

Field findings point to improved knowledge on provision of health services, including managing health complications of FGM and enable them to provide comprehensive SRHS and psychosocial support to girls and women. Improved knowledge means increased efficiency in delivery of services; and majority of questionnaire respondents (77.4%) indicated that indeed efficiency of health workers in provision of FGM-related services, including managing health complications of FGM and enable them to provide comprehensive SRHS and psychosocial support to girls and women, has increased.

Figure 8: # Responses on efficiency of healthcare workers in provision of services to FGM and child marriage survivors (N=429)

Source: Field Data, January 2019

Interviews with health professionals at Nyerere District Designated Hospital (NDDH), Machochwe Dispensary, Issenye Dispensary, Isseco Health Centre, Park Nyigoti Dispensary, and Mbalibali Dispensary, revealed that there has been improvement in provision of health services and more people are coming to access such services, including FGM-related services. The interviewees claimed that number of people seeking such services has increased due

availability of good and friendly services. They stated that equipped with GBV service provision skills, health workers are now in a better position to interact professionally with survivors, taking into consideration key issues such as confidentiality and respect of person.

“We provide youth-friendly services; and girls receive services regardless of age.”
*Interview with Health-In-Charge, Issenye Dispensary*

“In the past, the victims were not coming to seek health services at centres. They would stay home and bleed for fear of being arrested; and some of them bled to death.”
*Interview with Assistant DRCHCO Serengeti at NDDH*

Moreover, majority of men and women FGD participants and key informants also attested to the increased efficiency of healthcare workers in provision of health services to survivors of FGM, child marriage and other forms of GBV. However, they raised a concern regarding Tanzania Police Medical Examination form, popularly known as Police Form 3 (PF3), sometimes being a hindrance to accessing health services as in case of an accident/bodily harm. Without this form one cannot access health services to receive treatment, which may sometimes be quite costly, especially where one’s life is in serious danger.

“Victims should be attended to first and then PF3 could be provided thereafter, especially for those coming from remote areas.”
*KII with a CBO representative in Issenye*

7. **The project successfully facilitated establishment of gender and help desks at village and health facility levels in order to improve legal aid services for FGM survivors**

In collaboration with the police authorities, the project managed to facilitate establishment of police gender desks at 12 identified police posts. It also managed to facilitate establishment of 54 gender desks at health facilities. The desks serve community members though text messages, call system/hotline and complaint boxes. The project had also planned to orient 23 health workers and 23 police officers on analysis of complaints data, but instead managed to orient 60 police and health workers, 14 more than the target. Moreover, the project successfully sensitized 678 men and 1,200 women across 30 wards on the use of FGM/GBV complaints and referral services using IEC materials and community radios.

**Outcome 3: Community Based Organizations effectively advocate against FGM practices leading to increased commitment from authorities and resources allocation for anti GBV activities**

8. **The project successfully created forums to advocate for enforcement of GBV-related and policies in order to safeguard rights of women and girls**
In 2017, the project facilitated a dialogue forum on anti-FGM and GBV-related laws and policies affecting girls and women, bringing together 427 (145 male, 282 female) project stakeholders.\textsuperscript{22} It also successfully facilitate village-based dialogue forums on anti FGM/GBV laws and policies, for 2034 male and 1164 female participants from Inchugu, Inchage, Watatoga, Walenchoka and Ngoreme clans in 2016; and reached 4,084 boys and men through community based forums.\textsuperscript{23}

Furthermore, the project has managed to facilitate establishment of 137 school clubs (at 110 primary schools, 23 Government secondary schools and 4 private secondary schools) and organize gender specific forums at 140 schools. It also managed to effectively train 21 spiritual leaders of 3 FBOs on strategies to abandon FGM /GBV and related effects.\textsuperscript{24}

9. **The project encouraged formation of CBOs and built capacity of existing CBOs to ensure they advocate for rights of women and against FGM**

Formation of CBOs and empowering capacity of existing CBOs to ensure they advocate for rights of women and against FGM were achieved through sensitizing the community to form local CBOs on human rights issues and anti FGM; building the capacity of 66 local CBOs on policy advocacy and human rights monitoring, instead of 64 that were targeted; building the capacity of 64 local CBOs; facilitating formation of 137 anti-FGM/GBV clubs at schools, instead of the targeted 60; and formation of 78 village protect committees, one in each village.

10. **The project managed to engage, sensitize and build the capacity of local government authorities to ensure increased allocation of budget for GBV/FGM in annual budget. However, no budget was allocated for GBV/FGM until the final year of project implementation, which was itself not substantial.**

The project effectively facilitated a discussion forum with district authorities to advocate for prioritizing anti GBV activities in their annual Medium Term Expenditure Framework. The project had also planned to train 65 district staff on gender based budgeting and GBV related laws and policies, but managed to train 46 district officials. It also managed to facilitate a FGM/GBV needs assessment at district level for budgeting purposes and disseminated key findings to local government authorities for action.\textsuperscript{25}

KII findings indicate that budget is the key challenge in fighting against FGM/C and other forms of GBV. All respondents at ward and village levels confirmed that GBV and FGM budget are not prioritized in council plans.

“I have heard of budget allocation at council level. I am not aware of availability of such budget. They are not transparent. When you talk about FGM my thoughts go directly to Amref or Haki Elimu, not the government.”

*KII - Primary Teacher*

\textsuperscript{22} Tokomeza Ukeketaji Project Annual Report 2016; Project Annual Report 2017.
\textsuperscript{23} Ibid.
\textsuperscript{24} Ibid.
Table 9: GBV budgets of Serengeti DC, 2016/2017-2018/2019

<table>
<thead>
<tr>
<th>Year</th>
<th>GBV Budget in Serengeti DC</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016/2017</td>
<td>0</td>
</tr>
<tr>
<td>2017/2018</td>
<td>0</td>
</tr>
<tr>
<td>2018/2019</td>
<td>4,275,000</td>
</tr>
</tbody>
</table>

Source: Serengeti District Council

As indicated in table 8 above, budget for GBV and People with Disability not specifically included in Council Budget for the Year 2016/17 & 2017/18. However, only Tshs 4,275,000 of fund allocated for GBV in year 2018/2019. This result as efforts of Amref to ensure local government are sensitized, capacitated and eager to take lead to allocate enough resource for anti GBV/FGM activities on yearly basis in their budget. However, no any other GBV budget had been included separately in Serengeti District Council budget of 2018/2019.

Gender Needs Assessment report shows that FGM and GBV are not prioritized in the district projects and programs. For instance, Serengeti DC Primary Education department has been implementing a project known as Education Quality Improvement Programme (EQUIP), famously known in Swahili as ‘Mradi wa Kuinua Ubora wa Elimu Tanzania (MKUE-T),’ since June 2015. Although the program aims at improving quality of education, there is no activity to fight against FGM, early marriage or other forms of GBV in Serengeti.

3.3. Relevance

Question 2: To what extent do the achieved results (project goal, outcomes and outputs) continue to be relevant to the needs of women and girls?

11. The project goal, outcomes and outputs were found to be relevant to the needs of women and girls in Serengeti, owing to the gaps in knowledge among them and other members of the community, including legal and health professionals, and existence of gender inequalities in the district.

The project goal, outcomes and outputs were relevant and continue to be relevant to the needs of women and girls, chief of which are ensuring they are free from any form of VAW or VAC, which includes FGM, so that they can enjoy their rights. Women and girls had limited knowledge about GBV and FGM, including health effects of GBV, and did not perceive FGM to be a human rights issue, as did the majority of community members. They also had limited access to GBV and FGM services at health facilities and police gender desks. Women and girls in Serengeti also live in a male-dominated community, where they usually have decisions made for them and constantly face gender inequalities. Baseline study also indicated limited knowledge on FGM/GBV and how to handle FGM/GBV cases and capacity gaps among police officers, judicial officers, paralegals and healthcare workers. In view of these challenges, which hinder and continue to hinder women from effectively realizing and enjoying their legal and human rights, strategies employed by the project, such as trainings and awareness-raising sessions for women and girls; trainings for legal and health professionals to increase their
FGM/GBV knowledge and enable them to provide better FGM/GBV services; engagement of traditional leaders and circumcisers who have a strong influence on FGM practice; and engaging and training girls and young women at school and street levels, were relevant and continue to be relevant and appropriate to the needs of girls and women in Serengeti.

Quantitative study findings also point to the relevance and continued need of the project in Serengeti District. Asked whether anti-FGM project has been relevant to the community needs in Serengeti, overwhelming majority of questionnaire respondents (94%) said Yes, while 6% said No.

![Figure 9: % Responses on relevance of the project to community needs (N=429)](source: Field Data, January 2019)

Questionnaire respondents were also asked whether they would like for the project in Serengeti to continue. As shown in figure 12 below, findings show that 80% of the respondents want the project to continue, while only 14% do not wish for the project to continue. 6% of the respondents indicated that they do not know or are not sure whether the project should continue or not. Strong belief in customs and traditions was generally found to be a key factor among those who do not wish for the project to continue, including fear that total abandonment of FGM will result into a curse in the community.

![Figure 10: % Responses on wanting the project to continue (N=429)](source: Field Data, January 2019)
Qualitative findings mirror quantitative findings in terms of the project’s relevance. All KII respondents commended the work done by Amref, LHRC and other project partners in ensuring FGM is eradicated in Serengeti and expressed that they wish for the project to continue.  

One of them even expressed that he would like for the project to continue for even 15 years, so that the practice is completely wiped out in Serengeti. While reviewing project reports, the evaluation team also found out that targeted groups, wish not only for the project to continue, but also scale up.

Majority of the evaluation study respondents (70%), including women, girls and religious leaders, also demonstrated their intentions to spread the anti-FGM messages and being anti-FGM champions, following trainings and seminars they attended – seeking to spread the knowledge and information, including through communication and information products prepared under the project.

Review of project documents, including progress reports, revealed that at least 176 traditional leaders in Serengeti District have endorsed and signed a Memorandum of Understanding (MoU) on ending FGM, featuring all key clans, namely Inchugu, Inchage, Ngoreme, Walenchoka, Tatoga and Wakenye. 

This commitment of traditional leaders attests to the relevance of the project.

Further analysis indicated that those who found the project to be unimportant belong to three major categories. The first category is those who still think that FGM must continue as a key part of their customs and tradition. The second category is those who were initially supportive of the project but expected to somehow benefit from the project in terms of incentives such as cash, thus when their expectations were not met they decided to turn against the project. The third category is of those who arrested for participating in the FGM practice, hence developed hatred on the project and tried to influence other not to provide cooperation to the project.

Nevertheless, testimonies by the majority of respondents who were reached by the evaluation team at district, ward and village levels attests to the relevance of the project. It is therefore correct to conclude that the three-year anti-FGM project implemented by Amref and its partners in Serengeti has made a significant contribution in the fight against FGM and continues to be relevant to the needs of women and girls in the district, regardless of the few/minor challenges faced in the course of implementing it.

**Question 3: To what extent does the project respond to anti-FGM and GBV priority issues?**

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27 Amref and LHRC’s Annual Project Report, Year 1, 01/01/2016 - 31/12/2016; Amref and LHRC’s Annual Project Report, Year 2, 01/01/2017 - 31/12/2017.
28 Ibid.
12. To a large extent, the project responded to anti-FGM and GBV agenda contained in key national plans such as the National Plan of Action to End Violence against Women and Children in Tanzania 2017/18 – 2021/22 and the Tanzania Development Vision 2025.

Addressing FGM and GBV is vital to achieving national goals contained in different national plans and policies, which were reviewed by the evaluation team. Key among these plans are the the National Plan of Action to End Violence against Women and Children in Tanzania 2017/18 – 2021/22 and the Tanzania Development Vision 2025.

Tanzania is bound by the Protocol to the African Charter on Peoples’ and Human Rights on the Rights of Women in Africa (Maputo Protocol) of 2003, which obligates states parties to prohibit and condemn all forms of harmful practices which negatively affect the human rights of women, including prohibition, through legislative measures backed by sanctions, of all forms of FGM in order to eradicate them. In line with this obligation, Tanzania enacted the Law of the Child Act of 2009, which prohibits performance of FGM to a child, and criminalized FGM under its Penal Code, CAP 16, albeit for girls. Later, the Government consolidated all its action plans relating to violence against women and children to create the National Plan of Action to End Violence against Women and Children in Tanzania 2017/18 – 2021/22. The Action plan seeks to ensure women and children live free from violence and enjoy their rights in safe communities through elimination of VAW and VAC and improving their welfare. One of its operational targets is to reduce FGM prevalence from 32% to 11% and child marriages from 47% to 10%; and regarding FGM the targeted intervention is prevention, which is what the project is mainly focusing. Among the objectives of the Action Plan is ensure community members are free to report VAW/VAC incidents and fast-track judicial proceedings. It is therefore safe to conclude that the anti-FGM project implemented by Amref and LHRC in Serengeti for 3 years has been relevant in that it is in line with government plans, policies and priorities.

The evaluation found that the project was also important in relation to national priorities related to Sustainable Development Goals (SDGs) and Tanzania Development Vision 2025. SDG 5 seeks to achieve gender equality and empower all women and girls; and its targets include eliminating all forms of violence against all women and girls and eliminating all harmful practices, such as child, early and forced marriage and female genital mutilation. The first priority under the Tanzania Development Vision 2025 is a high quality livelihood, which among others, is attained through ensuring gender equality and empowering women in all socio-economic and political relations and cultures. Tanzania is committed to achieving these goals,

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29 See Article 5 of the Maputo Protocol.
30 Section 158(1) of the Law of the Child Act, 2009
31 See Section 169A of the Penal Code, CAP 16
32 See National Plan of Action to End Violence against Women and Children in Tanzania 2017/18 – 2021/22 at
33 See “Goal 5: Achieve gender equality and empower all women and girls, Goal 5 targets” at www.un.org
thus the project contributes in achieving this goal and therefore was to a large extent relevant to national plans and priorities.

Combatting FGM in Tanzania has thus been a national priority for several decades; and this is why there has been a close partnership and commitment between the Government at national and local levels and the project management in the course of project implementation in Serengeti. The project has been collaboratively working with the district officials on the proper ant-FGM campaigns in the communities, like the forming of the children protection committees. It thus builds on previous efforts by the government and other actors in combatting FGM and thus continues to be relevant as it targets raising awareness about the harmful practice of FGM and eradicating the practice, considering Mara is one of the regions with highest FGM prevalence rates.

3.4. Efficiency

**Question 4: To what extent was the project efficiently and cost-effectively implemented?**

The evaluation team generally found that the project was efficiently and cost-effectively implemented through timely delivery of activities, use of participatory and holistic approaches to address FGM and empowerment of effective strategies and approaches to empower targeted beneficiaries.

**13. The project was generally characterized by timely delivery of activities and all activities were implemented in line with project work plan and budget. Only a few activities were not delivered on time but valid reasons for the delays were given and they were effectively implemented.**

Through review of annual project reports of 2016, 2017 and 2018, the evaluation team found that all activities were implemented in accordance with the project work plan and budget. Most of the activities were also delivered on time, except for a few which could not be implemented within a specified timeframe due to circumstances which were beyond the project implementers. For instance, the activity of facilitating a study visit of 80 girls who had not undergone FGM to Kilindi District, under Outcome One and output 1.3 of the project could not be implemented in 2016 as scheduled. This was due to the fact that the ceremony in Kilindi District was schedule for June 2017. This was also the case with regard to the activity of facilitating a study visit of 60 traditional leaders and 62 circumcisers to Kilindi District. However, these activities were effectively implemented in 2017.

**14. The project employed participatory and holistic approaches in designing, managing and implementing the project to good effect and engaged external experts when needed in order to effectively and efficiently implement the project.**

The success of the anti-FGM project in Serengeti District centred on participatory and collaborative approaches, with Amref and LHRC mainly taking a facilitative role in the course of

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36 Ibid.
project implementation. Strengthening capacity of CBOs to enable them to carry out advocacy geared towards elimination of FGM and other forms of GBV was therefore a key action contributing to project effectiveness. Through collaboration with the Serengeti District authorities, the project also trained 64 anti-FGM CBOs on policy advocacy, human rights monitoring and FGM. FBOs and CBOs have been instrumental in advocating for behavior and attitude change in the community, as revealed by field findings. About 59.9% of questionnaire respondents indicated that FBOs in Serengeti District have been playing a key role of raising awareness about FGM and using their platforms or different forums to speak against the practice and encourage the masses to abandon it. Moreover, 37.5% of respondents expressed that CBOs have played a crucial role of providing FGM and child marriage education to community members.

One of the key informants in Serengeti DC mentioned Participatory Project Management (PPM) as a key factor for the success of the project in Serengeti, noting that incorporated and brought together various actors within the district to address FGM. The holistic and participatory approaches were therefore key for achievement of project objectives.

15. The project employed effective strategies and approaches to empower and build the capacity of targeted beneficiaries
The Tokomeza Ukeketaji Project employed a number of key strategies and approaches during trainings FGM, child marriage and GBV to judicial officer, paralegals, healthcare workers and police officials. A blended learning strategy, including Kolb model, eLearning and mLearning were used to a good effect.

Using these strategies and approaches effectively contributed to achievement of the project objective of building capacity of health and legal personnel to deliver effective services in combatting and handling cases of GBV, including FGM. These approaches allowed flexibility and minimal interference with the schedules of the targeted groups.

The project also employed the strategy of establishing FGM/GBV clubs at schools, which instrumental in empowering school-going girls to abandon and say no to FGM. This approach was also cost-effective, as utilizing school anti-FGM clubs to empower girls to abandon FGM employed minimal resources, as did trainings and seminars which brought together participants from different areas in Serengeti District.

Using mobile phones and peer educators to extend project activities to wider community was also cost-effective and contributed to project efficiency. One of the activities implemented under the project was sensitizing targeted groups, including women and girls, on health effects and human rights aspect of FGM using SMS texts and age-specific forums.

37 Questionnaire SPSS findings – Field Report, January 2019.
38 Ibid.
Implementation of gender-sensitive programming has also contributed to project efficiency. Being among the regions in Tanzania with high FGM prevalence rates, implementation of gender-sensitive programming for improved anti-FGM programming is fundamental to achieve gender equality and empower all women and girls in Mara Region. Key gender-sensitive programming activities implemented under the project include strengthening the capacity of duty bearers in responding to FGM; establishment of anti-FGM/GBV clubs in schools to ensure gender-sensitive programming; monitoring the implementation of legal and policy framework in order to ensure safeguard of rights of girls and women; and enhancing the capacity of health workers in remote areas. For instance, the project provided 34 bicycles to community health workers in Serengeti to ease their movements while providing FGM-related education to community members.

**Challenges affecting project efficiency**

The project was faced with a number of challenges, which impacted on its efficiency. One such challenge was a clash between project management and the Serengeti District Council over who should take lead in bringing about change in the project, despite efforts made to enhance the holistic approach. In some circumstances, the district council felt that it should have been more directly involved in implementation of project activities, with some of the authorities who were interviewed even insisting that the district council should receive some of the project funds to implement activities.

KIIIs with community health workers also revealed that although the project facilitated them with bicycles to reach out to community members and educate them about FGM and its effects, they were limited in their scope of operation due to lack of allowance to sustain themselves while moving from one area to another to conduct community sensitization. In study areas, KIIIs also mentioned that most computers that were intended for police posts and health centres were not distributed. For instance, the project disbursed 7 computers for Robanda, Majimoto, Mto Mara and Machochwe police stations/posts. However, 5 of these were not distributed, rather remained at district level, due to gaps in computer knowledge among police officers. In some areas identified for the computers/laptops, there was no power – making it a challenge to use the equipment. This issue was raised during an interview with the Officer Commanding District in Serengeti. The evaluation team also found that computers for health centres, to help with documentation of FGM and GBV data, were also not wholly distributed at ward level. This presented an issue for the project, as the computers were meant to facilitate data documentation, but did not reach most intended areas at ward level.

### 3.5. **Sustainability**

**Question 5:** To what extent will the achieved results, especially any positive changes in the lives of women and girls (project goal level), be sustained after this project ends?

**16. Effective strategies and approaches employed by the project have helped to institutionalize the anti-FGM project in Serengeti and build capacity of key**
stakeholders in order to sustain achieved results. The participatory and holistic approaches were key in institutionalizing the project, as were strategies such as engaging the traditional leaders and circumcisers to effectively participate in implementation of project activities and establishment of anti-FGM/GBV clubs in schools and local human rights CBOs.

As discussed in subchapter 3.4 above, participatory and holistic approaches were employed by the project to a good effect, creating a sense of project ownership among targeted beneficiaries and setting roots for project sustainability. Sustainability of this project was considered since the stage of conceptual design, and was linked with the identified activities per objectives. To ensure continuity, exit strategy for this project was locally designed in the framework of institutional, financial and cultural sustainability and these are revealed at various key levels, namely the community, district, national, financial and social and cultural levels respectively.

The project placed emphasis on training and capacity building of key beneficiaries, such as women, girls, traditional leaders, circumcisers, parents, boys, healthcare workers, police gender desk officers, judicial officials and paralegals. This strategy, as discussed in subchapter 3.2 (on effectiveness) above has significantly boosted knowledge levels and enabled beneficiaries to effectively address FGM and GBV related issues and seek and provide improved related services. Substantial knowledge improvements and commitment to stand against FGM demonstrated these beneficiaries suggest a likelihood of project sustainability.

The Tokomeza Ukeketaji project was designed to work in close partnership with the Serengeti district council, in the cause of implementation, the team managed to develop Anti-FGM model, which is cost-effective, feasible and appropriate for the Kuryan situation. The project strategically worked for a cost extension to ensure that this model is incorporated into the district development plans and budgets for these activities to continue to be financed following the end of the proposed cost extension.

However, the model needs further clarification particularly regarding the monitoring of the implementation as well as the data base systems to ensure constant monitoring of the situation and the development of response strategies

A second aspect of potential sustainability is synthesising new groups of stakeholders such as forensic doctors, prosecutors and judges regarding FGM. This will enhance the application of laws to combat the crime at national level.

In order to increase the potential of sustainability, it is important to ensure better use of media products, better exit strategies at local level and strengthening of support to government structures to ensure their ability to assume their roles.

The sustainability of the design and implementation of the project was found to be reasonably good and supported by increased ownership and enhanced institutional and individual capacity.
While the current funding gaps and limited gender mainstreaming activities into District plans and budget pose challenges to the sustainability of results, the project partners have created a solid foundation for continued progress and achievements worth to be credited.

3.6. Impact

**Question 6: To what extent has the project contributed to ending violence against women, gender equality and/or women’s empowerment (both intended and unintended impact)? To what extent has the project contributed to the project goal?**

17. The project has largely contributed to project goal through empowering women and girls to ensure they are free from FGM and GBV, which in has enabled them to enjoy more freedom to exercise their legal and social rights.

The project has brought about both intended and unintended change in communities in Serengeti. Intended changes include increased knowledge among project beneficiaries on FGM, GBV and their effects. Another intended change was for women and girls as well as other project beneficiaries such as traditional leaders and circumcisers to commit to abandoning FGM and embrace alternative rites of passage (ARP). Other changes include decline in FGM, improved and friendlier FGM and GBV services delivered by legal and health professionals and incorporation of GBV into district level budget.

However, the project also brought about changes that were not intended. These include increase in school attendance and decline in child marriage. Implementation of the project has enabled some of the community members to realize the importance of sending girls to school rather than mutilating them and prepare them for child marriage. Provision of education about FGM was said to have positively impacted girls' right to education as statistics show an increased rate of school attendance and girls' enrollment in secondary education in the past three years. This was revealed by 60% of respondents during FGDs with girls in Ikoma Ward as well as with women in Nyamisingisi, Singisi, Park Nyigoti and Machochwe Villages.

Field findings reveal that over 90% of questionnaire respondents think the interventions made under Tokomeza Ukeketaji Serengeti Project have brought about positive changes in their community, as indicated in the figure 13 below.
Figure 11: %Responses on whether the project has brought about any positive changes in the community (N=429)
Source: Field Data, 2019

Asked what changes have been brought about by the project, majority of respondents (27.3%), mentioned willingness on the party of community members to abandon FGM and child marriage, followed by decline of FGM (22.8%). Table 9 below presents a summary of responses on changes brought about by the anti-FGM project in Serengeti District.

Table 10: % Responses on what changes have been brought about by the project (N=429)

<table>
<thead>
<tr>
<th>Response</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community members have agreed to abandon the harmful cultural practices of FGM and child marriage</td>
<td>27.3</td>
</tr>
<tr>
<td>FGM has declined</td>
<td>22.8</td>
</tr>
<tr>
<td>Other</td>
<td>21.7</td>
</tr>
<tr>
<td>Community understands the effects of FGM and child marriage</td>
<td>13.3</td>
</tr>
<tr>
<td>FGM is now conducted secretly at night</td>
<td>5.8</td>
</tr>
<tr>
<td>School attendance has increased following project interventions</td>
<td>5.1</td>
</tr>
<tr>
<td>Child marriage has significantly declined</td>
<td>4</td>
</tr>
<tr>
<td>TOTAL</td>
<td>100</td>
</tr>
</tbody>
</table>

Source: Field Data, January 2019

18. The project has significantly contributed to women and girls taking a stand against FGM and committing to abandon it.

The implementation of the project activities such as trainings, seminars, capacity building sessions and public rallies conducted by Amref throughout the project areas has significantly enabled girls and women to take a stand against and commit to abandon FGM. As the project has paved the way to address FGM, it has also contributed to lighten up minds of young girls to stand firm and oppose FGM in Serengeti District. Prior to introduction of the project, it was quite unusual for a girl to stand up to her family when it came to the matter of FGM. Girls had
no power to dare argue with the parents on the issue of FGM. The project has thus instilled some confidence and courage in girls to say no to FGM. The positive changes brought by the project have resulted into some of the parents abandoning FGM, particularly in the wards such as Isenye, Nagusi and Ikoma.

“In the past, I mutilated on of my girls. But thanks to this project, I have learned the effects of FGM and decided not to mutilate my other two daughters. After receiving training and education, majority of community members do not want FGM to continue. However, in neighbouring Tarime, the practice is still prevalent.

KII- Machochwe Ward – Machochwe Village

“At the age of 12 years old, my parents wanted me undergo FGM. I strongly rejected, and I told them if they would use force to mutilate me, I would personally take them to the authorities. After realizing that I was not joking, they stopped their plans to have me mutilated.

FGD Mbibali Ward- Mbalibali Village

FGDs with primary school girls in 6 studied wards revealed that before project intervention, one of the major problems girls faced in their community was stigma and exclusion, whereby girls who had not undergone FGM were called names and deemed unfit.¹³⁹

“Our fellow girls who had been cut used to insult us, calling us ‘wasaghane’ – meaning uncircumcised girl.”

“When we were at school, even boys insulted us by telling us ‘You are wasaghane. We cannot marry you.”

FGD with girls in Machochwe Ward

Field findings also show that the number of girls who escape FGM significantly increased during the project implementation period in Serengeti. For instance, the information received from the Secretary of the traditional leaders shows that in 2012 about 176 girls came out to oppose FGM and in 2014 the number increased to 233 girls who escaped FGM and found placement at a safe house. After the project was introduced, the number of girls who escaped FGM and run to safe houses were 762, showing the project has contributed to reduce FGM by enabling girls to escape to safe houses.

¹⁹. Increased knowledge on FGM and its effects among project beneficiaries has resulted into change in mindset and attitude towards FGM

Quantitative study findings indicate a change in mindset and attitude towards FGM among men, women and community members at large. They generally show that majority of respondents are of the opinion that majority of members of the key targeted groups such as men, women and the community at large do not want FGM to continue. 80.2%, 84.4% and 87.4% of

³⁹ FGDs conducted at Machochwe Primary School in Machochwe Village, Machochwe Ward; Nyansurura Primary School in Nyansusura Village, Nyansusura Ward; Nyibereka Primary School in Nyibereka Village, Issenye Ward; Iharara Primary School in Iharara Village, Nagusi Ward; Robanda Secondary School in Robanda Village, Ikoma Ward; and Kitungurma Village in Mbalibali Ward.
respondents think that majority of community members, men and women respectively do not want FGM to continue in their community.

Before the project commenced, the general mindset was that FGM was too important a tradition to ignore and abandon. A woman or girl who had not undergone the cut was deemed unfit for marriage and faced discrimination from other community members. FGM was considered as initiation of girls from childhood to adulthood. This has had a key implication on the growth of the girls, which is that once mutilated, regardless of the age, they were deemed ready for marriage and to take on family responsibilities especially for girls who were in school, circumcision ceremonies mostly took place during holiday seasons and after performing these ceremonies they were now ready for marriages and most of them do not return to school but take up family roles in which impacts their engagement in formal education and thus causes truancy/absenteeism. Girls were considered as a source of income for families, particularly for fathers who have a final say on how family resources are deployed. But now the situation has changed. A woman no longer needs to undergo FGM in order to get married, as confirmed by the Village Executive Officer in Mbalibali Village during an interview with the evaluation team.

“The situation has changed following implementation of the project. This is because girls were usually circumcised during holidays, leading to truancy/absenteeism after reopening of schools. But there are no such cases at the moment and they even no longer wear the ropes they used to as a sign of having undergone the cut.”

Ward Education Coordinator, Issenye Ward

“Before the project was introduced women who had not undergone the cut were discriminated and segregated, but that is no longer the case. Also, most people now perceive FGM to be a bad practice.”

Former circumciser, Nyamsingisi Village

“Previously women and girls who had undergone the cut were seen as more important than those who were uncircumcised. But now the situation is different as those who have not undergone the cut are seen as educated and more fitting members of the community. There are less circumcised girls at school.”

Primary school teacher, Mbalibali Village

Even some of the mothers who initially supported the FGM practice and have themselves undergone the cut appear to have changed their attitude and do not wish for the practice to be performed on their daughters, following their sensitization on FGM and its effects. For instance, during FGD with women in Nyansusura Ward, one participant revealed that she had stopped sending her female children to undergo FGM even though she had undergone the cut herself. After learning about the effects of FGM on the health of girls and women, she did not want her children to suffer the same fate as her. Generally, during the evaluation, most men and women spoke coherently about the negative

“I have stopped sending my girls to be mutilated. I sent one but did not do so to another. The community has changed; the majority doesn’t want to mutilate their girls. Still there are few who do so in secrecy and during night hours. But once the government learns of the practice, all those involved are usually taken to court to face justice.”

FGD, Nyansurura Village – Nyasurura Ward
effects of FGM and recounted openly the stories of their lives. This kind of change is not likely to be reversible.

Even the mindset of local authorities has changed, as revealed during an interview with Serengeti District Commissioner, who noted that following the introduction of the project, the public and government institutions have understood their responsibility to stop FGM and child marriage. Previously, it was not clear whose responsibility it was, whether it was of the Police Force, the District Commissioner, the public, the District Executive Director or civil society organizations. Before the introduction of the Tokomeza Ukeketaji Project, all these institutions/authorities were reluctant to take action against FGM and child marriage, at one point in time, each thinking the others will. There was no proper coordination of the efforts to end FGM and early marriages, but now coordination exists and government authorities are paying closer attention to FGM.

“Before the launching of Tokomeza Ukeketaji Project, it was usual to see mutilated girls marching in streets and sometimes in front of the District Police Station. Some of the official institutions were reluctant to take action due to lack of proper coordination and role assignment. But, since 2016, we are very focused and determined to end FGM and child marriages. We are organized and committed to ensure we reduce FGM in Serengeti by more than 90%. We are making good progress. That’s why for the past three years, no public marching of mutilated girls has occurred. Even those ceremonies that were associated with FGM no longer take place openly. Those who still perform FGM do so in secrecy because they fear to be brought before justice. For us this is a huge achievement”

KII with District Commissioner, Serengeti DC

The evaluation team was able to interview the District Commissioner (DC), District Administrative Secretary (DAS) and District Social Officer (DSO), all of whom pointed out that they have organized a modality of having in place people (informers), who will be reporting planned FGM rituals and ceremonies to DAS office. The team also learned that the Mara Regional Commissioner (RC) was planning to meet with all traditional leaders in the region in an effort to engage them and understand the government’s position on FGM and plead with them to support or continue to support efforts to abandon the harmful practice.

Project progress reports indicate that more circumcisers are coming forward to lay down their FGM tools and commit to abandoning the practice. According to these reports two of them denounced FGM in the first half of 2018. One circumciser, who had mutilated about 680 girls and earned about Tshs.1,500,000 in 2016, eventually abandoned FGM and turned to the church to seek refuge and prayers. The project is also gaining support of more traditional leaders in its anti-FGM fight, with 18 traditional leaders from Getarungu Village also declaring interest to denounce FGM.

“I considered sending my girls t undergo the cut, but I have decided against it. I’m now of the view that girls must be taken to school rather than being mutilated and then get married. I’m taking my girls to school because it is their basic right to get quality education. Also, I hope they will help me in the future. The government is sensitizing people and making follow up on FGM very closely.”

FGD, Robanda Village-Ikoma Ward
Other key informants revealed that other circumcisers do not lay down their tools and abandon FGM because of the education provided by the project, but rather fear of being apprehended and sent to court, where they could face jail time. During an interview with the evaluation team, the District Commissioner in Serengeti confirmed that several circumcisers have been sent to court in past 3 years, whereby in 2016 about 20 cases FGM-related cases were registered, implicating parents, traditional leaders and circumcisers.

20. Project intervention to ensure increased commitment to abandoning FGM practice has contributed to a decline in FGM in Serengeti

Quantitative study findings point to a decrease in FGM in Serengeti following project interventions. As shown in figure 14 below, over 90% of the questionnaire respondents were of the view that FGM in their community has decreased.

Data obtained during interviews with secretaries of traditional leaders each clan in Serengeti generally support claims of decrease of decrease in FGM in the district. According to the data obtained from these secretaries, in 2012 about 15,274 girls were registered for FGM and about 14,041 (91%) of the registered girls were mutilated. In 2014, about 14,122 girls were registered for FGM and 13,855 (98%) were mutilated. Only 267 (2%) of girls who were registered escaped FGM in 2014. After the introduction of the project in 2016, the number of girls registered for FGM significantly dropped whereby only 5,621 girls were registered for FGM and only 2,313 (41%) were mutilated. The decrease of the number of girls who were mutilated in 2012 and 2014 in comparison with 2016, attests to the contribution of the project in reduction of FGM in Serengeti District. While the project was launched in January 2016, the cutting season is usually around the end of the year (November-December), hence there was ample

![Figure 14: % Responses on project impact on FGM (N=429)](source: Field Data, January 2019)
time for the project to bring about changes. In the year 2018, there were very few reported and recorded incidences of FGM.

KIIIs with different stakeholders and project beneficiaries, including a village chairperson, a priest and a former circumciser also suggest a decline in FGM in Serengeti.

“FGM has significantly declined. We had two circumcisers, one has retired and the other has denounced FGM. So, we do not have a circumciser at the moment.”
Chairman, Getarungu Village

“At the moment FGM has declined. Last year, most of the girls who were circumcised were the ones who did so voluntarily.”
Priest, Salvation Army Church, Getarungu Village

“The FGM practice is still carried out, but at a much lower rate and amid great secrecy, usually at night.”
Former traditional circumciser, Getarungu Village

“In my opinion, FGM has declined significantly; and not all girls and women who go to FGM sites undergo the cut, because I do believe a woman or girl ride a bicycle with ease immediately after having the cut carried out on them. Some of them pretend to have undergone the cut so as to conceal ‘shame’”
Councilor, Mbalibali Ward

However, despite the perceived decline in FGM, it was revealed during FGDs and KIIIs that some people are still practicing FGM, albeit in utmost secret, as opposed to conducting the ceremonies during the day as was the case before the introduction of the Tokomeza Ukeketaj Project. These people are reluctant to abandon their customs and traditions.

21. Project intervention has also contributed to increased number of FGM cases sent to court

The number of FGM-related cases sent to court was found to have increased as a result of project intervention through capacity building to law enforcement officials, with 13 out of 20 cases reported to gender and children desk cases registered in 2016 and 8 accused persons convicted and sent to prison. The project started in January 2016 and these trends were observed at the end of the year, which is the cutting season.

| Table 11: Trends of reported cases at police gender desk |
|-------------|------------------|
| Year        | No. of FGM, GBV and Early Pregnancy/Child Marriage |
| 2015 – 2016 | 275              |
| 2016 – 2017 | 430              |
| 2017 – 2018 | 387              |
Table 10 above shows the trends of reported cases of FGM, GBV and early pregnancy/child marriage in Serengeti District, reported from 2015 to 2018. Table 11 below provides information on FGM and GBV cases, showing specific age categories of survivors as well as specific forms of GBV. The total in the two tables, however, do not match; and this is because some of the data obtained during fieldwork were not well recorded and analysed. Moreover, the data were obtained from different sources.

Table 12: Statistics on reported cases of FGM, child marriage and other forms of GBV in Serengeti District

<table>
<thead>
<tr>
<th>Year</th>
<th>Age Category of Victims/Survivors</th>
<th>Police Gender Desk</th>
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<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>FGM</td>
<td>Early pregnancy/child marriage</td>
</tr>
<tr>
<td>2015-2016</td>
<td>0-9</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>10-14</td>
<td>20</td>
</tr>
<tr>
<td></td>
<td>15-19</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>20-24</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>25 +</td>
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</tr>
<tr>
<td>Total</td>
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</tr>
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<td>2016-2017</td>
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<tr>
<td></td>
<td>10-14</td>
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</tr>
<tr>
<td></td>
<td>15-19</td>
<td>0</td>
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<tr>
<td></td>
<td>20-24</td>
<td>0</td>
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<tr>
<td></td>
<td>25 +</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
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<td>2017-2018</td>
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<td>25+</td>
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<tr>
<td>Total</td>
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<td>71</td>
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</tbody>
</table>

Source: Field Data, January 2019 (Police Gender and Children Desk – Mugumu)

22. The project has ensured improved and friendlier services due to increased efficiency of health and legal professionals
As discussed in subchapter 3.2 above, over 50% of questionnaire respondents were of the view that the project intervention through trainings for health and legal professionals has significantly improved their efficiency in providing FGM and GBV related legal and health services. Consequently, the services provided are friendlier and more accessible to community members.

In a special way, respondents revealed that the project had increased the accessibility of health services for FGM and child marriage survivors. Due to the increased knowledge of FGM among community members, it was reported that even the few who oppose anti-FGM initiatives tend to seek medical assistance when they face problems like severe bleeding of FGM survivors. An interview with the District Health Department revealed that due to the increased sensitization, the community has become aware of the availability of health services, including services for FGM survivors. Despite their fear, but they have no option but coming for treatment, especially when their lives are on the line.

Question 7: To what extent is the project contributed to a long-term positive (and negative) effect on health of young girls and women in Serengeti?

23. The project has largely contributed to long-term positive effect on health of young girls and women in Serengeti through increased knowledge about FGM and its effects and improving their access to friendlier FGM and GBV services due to training and capacity building of legal and health professionals in the district.

As discussed in subchapter 3.2 above, the evaluation team found that the project has significantly increased the knowledge on health effects of FGM, human rights aspect and laws related to GBV to community members in Serengeti District, including women and girls, something which has prompted them to stand against FGM. It has also been revealed that trainings and capacity building sessions for legal and health professionals has resulted into increased efficiency in delivering legal and health series for women and girls in Serengeti. Equipped with increased knowledge on FGM and its effects and existence of friendly, more accessible and improved legal and health services related to FGM and GBV has largely contributed to long-term positive effect on health of young girls and women in Serengeti.

24. The project has successfully advocated for inclusion of GBV/FGM budget in district council annual budget

According to project progress reports, the project has strategically ensured that local government authorities are part and parcel of the project; and ensuring budgetary allocation for GBV. There was no budget for GBV before the project commenced but it has now increased from Tshs. 0 to Tshs. 3,500,000 to Tshs. 10,420,000 in the year 2018/2019. While the amount
allocated for GBV/FGM may not be sufficient, it will still help to address GBV and FGM issues and contribute to sustaining anti-FGM efforts in the district.

3.7. Knowledge Generation

**Question 8: To what extent has the project generated knowledge, promising or emerging practices in the field of EVAW/G that should be documented and shared with other practitioners?**

The Tokomeza Ukeketaji project was designed in such a way that the community itself takes lead in the overall project implementation, while the Amref and LHRC takes a facilitative role on the technical part of it, with that regard the project has been strategically adopting very cost effective and replicable methodologies in the course of its implementation. Traditional leaders are said to be the only and strong group holding and enhancing the existence of female genital cuts in the society. They have their remarkable contribution on the existence of female genital mutilation practice. They are the ones initiating and sometimes forcing the society through imposing sanctions and fines to all who are disobedient. Accumulatively traditional leaders can simply be termed as the female genital mutilation regulatory organ or entity. They are the ones to decide the modality, places and prices in carrying out female genital cuts process, below is the summary of the innovative methodology the project has undertaken sustainably mainly to ensure the FGM practices are wiped off by the community itself.

**Confusion over role of Amref with regard to policing of FGM**

The evaluation team observed some confusion and misunderstanding among some of the community members about the role and mandate of Amref. For instance, one community member said, "If I hear that a girl is about to be circumcised, I will call Amref. They will come and put them (the perpetrators) in jail." Obviously, it is not Amref Health Africa that puts people in jail. Amref Health Africa invested a lot of time and energy to build rapport and gain excess into communities. In general, the organization has a good reputation and their work on FGM is widely appreciated, except that despite these beneficial relationships with communities, there is still some hesitation from people who continue to favor FGM/C. Thus, Amref Health Africa was wrongfully perceived by some community members as being an enforcer of the law.

**Education is key in eliminating FGM in the long term**

Education was found to be a key solution to addressing FGM in the course of project implementation. Evidence from the field showed that the incidence of harmful practices such as female genital mutilation decreases with gains in female literacy. Comprehensive formal, non-formal and informal education may play a huge role in preventing and eliminating FGM. Girls who go to school and continue to attain education are less likely to be subjected to FGM and then prepared for marriage. As future educated parents, they are also less likely to subject their daughters to such harmful practices.

The Traditional Leaders Council Secretary for Inchugu and a Chairperson for Tokomeza Ukeketaji Steering Committee for Serengeti District confirmed that Waikoma and Wanata clans have completely abandoned FGM, and most girls have attended school and are very
economically supportive to their families. Even more so, it is apparent that lack of a comprehensive knowledge is thought to be the main problem causing the perpetuation of FGM/C. "I do not blame my parents, because they never had any knowledge and formal education. Nobody could tell them. The church could not speak about it. Also, the government did not do at that time. So they had to follow the culture as they were taught." (Young woman from Inchugu).

Education is construed as a form of female empowerment that is likely able to equalize the male-female balance. The assumption behind increased education is that women who are educated are aware of their rights and will be able to better claim and defend these rights for themselves and their daughters/children. Second, it may reduce their dependency and give them more economic stability, as women have their own income. One participant confirmed the role of education promoting women's empowerment: "You know, in my community the voice comes from the elderly, the elderly men who are the age of my father now. They are the ones who control everything in the community. The young warriors and the upcoming men, they just have to follow their culture. It is only if one is educated that we (as women) can stand and say: 'No, our fathers did it like this, but now there is another direction.'"

Case Study 2:
The project completed school-based bonza at school level, in which a total of sixteen primary schools and four secondary schools were reached. The sensitized schools are in the wards mostly affected by such harmful practices, including: Kisangura, Matare, Nyamoko, Maburi, Nyansurura, Rung’abure, Machochwe, Kebanchabancha and Sedecco. The team of facilitators was a combination of the officials from different institutions. Officials from the District Executive Director, Safe House, Police Force, Imara Foundation, Religious Leaders and project implementation team. A total number of 11319 (6019fe: 5300me) students were directly reached in this activity. The total number of students reached may categorically be defined as: 5738 (2096me: 3642fe) primary school students while 5581(3940fe:1641) were secondary school students.

Key lessons:

- Students proved to understand and realize the significance of alternative rites of passage as the best replacement of female genital mutilation.
- Getting well-centered students as the ambassadors on the fight against female genital mutilation.

Importance of male involvement
Involving men in anti-FGM initiatives is key in achieving results, especially men who are traditional leaders and religious, as they have a big influence over other community members. From an integral change approach, it is important not to overlook their concerns and stakes. Doing so can lead to setbacks in the future. They might feel ignored and want to maintain older practices, such as working to re-introduce FGM/C. The evaluation has found that the investment was solely based to majority of women and girls, which call for thinking of the men and boys in the scale up programing.

The role of traditional leaders
Traditional leaders are very crucial in the fight against FGM. Should they stand firm in condemning/speaking against FGM and promoting abandonment of the practise. This is one of the things which worked well for the project in Serengeti and contributed to its effectiveness, efficiency and impact.

**Case Study**

De-sanctification of female genital cut and the total burn of female genital cutting ritual tools was traditionally agreed by all traditional elders of the six clans (Inchugu, Inchage, Ngoreme, Tatoga, Waissenye, waikoma and Walenchoka) to be the final approach towards eliminating female genital cutting. Taking place on 10th December, which is the International Human Rights Day, the de-sanctification event considered to be a remarkable event, associated with the movement of protecting and preserving human rights in the world. The event was honored by Ms. Anna Rose Nyamubi – Buthama District Commissioner as a representative of the guest of honor the Mara Regional Commissioner. This event, was recorded to reach about 2200 (1263F:937M) people.

There are seven clans (Inchugu, Inchage, Ngoreme, Tatoga, Wakenye, Waikoma and Walenchoka) in the district that performs female genital mutilation; have finally agreed and designed their own kuryan ARP, thus, with the efforts of the project and the joint support from the government, the society is now aware and can strongly stand on their own to fight against FGM. Therefore, 2018 has marked for the first Kuryan ARP ceremonies, whereby a total of 359 girls graduated making 23.9% of the set target for the entire project life. ARP ceremony is the result of long time consultation with traditional leaders, long time plan and training.

**Lessons from this case study**
- Traditional leaders are becoming increasingly important in advocating for and promoting ARP.
- Traditional leaders understand the significance of ARP and are calling upon fellow community members to embrace it.

**Continuous monitoring and evaluation**

Ultimately, any intervention with the aim of encouraging people to abandon a historically-embedded cultural practice will likely suffer from some types of side-effects or negative unintended consequences. Unforeseen consequences, if negative to the well-being of community members, first and foremost for the girls themselves, need to be acted upon. To be able to do that strong monitoring and evaluation (M&E) structures and mechanism to monitor progress and consequences need to be put in place to enable follow-up on girls after they have participated in an ARP and community and institutions of accountability’s responses to FGM in general.

**Ability to adapt to changing circumstances**

The project has showed resilience and ability to adapt to changing circumstances as a result of a deep understanding of the context by all stakeholders particularly for traditional leaders and
End Term Evaluation in Female Genital Mutilation Elimination Project, March, 2019

FGM practitioners. This is reflected in the holistic and participatory approaches and active participations deployed throughout the project implementation phases.

Role played by the Serengeti District Council
The role played by Serengeti District Council Authority and Project Management unit was instrumental in keeping the issue of FGM a priority on the local and national agenda. This is due to the consistency and the regular building of coalitions and stakeholder groups to support the work of the project. The challenge remains on the ownership and sustainability of the project through resource allocation and monitoring frameworks.

Political will is key in the fight against FGM
Closely working with and engaging district and other local authorities as well as building their capacity on FGM, its effects and its human rights aspect helped in securing political will. Political will is key in achieving anti-FGM efforts and contributes to greater participation of other influential actors in the community such as religious leaders and traditional leaders in the fight. This is one of the things that to a large extent worked well.

The evaluation team was able to identify the following promising or good practices:

• Employment of holistic and participatory approaches in project implementation: As discussed in subchapters 3.2 and 3.4 above, the project centred on this strategy throughout its implementation, bringing aboard different key stakeholders at district, ward and village levels to collaboratively design and implement project activities. Amref and LHRC mainly played a facilitative role, while legal and health professionals, as well as law enforcement officers, were effectively used in sensitizing, providing FGM/GBV related services and taking action against perpetrators of FGM. District authorities largely contributed in coordinating the project and at times played an advisory role. Close collaboration with district and local government authorities is key in sustaining anti-FGM efforts.

• Engagement of traditional leaders, religious leaders and circumcisers: Traditional leaders, religious leaders and circumcisers are very influential people who hold a key in ending FGM in Serengeti. Effectively engaging them was therefore a critical approach that largely contributed to project effectiveness and impact. Securing commitment of traditional leaders, who signed anti-FGM declaration and committed to abandon the practice was a huge bonus for the project.

• Promotion of alterative rites of passage (ARP): The project was able to successfully pilot the ARP ceremony in Serengeti, which was one of the key highlights of the project.

• Education and awareness-raising: Comprehensive education and awareness raising programmes are key weapons in ending FGM and also contribute greatly in preventing the practice. Information and awareness-raising on the effects of FGM, its human rights aspect and its legal prohibition were key in ensuring project effectiveness and reducing
FGM in Serengeti. As discussed in subchapter 3.2 above, the project invested heavily in anti-FGM education and awareness-raising.

- **Use of peer educators**: One of the unique features of the anti-FGM project implemented by Amref and LHRC in Serengeti was the use of peer educators to reach parents and other project beneficiaries and provide them with education on FGM and its effects. This is a good practice and largely contributes to spread the anti-FGM messages to members of the community who cannot attend meetings, trainings and seminars.

- **Establishment and empowerment of local CBOs to increase protection and ensure availability of support services for women and girls in Serengeti after project completion**: This move was critical in ensuring sustainability of the project, as women and girls would, in the long run, continue to receive FGM/GBV services.

- **Involvement of women and girls who have undergone FGM in project implementation**: By sitting back and taking a facilitative role, the project enabled women and girls who have undergone FGM to share their experiences and play a role of anti-FGM champions. This move was crucial in ensuring project effectiveness and is key in eliminated FGM in the long-run.

3.8. **Gender Equality and Human Rights**

**Question 9: To what extent did the project incorporate human rights-based and gender responsive approaches throughout the project?**

The evaluation team generally found that the Tokomeza Ukeketaji Serengeti Project was implemented in line with the principles of gender and human rights.

→ Firstly, the project implementation observed the principle of participation, employing participatory and holistic approaches from the beginning. Amref and LHRC ensured regular consultation with project targeted groups in developing plans, strategies and approaches.

→ Secondly, all interests, needs and priorities of both women and young girls were taken into consideration. A gender needs assessment was conducted prior to project implementation.

→ All rights of the targeted respondents, including right to culture, were respected in the course of project implementation and people were allowed to express their views about the project, even negative ones. Traditional elders were fully involved in project activities.

→ The project focused more on changing mindset and attitude of community members, rather than bringing the FGM perpetrators to justice. This was done through engaging circumcisers and empowering them economically to seek alternative sources of income.

→ The project ensured that girls who ran away from FGM were treated well and placed at safe houses.

→ Trainings and seminars including human rights and gender aspects of GBV, FGM and child marriage as well as human rights of all targeted respondents.
The evaluation team was able to confirm considerations of gender and human rights principles in the course of implementation of the anti-FGM project during KII. For instance, in a KII with an executive director of a local organization in Isenyi Ward, it was revealed that the project considered the needs of and priorities of women and girls, as well as of other targets of the project. He also indicated that traditional leaders were fully involved in different project activities, including dialogues, meetings and seminars; and that human rights of all those involved in the project were respected.\textsuperscript{40} Human rights organizations involved in the project, including LHRC and WASHEHABISE helped to ensure respect of human rights of all those involved in the project. Participation in project activities was voluntary.

\begin{quote}
“The project considered human rights because no force was used, people were free to express their opinions at different forums and there was more use of dialogue.”
\textbf{Retired teacher, Park Nyigoti Village}
\end{quote}

The project has been fully aligned to international human rights and gender equality norms and standards as well as gender responsive based approaches are been incorporated through-out the project implementations, The project has also observed principles of participation and social inclusion and below are the areas observed:

Right to non-discrimination: The project ensured no girls are discriminated in the context of child marriage or child pregnancy by brining perpetrators before the law, and this was mainly done by the project trained police officers, paralegals, CHWs and whistler blowers.

Right to a safe, non-violent environment: Girls (and boys who don’t conform to traditional gender norms) are often at greater risk of facing physical and psychological violence in school, around school and on the way to school - so fulfilling the right to a safe and non-violent environment, the project trained police officers, teachers, WEOs, paralegals, CHWs and whistle blowers.

Right to know your rights: The project ensured this by bringing schools on-board, both primary and secondary schools, as schools play a pivotal role here and it means that girls were be empowered with knowledge of the protections offered under human rights law.in the Tokomeza project, this included the sexual and reproductive health rights.

Right to participate: The project again ensured this right particularly in schools, where the girls and boys under the anti-FGM school formed clubs, where girls and boys are oriented to have an equal right to participate in decision making in schools.

Sensitivity of budgets: The project also worked to ensure a responsive budgeting and planning in the district, where officials were trained on gender budgeting and planning.

\textsuperscript{40} KII in Isenyi Ward, Serengeti District.
According to GNA report, about 81.9% of boys and men were aware of FGM causing death too. 64.1% of the boys and men were of the view that FGM is against human right. This implies limited knowledge about human rights among boys and men, including implications of FGM on the right to life. Moreover, 89% of KII respondents and 95% of FGD participants acknowledged that human and gender rights are key factors during implementation of the project.

Chapter 4: Conclusions and Recommendations

4.1. Conclusions

<table>
<thead>
<tr>
<th>Evaluation Criteria</th>
<th>Conclusions</th>
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<tr>
<td>Overall</td>
<td>Findings addressed in this report are entirely based on feedback provided during field interactions (interviews, discussions and observations) as well as desk review of key documents related to FGM at national and project level. The conclusions are drawn in light of the relevant criteria for evaluation. Generally, the project was effectively implemented using strategies that were participatory and holistic. The strategies used were relevant to project needs and needs and priorities of women and girls in Serengeti, who were the primary beneficiaries. The evaluation team found the overall management and coordination of the project to be efficient, employing cost-effective strategies and characterized by timely delivery of activities. The evaluation also found that all project activities were implemented in line with the work plan, despite initial delays in commencement. The project’s strategies of effectively engaging key stakeholders and collaboratively implementing activities with them, yielded positive results and contributed to project sustainability. As a result, the project brought about positive changes in the communities in Serengeti, both intended and unintended. Intended changes include increased knowledge on FGM and its effects; commitment on the part of project beneficiaries to abandon FGM; and decline in FGM prevalence. Unintended changes brought about by the project include improved school attendance among girls and decline of child marriage. However, despite the good work done by Amref Health Africa and LHRC, the project did not manage to reach all its intended beneficiaries, particularly the primary beneficiaries (girls and women). Moreover, the project impact and sustainability are threatened by FGM practices in neighbouring districts such as</td>
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</table>
Bund and Butiama. Some of the community members in Serengeti have reportedly been sending their daughters and young women to undergo FGM in these district, where efforts to address the practice are almost non-existent.

Additionally, although FGM/C and child marriage knowledge is high, a significant number of respondents demonstrated limited knowledge on availability and services offered by the police gender desks, judiciary and paralegals, particular those in remote villages/areas. Furthermore, it was also reported that there are some weaknesses in documentation of services offered to survivors and their other information. For instance, in Park Nyigot, it was revealed that despite the project providing the health facility with equipment like computers, suggestion box and phones, such equipment are yet to be put to use. As a result, documentation is still done in terms of paper, which is more likely to affect accuracy and validity of stored data.

**Effectiveness**

The project has effectively and significantly increased awareness of health effects and human rights aspect of FGM among girls and young women, as demonstrated by increased knowledge levels and women and girls taking a stand against FGM.

The project effectively improved the awareness mostly to community members, CSOs, policy actors and traditional leaders on the socio-economic and health effects of FGM and - to some extent - gender based violence and gender mainstreaming approaches for sustained efforts. In their work, stakeholders also became more aware of gender needs and analysis. However, gender knowledge building and gender mainstreaming towards more gender equality in organizations’ structures and procedures require more time and resources to be effective.

Moreover, even though the project’s activities contributed to significant knowledge gains, however, the integration of gender knowledge in activities by the stakeholders and particularly in the District Council was observed to be limited. Moreover, the shape and focus of gender mainstreaming efforts are still evolving. It is clear that gender mainstreaming requires more time and resources to be effective.

The project has also significantly contributed to increased awareness on health effects and human rights aspect of FGM among parents/caregiver, traditional leaders, boys, men and circumcisers, which in turn has created an environment for these groups to discourage FGM. Girls and young women are now more confident of saying NO to FGM and seek
assistance when they are forced to undergo the cut.

Furthermore, the project has effectively established the ARP model and engaged traditional leaders, circumcisers and young women and girls to abandon FGM practices using the model. This is a significant achievement of the project as girls are now free to pass into adulthood without having to undergo the cut.

Through trainings for healthcare workers and mothers attending clinics, the project has significantly improved their knowledge on avoiding effects of FGM. This means girls and women now have access to better and friendlier health services.

Additionally, the project effectively engaged and trained 30 police gender desks officers, paralegals and judicial officers to improve their legal knowledge to effectively respond to FGM cases and ensure perpetrators are brought to justice. It also effectively trained 178 healthcare workers and 104 community health workers to improve their knowledge on managing health complications of FGM and enable them to provide comprehensive SRHR and psychosocial support to girls and women. Consequently, there is improved access to and quality of legal and health services.

Moreover, project successfully created forums to advocate for enforcement of GBV-related and policies in order to safeguard rights of women and girls and spearhead formation of CBOs and built capacity of existing CBOs to ensure they advocate for rights of women and against FGM. Empowerment of these CBOs is key for spread of knowledge and project sustainability.

The project also managed to engage, sensitize and build the capacity of local government authorities to ensure increased allocation of budget for GBV/FGM in annual budget. However, no budget was allocated for GBV/FGM until the final year of project implementation, which was itself not substantial.

### Relevance

The project goal, outcomes and outputs were found to be relevant to the needs of women and girls in Serengeti, owing to the gaps in knowledge among them and other members of the community, including legal and health professionals, and existence of gender inequalities in the district.

To a large extent, the project responded to anti-FGM and GBV agenda contained in key national plans such as the National Plan of Action to End

The project clearly addressed the dire needs of the FGM situations and policy context in Serengeti District which can be motivated and replicated to other parts of the Region if not the country at large. It has been a unique and forward-looking endeavour in abandonment of FGM and other forms of violence in Serengeti district due to its importance as the district’s first serious effort to end FGM and all its forms. The fieldwork confirmed that even before the start of this project, only very few projects or activities addressed the needs of survivors of FGM/GBV such as *nyumba salama* (safe houses) and there was a lack of serious attention by the local authorities. Thus, this project has been a highly relevant initiative by the project partners.

The project offered a well-suited combination of activities in all critical dimensions of FGM/GBV as enshrined by the international, regional and national instruments, policy context strategies, plans and guideline as discussed earlier in this report. The overall strength of the project design was its inclusiveness and comprehensiveness.

The project’s main goal, outcomes and outputs were thus relevant and remain highly relevant not only in the district context but also to the neighbouring districts (Tarime, Bunda and Butiama) and the country at large.

**Efficiency**

The project was generally characterized by timely delivery of activities and all activities were implemented in line with project work plan and budget. Only a few activities were not delivered on time but valid reasons for the delays were given and they were effectively implemented. The achievement of results has been cost-effective and funding has been spent in strict accordance with the original budget and work plan despite delays of disbursement in periods.

The project employed participatory and holistic approaches in designing, managing and implementing the project to good effect and engaged external experts when needed in order to effectively and efficiently implement the project. It also employed effective strategies and approaches to empower and build the capacity of targeted beneficiaries. What strikes the eye is the comprehensive approach of the project design throughout, working from various angles, including the acknowledgement of and the work on underlying causes of issues such as cultural constraints factoring FGM.
The project relied on professional work in planning, management and coordination; and a high level of commitment by project partners’ and staff. Volunteering spirits demonstrated by project stakeholders, including the council management team, traditional leaders, community health workers, paralegals and many others, even during the evaluation exercise substantially contributed to the design, management and implementation of the project.

Some aspects somewhat affected project efficiency. These include institutional weakness and limited capacity on gender analysis and baseline data of partners at times created practical obstacles to moving forward efficiently. The Local Government definitively has increased its commitment, but human and financial resources continue to pose a challenge on their good intentions. Moreover, the evaluation concludes that even though the project was well designed and the approaches appeared to be balanced, the monitoring and data base were found to be a challenge. Another constraining issue are the gaps in Tanzanian legal framework and also the fact that laws are not always timely enacted and even if they are enacted, effective implementation and compliance is usually lacking and not uniformly applied.

**Sustainability**

Effective strategies and approaches employed by the project have helped to institutionalize the anti-FGM project in Serengeti and build capacity of key stakeholders in order to sustain achieved results. The participatory and holistic approaches were key in institutionalizing the project, as were strategies such as engaging the traditional leaders and circumcisers to effectively participate in implementation of project activities and establishment of anti-FGM/GBV clubs in schools and local human rights CBOs.

The sustainability of the design and implementation of the project was found to be reasonably good and supported by increased ownership and enhanced institutional and individual capacity. While the current funding gaps and limited gender mainstreaming activities into District plans and budget pose challenges to the sustainability of results, the project partners have created a solid foundation for continued progress and achievements worth to be credited.

In summary, a number of benefits produced by the project continue after the external assistance has come to an end. In particular, sustainability can be found in the continuation of momentum and commitment, in the
application of knowledge and skills, and in the use and broadening of networks. However, there is a clear gap in the systematic institutionalization of gender perspectives.

**Impact**

The project has largely contributed to project goal through empowering women and girls to ensure they are free from FGM and GBV, which in has enabled them to enjoy more freedom to exercise their legal and social rights. It has managed to bring about several changes in Serengeti District, mainly:

- Significantly contributing to women and girls taking a stand against FGM and committing to abandon it;
- Increased knowledge on FGM and its effects among project beneficiaries has resulted into change in mindset and attitude towards FGM;
- Increased commitment to abandoning FGM practice has contributed to a decline in FGM in Serengeti;
- Increased number of FGM cases sent to court;
- Improved and friendlier services due to increased efficiency of health and legal professionals;
- Contributing to long-term positive effect on health of young girls and women in Serengeti through increased knowledge about FGM and its effects and improving their access to friendlier FGM and GBV services due to training and capacity building of legal and health professionals in the district; and
- Successfully advocating for inclusion of GBV/FGM budget in district council annual budget.

In summary, the anti-FGM project in Serengeti accomplished a great deal of what was intended and produced significant progress in ending FGM in the district and ensuring women and girls are free from effects of the practices and freely enjoy and realize their rights. It has also brought about unintended impact, such as boosting girls’ school attendance and contributing to decline of child marriage.

**Knowledge Generation**

Among the key lessons that emerged during the evaluation study are:

- There was a confusion among some of the community members over role of Amref with regard to policing of FGM
- Education is key in eliminating FGM in the long term
- Involving men in anti-FGM initiatives is key in achieving anti-FGM results
- Traditional leaders are very crucial in the fight against FGM as they hold a big influence over other community members
- Continuous monitoring and evaluation is key for sustained anti- FGM efforts
- Ability to adapt to changing circumstances was one of the key
The evaluation team was able to identify the following promising or good practices:

- Employment of holistic and participatory approaches in project implementation
- Engagement of traditional leaders, religious leaders and circumcisers: Promotion of alterative rites of passage (ARP)
- Education and awareness-raising as key weapons in achieving project objectives
- Use of peer educators to reach out to wider section of the community
- Establishment and empowerment of local CBOs to increase protection and ensure availability of support services for women and girls in Serengeti after project completion
- Involvement of women and girls who have undergone FGM in project implementation

### Gender Equality and Human Rights

In terms of gender equality and human rights, the Tokomeza Ukeketaji Project was able to employ key human rights and gender equality principles, chief of which were the principles of participation and non-discrimination. Gender needs assessment was conducted to identify the needs and priorities of women and girls and all human rights concerns were taken into consideration in the course of implementing the project.

In summary, the project made important contributions in promoting gender equality and human rights; and ensured safeguard of the rights of girls and women, who were primary beneficiaries, as well as rights of other project beneficiaries in the course of project implementation. It maintained a strong focus on human rights throughout the project implementation period and observed principles of participation and social inclusion.

### Others (if any)

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### 4.2. Recommendations

**The Government and Parliament**
• Although Tanzania is doing well in addressing FGM and other forms of VAW/VAC through implementation of the plan of action to protect women and children from violence, which incorporate strategies to end FGM and contributed in reduction of prevalence rate from 15% in 2010 to 10% in 2015, these initiatives need to be complimented by enactment of FGM/GBV specific legislation which will fully ensure prevention and abandonment of the practice and create a sustained mechanism for legal redress. The necessity of improving dissemination of the meaning and content of laws requires close collaboration with both civil society and the media and dissemination of information through user-friendly languages.

• The plan of action and budget requires commitment to budgeting for and providing adequate funds for their implementation at the national and district levels.

• In regards to government responsibilities, the Human Rights Council (HRC), during its 38th Session in July 2018, called upon states in Recommendation 3 to: develop and implement, with the participation of the relevant stakeholders — including girls, women, religious and traditional leaders, community leaders, health- care providers, civil society, human rights groups, men and boys and youth organizations — integrated, comprehensive and coordinated strategies and policies to prevent and eliminate all forms of female genital mutilation.

• Further, in Recommendation 10 the HRC called upon states to: provide assistance to women and girls who are victims of female genital mutilation, including through appropriate support services for treatment of the physical, physiological and psychological consequences such as One Stop centres be established at the District level.

• We suggest an emphasis be put on the further engagement of the traditional leaders’ council, which has the power to make culturally-binding decisions.

• Government authorities have a responsibility to ensure that the media plays a full and productive role in the dissemination of information on the law and FGM and does not face restrictions and threats for contributing to national plans to end FGM.
  
  ▪ Increased use of all the media, including social media, would help raise public awareness on FGM/GBV, effects and related laws.
  
  ▪ Increased support from the local governments for the role of media would boost dissemination of information about FGM, its effects and its human rights aspect.
  
  ▪ Tribunals and quasi-judicial bodies should be encouraged to ensure any cases and prosecutions relating to FGM are clearly reported through appropriate media channels.

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**Serengeti District Council**

SDC needs to develop and implement up-to- date national strategies and action plans to tackle FGM and meet their commitments under international treaties and the SDGs. District strategies should include:

• Funding commitments and set out budget lines and adequate funding to support the work to end FGM in line with the National Plan to End Violence Against Women and
Children and directives from the National Annual Guideline for Preparation of Plan and Budget;

- Training around FGM and anti-FGM laws and prevention mechanisms for all members of the police and judiciary (from local police officers through to Community health Workers and border control district) and all those in positions of authority, including medical professionals, social workers, teachers and faith and community leaders;
- Develop behaviour change communication materials which also need to be made accessible to all members of society and drafted in friendly languages to be locally understood;
- Where they are currently unavailable and a need is identified, appropriate protection measures (such as emergency telephone hotlines or safe spaces) should be put in place for women and girls at risk of FGM; and
- Adequate monitoring and reporting of FGM cases to improve efficiency and inform policy makers, the judiciary, the police, civil society and all those working to implement and enforce the law as well as allocating resources.

**PMU/AMREF/Donor**

As discussed in the report, the neighbouring districts such as Butiama, Bunda and Tarime pose a threat to project sustainability. It is understandable that, anti-FGM campaigns take long to yield results, and have to be part of a larger process of social change. Hence, the evaluation recommends existence of sustainable efforts to address FGM in the neighbouring districts, where those who continue to embrace FGM flock to in search of FGM services.

Generally the evaluation team observed that Amref stands a better position to provide the best practises and strategic framework with evidence-based knowledge and tools enable both policy-makers and in-country anti-FGM campaigners to be successful and make a sustainable change to end FGM as a result of project achievements. However, should the scale up or extension happen the evaluation recommends for the following to be considered in order to realise the maximum potentiality of the investments:

**Need to engage in joint advocacy with other CSOs and key stakeholders to ensure Government disbursement of funds for GBV/FGM**

Financial resources of Government came up as a constraint under a number of conclusion areas. Although the Government has shown policy commitment through National Plan of Action to End Violence Against Women and Children and the National Guideline for preparations of Plans and Budget, and funds are minimally budgeted and allocated, the necessary funds are frequently not disbursed or timely disbursed. To address this, the project needs to expand their involvement with the government under other key actors in developing an advocacy strategy which will ensure timely and adequately budget allocation and disbursement at the LGA level. The evaluation has noted the Gender Responsive Budgeting training to LGA Council Management Team but this was conducted towards the end of the project, the outcomes which need to be realised at the next level of the project.
• Whilst this is something that Amref and its partners will not be able to do alone, it is important to form strategic alliances within and outside the project scope, to jointly advocate with the Government to disburse the funds even from the District own source, necessary to improve the impact of the project.

Address the Economic Empowerment for Women and Girls
It is important to expand efforts of economically empowering women and girls as a key initiative to ensure abandonment of FGM. It is critical to consider and facilitate alternative sources of income for circumcisers and traditional leaders. Moreover, based on economic deprivation of women and girls, strategic approaches need to be addressed for women’ economic empowerment, such as investing on entrepreneurship skills to Income generating Groups and linking them with the Government Development Fund at the local Level. Investing the limited resources in this area may deliver more results at the local and national level.

Need to use a more structured approach on evidence gathering and knowledge management, including by involving academia and ensuring essential human resources for M&E framework in place
The evaluation has found that the project has done its best in capturing results from the ground through Community health workers in particular, and other key actors. However, the major gaps has been a systemic result framework and data base in capturing gender disaggregated data which has resulted in unreliable and inconsistent data during the field work. Moreover, it does not have a sufficiently structural approach to gathering evidence on results and impact and using it for influencing policy, visibility and making decisions.

The project should develop a strategy for evidence gathering, and start with addressing the knowledge gaps and making those the priority for data collection, analysis and use for decision-making. Moreover, the project must make better use of its interventions and gather data through its partners or by involving staff or experts along with developing a Comprehensive management Information System (MIS)

In order to gather good quality information, the project may contemplate partnering with an academic institution/resource people with relevant skills and experience on gender disaggregated data collection as well as recruiting senior M&E specialist and gender expert staff as soon as possible.

Need for a better structured approach
Better structural approach is critical for strengthening the structural mechanism through rebuilding family and community structures and support systems in dealing with FGM/GBV for early warning and or supporting survivors by:
• Establishing at least One STOP CENTRE (pilot). This will facilitate in addressing the roots and indicators not the effects
• Gender Desks at least in all critical wards with higher prevalence rates of GBV/FGM
• Paralegal units in every ward to compliment efforts of CHW
• Psycho social support desks in schools for children’s victims of violence perpetuated at home and other areas within a particular community
• Community based knowledge centers where traditional leaders and CHW may provide counseling and teaching. This was commented by almost 75% of respondents particularly elderly in rural setting and that will be effective for the sustainability of the project. Amref may partner with and/or seek experience from TGNP Mtandao, which has had a success stories in community based-knowledge centers.
• There is a need to have a Safe House owned by the District Council. This may have considered as an intermediary interventions as the current safe house is owned by a church administration’s
• Establish Social accountability monitoring for perpetrators and budgeting for FGM/GBV and also to ensure that FGM/GBV should be one of the cross cutting agenda in all meetings within the district.
• Closely monitor and document the effectiveness of the established 100 child protection committees in every ward as directed by National Plan of Action to End Violence Against Women and Children.
• Establish a gender-sensitive macro working/technical group in the district to monitor and document gender mainstreaming approaches and strategies in the district
• Amref needs to conduct a baseline survey on the current situation of GBV/FGM in Bunda, Tarime and Butiama to determine socio-cultural norms and barriers potential threats to Serengeti District in ending FGM before considering scaling up.

Civil Society
The evaluation team is of the view that local CBOs, working alongside local police and the judiciary, are best placed to provide education on laws and raise awareness of the effects of FGM, but they need robust legislation in place to start with, the ongoing support of the government and adequate funds to maximise the impact of their work in future.

- Increased funding and empowerment of local activists is needed to ensure greater promotion of anti-FGM laws in their advocacy work.
- Civil society has a vital role to play in disseminating information on the law and FGM. Moving forwards, LGA and government authorities need to work in close partnership with these organisations to ensure that the content of the law is easy to understand (simplified materials) and available to all members of society.
- The development of NGO coalitions that can share knowledge and best practice is welcomed and should be encouraged by all governments as part of their annual plans.
- Civil society, in partnership with government authorities and the media, can provide access to communities at a grassroots level to supply vital awareness-training on FGM/GBV and related laws.
- Other NGOs with gender and children protection and rights focus may be encouraged to incorporate anti-FGM initiatives in their plans.
ANNEXES

1. Terms of reference

Consultancy service to conduct End Term Evaluation for the project titled ‘Female Genital Mutilation elimination project-FGM (Tokomeza ukeketaji) in Serengeti District, Mara region

About Amref

Amref Health Africa is an international health development organization dedicated to finding African solutions to African challenges and health problems. Founded in 1957 and with its headquarters in Nairobi, the organization has country offices in Kenya, Uganda, Tanzania, South Africa, Ethiopia, Senegal and South Sudan, conducts programs in over 30 African countries. Amref Health Africa’s Vision is “For Lasting health change in Africa: Communities with the knowledge, skills and means to maintain their good health and break the cycle of poor health and poverty” and it believes “The power for lasting transformation of Africa’s health lies within its communities. Amref Health Africa works side by side with individuals in communities to empower them to build the knowledge, skills and means to transform their own health”, and focuses on “Improving the health of women and children in Africa’s communities”.

Communities are at the heart of Amref Health Africa’s approach in Africa. This is what sets Amref Health Africa apart from many other health development organizations. Amref Health Africa listens to, gains respect and becomes a part of the community by empowering its members to build on their resources and inherent strengths to take charge of their own health. Amref Health Africa helps communities connect and integrate with formal health systems and acts as a powerful catalyst for lasting health change from within.

Introduction - Project Background and Context

Female Genital Mutilation (FGM) is defined by the WHO as comprising ‘all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons’. The practice of FGM has no known health benefits. On the contrary, it is known to be harmful to girls and women. As well as severe pain suffered during cutting, the removal of, or damage to, healthy, normal genital tissue interferes with the natural
functioning of the body. Immediate and long-term health consequences of FGM include severe bleeding, infections, retention of urine, and later, potential complications during childbirth that can lead to maternal and newborn deaths.

The prevalence of FGC in the country appears to have dropped slightly, from 18 percent in the 1996 TDHS to 15 percent in the 2010 TDHS. Despite the number of measures taken by the Government of Tanzania and partners to abolish Female Genital Mutilation (FGM), the practice is still widely implemented in many parts of the country including Serengeti District whereby an estimated 75% of women among the dominant Kurya tribe have undergone FGM to-date.

Recognizing this gap, Amref secured funds from UN Women to implement a three years (01.01.2016-31.12.2018) project that will contribute towards the elimination of FGM practice among girls and young women in Serengeti District. It is expected that at the end of this project, the incidence of FGM practice will be reduced to 10% among new girls and young women. The project will also ensure that girls and women, boys and men, parents, traditional leaders, circumcisers are aware of the health effects of FGM and commit to abandon the practice. The survivors of Gender Based Violence (GBV) and FGM will have access to effective health, legal and social services. Lessons from the project will be used to influence policy and legal reforms focusing on addressing FGM practice in Serengeti and other parts of Tanzania.

**Overall Goal:** Young women and girls in Serengeti district are free from effects of FGM practice and have more opportunity to exercise their legal and social rights by 2018.

**2.1 Project Objectives**

1) To empower girls, women and community in Serengeti District to abandon FGM/C practice.

2) To build the capacity of health and legal personnel in Serengeti District to deliver effective services in combatting and handling cases of gender based violence including FGM.

3) To strengthen the capacity of community based organizations to carry out policy and law advocacy on elimination of FGM/GBV practices.

**Project’s theory of change:**

Our project is guided by a holistic theory of change, Amref and LHRC believe that the reduction of new cases of FGM to 10% by 2018 and provision of quality health care and legal aid for the girls and women who have been / were mutilated before, needs political commitments, availability of resources, community participation and commitment to abandon FGM and change agents. We believe that IF we empower girls and women to voice out their rights, and change a marriage, empower cutters and parents with health effects of FGM and related laws to commit abandonment of FGM and strengthen existing community systems through innovative capacity building approaches and advocacy forums, THEN we will reduce the new cases of FGM to 10% in Serengeti district by 2018. There will be multiplier effects associated with empowerment of the communities since the approaches for awareness creation, capacity building and advocacy will use community resource persons. In addition, the drivers of mutilations, of which have been primarily the cutters will be trained in
entrepreneurship skills, supported with start up capital, facilitated to join financial institutions in group and coached on the best way to do business. In turn, the same cutters will be used as future ToTs and change agent. This will ensure that there is continuity of the project interventions even after the project phases out. The community will be capacitated to carry ARP without Amref support in the future.

**Expected Outcomes**

1. Traditional leaders, caregivers, parents, circumcisers, and girls commit to abandoning the practice of FGM and this is sustained through community institutional structures.
2. Health, legal and social structures effectively provide required services to GBV and FGM victims and survivors.
3. Community based organization effectively advocate against FGM practices leading to increased commitment from authorities and resources allocations for anti GBV activities

### 2.3 Project Beneficiaries

**Primary beneficiaries:** Women and Girls in general who are vulnerable and victims of FGM.

**Secondary beneficiaries:** CBOs, general public, police forces and judicial system, circumcisers, Teachers, Traditional healers, Health workers boys and men, parents and caregivers, Health workers and community peer educators, FBOs, district authorities.

**Project Partners:**

i. Ministry of Health, Community Development, Gender, Elderly and Children

ii. Local Government Authorities (District Council)

i. District Executive Director’s office (District Medical Officers’ office, District Community Development officer’s office, District Educational officer’s office-primary and secondary, District Commissioner’s office)

i. Legal and Human Rights Centre (works as a sub recipient in this project)

ii. Anglican Church Diocese of Mara-Serengeti Safe House

**Project Current Status:**

i. The FGM practices have drastically dropped, as per project level assessment in 2016; a total of 5621 girls aged 4-7 were registered to be cut, out of which 2313(41.1%) are reported to be cut in the whole district. These were cut mostly in the neighboring district (Tarime) or else in their households done at midnights. However, 762 (13.5%) of girls are reported to openly denounce the practices despite the parents and relatives’ enforcement.

ii. However, the project is proud to report the commitment shown by Traditional Leaders, caregivers, parents, circumcisers, women and girls who are project champions and want to abandon FGM practices in Serengeti. Example; in the reporting period of Jan-June2018, we have had two cutters (Ms.Esther Bhoke (40), a resident of Getarungu Village, has been cutting since 2016, where in that year, she cut more than 600 girls. While the 2nd one was (Rhobi Gichana (46) from Melenga ward, recorded 806 girls cut in 2016. Together with her, 18 traditional leaders from the same ward came to also declare interest of denouncing FGM practices in their Melenga communities; these altogether,
denounced the practice.

iii. Facilitated the signing of the Serengeti District anti-FGM declaration-96 traditional leaders were involved.

iv. The project has strategically ensured that the local government authorities are part and parcel of the project implementation, namely, today in the comprehensive council plan GBV is treated with due value whereas, there was no budget for the same before the project but in the course of two years on the budget has almost double from 0.0TSH to 3,500,000 TSH to 10,420,000 TSH in this physical year of 2018/2019.

v. 20 FGM cases reported and 8 were filed for ruling, out of which 8 are presented before the court for ruling. Only 4 cases are ruled, 4 are still on hearing process. This shows the community and the government is taking lead in the anti-GBV related cases.

Purpose and Objectives of the End Term Evaluation
Amref Health Africa wishes to conduct Final Evaluation for the UN Women funded Tokomeza Ukeketaji project. The main objective of the Final Evaluation is to measure project outcomes and achievement against the set outcome indicators. The evaluation will further record lessons learnt (challenges and opportunities), best practices and provide recommendations for future project implementation.

The evaluation will attempt to determine, as systematically and objectively as possible, the relevance, value for money (efficiency and effectiveness), impact, results, innovations and sustainability of the project. It will also identify significant factors that hindered/contributed to achievement of the outcomes and outputs.

The specific objectives of the Final Evaluation include:

- To evaluate the entire project (three years from start to end date), against the effectiveness, relevance, efficiency, sustainability and impact criteria, as well as the cross-cutting gender equality and human rights criteria.
- To identify key lessons and promising or emerging good practices in the field of ending violence against women and girls, for learning purposes.
- How much the project has contributed to the reduction of FGM/C and Child Marriage practices in Serengeti district.
- Measure the current levels of knowledge, attitudes and practice towards FGM/C and Child Marriage practices in each of the targeted communities (including traditional leaders, young girls, women, parents, district officials, boys and etc).
- Measure the current level of knowledge; attitude and practice of judicial, paralegals and police officers towards provision of legal services to FGM and child marriage victims.
- Measure the current level of knowledge; attitude and practice of health care workers and community health workers towards provision of health services to FGM and child marriage victims.
• Determine the capacity of the district legal and health systems (including police gender desks and health gender desks) to provide legal and health services aids. This includes the availability of personnel to provide legal and health services for young girls and women.
• Measure availability, accessibility and quality of legal aid services and health services offered in the police gender desks and health facilities gender desks.
• Assess the gaps in police and health referral systems (pathways, current practice and tools) in Serengeti district.
• Establish the opportunities that exist for institutionalization and sustainability of anti-FGM initiatives among the stakeholders and the communities in Serengeti.
• Assess budgetary allocations and expenditure trends for FGM/C and GBV at districts level with reference to Comprehensive Council Health Plans (CCHPs) vis-à-vis overall health budgets; and annual financial expenditure reports.
• Assess the implementation of gender sensitive programming for improved Anti-FGM programming in the district through gender mainstreaming in the project activities.
• Collect data on project indicators and compare with baseline values of the indicators.

Scope of work

Relevance
1. To what extent do the achieved results (project goal, outcomes and outputs) continue to be relevant to the needs of women and girls?
2. To what extent does the project respond to anti-FGM and GBV priority issues?
3. To what extent were the objectives of the project valid?
4. Are there any major risks or ‘killer assumptions’ that were not taken into account?
5. What was the value of the intervention in relation to the national priorities, etc.?

Efficiency / Transparency
6. To what extent was the project efficiently and cost-effectively implemented?
7. Were the plans used, implemented and adapted as necessary?
8. To what extent resources were being used economically to deliver the project products
9. Was financial spending in line with the plan?
10. Was monitoring data being collected as planned, stored and used to inform future plans
11. Assess other programme management factors important for delivery, such as:
   1. Working relationships within the team
   2. Working relationships with partners, stakeholders and donors
   3. Capacity gaps (these could be in the project team, other internal functions such as HR or Finance, or external organisations as appropriate).
   4. Learning processes such as self-evaluation, coordination and exchange with related projects.
   5. Internal and external communication.
Effectiveness

12. Assess the major achievements of the project in relation to its stated objectives and intended results -- To what extent were the intended project goal, outcomes and outputs (project results) achieved and how?

13. Assess what has been achieved, the likelihood of future achievements, and the significance/strategic importance of the achievements

14. Refer to quantitative assessments as far as possible

15. Include also qualitative evidence e.g. opinions on the project’s effectiveness based on impressions and interviews with target groups, partners, government, etc.

16. Identify any exceptional experiences that should be highlighted e.g. case-studies, stories, best practice

Impact

17. To what extent is the project contributing to a long-term positive (and negative) effect on health of young girls and women in Serengeti?

18. How is it making a difference?

Sustainability / Potential for Replication

19. Assess the key factors affecting sustainability of the project, such as:

6. What is the social and political environment/acceptance of the project?

7. Will the project contribute to lasting benefits?

20. Is such replication likely?

21. What are the cost implications for scaling up impact?

22. Assess and make recommendations on the key strategic options for the future of the project i.e. exit strategy, scale down, replication, scale-up, continuation, major modifications to strategy

Equity

23. Are the interests, needs and priorities of both women and young girls are taken into consideration?

24. The extent to which human rights based and gender responsive approaches have been incorporated throughout the project and to what extent.

25. Gender equality is not only a “women’s issue”, but concerns and should fully engage men as well as women.

26. Equality between women and men, girls and boys is seen both as a human rights issue and as a precondition for, and indicator of, sustainable people-centered development.

Causality

27. Validity of programme logic and Amref support models

28. Is the achieved impact caused by the intervention?

29. How is the relation between the different performed activities?

30. Which other factors could have had an influence on the impact?
Knowledge Generation

- To what extent has the project generated knowledge, promising or emerging practices in the field of EVAW/G that should be documented and shared with other practitioners?

Approach and focus

The focus of the End Term Evaluation should be Outcome Evaluation and the proposed approach is Participatory Gender-Responsive Evaluation.

Methodology:
The consultant will design a methodology that is suitable and acceptable for conducting scientific enquiry, using relevant evaluation methods and techniques. However, this may be discussed and agreed by the evaluator and Amref Health Africa with the aim of ensuring that every possible source of important information is consulted. The evaluation shall be carried out through analysis of available project documents and other documents considered necessary by the Consultant. To ensure the methodology is participatory, interviews shall be carried out with, but not limited to project beneficiaries, representatives of the organization, community members, strategic partners, and other relevant stakeholders.

Evaluation Ethics:
The evaluation must be conducted in accordance with the principles outlined in the UNEG ‘Ethical Guidelines for Evaluation’

The evaluator/s must put in place specific safeguards and protocols to protect the safety (both physical and psychological) of respondents and those collecting the data as well as to prevent harm. This must ensure the rights of the individual are protected and participation in the evaluation does not result in further violation of their rights. The evaluator/s must have a plan in place to:

- Protect the rights of respondents, including privacy and confidentiality;
- Elaborate on how informed consent will be obtained and to ensure that the names of individuals consulted during data collection will not be made public;
- For all children (under 18 years old), the evaluator/s must consider additional risks and need for parental consent;
- The evaluator/s must be trained in collecting sensitive information and specifically data relating to violence against women and select any members of the evaluation team on these issues.
- Data collection tools must be designed in a way that is culturally appropriate and does not create distress for respondents;
- Data collection visits should be organized at the appropriate time and place to minimize risk to respondents;
- The interviewer or data collector must be able to provide information on how individuals in situations of risk can seek support (referrals to organizations that can provided counseling support etc)

Evaluation Time Plan/Duration
Provide a clear definition of the timetable for the end term evaluation. A clear breakdown helps to estimate the total duration in days. To be realistic, a timetable must allocate adequate time for:

- Development of the evaluation design; finalization of the evaluation matrix; sampling strategy
- Development of research instruments or tools (questionnaires, interview guidelines, etc.)
- Review of documentation
- International travel; domestic travel
- Field (or desk) research
- Data analysis (usually half the number of days of the research)
- Meeting with project staff and stakeholders on the initial findings and recommendations
- Preparation of the draft report
- Incorporation of comments and finalization of the evaluation report

Note: This considers both the Amref technical team review time plus the Donor’s review time which is:

<table>
<thead>
<tr>
<th>Description</th>
<th>Amref-Tanzania</th>
<th>UNTF</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inception Report</td>
<td>3 working days</td>
<td>5 working days</td>
</tr>
<tr>
<td>Draft report</td>
<td>7 working days</td>
<td>10 working days</td>
</tr>
<tr>
<td>Final report</td>
<td>7 working days</td>
<td>5 working days</td>
</tr>
</tbody>
</table>

Note: The time above is exclusive the field work.

**The Evaluation team composition and required competencies**

Provide details in the specific skills, competencies and characteristics of the evaluator or evaluation team specific to the evaluation, including roles and responsibilities of team members. Evaluators must be independent from any organizations that have been involved in designing, executing, managing or advising any aspect of this project and any other UN Trust Fund-funded projects. Below is the generic list of competencies required for this type of evaluation.

**Evaluation Team Composition and Roles and Responsibilities:**
The Evaluation Team is recommended to consist national consultant(s)/experts who are familiar with the Tanzanian traditions and customs.

The senior evaluator will be responsible for undertaking the evaluation from start to finish and for managing the evaluation team under the supervision of MnE Manager of Amref Tanzania, for the data collection and analysis, as well as report drafting and finalization of the final report. Field Research Enumerators will be responsible for undertaking data collection activities and other assignments, as the supervisor will assign it. These will be established and supervised by the senior evaluator. Report Editors will be responsible for undertaking the thorough review of all versions of this evaluation reports, these will work under the close supervision of the Amref Head of Programs,
these will included the program manager of the RMNCH programs, MnE Manager and other members of SMT.

**Required Competencies:**

**Based on this project interventions** (i.e.: interventions in schools, engagement, engagement with girls, boys and women with disabilities etc), the specific competencies required include:

**For the Senior Evaluator:**

- Evaluation experience at least 10 years in conducting external evaluations, with mixed-methods evaluation skills and having flexibility in using non-traditional and innovative evaluation methods
- Expertise in gender and human-rights based approaches to evaluation and issues of violence against women and girls
- Experience with program design and theory of change, gender-responsive evaluation, participatory approaches and stakeholder engagement
- Specific evaluation experiences in the areas of ending violence against women and girls
- Experience in collecting and analysing quantitative and qualitative data as well as data visualization
- In-depth knowledge of gender equality and women’s empowerment
- A strong commitment to delivering timely and high-quality results, i.e. credible evaluation and its report that can be used
- A strong team leadership and management track record, as well as interpersonal and communication skills to help ensure that the evaluation is understood and used.
- Good communication skills and ability to communicate with various stakeholders and to express concisely and clearly ideas and concepts
- Regional/Country experience and knowledge: in-depth knowledge of Tanzania as a country is required.
- Language proficiency: fluency in Swahili and English is mandatory; good command of local Kurya language is desirable.

**For other supporting evaluation team members**

Detail the specific skills or characteristics needed in the evaluation team members, e.g.:

1) Technical knowledge
2) Familiarity with the country / culture, language proficiency
3) End Term Evaluation Survey experience
4) Facilitation and interviewing skills

**Outputs and Deliverables**

Consultant is expected to:

- An inception report having a detailed methodology, work plan, sampling procedure, data collection tools and budget. This should be prepared and shared with Amref before the tools are finalized and data collection begins.

**Inception Report Outline**
Introduction:

a. Background and context of the project
b. Description of the project (including theory of change and the results chain – project goal, outcomes and outputs)
c. Purpose, objectives and scope of the evaluation
d. Evaluation criteria and key questions (including – but not limited to – the mandatory questions requested by the UN Trust Fund-Refer the UNTF guideline)

Methodology

a. Evaluation design, including:
   1. Description of overall design
   2. Data sources
   3. Method of data collection and analysis
   4. Sample and sampling design
   5. Limitations of the methodology and how these will be addressed

Safety and ethical considerations and protocols to be put in place

Workplan including roles and responsibilities

a. A work plan with associated activities, deliverables, timeline, roles and responsibilities, as well as travel and logistical arrangements.

Annexes

a. Evaluation Matrix (this matrix summarizes the key aspects of the evaluation exercise by specifying what will be evaluated and how and the key indicators the evaluator/s will use to measure results – see template –Refer the UNTF guidelines).
b. Data collection instruments (questionnaires and interview guides, etc., including ethical and safety protocols such as consent forms)
c. List of documents consulted
d. List of stakeholders/partners to be consulted
e. Draft outline of final report

A PowerPoint presentation of key findings to Amref team.

The final report that will be prepared by the Consultant should not be more than 30 pages (excluding references and appendixes). The report should detail the following

- An executive summary of key findings, lessons and key recommendations
- Introduction of the study
- The methodology
- Key findings
- Conclusion and recommendations that would be taken into consideration

A copy of updated Result and Resource Framework with baseline findings.
Structure of the End Term Evaluation Report

1. Acknowledgements
2. Table of Contents
3. List of Acronyms and Abbreviations
4. Full abstract (Background, Methods, Results, Discussion and next steps)
5. Executive Summary (1-2 pages), including summary of the key findings (outcomes)
6. Project description and context
7. Purpose and expected use of the evaluation
8. Objectives of the evaluation
9. Evaluation Methodology, including safety and ethical considerations
10. The evaluation report detailing:
11. Evaluation findings
12. Conclusions, especially relating to project goals / targets
13. Lessons learned
14. Recommendations

Budget

Estimate the costs and prepare a detailed budget. Note: the source of funds and link the budget to the key activities if possible.

The cost involved in an Evaluation should include two major sections;

- **Reimbursable Costs**
  - Stationery: Writing paper, pencils/pens, photocopying paper, printing paper, notebooks, clipboards, flip charts etc
  - Transport: Fuel and vehicle maintenance
  - Travel: international and in country
  - Allowances /per diem: Per diem based on night out rates, lunch allowances etc
  - Data analysis: a computer, printer etc
  - Photocopying of questionnaires etc.
  - Report production and distribution: report printing, report mailing......, etc.

- **Professional/Consultancy Fee**
  - Personnel: Team leader/Lead Consultant rate, Co-consultants rates (The rates of Lead Consultant and Co-consultants should differ)

Logistical Support (normally provided by the relevant project)

- Provision of documentation
- Scheduling of interviews
- Local travel
- Assist to arrange accommodation for the evaluation team.
- Access to office facilities
- Special procedures e.g. on relation with press or security
- Assist in arranging the services such as local translators, interviewers, drivers etc
- Availability and provision of office space, cars and procedures for arranging meetings.

## Role of Amref and CONSULTANT

<table>
<thead>
<tr>
<th>Amref</th>
<th>CONSULTANT</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Amref will provide the funds, logistical support and program documents for review</td>
<td>• Planning, scoping, conducting the study</td>
</tr>
<tr>
<td>2. Amref will be the link between the Consultant and key partners as well as the communities.</td>
<td>• Carrying out the day–to–day management of operations/activities</td>
</tr>
<tr>
<td>3. Provide technical oversight, quality assurance as well as quality control for the evaluation as necessary.</td>
<td>• Informing Amref Monitoring and Evaluation Manager about developments, including regular progress reporting</td>
</tr>
<tr>
<td>4. Amref will work with the partners to provide venues for discussions serve as community guides and mobilize the required persons for interviews and group discussions.</td>
<td>4) Producing deliverables (as per contractual requirements)</td>
</tr>
<tr>
<td>5. Amref will provide the reporting format to the consultant.</td>
<td>5) Report as per format given in three-bonded hard copy with soft copy in cd or flash.</td>
</tr>
</tbody>
</table>

### Additional requirements

i. Intellectual properties rights (remain solely with Amref, unless specified in advance by a contract with a project partner; use of data by consultants or other parties without Amref permission in writing is prohibited)

ii. Submission details (number of hard and soft copies)

### Responses to the TOR: The consultant should develop a detailed technical proposal with the following components.

#### Technical

i. Understanding and interpretation of the TOR

ii. Methodology to be used in undertaking the assignment.

iii. Time and activity schedule

iv. Profile of the Consultant including the working team

v. Curriculum vitae of key personnel

#### Financial

- Detailed cost proposal in Tanzania shillings for the consultancy work. This should be split into two parts reimbursable cost and professional fee.

### Reporting Lines and Supervision of the Work
The lead consultant will be reporting to the Monitoring and Evaluation Manager at Tanzania Country Offices.

Consultants will neither assign nor sub-contract this assignment. Amref reserves the right to terminate the consultancy in the any event with regard to the above notice or breach of any clause of the contract.

Delays in submission of deliverables by more than 5 business days without prior negotiated adjustments will result in a 5% deduction of the total consultancy fee and a 0.5% additional penalty will accrue per business day that deliverables are not received.

The consultant in writing must make request for extension of time three days before deadline. Provided decision regarding such request will be made before the expiry of the consultancy duration.

Once completed the evaluation will be the property of Amref. Any replication of deliverables to any third party will only be accepted when Amref gives approval with clearly defined boundaries for its use.

**Evaluation and award:** Amref will evaluate the proposals and award the assignment based on technical and financial feasibility. Amref reserves the right to accept or reject any proposal received without giving reasons and is not bound to accept the lowest, the highest or any bidder. Only the successful applicant will be contacted.

**ToR annexes**

1. **Documents to be consulted** include project documents (Proposal, project reports, data collection tools etc) and relevant national strategy

2. **Evaluation matrix**

The evaluation matrix is a key tool that elaborates how the evaluation question was answered through the evaluation methods.

<table>
<thead>
<tr>
<th>Evaluation Criteria</th>
<th>Evaluation Questions</th>
<th>Indicators</th>
<th>Data Source and Data Collection Methods</th>
</tr>
</thead>
<tbody>
<tr>
<td>Effectiveness</td>
<td>To what extent were the intended project goal, outcomes and outputs (project results) achieved and how?</td>
<td>Process&lt;br&gt;Indicators&lt;br&gt;Impact&lt;br&gt;Indicators&lt;br&gt;Outcome&lt;br&gt;Indicators&lt;br&gt;Output&lt;br&gt;Indicators</td>
<td>Literature Review&lt;br&gt;Interviews&lt;br&gt;FGD&lt;br&gt;Questionnaire&lt;br&gt;Direct Observations&lt;br&gt;Data Source&lt;br&gt;Baseline survey report. ITT&lt;br&gt;Result Framework&lt;br&gt;Project Documents and Reports</td>
</tr>
<tr>
<td>Relevance</td>
<td>To what extent do the achieved results (project goal, outcomes and outputs) continue to be relevant to the needs of women and girls?</td>
<td>Process&lt;br&gt;Indicators&lt;br&gt;Impact&lt;br&gt;Indicators&lt;br&gt;Outcome</td>
<td>Literature Review&lt;br&gt;Interviews&lt;br&gt;FGD&lt;br&gt;Questionnaire&lt;br&gt;Direct Observations</td>
</tr>
</tbody>
</table>
### 3. Beneficiary data sheet

<table>
<thead>
<tr>
<th>Type of Primary Beneficiary</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indigenous Women/from Ethnicity Group</td>
<td>184</td>
<td>30</td>
<td>19</td>
<td>233</td>
</tr>
<tr>
<td>Female Political Activists/Huma Rights Defenders</td>
<td>38</td>
<td>15</td>
<td>20</td>
<td>73</td>
</tr>
<tr>
<td>Women/Girls with Disabilities</td>
<td>50</td>
<td>50</td>
<td>40</td>
<td>140</td>
</tr>
<tr>
<td>Women/Girls survivors of Violence</td>
<td>833</td>
<td>833</td>
<td>834</td>
<td>2500</td>
</tr>
<tr>
<td>Women and Girls in General</td>
<td>10250</td>
<td>8560</td>
<td>7048</td>
<td>25858</td>
</tr>
<tr>
<td>Others</td>
<td>465</td>
<td>137</td>
<td>147</td>
<td>759</td>
</tr>
<tr>
<td><strong>Total Primary Beneficiaries</strong></td>
<td>11820</td>
<td>9625</td>
<td>8118</td>
<td>29,383</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Type of Secondary Beneficiary</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
<th>Total</th>
</tr>
</thead>
</table>

| DATA SOURCE FROM THE PROJECT REPORTS |
### Participants

<table>
<thead>
<tr>
<th>Category</th>
<th>Members</th>
<th>Zero</th>
<th>One</th>
<th>Two</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Members of Civil Society Organizations</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Members of Community Based Organization</td>
<td>67</td>
<td>0</td>
<td>0</td>
<td>67</td>
<td>134</td>
</tr>
<tr>
<td>Members of Faith Based Organizations</td>
<td>21</td>
<td>21</td>
<td>21</td>
<td>63</td>
<td>84</td>
</tr>
<tr>
<td>Education Professionals (Teachers, Educators)</td>
<td>137</td>
<td>0</td>
<td>0</td>
<td>274</td>
<td></td>
</tr>
<tr>
<td>Government Officials (Policy Makers/Implementers)</td>
<td>103</td>
<td>21</td>
<td>22</td>
<td>146</td>
<td></td>
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<tr>
<td>Heath Professionals (Doctors, Nurses, health Practitioners)</td>
<td>261</td>
<td>170</td>
<td>0</td>
<td>451</td>
<td></td>
</tr>
<tr>
<td>Journalist/Media</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Legal Officers (Lawyers, Prosecutors, Magistrates)</td>
<td>85</td>
<td>0</td>
<td>0</td>
<td>85</td>
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<tr>
<td>Men/OR Boys</td>
<td>2345</td>
<td>3567</td>
<td>3567</td>
<td>9479</td>
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<td>Parliamentarians</td>
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<td>1</td>
<td>2</td>
<td></td>
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<tr>
<td>Private Sector Employers</td>
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<td>0</td>
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<td>0</td>
<td></td>
</tr>
<tr>
<td>Social/Welfare Workers</td>
<td>8</td>
<td>0</td>
<td>0</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td>Uniformed Personnel (Police, Military, Peace Keeping)</td>
<td>30</td>
<td>0</td>
<td>0</td>
<td>30</td>
<td></td>
</tr>
<tr>
<td>Others</td>
<td>334</td>
<td>50</td>
<td>0</td>
<td>384</td>
<td></td>
</tr>
<tr>
<td>Total Secondary Beneficiaries</td>
<td>3395</td>
<td>3967</td>
<td>3610</td>
<td>10,972</td>
<td></td>
</tr>
</tbody>
</table>

### Indirect Beneficiaries

- **Conduct sensitization forum to 10245 Parents using role models/peer educators/parents who abandoned FGM as a result of ARP Approach on health effects of FGM:**
  - 3415
  - 3415
  - 3415
  - Total 10245

- **Sensitize 21851 parents on the health effects and human rights aspect of FGM using SMS texts, Home visits, awareness campaigns with cultural dances, and community radio:**
  - 7285
  - 7285
  - 7285
  - Total 21851

- **Facilitate age and gender specific dialogue fora with 5912 boys and men on health effects of FGM and laws related to GBV:**
  - 1972
  - 1970
  - 1970
  - Total 5912

- **Total Indirect Beneficiaries:**
  - 12672
  - 12668
  - 12668
  - Total 38,008

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### 4. Data collection instruments and protocols

#### Interview Guide for Project Staff

**Introduction**

My name is……………………………………..I am a research assistant/enumerator with AMREF Health Africa, an organization that provides medical and health-related services in Africa. We are conducting an end term evaluation of Amref’s Female Genital Mutilation Elimination Project that has been implemented in Serengeti District. The study seeks to determine the relevance, efficiency, effectiveness, impact and sustainability of the project. It also aims at recording lessons learnt and best practices that will help to shape future interventions. The answers you provide will inform a report to be published by
AMREF Health Africa. You may choose not to answer any question and feel free to opt out of this study at any time. Do I have your permission to proceed with this interview? If you have no objection, I would like to record our interview so that I can accurately capture the information you provide.

Interview Number..................

General Information

<table>
<thead>
<tr>
<th>Name (optional):</th>
<th>Sex: Male [    ] Female:[    ]</th>
</tr>
</thead>
<tbody>
<tr>
<td>District:</td>
<td>Ward:</td>
</tr>
<tr>
<td>Signature:</td>
<td>Date:</td>
</tr>
</tbody>
</table>

Questions

Project Overview

1. What is your specific role in the FGM elimination project, and how long have you been involved in the project?

2. What were the key project objectives?

3. What objectives did you think were not relevant in this project and which one do you think were very key to the project’s success? Why?

4. Do you think the intended objectives and goals of the project have been achieved?

5. What is the main achievement that you can proudly speak of as a project staff member?

6. What are the stakeholders you worked with in the project?

7. What was the contribution of other stakeholders in your project?

8. To what extent did you work with government authorities in project implementation? Specifically, who did you work with? Who among these was key to your project outcomes?

9. Were all the planned activities carried out as planned? If not, which activities are pending and why?

10. Was the funding adequate for your activities as you budgeted or what do you think in this case?

11. To what extent has the project incorporated gender issues? What gender issues arose and how were they addressed?

Relevance

12. Were activities carried out relevant in relation to the results, purpose and goal of the project?

13. Was the chosen project methodology/approach socially, culturally and ethically relevant?
14. Have the project activities been relevant to the real needs of the project beneficiaries?

Effectiveness
15. To what degree has the project achieved its results?

16. Which factors have facilitated/hindered the achievement of the expected project results?

Efficiency
17. Has the use of human and financial resources been efficient in relation to the project’s achievements?

18. Did the choice of methodology and strategy contribute to efficient use of available resources?

19. What communication methods and channels were used by project and are there better ways to communicate in future in order to make the project more efficient?

Impact
20. What is the main key impact of the project in your area of operation?

21. Has the project reached its goal?

22. Have there been changes in the attitudes of the women and men on FGM?

23. What kind of attitude changes (positive and negative) have taken place in the project area?

24. Which social, political and economic (external to the project) factors have contributed or hindered the project impact?

25. Which strategies should be undertaken in a possible continuation of the project in order to strengthen the project impact?

26. Have there been similar projects in the area? If Yes, how do you assess the impact of the project compared to other similar projects in the area?

Sustainability
27. Are the project results and development impacts socially, institutionally and economically sustainable?

28. What factors might influence the sustainability of the impact and/or results?

29. What strategies should be put in place in case of continuation of the project to strengthen sustainability?
30. What in your opinion will be the key changes you want made in a similar future projects?

31. Is there a sustainability strategy in this project in the event the donors pull out? Was a human right approach part of your programme implementation-how and why?

32. What factors (positive or negative) are likely to support or hinder the sustainability of the project’s achievements? To what extent are the achievements and changes that the project has contributed to likely to last?

Challenges
33. What were the challenges that you experienced during the anti-FGM project implementation?

34. What problems (in your opinion) arose in connection with the activities that were undertaken in regard to the FGM elimination project? (List as many reasons as possible with possible explanations)

35. What measures were adopted to cope with these identified problems during the implementation of the anti-FGM project?

Lessons Learnt
36. What are the best practices and lesson leant during the project implementation?

Additional comments
37. Any additional comments?

KII Guide for Key Stakeholders

Introduction
My name is………………………………I am a research assistant/enumerator with AMREF Health Africa, an organization that provides medical and health-related services in Africa. We are conducting an end term evaluation of Amref’s Female Genital Mutilation Elimination Project that has been implemented in Serengeti District. The study seeks to determine the relevance, efficiency, effectiveness, impact and sustainability of the project. It also aims at recording lessons learnt and best practices that will help to shape future interventions. The answers you provide will inform a report to be published by AMREF Health Africa. You may choose not to answer any question and feel free to opt out of this study at any time. Do I have your permission to proceed with this interview? If you have no objection, I would like to record our interview so that I can accurately capture the information you provide.

Interview Number..................  

General Information

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<thead>
<tr>
<th>Name (optional):</th>
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<tbody>
<tr>
<td>District:</td>
<td>Ward:</td>
</tr>
<tr>
<td>Signature:</td>
<td>Date:</td>
</tr>
<tr>
<td>Organization/Institution:</td>
<td>Position:</td>
</tr>
</tbody>
</table>
Questions
1. Are you aware of the FGM elimination project, implemented by Amref Health Africa in Serengeti District?

2. Have you ever been involved in project implementation? If Yes, how/under what capacity?

3. Do you think the project took into consideration the needs and priorities of both women and young girls?

4. To what extent have which human rights based and gender responsive approaches been incorporated throughout the project?

5. Were activities carried out relevant in relation to the results, purpose and goal of the project? Have the activities responded to the needs of the community in addressing FGM and its associated risks?

6. Was the chosen project methodology/approach socially, culturally and ethically relevant?

7. Have the project activities been relevant to the real needs of the project beneficiaries?

8. In your opinion, has the project achieved its results? If Yes, to what extent?

9. Which activities carried out under the project were key in achieving the intended results? Were you part of such activities? Can you give specific examples of the activities?

10. Have there been changes in the attitudes of the women and men towards FGM?

11. What kind of attitude changes (positive and negative) have taken place in the project area?

12. Do you think FGM awareness among the people has increased? If Yes, to what extent? Among which groups mostly?

13. To your knowledge, has there been reduction in FGM practice in your area?

14. In your opinion, is the FGM practice for girls and women still supported by many people in your area?
15. How would you evaluate the collaboration between AMREF and other key stakeholders, especially the government, in combating FGM? Was it effective? What needs to improve?

16. Which social, political and economic (external to the project) factors have contributed or hindered the project impact?

17. Which strategies should be undertaken in a possible continuation of the project in order to strengthen the project impact?

18. Have there been similar projects in the area? If Yes, how do you assess the impact of the project compared to other similar projects in the area?

19. Are the project results and development impacts socially, institutionally and economically sustainable?

20. What factors might influence the sustainability of the impact and/or results?

21. What in your opinion will be the key changes you want made in a similar future projects?

22. In your opinion, what are key lessons and promising or emerging good practices in the field of ending violence against women and girls?

23. Are judicial officers, paralegals and police officers adequately equipped to address/combat FGM? In your view, do they readily provide legal services to FGM and child marriage victims in Serengeti?

24. Do health care workers provide friendly health services to FGM and child marriage victims?

25. In your opinion, are the legal and health systems (including police gender desks and health gender desks) well equipped to provide legal and health services to FGM and child marriage victims? Are there any gaps in police and health referral systems?

26. Any additional comments?

Thank you for your time!
FOCUS GROUP DISCUSSION GUIDE

FGD Facilitator/Moderator...........................................................................................................................
FGD Note Taker/s: ...........................................................................................................................................
Group:...........................................................................................................................................................
Number of Respondents........ ............
Age Category........................................
Site/Location:..........................................................
Time discussion started:.................................
Time ended:..........................................................
Date:...................................................................................................................................................

NOTE TO INTERVIEWER

• For each group, priorities and concentrate on the questions most relevant given their background and expertise. Supply the consent form before commencing the discussions
• Provide some explanation or examples to clarify the question where required but this should be done carefully and for purposes of illustration only to avoid induced or suggestive answers or to pre-empt the informants or influence their opinions and thoughts on each question.
• Document all case studies

Note: This tool should be used during small group discussions. The team should ensure participants that all information shared within the discussion will remain confidential; if the secretary takes down notes, s/he will not have any information identifying or associating individuals with responses. Some of these questions are sensitive. You should take all potential ethical concerns into consideration before the discussion. Ask the group to respect confidentiality and not to divulge any information outside of the discussion. The group should be made of like members – community leaders, women, youth, etc. should not include more than 10 to 12 participants, and should not last more than one to one-and-a-half hours.

Introduction
My name is _________ and this is my colleague ______________. I work for _____ and she/he works for _____________. We would like to ask you some questions about the issues affecting women and children in your community so that we can better understand your needs and concerns about these groups.

We are not asking for your specific stories; please do not use any names. Participation in the discussion is completely voluntary and you do not have to answer any questions that you do not want to answer. If you feel uncomfortable at any time you can leave.

AMREF

End Term Evaluation in Female Genital Mutilation Elimination Project, March, 2019
We have nothing to offer other than listening; there will be no other direct benefits related to this time we spend together today. We will treat everything that you say today with respect, and we will only share the answers you give as general answers combined with those from all the people who speak to us. We ask that you keep everything confidential, too. Please do not tell others what was said today. I expect our discussion to last for a maximum time of one hour to one-and-a-half hours.

**Do you have any questions before we begin?**

<table>
<thead>
<tr>
<th>First I would like to ask you some general questions about life, or the way you live in your community or in this area.</th>
</tr>
</thead>
<tbody>
<tr>
<td>What are the most significant achievements of the FGM project? How do you know where you are so far in regards to the FGM project implementation in Serengeti?</td>
</tr>
<tr>
<td><strong>Probe:</strong> Effectiveness, relevance, efficiency, sustainability and impact criteria, as well as the cross-cutting gender equality and human rights criteria.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>What are the problems/challenges that women and girls face when they move around in this community? (Ask for specific examples)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Probe:</strong> What are the key lessons and promising or emerging good practices in the field of ending violence against women and girls</td>
</tr>
</tbody>
</table>

| How project contributed to the reduction of FGM/C and Child Marriage practices in Serengeti district |

| What are the current levels of knowledge, attitudes and practice towards FGM/C and Child Marriage? (including traditional leaders, young girls, women, parents, district officials, boys and etc) |

| What are the existing structures or opportunities in responding to FGM/C in this community? Where can women seek support if they are facing problems or have faced violence? |
Probe: Availability, accessibility and quality of legal aid services and health services offered in the police gender desks and health facilities gender desks, judicia, paralegals.

What would you recommend in the future FGM project(s)?

What are some things that you could do?

Closing

That is all of my questions. Do you have anything you would like to add?

Do you have any questions for us?

Do you have any questions that you think should be asked of other groups?

As I told you in the beginning, our discussion today is meant to help us learn about the concerns that you have for women and children in your community. Please remember that you agreed to keep this discussion to yourself. If anyone would like to speak to me or __________ (person taking notes) in private we are happy to talk to you.
HEALTH FACILITY CHECKLIST

A: General Background Information

This section is designed to provide general information about the facility and certification status.

(1). Date of Visit: __________________________

(2). Name of Facility: __________________________

(3). Location: Ward____________________ District:__________________ Region:____________________

(4). Type of Facility:  
Public  
NGO  
Private  
Other         (Tick ( √ ) where appropriate)

(5). Level of Facility: Dispensary  
Clinic  
Health Center  
Hospital      (Tick ( √ ) where appropriate)

(6). Number of rooms in facility: Total_______

(7). What days and hours is the facility open during the week? 
______________________________________________________________________________

(8). Type/Cadre of Staff Interviewed: ______________________________

B: Services Offered

<table>
<thead>
<tr>
<th>Services Offered</th>
<th>Available (Y/N)</th>
<th>Comments (Probe for FGM and Early Pregnancy)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Counseling</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sexual &amp; Gender-Based Violence</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Youth Friendly services</td>
<td>Friendly</td>
<td></td>
</tr>
<tr>
<td>Pregnancy test</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other services (Specify)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Is there either service available in this facility to assist women and girls who experienced FGM and Child pregnancy? 

If yes, what services are available?

Are all the services you mentioned currently available or have been available within the three years?

If No, why are the services not available?

C: Elements of Friendly Services

**LEGEND:** FA: interview facility manager/administrator, C: interview girls and women, SP: Interview service providers, O: observe client-provider interaction and facility environment, R: review facility policies, procedures, standards and guidelines, S:

Review services statistics

<table>
<thead>
<tr>
<th>Essential Elements Methods / Questions</th>
<th>Response and Indicators</th>
<th>1, 2,3</th>
<th>Comments/Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Confidentiality is ensured</td>
<td>Clients confirm that facility assures client confidentiality regarding consultation(s), testing, and medical records (storage and registration). A written policy exists outlining client confidentiality.</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Do written procedures exist for</td>
<td>Facility assures client confidentiality most of the time regarding consultations, testing, or medical records (storage and registration). A written policy may or may not exist.</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>protecting client confidentiality?</td>
<td>Facility fails to assure client confidentiality most of the time. No written policy exists.</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### 2. Respect for all clients

- Do providers show respect for clients (women and girls) during counseling and service delivery show respect regardless of age and marital status?
- Do providers allow women and girls clients to ask questions?

<table>
<thead>
<tr>
<th>Description</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clients/observation confirms that all clinic staff (receptionist, counselor, and provider) treats both women and girls clients with respect and courtesy and allows clients time to ask questions.</td>
<td>3</td>
</tr>
<tr>
<td>Clients report/observation shows that sometimes clinic staff do not treat women and girls with respect and courtesy and allow clients time to ask questions OR clinic staff report they treat all clients with respect but this cannot be confirmed through interviews with women and girls clients or through observation</td>
<td>2</td>
</tr>
<tr>
<td>Most of the time clinic staff do not treat women and girls clients with respect and courtesy and do not allow clients time to ask questions</td>
<td>1</td>
</tr>
</tbody>
</table>

### 3. Women and girls are served regardless of age or marital status

- Do clear written guidelines for serving women and FGM and Early pregnancy exist?
- Is there a minimum age requirement for FGM and Early pregnancy services?
- Are spousal or parental consent required? Please explain.
- Scenario question: If a 15 year-old girl comes to you and says she wants to prevent pregnancy, how do you respond?

<table>
<thead>
<tr>
<th>Description</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Women/Girls/observation/statistics confirm that women and girls Services are served regardless of age or marital status to the full extent of the law.</td>
<td>3</td>
</tr>
<tr>
<td>Most providers serve adolescents while a few may have biases against providing certain services to adolescents.</td>
<td>2</td>
</tr>
<tr>
<td>Women and girls below 18 years are often refused one or more services because of age, contradicting existing law or policy.</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td><strong>4. Sufficient supply of appropriate equipment and supplies</strong></td>
<td>Observation confirms that appropriate equipment and supplies are available and working for friendly FGM and Early pregnancy services</td>
</tr>
<tr>
<td></td>
<td>Most (&gt;50%, more than half) equipment and supplies are available and working, however some necessary equipment/supplies are not available or working.</td>
</tr>
<tr>
<td></td>
<td>Many of the equipment and supplies for friendly FGM and Early pregnancy services are not available.</td>
</tr>
<tr>
<td><strong>5. Educational materials available (computers, printed material)</strong></td>
<td>Clients/observation confirms that brochures and pamphlets on FGM and Early pregnancy are available both to use on-site and to take away. Other educational opportunities (e.g., videos or health talks) might be provided at the facility.</td>
</tr>
<tr>
<td></td>
<td>Brochures and pamphlets on some topics are available some of the time both to use on-site and</td>
</tr>
<tr>
<td>available on site? Which ones?</td>
<td>Brochures and pamphlets on key FGM and Early pregnancy/child marriage topics are not available, and the clinic does not provide other educational opportunities.</td>
</tr>
<tr>
<td>Are there print materials available for Women and girls to take?</td>
<td></td>
</tr>
<tr>
<td>Describe which ones. Are health talks given? Please describe.</td>
<td></td>
</tr>
</tbody>
</table>

**6. Privacy is ensured in FGM and Early pregnancy/child marriage**

**Does the examination and counseling room(s) for FGM and Early pregnancy/child marriage offer visual and auditory privacy?**
- Are there doors and are they shut during consultation?
- Are there curtains in the window?
- If windows are left open, can anyone easily hear what is being said?
- Are privacy screens used?
- Does personal history taking, screening or asking why the client has come for services occur in public?
- Are there any non-essential interruptions during counseling, exams, or lab procedures?

**Client/observation confirms that visual and auditory privacy is ensured most of the time in consultation rooms with adequate enclosures. There are no non-essential interruptions or intrusions.**

**Visual and auditory privacy is ensured some of the time in consultation rooms with adequate enclosures or there are limited non-essential interruptions or intrusions.**

**Visual and auditory privacy are not ensured or there are many non-essential interruptions or intrusions.**

| 7. Competency of staff | Clients/observation confirm that staff are able to communicate well with clients, | 3 |
| Did all staff members | | |
**End Term Evaluation in Female Genital Mutilation Elimination Project, March, 2019**

<table>
<thead>
<tr>
<th>Question</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>receive training on how to serve clients on FGM and Early pregnancy?</td>
<td>Some staff are able to communicate well with clients, competently deliver FGM and Early pregnancy services to both women and girls, discuss dual protection, and answer client questions.</td>
</tr>
<tr>
<td>• What type and for how long?</td>
<td>Some staff are able to communicate well with clients, competently deliver FGM and Early pregnancy services to both women and girls, discuss dual protection, and answer client questions.</td>
</tr>
<tr>
<td>• Has staff received training in the different technical areas that they provide services?</td>
<td>Some staff are able to communicate well with clients, competently deliver FGM and Early pregnancy services to both women and girls, discuss dual protection, and answer client questions.</td>
</tr>
<tr>
<td>• How well do staff communicate with clients?</td>
<td>Some staff are able to communicate well with clients, competently deliver FGM and Early pregnancy services to both women and girls, discuss dual protection, and answer client questions.</td>
</tr>
<tr>
<td>• How well do they serve youth with different services?</td>
<td>Some staff are able to communicate well with clients, competently deliver FGM and Early pregnancy services to both women and girls, discuss dual protection, and answer client questions.</td>
</tr>
<tr>
<td>• Are there job aids available to help service providers in their daily work (i.e. flipchart, posters that remind them of key messages, clients’ rights, etc.)?</td>
<td>Some staff are able to communicate well with clients, competently deliver FGM and Early pregnancy services to both women and girls, discuss dual protection, and answer client questions.</td>
</tr>
<tr>
<td><strong>8. Treatment guidelines, procedures and protocols exist and are followed</strong></td>
<td>All of the above documents are found (Observation confirms the existence of FGM and Early pregnancy services delivery guidelines and protocols are routinely followed).</td>
</tr>
<tr>
<td>• Are there guidelines for women and girls?</td>
<td>Most of the above documents are found (FGM and Early pregnancy service delivery guidelines exist. Protocols are followed most of the time.)</td>
</tr>
<tr>
<td>Are there service delivery procedures for FGM and Early pregnancy (services (including treatment, counseling, and referrals)?</td>
<td>Most of the above documents are found (FGM and Early pregnancy service delivery guidelines do not exist and protocols are rarely followed.)</td>
</tr>
<tr>
<td>• Are the protocols routinely followed?</td>
<td>Most of None of the above documents are found the above documents are found (FGM and Early pregnancy service delivery guidelines exist. Protocols are followed most of the time.)</td>
</tr>
<tr>
<td><strong>9. Waiting time not excessive</strong></td>
<td>Client interview/observation confirms that FGM and Early pregnancy clients can be seen within 2 hours of arrival; internal referrals are done in an expedited</td>
</tr>
<tr>
<td>How long would a FGM and Early pregnancy clients wait, on average</td>
<td>Client interview/observation confirms that FGM and Early pregnancy clients can be seen within 2 hours of arrival; internal referrals are done in an expedited</td>
</tr>
<tr>
<td>13. Affordable Fees for Women and Girls on FGM and Early pregnancy</td>
<td></td>
</tr>
<tr>
<td>---</td>
<td></td>
</tr>
<tr>
<td><strong>How much are clients charged for FGM and Early pregnancy/child marriage Services?</strong></td>
<td></td>
</tr>
<tr>
<td>Client confirms that the cost of FGM and Early pregnancy/child marriage services is free, or at a level not comprising a barrier to access for most women and girls.</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
</tr>
<tr>
<td><strong>Are these fees affordable for women and girls?</strong></td>
<td></td>
</tr>
<tr>
<td>The cost of some services is free, or at a level not comprising a barrier to access for most women and girls.</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
</tr>
<tr>
<td><strong>Referrals available</strong></td>
<td></td>
</tr>
<tr>
<td>Referrals are made for services not provided at the facility. The facility has established referral mechanisms and referral forms, records referrals, and attempts to follow-up on referrals as best they can.</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
</tr>
<tr>
<td><strong>Are referrals made for services not provided at the facility?</strong></td>
<td></td>
</tr>
<tr>
<td>Referrals are made in some cases but the clinic does not have a full referral system in place.</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
</tr>
<tr>
<td><strong>Is there a formal referral system, including tracking and follow-up, in place for FGM and Early pregnancy?</strong></td>
<td></td>
</tr>
<tr>
<td>A referral system is not in place and referrals are either not made or made in an informal manner (i.e., verbal referrals are given).</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Supporting Elements Methods/Question s</td>
<td>Indicators</td>
</tr>
<tr>
<td>---------------------------------------</td>
<td>------------</td>
</tr>
<tr>
<td><strong>15. Comfortable setting</strong>&lt;br&gt;Does the facility provide a comfortable setting for women and girls?</td>
<td>Clients/observation confirm that the facility environment includes items to make women and girls feel at ease and comfortable, such as private or semi-private waiting area for FGM and Early pregnancy-oriented posters and an environment that is clean and not crowded.</td>
</tr>
<tr>
<td></td>
<td>The facility has made some attempts to make the setting comfortable for women and girls (e.g., women and girls posters on walls) but other factors (e.g., limited space and crowding) still make the environment uncomfortable for young people.</td>
</tr>
<tr>
<td></td>
<td>The facility environment does not include items to make women and girls clients at ease and comfortable, and is not clean.</td>
</tr>
<tr>
<td><strong>16. FGM and Early pregnancy data is accurately collected and reported</strong>&lt;br&gt;Is there a system for filing and retrieval of clients’ records?&lt;br&gt;Is the collected data reviewed and analyzed?</td>
<td>Observation confirms that FGM and Early pregnancy data are accurately maintained and filed, and interviews reveal that data is analyzed and used by key facility staff.</td>
</tr>
<tr>
<td></td>
<td>FGM and Early pregnancy data are accurately maintained and filed, BUT data may or may not be analyzed and used by key facility staff.</td>
</tr>
<tr>
<td></td>
<td>FGM and Early pregnancy data are not accurately maintained or filed, and data are not analyzed nor used by key facility staff.</td>
</tr>
</tbody>
</table>

To what extent have services improved over the last three years?
What are the main barriers to effective service provision?

______________________________________________________________

______________________________________________________________

What can be done to help improve health services for women and girls with FGM or early pregnancy?

______________________________________________________________

______________________________________________________________

Are there any other comments you wish to make?

___________________________________________________________________

______________________________________________________________

______________________________________________________________

Police Gender and Children’s Desk Checklist

A. GENDER DESK ENVIRONMENT

1. How many police officers are responsible for gender desk at the police station?
   i. Male: ___________________
   ii. Female: ________________

2. For how long does the survivor of FGM and early pregnancy/child marriage have to wait before they are attended to?
   Less than 10 minutes___________10 – 30 minutes_________________________1 hour______________Over 1 hour

3. The following statements relate to gender desk environment at police station. Please indicate the degree of agreement you attach to each of the following statements. Put (✓) mark in the appropriate space, which you think best expresses your opinion

<table>
<thead>
<tr>
<th>Statement</th>
<th>SA</th>
<th>A</th>
<th>N</th>
<th>D</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>There is privacy when reporting FGM and early pregnancy/child marriage cases.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>There is a safe room or a protection unit for FGM and early marriage cases.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

End Term Evaluation in Female Genital Mutilation Elimination Project, March, 2019
pregnancy/child marriage survivors. Gender desk has a free telephone service for victims and survivors to report and follow up on cases.

FGM and early pregnancy/child marriage have secure record filling and storage space. Investigating officer is friendly and easily to talk to.

There are reassuring pictures on the walls of the rooms where FGM and early pregnancy/child marriage cases are handled.

<table>
<thead>
<tr>
<th>4. Does the officer attending the FGM and early pregnancy/child marriage survivors put on police uniform?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes ______________ No __________________________</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>5. How many rooms are reserved for the gender desk?</th>
</tr>
</thead>
<tbody>
<tr>
<td>One_________ Two _________ Three______________ More than three</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>6. What is the state of the gender desk facilities? (table, chairs, stationery, computers, walls etc)</th>
</tr>
</thead>
<tbody>
<tr>
<td>7. What is the state of the vehicles, fuel, drivers, state of repair</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>8. Apart from the initial police training, have the gender desk officers had any specialized training on how to handle FGM and early pregnancy/child marriage cases?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes____________ No____________________</td>
</tr>
</tbody>
</table>

B. SERVICES OFFERED BY THE GENDER DESK TO FGM AND EARLY PREGNANCY/ CHILD MARRIAGE SURVIVORS

<table>
<thead>
<tr>
<th>9. The following statements relate to how gender desk prevents occurrence of FGM and early pregnancy/child marriage cases. Please indicate the degree of agreement you attach to each of the following statements. Put (✓) mark in the appropriate space, which you think best expresses your opinion.</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>SA –strong agree A- agree N –neutral D- disagree SD- strong</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increase public awareness on FGM and early pregnancy/child marriage</td>
</tr>
<tr>
<td>Police conduct patrols to prevent occurrence of abuses</td>
</tr>
<tr>
<td>Counseling</td>
</tr>
</tbody>
</table>

10. Gender desk response to FGM and Early Pregnancy/ Child Marriage
The following statements relate to gender desk response to FGM and early pregnancy/child marriage cases. Please indicate the degree of agreement you attach to each of the following statements. Put (✓) mark in the appropriate space, which you think best expresses your opinion.

<table>
<thead>
<tr>
<th>SA –strong agree</th>
<th>A- agree</th>
<th>N –neutral</th>
<th>D- disagree</th>
<th>SD- strong disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Police gain entry into victims’ home and save them from violence</td>
<td>SA</td>
<td>A</td>
<td>N</td>
<td>D</td>
</tr>
<tr>
<td>Police separate victim from the perpetrator</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Police refer the victims to the relevant health and social agencies</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Police conduct risk assessment and identify whether the victims in danger of future of harm</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Police conduct an interview with the survivor in line with ethical guidelines</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Police conduct interviews with perpetrator separately</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

11. Explain step by step the services provided at the gender desk from the point of abuse up to disposal of the case
   - Reporting
   - Provision of PF3
   - Referral to hospital and other organizations
   - Statement taking from the witnesses
   - Arrest of perpetrator
   - Ensuring security of the survivor
   - Taking the case to Court
   - Bonding the witnesses
   - Testifying in the case

C. CHALLENGES ENCOUNTERED BY THE GENDER DESK
12. Which challenges encountered are by the gender desks?

D. STRATEGIES OF ADDRESSING THE CHALLENGES
13. How can these challenges be addressed?

14. Is there any information or comments that you would like to make concerning the effectiveness of police gender desk on FGM and early pregnancy/child marriage?

E. STATISTICS OF FGM AND EARLY PREGNANCY/CHILD MARRIAGE SURVIVORS CASES IN SERENGETI DC

<table>
<thead>
<tr>
<th>Year</th>
<th>Age Cendency</th>
<th>FGM</th>
<th>Early Pregnancy/child marriage</th>
<th>Abandon</th>
<th>Rape</th>
<th>Woman beating</th>
<th>Abortion</th>
<th>Sodomy</th>
<th>Verbal abuse</th>
<th>Stigma</th>
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</thead>
<tbody>
<tr>
<td>2015-</td>
<td>0-9</td>
<td></td>
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</table>
### School Checklist

**A. General FGM and Early Pregnancy/Child Marriage Needs**

<table>
<thead>
<tr>
<th>1. Policy</th>
<th>Yes</th>
<th>No</th>
<th>Comments</th>
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<tbody>
<tr>
<td>FGM and early pregnancy/child marriage is included in the following policies</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Relationship and sex education (RSE)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Safeguarding</td>
<td></td>
<td></td>
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<tr>
<td>• Attendance</td>
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</tr>
</tbody>
</table>

2. **Practical Needs**

- Health center staff visits school to train teachers and give lessons on FGM and early pregnancy/child marriage
- Teachers give regular lessons on FGM and early pregnancy/child marriage
- Teachers have FGM and early pregnancy/child marriage teaching aids (posters, booklets, etc.).
- School FGM and early pregnancy/child marriage clubs exist
- Other unfriendly environments as per comments from authority

3. **Staff**

- Every member of staff has received training on FGM and early pregnancy/child marriage
- All members of staff are confident about what to do if they have concerns or receive information about possible or probable early pregnancy/child marriage and FGM practice
- The responsible lead staff have received specialist training on FGM
- All teachers are equipped to teach about FGM and early pregnancy/child marriage
4. Parents

- Every Parent have been invited to attend a parent awareness raising workshop about FGM and early pregnancy/child marriage (can be part of wider safeguarding workshop)
- Head teacher and lead staff have informed parents about FGM and early pregnancy/child marriage law
- Head teacher and lead staff have informed parents about the school’s approach to FGM and early pregnancy/child marriage

5. Pupils

- All pupils and students have attended RSE lessons and received a leaflet about FGM and early pregnancy/child marriage
- All pupils and students know where to go if they have concerns regarding FGM and early pregnancy/child marriage

6. Safeguarding

- All staff members, including support staff, are aware of the safeguarding protocol relating to FGM and early pregnancy/child marriage and know what to do when the issue arises?
- The lead staff is aware of the new mandatory duty to report all known cases of FGM and early pregnancy/child marriage?
- They know how to do this?

B. School Dropout

<table>
<thead>
<tr>
<th>Year</th>
<th>Enrolled Boys</th>
<th>Enrolled Girls</th>
<th>Completed Boys</th>
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<th>District</th>
<th>Ward</th>
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<td>2015-2016</td>
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<td>2017-2018</td>
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</table>

<table>
<thead>
<tr>
<th>Comments</th>
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<th>Completed STD</th>
<th>Transferred</th>
<th>Deceased</th>
<th>Repeaters</th>
<th>Dropouts</th>
<th>Enrolled F1</th>
<th>Completed F1</th>
<th>Transferred</th>
<th>Deceased</th>
<th>Repeaters</th>
<th>Dropouts</th>
<th>Major Reasons</th>
</tr>
</thead>
</table>
Boys

Girls

General comments

**Explain how FGM and early pregnancy/child marriage contributes to school dropout**

**Any other comment**

**General ethical issues**

Ethical protocols refer to a requirement that participants in research are treated with dignity and respect throughout the research process. The main guiding principles of ethical human research are respect, benefit and justice. These principles influenced the general behaviour of the researchers as they carried out their work. The following will guide the general ethics on this task:

1. Consultant will work closely with Amref to expedite application and acquirement of ethical clearance from Relevant authorities at various levels. This will guarantee not only for creating confidence to the authorities but also ensure safety to the evaluation team as well as smooth in data gathering.

2. The Evaluation Team will be trained and re-oriented on research ethics. In addition, Consent forms will be prepared and administered before commencement of the interviews. Any Respondent will be allowed to pull out without any pressure in case he/she feels not wanting to participate in the evaluation.

3. The collected data will be kept confidential under lock and key. The data will be stored in computer folder with a password. No information will be revealed to third party.

4. The selection of the participants will be non-discriminatory based on the fact that they had specific information needed.

5. Participants shall part in the evaluation assesment on a voluntary basis. This voluntary intent will be communicated to all participants before interviews proceeded.

6. Gender Sensitivity will be of paramount considerations in conducting interviews and discussions to adhere to the differences in practical and strategic gender needs,
concerns and interests between men and women, boys and girls. Male discussions will be moderated and recorded by male facilitators while female discussions will be by female respectively.

7. Closely linked with voluntary participation is the ethical requirement for researchers to obtain individual participants’ informed consent or willingness to participate. The researchers shall ask individual participants to give their informed consent and to sign a consent form. Obtaining informed consent for research is an important means of demonstrating respect for the dignity of participants.

The consent form includes the following information:

a. The purpose of the evaluation and the introduction of the evaluation team;
b. The expected duration of the interview or discussion;
c. Issues to be addressed and the right not to respond to specific questions;
d. Measures to be taken to ensure confidentiality; and
e. Contact person(s) in case of a need for further information or clarification.

Safety Protocol

Consultant understand that the evaluation encompasses a sensitive subject of FGM which draws attention of many beneficiaries in the project site either positively or negatively, therefore the following safety measures are taken into considerations;

1. The principle of no harm, requires researchers not to place respondents at risk of harm or injury through acts of commission or acts of omission, as a result of their participation. During the evaluation assessment in relation to their safety or health, participants will be protected from harm by interviewing them in private areas where nobody can eavesdrop.

2. In addition and where necessary, all photos faces will be blind-folded to conceal possible identity, names in captions will be changed, and pictures will be taken at angles to conceal identity. Where faces will be identifiable, researchers will request the informed consent of the participant for his or her photograph to be used in the research findings.

3. The information sheet and consent process will be administered to respondent to ensure clarity of the terms and conditions being applied.
4. Respondents will be informed about their right to decline participation in the assessment without prejudice and asked for their signed consent to voluntarily participate in the assessment or to decline the interview or discussion. Proof of consent will be through a signature of the respondent or a thumbprint where the respondent is unable to write. The assessment participants will be informed that there will be no direct benefits to them prior to them consenting to be involved in the evaluation process.

Questions that may be asked to assess the risk:

- Do you have any concerns about carrying out this interview with me?
- Do you think that talking with me could pose you any problems, for example with those who trafficked you, surround you such as your friends, or someone who assists you?
- Do you feel that this is a good place to discuss your experience? If not, is there a better time and/or place?

Ethical Issues to Children Under 18

While it is important to collect information from adolescents and gatekeepers to assess adolescent FGM and early/forced marriages, it is also essential to address any ethical issues that may arise, particularly through consulting children who are under 18 years of age (and considered children). The guiding principle is that the best interests of the adolescent should be protected always, and that the assessment activities should do no harm to participants. All team members will be briefed on and understand the following specific guidelines:

1. Adolescents should only be consulted if necessary – in other words not if the information you need is already available from an existing source.
2. If adolescents are under 18 years old it may also be necessary in some settings to get consent from their parent or guardian for their participation.
3. Enumarators will be trained on how to protect the identity of participants. This means treating information anonymously (for example, not recording the names of participants), and confidentially (not sharing the information given with other people, unless with the participant’s permission). These are ways of making sure that those involved don’t suffer as result of participating in the assessment or of information disclosed.
4. They will also be trained on thinking in advance about how to deal with sensitive issues or needs raised, for example by referring adolescents to services where necessary, or providing them with information.

**Ethical issues on Interviews to the Rest of Community**

In addition, there are some general rules of good practice for working with communities, which should be followed by team:

1. Always demonstrate that you **respect and value the opinions** of the people you consult.

2. **Avoid raising expectations** that won’t be met by being clear to those involved and the wider community about the aims of the survey.

3. It is best to avoid providing incentives to participants. However, plan to meet them in a way that causes **minimum disruption** to their lives, for example at a time when they are not working and so won’t lose on income, at a convenient location that they do not have to travel to, and not at meal times.

**Key Stages and Safety/Ethical Considerations**

Each stage of the interview may present a risk. Those potential risks should be acknowledged and assessed, and appropriate security measures must be undertaken. It is essential to take into account the risk associated with GBV and other GBV incidences in each case before the interview. In this regard, therefore the team plans as follows in each stage of the evaluation process;

**Stage 1: make the initial contact**

Generally speaking, respondents particularly women and girls who will be interviewed as part of the evaluation assessment will be coming from the FGM practising communities., we have to keep in mind that the simple fact of approaching puts them at risk by raising suspicions about their loyalty to cultural sensitivity. They are rarely unsupervised. And even though interviewed
women and girls who are staying in a shelter we still have to be very discreet when conducting the interviews or discussions.

**Stage 2: identify a time and a place to conduct the interview**

*Field Plan:*

- Interviews should be conducted in a secure and private setting and in total privacy. NGO or social support services are often among the safest options. Interviews should not be held in a location where some people may pass by or “drop in”, or where random interruptions may occur. This could make the respondent feel uncomfortable and nervous.

- Before and through the interview, the respondent should be free to reschedule (or relocate) the interview to a time (or place) that she considers to be safer or more convenient for her/him.

- Tight schedules are not practical or realistic and may lead interviewers to take risks. Similarly, interviews should not be too long nor emotionally draining. The more at ease the respondent feels, the more likely they will share valuable information.

- It is a good idea to clarify at the start of the interview at what time the respondent needs to leave and how flexible time is (if the interview can last a bit longer or if they have to leave on time).

- It is essential to make sure that the extension of the length of the interview do not pose her any problem.

- If necessary, we should explain to the respondent that we might need to have another meeting in order to finish the interview.

**Stage 3: conduct the interview**

Firstly, we may leave preconceived notions behind, and listen without any judgement. If the interviewer has preconceived ideas or emotions related to some experiences and reactions, or in relation to the woman’s personality or character, he/she will certainly miss important information and overlook the unique nature of each woman’s experience.

*Field Plan:*

- Keeping an open mind and having strong listening and interpreting skills is essential to conduct such interview.

- It is very important to be able to detect when a respondent feels unsafe.

- Events can change suddenly during the course of an interview. These changes may pose physical or psychological risks to a respondent.

- Even if the original conditions set for the interview were acceptable, a respondent may feel unsafe or ill at ease during the interview.

- It is important to pick up on these clues, because the interview situations may have become
Occurences that can change the nature of an interview include:
✓ Someone entering the room or walking by;
✓ Questions that make her suspicious or nervous of the interviewer’s intentions such as requests for specific names or addresses or questions about her/his family or her age
✓ Interviewer’s loss of confidence or show of signs of anxiety

Stage 4: close the interview

Recommendations:
✓ Whenever possible, the interviewer should end in a positive way.
✓ The interviewer can remind the interviewee of how well she/her coped and how what she told will be used to help others.

5. List of stakeholders interviewed or consulted (without direct reference to individuals unless consent has been given)

a. List of stakeholders reached at District level
   1. Amref staff
   2. Community Development Officer (CDO)
   3. Council HIV and AIDS Coordinator (CHAC)
   4. District Administrative Secretary (DAS)
   5. District Commissioner (DC)
   6. District Education Officer (DEO) - Primary & Secondary
   7. District Executive Director (DED)
   8. District Medical Officer (DMO)
   9. District Planning and Logistic Officer (DPLO)
   10. District Reproductive and Child Health Coordinator (DRCHCO)
   11. District Resident Magistrate
   12. District Social Welfare Officer (DSWO)
   13. Member of Parliament (MP)
   14. Nyumba Salama
   15. Officer Commanding District (OCD)
   16. Police Gender and Children Desk
   17. Traditional Leader (District Secretary)
   18. Paralegal - Wasaidizi wa Sheria na Haki za Binadamu Serengeti (WASHEHABISE)

b. Summary of study participants per study wards

<table>
<thead>
<tr>
<th>No</th>
<th>Ward</th>
<th>KII Reached</th>
<th>No</th>
<th>Position</th>
<th>Sex</th>
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<td>1</td>
<td>Machochwe</td>
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<td>1</td>
<td>Pastor</td>
<td>M</td>
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<td></td>
<td></td>
<td></td>
<td>2</td>
<td>Ward Education Officer</td>
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</tr>
<tr>
<td>Area</td>
<td>Name</td>
<td>Gender</td>
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<tr>
<td>3.</td>
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<tr>
<td>4.</td>
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<tr>
<td>5.</td>
<td>Village Security guard</td>
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<td>6.</td>
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<td>Ikoma</td>
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</table>
6. List of documents reviewed

- Amref and LHRC’s Annual Project Reports
- Baseline Survey Report
- Country profile: FGM in Tanzania
- Demographic Health Survey Report (2015/2016),
- Guidelines for the Preparation of Plans and Budget in (2018/2019)
- Indicator Matrix
- National Housing and Population Census (2012)
- National Plan of Action to End Violence Against Women and Children in Tanzania 2017/18 – 2021/22
- Needs assessment reports
- Progress reports
- Project document.
- Serengeti District Strategic Plan (2016/17 – 2020/21),
- Tanzania Demographic and Health Survey (TDHS) 2015-16
- Tanzania Development Vision 2025

7. List of Operating Health Facilities in Serengeti DC

<table>
<thead>
<tr>
<th>S/N</th>
<th>Region</th>
<th>Council</th>
<th>Facility Name</th>
<th>Facility Type</th>
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<tbody>
<tr>
<td>1</td>
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<td>Dispensary</td>
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<td>Busawe Dispensary</td>
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<td>3</td>
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<tr>
<td>S/N</td>
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<td>Council</td>
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<td>Facility Type</td>
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<td>Public - LGA</td>
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<td>Robanda Health Centre</td>
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<td>Fort Ikoma Tanapa</td>
<td>Dispensary</td>
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<table>
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<tr>
<th>Sector</th>
<th>Year</th>
<th>Planned Activities</th>
<th>Approved</th>
<th>Actual</th>
<th>Target Beneficiaries</th>
<th>Performance Indicators</th>
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<tbody>
<tr>
<td><strong>Health</strong></td>
<td>2016/2017</td>
<td>Provision of quality health services and infrastructures</td>
<td>1,264,11,000</td>
<td>826,411,000</td>
<td>Serengeti DC resident</td>
<td>Prevalence rate of diseases case reduced</td>
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<tr>
<td></td>
<td>2017/2018</td>
<td>% of people with access to potable water within 400 meters increased from 62.4% to 75% by construction of water schemes and rehabilitation of water infrastructures</td>
<td>1,585,483,392.94</td>
<td>1,510,483,600</td>
<td>Serengeti DC resident</td>
<td>% of quality health services provided</td>
</tr>
<tr>
<td></td>
<td>2018/2019</td>
<td>% of people with access to potable water within 400 meters increased from 62.4% to 75% by construction of water schemes and rehabilitation of water infrastructures</td>
<td>827,817,000</td>
<td>Serengeti DC resident</td>
<td>% of quality health services provided</td>
<td></td>
</tr>
<tr>
<td><strong>Water</strong></td>
<td>2016/2017</td>
<td>Provision of quality health services and infrastructures</td>
<td>1,513,997,000</td>
<td>112,594,553</td>
<td>Serengeti DC resident</td>
<td>Number of water schemes constructed and rehabilitated</td>
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<tr>
<td></td>
<td>2017/2018</td>
<td>Provision of quality health services and infrastructures</td>
<td>1,521,787,370</td>
<td>255,310,471</td>
<td>Serengeti DC resident</td>
<td>Number of water schemes constructed and rehabilitated</td>
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<tr>
<td></td>
<td>2018/2019</td>
<td>Provision of quality health services and infrastructures</td>
<td>582,553,000</td>
<td>Serengeti DC resident</td>
<td>Number of water schemes constructed and rehabilitated</td>
<td></td>
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<tr>
<td><strong>Education</strong></td>
<td>2016/2017</td>
<td>Provision of quality health services and infrastructures</td>
<td>1,048,954,000</td>
<td>1,217,266,991</td>
<td>Students, Teachers and Ward Education Officers (WEC)</td>
<td>-Performance of students In their nation exams -Number of infrastructures constructed/rehabilitated</td>
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<td>2017/2018</td>
<td>Provision of quality health services and infrastructures</td>
<td>999,197,614</td>
<td>756517614</td>
<td>Students, Teachers and Ward Education</td>
<td>-Performance of students In their nation exams -Number of infrastructures constructed/rehabilitated</td>
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<tr>
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<td></td>
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<td><strong>Transport</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2016/2017</td>
<td>Construction of roads and culverts through spot, routine and periodic maintenance</td>
<td>1,736,598,755</td>
<td>1,320,123,680</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>2017/2018</td>
<td></td>
<td>950,300,000</td>
<td>0</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>2018/2019</td>
<td>Budget for roads is now under Tanzania Rural and Urban Roads Agency (TARURA)</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td><strong>GBV</strong></td>
<td></td>
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<tr>
<td>2016/2017</td>
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<tr>
<td>2017/2018</td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>
| 2018/2019                 | - Advocacy social welfare issues on child rights on gender mainstreaming  
                           |                                  | 4,275,000                        | Children, Youth, women and people with disabilities |
|                           | - To facilitate commemoration of African child day and women world day |                                  |                                  |
| **Women Development Fund**| To facilitate 12 women group to undertake income generating activities | 91,880,300                       | 101,500,000                      |
| 2017/2018                 | facilitate 23 women group to undertake income generating activities | 155,612,550                      | 63,000,000                       |
| 2018/2019                 | To facilitate 20 groups of women to undertake economic activities | 130,375,320                      |                                  |
| **Youth**                 | To facilitate 12                  | 91,880,300                       | 116,470,000                      |

**Officers (WEC)**

- Performance of students in their national exams
- Number of infrastructures constructed/rehabilitated

**Students, Teachers and Ward Education Officers (WEC)**

- KM of roads and culverts constructed

**Residents and businesswoman from outside Serengeti**

- KM of roads and culverts constructed
<table>
<thead>
<tr>
<th>Development Fund</th>
<th>Outcome Indicators</th>
<th>Baseline data</th>
<th>Number/Percentage</th>
<th>Evaluation data</th>
<th>Number/Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>women group to undertake income generating activities</td>
<td></td>
<td></td>
<td>groups by youth groups</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Development Fund</th>
<th>Outcome Indicators</th>
<th>Baseline data</th>
<th>Number/Percentage</th>
<th>Evaluation data</th>
<th>Number/Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>groups by youth groups</td>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>People with Disability Fund</th>
<th>Outcome Indicators</th>
<th>Baseline data</th>
<th>Number/Percentage</th>
<th>Evaluation data</th>
<th>Number/Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016/2017</td>
<td></td>
<td></td>
<td></td>
<td>groups by youth groups</td>
<td></td>
</tr>
<tr>
<td>2017/2018</td>
<td></td>
<td></td>
<td></td>
<td>groups by youth groups</td>
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</table>

Source: Budget officer/planning officer- Serengeti DC

9. Indicators Matrix Table
<table>
<thead>
<tr>
<th>Indicator 1. Perspective of young women and girls who experienced legal protection and promoted dignity in the past 36 months</th>
<th>Access to legal protection is a challenge and one has to be very determined to have access to legal protection, it is not something that is readily available for girls and women to have access to</th>
<th>0</th>
<th>Access to legal protection is still a challenge, some girls and women are not aware of where to access legal protection. However it was disclosed from paralegals and gender desk that a total of 1,471 young women and girls experienced legal protection.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indicator 2. % of women and girls who have experienced new cases of FGM in the past 36 months.</td>
<td>The number of girls and young women who experienced new cases of FGM has dropped from 41% during 2016 to 25.2% in December 2018. However, statistics obtained from field shows that from 2016 to 2018, 35 cases of FGM were reported. About 15 (43%) cases of FGM were sent to court, whereby 5 cases were ruled and two perpetrators sentenced to ten years imprisonment, plus 1 Ngariba.</td>
<td>74.3</td>
<td>25.2%</td>
</tr>
<tr>
<td>Indicator 3. Perspective of young women and girls who have experience safe motherhood in the past 36 months.</td>
<td>The perspective is mixed, those who delivered at health facilities appreciated the service but others were not. The general trend also in some villages is that women do deliver at homes thus were not able to comment on deliveries at the health facilities.</td>
<td>0</td>
<td>Most of the motherhood who delivered at health facilities appreciated the service rendered by health care workers and insisted that the efficiency of the service rendered has increased comparing to the past 36 months. About 1,547 (1.08%) of young girls and women who have been victims of FGM and GBV in genera appreciated the services.</td>
</tr>
</tbody>
</table>

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43 Project Report (January-December 2018 Final
44 Ibid
45 Police Gender and Children Desk – Mugumu, January 2019
<table>
<thead>
<tr>
<th>Indicator</th>
<th>Description</th>
<th>Value</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>% of young women and girls aggregated by age that reported/confessed not to be subjected to FGM practices in the past 36 months</td>
<td>11.8 (women above 25 years) 41.4(women 25 years and below)</td>
<td>Alternative Rites Passage (ARP) was possible in 2018, where a total of 359 girls graduated. About 23.9% were women of 25 years and below. KII confirmed about 234 girls from Issenyi ward passed Alternative Rites Passage without cutting.</td>
</tr>
<tr>
<td>2.</td>
<td>Perspective of circumcisers and traditional leaders reported to abandon FGM practices in the past 36 months.</td>
<td>None of the circumcisers and traditional leaders were not ready to abandon FGM practice.</td>
<td>The circumcisers and traditional leaders have increased commitment in abandoning FGM practices. About 156 traditional leaders and cutters who openly denounced the FGM practices. These have been the total results of the awareness rising made through sensitization and training activities at the community level. Though in some village like Nyansurura, Mbalibali some traditional leaders are not ready to abandon FGM practice. FGM/GBV practices are still taking place and with higher degree of secrecy among the community members, more efforts should basically set to reach remote areas.</td>
</tr>
<tr>
<td>3.</td>
<td>Perspective of parents and care givers who confess to denounce FGM practices.</td>
<td>20</td>
<td>Parents and care givers especially women have increased commitment to abandoning FGM practices though there are still some men who are not ready to denounce FGM practice. About 1904 (1.4%) women and about 1010 (0.7%) men. A total of 2914 (2.1%) openly denounced the FGM practices during the ARP ceremony.</td>
</tr>
<tr>
<td>4.</td>
<td>% of survivors (girls and women) of FGM who have access to improved health care and legal services.</td>
<td>188 (0.1%)</td>
<td>About 188 (0.1%) Women 0-9=11 10-14=93 15-18=75 19-25=175 26-49=2 60=&gt;=</td>
</tr>
<tr>
<td>5.</td>
<td>% of health care workers demonstrating skills in providing quality health care services in the past 36 months.</td>
<td>0</td>
<td>Out of 139 trained health worker only 106 (29.04%) are active trained health care workers demonstrated the technical skills on the psychosocial support and other health care services needed by survivors in Serengeti. About 77.4% of respondents from the questionnaire confirmed that</td>
</tr>
</tbody>
</table>

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46 Project Report (January-December 2018 Final
47 Field data from Issenyi ward
| Indicator 6. % of legal officers and paralegals demonstrating improved skills in providing legal services in the past 36 months. | 0 | 0 | About 86 legal officers and paralegals demonstrated improved skills in providing legal services; This implies that there are about 63.9% of legal officers and 36.05% of paralegals serving as liaison between survivors and other parties mainly to ensure FGM and GBV perpetrators are brought to justice. About 50.1% of questionnaire respondents confirmed that legal officers and paralegals demonstrating improved skills in providing legal services in the past 36 months. | 63.9% of legal officers and 36.05% of paralegals |
| Indicator 7. % of government budget at district level allocated for addressing GBV including FGM in the past 36 months. | 0 | 0 | The Government of Tanzania is committed at policy level to fight Violence against women and FGM in particular. However, the challenge remains in translating these policies into realities and resources. Today, Serengeti DC, has lesser than ten million budgeted for GBV as oppose to baseline which was zero. However in the wards visited the government didn’t allocate budget on FGM/GBV issues. | 0% |
| Indicator 8. Perspective of decision makers at district level informed and committed to address GBV including FGM in the past 36 months. | 0 | 0 | Decision makers at district level support and commit to address the ant FGM project to the community on the effects of FGM and GBV in public meetings but fails to allocate the budget due to limited revenue from own Source. About 51 decision makers at district level were informed (trained and oriented in various packages that are intended to fight GBV) and committed to address GBV including FGM. They have been actively undertaking initiatives that address the FGM practices in the district. | 51 |
| Indicator 9. % of CBOs formed and strengthened and effectively engages in advocating for anti GBV/FGM in the past 36 months. | 0 | 0 | About 51 (13.2%) formed and strengthened CBOs have been increasing their initiatives to advocating against FGM and GBV in general, including community based lobbying for the enactment and enforcement of Bi-laws against FGM. | 13.2% |

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48 Project Report, January – December 2018 Final  
49 Field data  
50 Ibid  
51 Project Report, January – December 2018 Final
## Output Indicators

<table>
<thead>
<tr>
<th></th>
<th>Count</th>
<th>Percentage</th>
<th>Description</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td># of girls and young women who are aware of the health effects of FGM and laws related to GBV</td>
<td>257</td>
<td>37.9%</td>
<td>There is an increase in awareness of health effects of FGM and laws related to GBV From 37.9% to 80.2% of girls and young women. According to FGDs and questionnaires the awareness of health effects of FGM and laws related to GBV has increased to 90%.</td>
<td></td>
</tr>
<tr>
<td># of indigenous women who are aware of effects of FGM and laws related to GBV</td>
<td>5</td>
<td>NA</td>
<td>The GNA report, reads, women are more against FGM now in Serengeti, but denied decision-making power, hence driven by men. Thus, the project ensured men and boys be part of the awareness forums for a total behavior change against FGM and the prevailing GBV issues in Serengeti.</td>
<td></td>
</tr>
<tr>
<td># of girls and women with disabilities who are aware of effects of FGM and laws related to GBV</td>
<td>10</td>
<td>50</td>
<td>About 56 Girls and women with disabilities are aware of effects of FGM and Laws related to GBV.</td>
<td>56</td>
</tr>
<tr>
<td># of parents are aware of health effects and human rights aspects of FGM and ready to discourage FGM practice.</td>
<td>834</td>
<td>59.9%</td>
<td>About 2914 (2.1%) parents (1904 [1.4%] women and 1010 [0.7%] men) are aware of health effects and human rights aspects of FGM. There are an increased in number of parents who are aware of the health effect compared to the baseline data. However men still need more education on health effects on FGM.</td>
<td></td>
</tr>
<tr>
<td># of traditional leaders or parents who are aware of health effects and human rights aspects of FGM and ready to discourage FGM practice.</td>
<td>12</td>
<td>0</td>
<td>About 116 traditional leaders or parents are aware of the health effects and human rights and discouraged FGM practice. However FGD girls reveal that parents need more seminars on the health effects of FGM.</td>
<td></td>
</tr>
<tr>
<td># of boys and men</td>
<td>439</td>
<td>61.48%</td>
<td>Comparing to the baseline data there are 6491 boys and men who are aware of the health effects of FGM.</td>
<td>6491</td>
</tr>
</tbody>
</table>

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52 Ibid
53 Gender Needs Assessment
54 Field Data
55 Gender Needs Assessment
56 Project Report, January 2018 Final
57 Ibid
58 Gender Needs Assessment
59 Field Data
are aware of health effects and human rights aspects of FGM and ready to discourage FGM practice.

| # of traditional leaders are committed to denounce FGM due to learning from communities already practicing ARP model. | 12 | 0 | About 116 traditional leaders were committed to denounce FGM due to learning from communities already practicing ARP model<sup>61</sup>. |
| # of care givers are ready to withdraw FGM mind set due to learning from communities already practicing ARP model. | 476 | 0 | About 2914 care givers are ready to withdraw FGM mind set due to learning from communities<sup>62</sup>. |
| # of girls are ready to denounce FGM due to learning from communities already practicing ARP in Serengeti district. | 87 | 0 | There is an increase of about 1471 girls who are ready to denounce FGM due to learning from communities already practicing ARP in Serengeti district<sup>63</sup>. |

**Perspective of women on the provision of integrated education against FGM during antenatal, post-natal, family planning and well-baby clinics**

| Women are very positive on the provision of integrated education against FGM during antenatal, post-natal, family planning and well-baby clinics | 0 | About 424 mothers and expected mothers were mentored on effects of FGM during the antenatal, postnatal and family planning and well-baby clinics<sup>64</sup>. However, Health facilities confirmed the project to have a component of provision of integrated education against FGM<sup>65</sup>. |

**# of pregnant women who receive education against FGM during antenatal, family planning and well-baby clinics**

| 76 | 0 | A total of 235 women 20 – 24 (24%) and 25 – 59 (76%) were recently recorded to have improved their knowledge on avoiding effects of FGM as they are attending antenatal during the family planning awareness sessions. Their partners have also benefited from counselling to enable them to explore and understand the |

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<sup>60</sup> Project Report, January 2019 Final
<sup>61</sup> Ibid
<sup>62</sup> Ibid
<sup>63</sup> Ibid
<sup>64</sup> Ibid
<sup>65</sup> Field Data
| # of pregnant women who receive education against FGM during post-natal care clinic | 76 | 0 | According to the project report, there is an increase of 189 pregnant women 20–24 (32%) and 25 - 59 (68%) received education against FGM during post-natal care clinic. | 20–24 (32%) 25 – 59 (68%) |
| # of trained police gender desk officers effectively respond to cases of FGM and ensure perpetrators are brought to justice | 15 | 0 | A total 30 (16%) police were trained effectively respond to cases of FGM and ensure perpetrators are brought to justice. There is an increase of 8% of trained police who helped to file 20 FGM cases. About 8 cases are on hearing process and 4 ruled for the minimum of 5 years imprisonment. KII confirmed. | 16% |
| # of trained paralegal officers effectively respond to cases of FGM and ensure perpetrators are brought to justice | 3 | 0 | A total of 31 (94%) paralegals were trained on health effect of female genital cut and laws and policies relating to FGM/GBV. There is an increase of 85% of trained Paralegals. They have been so able to provide legal advice to victims of FGM/GBV. The result of such training is capability of the paralegal units to serve/attend at least minimum of 13 cases quarterly. Legal advice by the paralegals have been sometimes the direct assistance to victims before the court of law. | 94% |
| # of trained judicial officers effectively respond to cases of FGM and ensure perpetrators are brought to justice | 0 | 0 | The project managed to train 29 Judicial Officials on health effect of female genital cut and FGM/GBV related laws and policies. With the result of training there have been a fast trucking of all cases in relation to female genital cut/GBV. | 29 |
| # of HCWs who are capable to effectively manage health complications of FGM to girls and women | 30 | 0 | About 106 (29%) 62 males and 44 females HCWs are capable of effectively manage health complications of FGM to girls and women. There is an increase of 72%. | 29% |
| # of HCWs who are capable to effectively provide psychosocial support to girls and women | 15 | 0 | About 106 (29%) 62 males and 44 females HCWs are capable of effectively provide psychosocial support to girls and women. There is an increase of 86%. | 29% |

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66 Project Report, January 2019 Final  
67 Ibid  
68 Ibid  
69 OCD-Serengeti Police Station  
70 Project Report, January 2019 Final
| Perspective of the community members on the presence of the referral and feedback mechanism related to legal aspects of FGM. | Referral and feedback mechanism on health effects of FGM are desired although referral process is not very clear. Formal referral networks that integrate across services are virtually nonexistent. | According to the GNA 2018 report it was commended that police gender and child desk is faced with insufficient budget to reach remotes of area, meeting treatment and transport costs of victims. Police Gender Desk Checklist confirmed there is a limited budget to meet transport cost, treatment of victims, lack of direct communication with victims/survivors and ensuring security.

| Perspective of the community members on the presence of the referral and feedback mechanism on health effects of FGM. | Actions on FGM and GBV complaints are not taken seriously. There are no feedbacks on action taken against the culprits. Fear of social stigma and community disapproval (including traditional | According to the GNA, 2018 report, key informants involved in the study stated that the current FGM legislation, Penal Code and Law of the Child Act, is not adequate as it prohibits FGM against women below 18 (girls). There is no legal protection of women above 18 against FGM. |

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71 Gender Needs Assessment 2018
72 Police Gender Desk Mugumu
73 Police Gender Desk Mugumu
74 Gender Needs Assessment

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| women | # of community health workers trained to provide home based health care and anti-FGM education. | About 104 (28.5%) (55 males and 49 females) community health workers trained to provide home based health care and anti-FGM education. | 28.5% |

| Perspective of the community members on the presence of the referral and feedback mechanism related to legal aspects of FGM. | The perspective of the community members is that there is limited referral and feedback mechanism related to legal aspects of FGM | According to the GNA 2018 report it was commended that police gender and child desk is faced with insufficient budget to reach remotes of area, meeting treatment and transport costs of victims. Police Gender Desk Checklist confirmed there is a limited budget to meet transport cost, treatment of victims, lack of direct communication with victims/survivors and ensuring security. | 260
Male=136
20-24=66
25-59=70
Female=124
20-24=73
25-59=51 |

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| Perspective of the community members on the presence of the referral and feedback mechanism on health effects of FGM. | Referral and feedback mechanism on health effects of FGM are desired although referral process is not very clear. Formal referral networks that integrate across services are virtually nonexistent. | According to the GNA 2018 report it was commended that police gender and child desk is faced with insufficient budget to reach remotes of area, meeting treatment and transport costs of victims. Police Gender Desk Checklist confirmed there is a limited budget to meet transport cost, treatment of victims, lack of direct communication with victims/survivors and ensuring security. | 260
Male=136
20-24=66
25-59=70
Female=124
20-24=73
25-59=51 |

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| Perspective of the community members on the actions undertaken on complaints and feedback raised related to FGM/GBV. | Actions on FGM and GBV complaints are not taken seriously. There are no feedbacks on action taken against the culprits. Fear of social stigma and community disapproval (including traditional | According to the GNA, 2018 report, key informants involved in the study stated that the current FGM legislation, Penal Code and Law of the Child Act, is not adequate as it prohibits FGM against women below 18 (girls). There is no legal protection of women above 18 against FGM. | 260
Male=136
20-24=66
25-59=70
Female=124
20-24=73
25-59=51 |
<table>
<thead>
<tr>
<th>Perspective of the community members on presence of forum at district level discusses GBV related laws so as to meet the international human rights standards.</th>
<th>Forums on issues of FGM and GBV at district level are supported. The Community preferred Civil society organizations (NGOs, CBOs, FBO) and outsiders to work closely with the district council because of the possibility of getting easy acceptance compared with indigenous or local leaders who are frequently involved in FGM and GBV</th>
<th>0</th>
<th>Full participation of the district officials in all activities implemented by the project have been a great assistance in reaching all the achievement attained by the project. However, they need to do their part in creating forums to discuss GBV related law so as to meet the international human rights standard. The district should prioritize FGM and GBV by allocating funds in their budgets.⁷⁵</th>
<th>4 Forums⁷⁶</th>
</tr>
</thead>
<tbody>
<tr>
<td>Perspective of the community members on presence of village based forum that is age and sex structured to discuss FGM policies and law issues.</td>
<td>Village based forums for discussing FGM and GBV issues are preferable, but under the guidance of external organizers not involving in FGM and GBV</td>
<td>0</td>
<td>The GNA report shows that at district level FGM/GBV is not one among the district priorities, lesser than three million budgeted for GBV is set. Sustaining forums is a challenge.⁷⁷</td>
<td>4 Village forums are formed⁷⁸</td>
</tr>
<tr>
<td>Perspective of the community members on presence of school based forum to discuss FGM policies and laws.</td>
<td>Have a positive perspective on the presence of school based forums to discuss FGM policies and laws. Children will be aware of</td>
<td>0</td>
<td>Community members have declared that the presence of school based forums to discuss FGM policies and law has created awareness and confidence to girls to fight against FGM practice. Sensitization and training activities provided to young students both at primary and</td>
<td>3 school based forums are formed⁷⁹</td>
</tr>
</tbody>
</table>

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⁷⁵ Field data
⁷⁶ Project Report, January 2019 Final
⁷⁷ Gender Needs Assessment Report
⁷⁸ Ibid
⁷⁹ Project Report, January 2019 Final
<table>
<thead>
<tr>
<th>Perspective of the community members on coordination of the local CSOs/CBOs advocating against FGM issues.</th>
<th>So far CSOs and CBOs and FBOs are operating independently, there is no coordination. This applies even to links between police, safe house, village leaders</th>
<th>Community member believes that if CSOs, CBOs and FBOs coordinate effectively advocate campaigns against FGM practices will lead to increased commitment from authorities and resources allocation for anti-GBV activities. Still there is no coordination. However, in the final project report, it was reported that coordination strengthened.</th>
</tr>
</thead>
<tbody>
<tr>
<td># of capable CBOs able to manage and govern anti-FGM related interventions</td>
<td>5</td>
<td>There is a total of 58 CBOs capable of managing and government anti-FGM related interventions.</td>
</tr>
<tr>
<td># of CBOs undertaking anti-FGM advocacy agenda</td>
<td>0</td>
<td>There are 58 active CBOs undertaking anti-FGM advocacy agenda and usually report to DCDO’s office.</td>
</tr>
<tr>
<td># of FBOs undertaking anti-FGM advocacy agenda</td>
<td>8</td>
<td>The project held 4 several meetings across the process mainly to discuss and analyze budgetary allocations and expenditure trends for FGM and GBV specific at district level with reference to Comprehensive Council Health Plan (CCHPs) and overall health budgets; and annual financial expenditure reports.</td>
</tr>
<tr>
<td># of meetings held with district officials to promote inclusion of Anti-GBV-FGM in the Medium Term Expenditure.</td>
<td>0</td>
<td>There is about 30 technical staff trained on gender based budgeting and championing anti-FGM in Serengeti district.</td>
</tr>
<tr>
<td># of technical staff championing anti-FGM trained in gender based budgeting.</td>
<td>0</td>
<td>Gender Needs Assessment report (2018) shows that budget is the key challenge in the campaign against GBV and FGM. They frequently mentioned that GBV and FGM</td>
</tr>
</tbody>
</table>

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79 Field Data  
81 Field Data  
82 Project Report, January 2019 Final  
83 Project Report, January 2019 Final  
84 Ibid  
85 Ibid  
86 Ibid  
87 Ibid
| purposes using opportunity and obstacles to development approach. | they receive limited budget which is even difficult for development related plans | budget are not given priorities in council plans rather they depends on organizations such as Amref to fight GBV especially FGM. |