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Burying the Blades

Can the Goal programme Help Discontinue

Female Genital Mutilation and Cutting in North-Eastern Kenya?

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Abstract

In the light of international efforts to bring Female Genital Mutilation and Cutting to an end, this study aimed to investigate to which extent the Goal programme of Women Win can help to discontinue FGM/C in North-Eastern Kenya. First, a literature review was conducted to find factors which are positively associated with the discontinuation of the practice. Secondly, factors that were represented in the programme were extracted. Represented factors included the encouragement of a (a) high level of autonomy and (b) high SES of individuals, as well as the attention for (c) women empowerment, (d) gender rights discussion, (e) health consequences of FGM/C, and (f) the potential of individuals to become role models. Thirdly, the six factors were assessed for their effectiveness, using survey data of 11 countries that implemented the programme in 2017. It can be concluded that the Goal programme can be regarded as a promising intervention for the discontinuation of FGM/C in North-Eastern Kenya, as it empowers participants to be role models and make well-informed and autonomous life choices with regard to gender rights, sexual and reproductive health and rights, as well as financial management. However, several adaptations for the programme are recommended to increase its potential. Main recommendation is to not only target at the at-risk group of girls, but also involve the community to achieve social norm change and bury the blades forever.

Keywords: female genital mutilation and cutting, FGM/C, discontinuation, intervention, Kenya

Samenvatting

In het kader van internationale inspanningen om vrouwenbesnijdenis (FGM/C) te uit te bannen, is onderzocht in welke mate het Goal programma van Women Win kan helpen om FGM/C te beëindigen in Noordoost Kenia. Ten eerste is een literatuurstudie gedaan om factoren te identificeren die positief samenhangen met het stoppen van FGM/C. Ten tweede is er onderzocht welke van deze factoren vertegenwoordigd waren in het Goal programma. Vertegenwoordigde factoren waren: het aanmoedigen van een (a) hoog niveau van autonomie en (b) een hoge SES van individuen, en daarnaast aandacht voor (c) het versterken van de eigen kracht van vrouwen, (d) genderrechten, (e) gezondheidsconsequenties van FGM/C, en (f) het potentieel van individuen als rolmodellen. Ten derde zijn de zes factoren beoordeeld op hun effectiviteit, door survey gegevens van 11 landen te gebruiken die het programma in 2017 implementeerden. Er kan geconcludeerd worden dat het Goal programma een veelbelovende interventie is die kan bijdragen aan het beëindigen van FGM/C in Noordoost Kenia, omdat het participanten in staat stelt om rolmodellen te zijn en goed geïnformeerde en autonome levenskeuzes te maken met betrekking tot genderrechten, seksuele en reproductieve gezondheid en rechten, en financieel management. Desalniettemin, worden enkele aanpassingen voor het programma aanbevolen. Een belangrijke aanbeveling is om niet alleen te richten op meisjes die risico lopen op FGM/C, maar ook de gemeenschap te betrekken om de sociale norm te veranderen en de messen voorgoed te begraven.

Trefwoorden: vrouwenbesnijdenis, FGM/C, beëindiging, interventie, Kenia

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Throughout the human life course, important life events are often marked by ritual events (Markstrom & Iborra, 2003). For example, love is celebrated by marriage, and funerals take place after death. These ritual events are named *rites of passage* (Van Gennep, 2004), which can be defined as a process of rituals, used to mark the transition from one status to another (Holm & Bowker, 1994). For example, from life to death, or from adolescence to adulthood. With regard to the latter, most cultures characterize the transition to adulthood by completing education, becoming financially independent, and taking responsibility for one's own household (McCarthy, de Souza, & Jafaar, 2014). Although these similarities across cultures exist, the transition to adulthood is accompanied by different rites of passage. For example, young Norwegians celebrate the start of their adult life for a period of two weeks, right after graduation from secondary education, by spending time with other graduates, consuming alcohol, and wearing special clothes (Sande, 2002). In contrast, the transition to adulthood is marked in a less benign way among some non-Western populations, where girls undergo Female Genital Mutilation and Cutting (FGM/C) to declare their readiness for the next life phase as a marriageable adult.

FGM/C is a term used to describe any event in which the external female genitalia are injured, or partially or totally removed, based on cultural grounds (WHO, 2008). The practice is carried out in Africa, Asia, the Middle East, as well as among immigrant groups in North-America, Europe, and Australia. The mutilation is mainly targeted at girls below the age of fifteen (UNICEF, 2005, 2013) and practiced by traditional circumcisers who use a sharp object (e.g. razor, blade, glass) to perform the cutting. Variations are seen between and within countries

regarding the type of genital cutting that is performed. For example, some girls undergo (partial) cutting or flesh removal, whereas in other cases girls' genitals are nicked, or sewn closed. FGM/C can cause serious health complications (UNICEF, 2013), as well as lead to negative socio-economic effects (e.g. high health care costs) for individuals, families, and communities (Waigwa, Doos, Bradbury-Jones, & Taylor, 2018).

FGM/C practices are a clear violation of the right to health and freedom from torture or cruel, inhuman or degrading treatment and, possibly, even the right to life (WHO, 2008). Although this is widely recognized, and FGM/C is therefore prohibited by many treaties, it is still a prevalent practice in several continents (Adam et al., 2010; UNICEF, 2005, 2013). The prevalence of FGM/C is estimated at around 200 million girls and women (i.e. aged 15 to 49) alive today (WHO, 2018). Every year, three million girls are at risk of undergoing the practice (WHO, 2008). It is estimated that by 2050, up to 63 million more women will have undergone FGM/C (UNICEF, 2016). One of the highest prevalence rates is seen in North-Eastern Kenya. Whereas the national prevalence rate of FGM/C among Kenyan women, aged between 15 and 49 years, was 21 percent in 2014 (28TooMany, 2016), a rate of about 97,5 percent was observed in the North-Eastern part of the country (Forward, n.d.). In this area, FGM/C is mostly prevalent among the Somali (93.6%), Samburu (86%), Kisii (84,4%), and Maasai (77,9%).

The objectives of the present study are to identify the factors that have been shown to be positively associated with the discontinuation of FGM/C, and assess the extent to which an intervention of the non-governmental organization (NGO) Women Win, called the 'Goal programme,' can be used in North-Eastern Kenya to discontinue the practice and consequently, enable girls in this area to be protected from the negative consequences of FGM/C.

Reasons for FGM/C

To know how to discontinue the practice, it is important to understand why FGM/C is practiced worldwide. According to a study by UNICEF (2013), genital cutting is often seen as a rite of passage to adulthood, and a symbol of virginity, which increases girls' marriageability. Furthermore, some believe being cut boosts men's sexual pleasure. Another reason for continuing the practice is the belief that circumcision is a religious necessity, in which FGM/C serves as a cleansing rite to prepare women for proper praying. The most important reason for the continuation of FGM/C is the belief that when one does not conform to the practice, serious consequences will follow, such as social exclusion, criticism, ridicule, stigma, or decreased marriageability. Therefore, individuals continue the practice and enforce the norm for next generations (UNICEF, 2013).

In North-Eastern Kenya, the most important reasons for performing FGM/C are the use of the event (1) as a rite of passage, (2) to secure marriageability, and (3) to mark sexual purity and the control of one's desires (Forward, n.d.). Girls living in this region of Kenya are mostly cut between the ages of five and fourteen, with Somali girls being the ones who are cut at the youngest age (Forward, n.d.). With regard to the type of FGM/C, in most cases flesh is (partially) removed (Forward, n.d.; UNICEF, 2013).

Consequences of FGM/C

FGM/C can negatively affect girls' health, as well as the socio-economic situation of individuals and their families. With regard to health, immediate consequences include pain, bleeding and infections, which can lead to death via hemorrhagic shock (Refaei, Pourreza, & Masoumi, 2016; UNICEF, 2013; WHO, 2008). Possible long-term consequences are decreased sexual enjoyment, urinary, vaginal and menstrual problems, psychological trauma, infertility, susceptibility to infections, and damage to organs (Refaei et al., 2016; UNICEF, 2013; WHO,

2008). Not only girls who undergo FGM/C are at risk for complications, but also their unborn babies might suffer from pain, or die during birth (Banks et al., 2006).

Socio-economic consequences of FGM/C have not been widely studied. It is suggested that individuals that undergo FGM/C show a high risk of school dropout, early marriage, and poor literacy, which can increase the likelihood that they will fail to meet their rights throughout their lives (28TooMany, 2013; Mpinga et al., 2016). Not only individuals, but also families can be affected by FGM/C. First of all, the family income might suffer when their daughters are not healthy enough to work and earn money. Secondly, families might be confronted with financial problems, due to expensive medical treatment their daughters need to cope with the health complications resulting from the circumcision (Mpinga et al., 2016; Refaei et al., 2016). Moreover, high health-care costs might affect national economies as well (Mpinga et al., 2016; Refaei et al., 2016).

Discontinuing FGM/C in Kenya

In 2001, the Kenyan government prohibited FGM/C by introducing the Children's Act. Another law, the Prohibition of Female Genital Mutilation Act, came into force in 2011 and included an extraterritoriality clause, making it possible to sentence citizens who practice FGM/C outside the country's border. Furthermore, this act banned citizens from withholding information about possible continuing FGM/C practices, and prohibited the stigmatization of un-cut women (National Council for Law Reporting, 2011). Despite the fact that a decrease of FGM/C has been observed since 1998, the practice still takes place, especially in North-Eastern Kenya (28TooMany, 2016). Reasons for the decrease are unclear, but it seems that legislation in itself is not a powerful vehicle to abandon FGM/C and might have even caused people to practice it in secret (e.g. across country borders) (28TooMany, 2016; UNICEF, 2010).

Furthermore, it has been observed that girls are being cut at a younger age than before, as girls are less likely to refuse at that time. Also, an increased medicalization has occurred, which means that FGM/C is more often practiced by health-care professionals, as people might believe this reduces the health risks. This, however, is not the case (28TooMany, 2016). It is also suggested that due to changes in attitude, culture, or legislation, the types of FGM/C have changed since 1998. It seems that less rigorous types of FGM/C (i.e. no fully sewn closed vulva) are practiced, nevertheless still causing many health complications (28TooMany, 2016).

As the abandonment of FGM/C cannot be achieved merely by legislative efforts, it is relevant to explore how interventions can contribute to the discontinuation of the practice. Since 2015, Women Win has been active in Nairobi, capital city of Kenya, using the Goal programme to work with local partners to empower young adolescent girls (Standard Chartered bank, 2015). Currently, Women Win does not work together with local partners in rural areas and does not yet explicitly cover the topic of FGM/C within the Goal curriculum. As FGM/C is still a highly pressing issue in the rural, North-Eastern part of the country, threatening the health and rights of many girls every day, Women Win is interested in finding out whether the implementation of the Goal programme could contribute to the discontinuation of the practice.

The Goal programme

Design. The Goal programme is a collaborative initiative of Women Win and the Standard Chartered bank which has reached more than 381,000 girls across more than 20 developing countries between 2006 and 2017 (Women Win & Standard Chartered Bank, n.d.). It is designed to empower girls between the ages of 12 and 18, by using play-based education to teach them important life skills, and sports activities, to let them raise their voice and practice leadership (Standard Chartered Bank, n.d.; Women Win, 2018, p. 2). It is believed that the newly

acquired knowledge and tools to shape their future lead to increased wealth for individuals, as well as for their communities and societies (Standard Chartered bank, 2015).

   Content. The curriculum is offered over the course of ten months and consists of 29 weekly sessions across four main domains, which are: leadership, sexual and reproductive health and rights, gender-based violence, and economic empowerment. These topics are translated into four modules, which include (1) Be Yourself (6 sessions), (2) Be Healthy (7 sessions), (3) Be Empowered (6 sessions) and (4) Be Money Savvy (6 sessions). Be Yourself addresses communication, personality, social behavior, roles and responsibilities. Be Healthy focuses on the topics of general and reproductive health and hygiene. Be Empowered addresses gender roles and equity, knowing one's rights, and using support resources. Be Money Savvy teaches participants how to make, borrow, manage, and save money wisely. The remaining four sessions are focused on breaking the ice, getting to know each other, establishing ground rules for a beneficial working environment, and finally, a closing ceremony (Women Win & Standard Chartered Bank, n.d.).

   Implementation. In collaboration with their programme partners in several countries, Women Win trains local coaches to facilitate the sessions. Besides direct training they also receive an activity guide, which outlines all sessions using explanation sheets. During the training and in the activity guide, Women Win stresses the importance of cultural sensitivity during implementation of the programme. Therefore, the curriculum can be adapted to different contexts, in collaboration with local partners (Women Win & Standard Chartered Bank, n.d.).

The Present Study

Women Win expects that the Goal programme already covers some factors that could prevent FGM/C, but the organization is interested in finding out whether adaptations are necessary to increase its potential.

Therefore, the main objective of this research is to examine the extent to which the Goal programme can contribute to the discontinuation of Female Genital Mutilation and Cutting (FGM/C) in North-Eastern Kenya. First, the factors that are positively associated with the discontinuation of FGM/C will be identified via a literature review. Secondly, factors which are represented within the Goal curriculum will be extracted and, thirdly, the extent to which these factors were addressed effectively during implementation of the programme in 2017 will be investigated.

Methods

Study Design

A mixed-method study design was selected, including a literature review, as well as a survey analysis. Literature was collected using several databases and websites. Selected literature was analyzed thematically, in order to identify factors positively associated with the discontinuation of FGM/C. The Goal programme website and activity guide were examined to identify which factors were represented in the programme content and characteristics (i.e. target group, design, implementation). Factors that were represented in the programme content were assessed for their effectiveness, using survey data of 11 countries that implemented the programme in 2017. The effectiveness of the factors that were represented in the programme characteristics could not be assessed, since no measuring instrument was available to do this. Possible recommendations regarding the programme characteristics were included in the discussion section. Factors that were positively associated with the discontinuation of FGM/C,

but were not represented in the Goal programme, were also addressed in the recommendations.

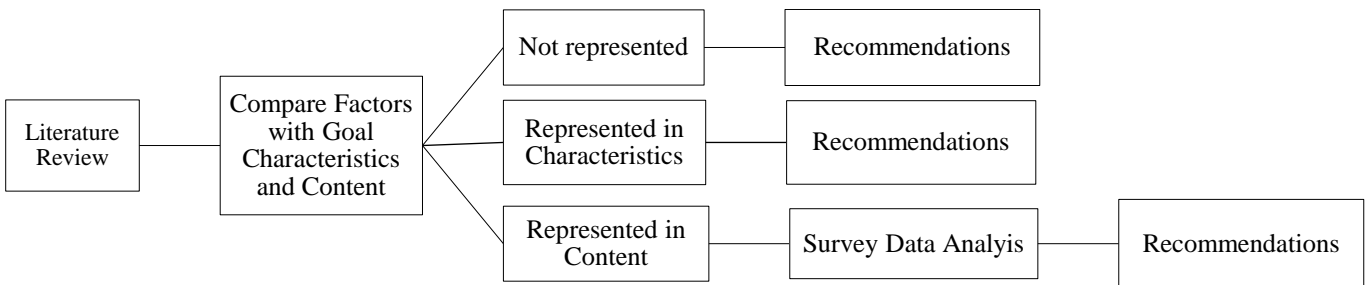The detailed research strategy can be found in Figure 1.

Figure 1: Research Procedure

Data Collection

Literature Review. A literature review of academic articles and reports from several

well-known NGOs and Research Institutes was conducted to identify the factors that are

positively associated with the discontinuation of FGM/C. A total of 19 academic articles and six

reports were included in this study. The detailed review strategy can be found in Figure 2.

Academic literature. The databases used to identify relevant literature were Web of

Science and Worldcat (including 102 databases, e.g. JSTOR). The keywords used for the

research were 'FGM' OR 'Female Genital Mutilation' OR 'Female Genital Cutting', combined

with a second keyword, which was 'factor*'OR 'strateg*' OR 'approach*' OR 'act*'. The third

keyword added was either 'prevent*' OR 'predict*'OR 'stop*' OR 'end*'. Eligible studies for

inclusion were (1) published between 2013 and 2018, (2) peer-reviewed, and (3) written in

English.

A total of 4060 academic articles were identified through database searches. All articles

that addressed medical treatment of health complications related to FGM/C were excluded

(N=3,782), and the abstracts of 278 studies were screened to determine whether they were

eligible for inclusion. Articles that addressed factors associated with the prevalence of FGM/C

were included. After removing duplicates and adding three studies through a manual search of

records, 34 full texts were examined. Two of the three additional studies (Berg & Denison, 2012;

Karmaker, Kandala, Chung, & Clarke, 2011) did not meet the publication date criterion.

However, the researcher decided to include them based on their relevance for the literature

review. As mainly independent qualitative studies were found, the researcher decided to exclude

those and only study the published literature reviews, together with all mixed-method and

quantitative studies. Once the independent qualitative studies had been excluded, 19 studies

remained.

     Reports. In addition to the academic database searches, the online databases of UNICEF,

the Population Council, the Population Reference Bureau, and the International Research Center

for Research on Women have been used to find relevant reports on the topic of FGM/C

prevention. Eligible reports for inclusion were (1) published between 2005 and 2018, and (2)

written in English. Using the website search engines, fourteen reports were selected based on if

their title mentioned FGM/C. After reviewing their table of content and summary, six reports

were determined eligible for inclusion, if best practices were addressed.

     Description of studies. Among the 19 selected academic articles, there were 11

quantitative studies, five systematic literature reviews, two literature reviews, and one mixed

method study using both a literature review and a set of qualitative methods. Regarding the six

reports, two reviewed literature and four used a mixed methods design, of which three used both

quantitative and qualitative methods and one used several qualitative methods. All 11

quantitative studies used survey data, of which two studies used a longitudinal design. Six

quantitative studies used national demographic and health surveys (e.g. Burkina Faso) and five

studies used an independently designed survey. The main study objectives of all selected

literature were (a) identifying factors associated with FGM/C, (b) reviewing the effectiveness of anti FGM/C interventions, or (b) exploring the practice of FGM/C in a specific geographical context. The populations studied were from the continents of Africa, Europe, North-America, South-America, and Australia, and included girls, mothers, school teachers, health care providers, and men. The characteristics of the articles and reports reviewed are presented in respectively Table 1 and Table 2.
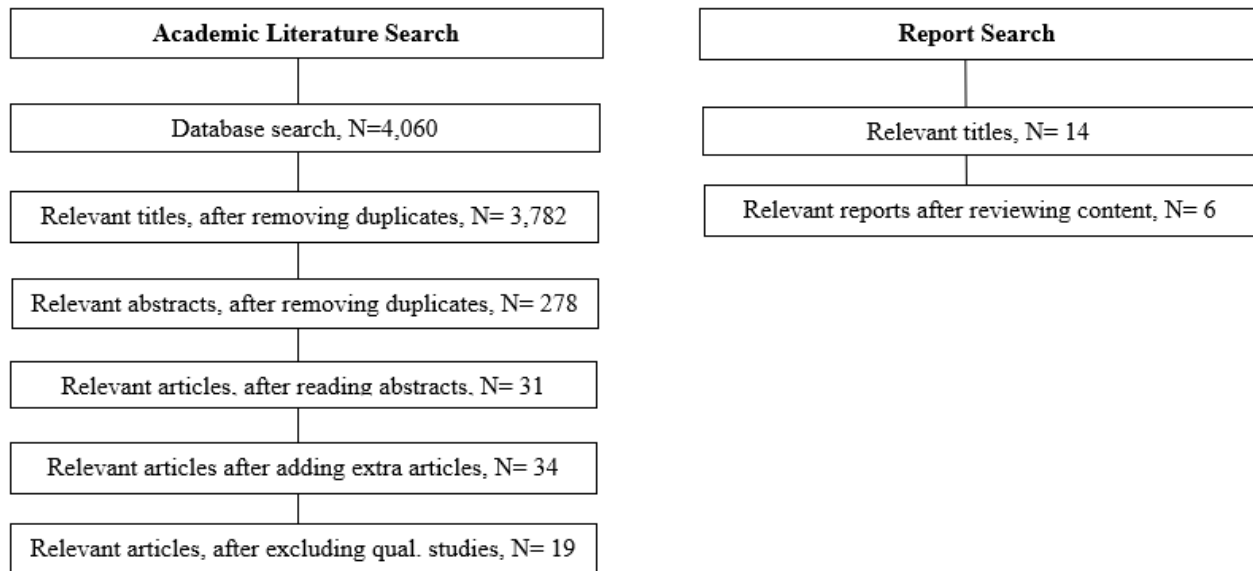

Figure 2: Literature Review Procedure

Table 1

Characteristics Academic Articles

ID nr.	Authors	Objectives	Design	Context
1	(Abolfotouh, Ebrahim, & Abolfotouh, 2015)	Assess the awareness and the predictors of FGM/C among young health advocates	Quantitative	Egypt
2	(Achia, 2014)	Clustering of FGM/C in Kenya and identifying those areas where women still intend to continue, or do not debate the practice	Quantitative	Kenya
3	(Adeniran et al., 2015)	To determine the experience of school teachers about	Quantitative	Nigeria

		FGM/C and their possible role in contributing to its eradication		
4	(Baillot, Murray, Connelly, & Howard, 2018)	Explore FGM prevention and response interventions and describe available primary evidence on European initiatives	Lit. Review + Qualitative	EU
5	(Berg & Denison, 2012)	Review evidence regarding evaluations of interventions to prevent FGM/C	Sys. Lit. Review	Africa
6	(Berg & Denison, 2013a)	Review the key factors that underpin FGM/C	Sys. Lit. Review	Africa
7	(Berg & Denison, 2013b)	Review the effectiveness of anti-FGM/C interventions	Sys. Lit. Review	Africa
8	(Besera & Roess, 2014)	Investigate the relationship between women's autonomy and attitudes toward FGC	Quantitative	Eritrea
9	(Chikhungu & Madise, 2015)	Analyze the trends in the prevalence of FGM and identify factors that are associated with the practice	Quantitative	Burkina Faso
10	(Doucet, Pallitto, & Groleau, 2017)	Review literature exploring the factors that are associated with the medicalization of FGM	Lit. Review	Africa, EU, AUS, US
11	(Kaplan, Hechavarría, Bernal, & Bonhoure, 2013)	Examining the knowledge, attitudes, and practices regarding FGM/C among health care professionals working in rural settings	Quantitative	The Gambia
12	(Karmaker et al., 2011)	Explore associations between potential risk factors and the prevalence of FGM	Quantitative	Burkina Faso
13	(Modrek & Liu, 2013)	Document the trends in the decline of FGM/C and explore the influences of 3 pathways (socio-economic development, social media, women empowerment) for explaining the trends	Quantitative	Egypt
14	(Pashaei, Ponnet, Moeeni, Khazaee-pool,	To explore factors associated with FGM behavior among Iranian mothers and their daughters	Quantitative	Iran

& Majlessi, 2016)

15	(Reig Alcaraz, Siles González, & Solano Ruiz, 2014)	To describe the attitudes towards the practice of FGM/C in relation to different health systems and the factors that favor its discontinuation	Lit. Review	Africa, EU, US, New-Zealand
16	(Shabila, 2017)	To determine mothers' factors associated with the occurrence of FGM among their daughters	Quantitative	Iraq
17	(Shahid & Rane, 2017)	To study the attitudes of African migrant males residing in Australia, and the effectiveness of an education package as an interventional strategy in changing their attitudes towards FGM/C	Quantitative	AUS
18	(Varol, Turkmani, Black, Hall, & Dawson, 2015)	To review publications that explored men's attitudes, beliefs, and behaviors with regards to FGM,	Sys. Lit. Review	Africa, EU, US
19	(Waigwa et al., 2018)	To synthesize findings of studies about effectiveness of health education to prevent FGM/C	Sys. Lit. Review	Africa, Middle-East

Table 2

Characteristics Reports

ID nr.	Authors	Organization	Objectives	Design	Context
20	(Esho, Karumbi, & Njue, 2017)	Population Council	Review high-quality studies to explore the evidence for intervention impact	Lit. Review	Africa
21	(Feldman-Jacobs & Ryniak, 2006)	Population Reference Bureau	Review 3 interventions that promote the abandonment of FGM/C	Lit. Review	Africa
22	(Mberu, 2017)	Population Council	Examine key trends in the evidence base of FGM/C and	Mixed (qual. & quant.)	Nigeria

			gaps in knowledge		
23	(Powell & Yussuf, 2018)	Population Council	Explore views, experiences, changes, factors related to FGM/C	Mixed (qual.)	Somaliland
24	-	(UNICEF, 2010)	Identify and examine the factors that help or hinder the process towards FGM/C abandonment	Mixed (qual. & quant.)	Africa
25	-	(UNFPA & UNICEF, 2013)	Assess the extent to which and under what circumstances the joint programme has accelerated the abandonment of FGM/C	Sys. Lit. Review.	Kenya

Survey data. In 2017, 41,728 girls took part in the Goal programme in 11 countries (Women Win, 2018). Before starting the programme, all girls signed an informed consent form. If girls were below the age of eighteen, they signed an assent form and their parents signed an informed consent form. The forms allowed the researcher to use their anonymized data, and therefore it was not necessary to consult with an ethical committee.

All girls filled in a paper-and-pencil survey that was administered by the local implementer of the programme before participating in the programme (*baseline*). A subsample of 5,860 girls also completed a survey after participating in the programme (*endline*). For the present study, a total of 5,860 matching base- and endline surveys were analyzed. As the survey has previously been experienced as helpful by Women Win in measuring the impact of the Goal programme, it was decided to use the survey data available. Consequently, there was no data available for all factors identified by the literature review.

Participants. All participants were living in one of the 11 countries implementing the programme. In the past, Women Win experienced many cases in which girls did not know their own age. This might have been the case for the participants of this study too. Although the aim was to reach girls between 12 and 18 years old, the dataset showed outliers (e.g. a three-year-old participant). However, because it was likely that girls simply did not know their age, all outliers have been included in the sample. The mean age of the girls included for the present study is 14.40 years old (N= 5,860, SD=3.35). When outliers are excluded, the mean is 14.09 years old (N= 4,610, SD=1.86). Eighty-five percent of the girls was attending secondary school, fourteen percent was in primary school, and one percent in higher education. The large majority was not married (99.0%) and did not have children (99.9%). The participant characteristics per country can be found in Table 3.

Table 3

Participant Characteristics

	N_{total}	$N_{complete}$	M_{age}	SD_{age}
Bangladesh	7830	578	14.66	2.81
India	12241	607	14.38	2.03
Jordan	6865	313	14.51	1.11
Kenya	1615	153	12.81	2.45
Myanmar	1991	101	13.49	1.04
Nigeria	929	1637	12.56	1.50
Pakistan	1207	291	13.34	1.72
South Africa	1272	274	12.74	1.89
Uganda	6452	1409	17.78	4.31
Vietnam	764	381	12.27	0.70
Zambia	562	106	14.39	2.04

| Total | 41,728 | 5860 | 14.40 | 3.35 |

Measuring Instrument. The baseline survey consists of 66 items, divided over four

sections, including 'Community Involvement', 'What do you think', 'How do you feel', and

'Community Resources'. The endline survey uses the same sections containing 66 questions,

however, an extra section (i.e. 'Activities') consisting of 7 questions is added, to measure

participants' experience of the Goal programme. In this study, 47 items, asked in both the base-

and endline survey, were included because they measure participants' behavior, attitude, and

knowledge on the four domains that the programme addresses. These domains were found to be

relevant for analysis, because factors associated with the discontinuation of FGM/C were

represented within the domains. This was determined after an analysis of the programme content

and characteristics (i.e. target group, design, implementation), as described on the programme

website (Goal, n.d.) and in the activity guide (Women Win & Standard Chartered Bank, n.d.).

From the total 66 items, 19 were excluded, as they measure participants' experience with the

programme, extracurricular activities, behavior and attitude with regard to sport and community

life.

Among the 47 items, 26 used binary answer options (i.e. 8 'true/false', 18 'yes/no'), 18

used a 4-point Likert type scale ranging from 'strongly disagree' to 'strongly agree', and 3 were

three-choices questions using 'low/no/high risk' as answer options.

To simplify the data analysis, all questions using a binary scale (i.e. true/false, yes/no)

were assigned a 1 or 4, in which the 1 represented a positive answer and the 4 represented a

negative answer. For example, participants answering 'false' to the question 'I know how to

prevent pregnancy' were assigned a 1, as the positive answer would be 'true', indicating

knowledge on pregnancy prevention. Correspondingly, participants answering 'true' were

assigned a 4. With regard to the 4-point Likert Scale questions, participants were assigned a 1, 2, 3, or 4, in which the 1 represented the least positive answer and the 4 indicated the most positive answer. For example, participants answering 'strongly disagree' to the question 'Women should tolerate beating by their husband to keep the family together' were assigned a 4, as this was the most positive answer to this question. Participants answering 'disagree' were assigned a 3, because it is a less positive answer than 'strongly disagree' (4), but more positive than 'agree' (2).

Within the 47 items, 13 composites were created to measure 13 constructs related to the four domains. Each composite was created based on unity of meaning. Although several composites showed low reliability, the researcher still included them for data analysis, because they conceptually made sense and no other items were available to increase the reliability. The composites per domain are outlined below.

Sexual and Reproductive Health and Rights.

Attitude towards Sexual and Reproductive Rights. This composite consists of two items (baseline $r = 0.426$, $p < .01$; endline $r = 0.317$, $p < .01$) measuring the attitude of participants towards the autonomy of women with regard to their sexual and reproductive rights. For example, participants indicated if they agreed with the statement 'If a woman does not want to be touched or have sex, it is her right to say no'.

Knowledge on Prevention. A total of ten items (baseline $\alpha = 0.696$, endline $\alpha = 0.734$) tested participants' knowledge on prevention of illnesses, HIV, pregnancy, and sexually transmitted infections. For example, participants assessed the risk (i.e. no, low, or high risk) of the statement 'Two people are hugging. One of them is living with HIV'.

Knowledge on Support. The item 'I know a place or person near my home or school where I can discuss my reproductive health' was the only item available to assess participants' knowledge on sources of support within their community.

Economic Empowerment.

Financial Behavior. Seven items (baseline $\alpha = 0.879$, endline $\alpha = 0.816$) tested participants' behavior regarding their finances (i.e. making and managing money). For example, participants indicated if they deposited money in a savings account (i.e. in the bank or by phone).

Knowledge on Financial Management. A total of three items (baseline $\alpha = 0.398$, endline $\alpha = 0.356$) assessed participants' knowledge on topics related to financial management. For example, participants indicated if the statement 'A budget is a plan of the money that I have and the money that I will spend' was true or false.

Attitude towards Financial Management. To test participants' attitude towards financial management, and women's ability to do so, six items were used (baseline $\alpha = 0.697$, endline $\alpha = 0.692$). For example, participants indicated if they agreed with the statement 'When a shopkeeper gives me money back after a purchase, I always check to make sure the amount is correct'.

Gender Based Violence.

Knowledge on Community Resources. Two items (baseline $r = 0.343$, $p < .01$; endline $r = 0.340$, $p < .01$) tested participants' knowledge on where to go in their community, when encountering unsafe or violent situations. For example, participants answered 'yes' or 'no' to 'I know a place or person near my home or school where I can go to report violence or abuse of a girl or women'.

Knowledge on Gender Rights. To assess participants' knowledge on gender rights, two items were used (baseline $r = 0.170$, $p < .01$; endline $r = 0.144$, $p < .01$). For example, the item

'Verbal insults, humiliation, and threats are forms of violence' tested participants' knowledge on what can be considered as violence.

Attitude towards Gender Rights. A total of two items (baseline $r = 0.224$, $p < .01$; endline $r = 0.168$, $p < .01$) measured participants' attitude towards gender rights. For example, participants indicated if they agreed with the statement 'Women should tolerate beating by their husband to keep the family together'.

Leadership.

Attitude towards own Abilities. Five items (baseline $\alpha = 0.784$, baseline $\alpha = 0.724$) tested participants' attitude towards their personal strengths. For example, participants indicated if they agreed with the statement 'I feel fit and strong'.

Communicative Behavior. A total of five items (baseline $\alpha = 0.606$, endline $\alpha = 0.554$) assessed participants' communicative behavior. For example, participants indicated to what extent they agreed with the statement 'I feel confident to say no to my friends if they ask me to do something I don't want to do'.

Leadership Behavior. The item 'Have you had any leadership position in the last six months in your school, community, or sports programme?' assessed participants' leadership behavior.

Attitude towards Community Roles. The item 'I see unequal power relationships in my community' measured if participants showed a reflective attitude on the social roles within their community.

Data Analysis

The first goal of this study was to identify factors positively associated with the discontinuation of FGM/C. To do this, a literature review was conducted. Selected literature was

analyzed using the *constant comparison method* (Flick, 2014), which involved using descriptive open coding, and when saturation appeared, axial coding. A codebook was drafted, and the researcher identified five categories of factors, consisting of 21 factors and 54 sub-factors, positively associated with the discontinuation of FGM/C (Table 4).

To analyze the extent to which the factors were represented within the Goal programme, the Goal activity guide and website were studied. Based on the programme characteristics as described on the website (Goal, n.d.), and the session content as described within the activity guide (Women Win & Standard Chartered Bank, n.d.), the researcher identified 11 unique factors (i.e. duplicates removed), that were addressed within the Goal Programme. Including duplicates, ten factors were related to the programme characteristics, including the programme target group (4 factors), design (2 factors), and implementation (4 factors). Six factors, were represented across the four content domains the Goal curriculum is built around, resulting in the selection of survey data on these domains. An overview of the overlapping factors and gaps can be found in Table 5.

To assess the extent to which the factors represented within the Goal curriculum were addressed effectively in 2017, 47 survey questions were analyzed with SPSS v.24. Paired t-tests were conducted to examine to what extent the Goal programme led to significant changes on the constructs measured. Because of the large homogeneity of the population (i.e. age, educational level, family status), these covariates were not taken into account during analysis. Only the differences between countries implementing the Goal programme were considered during analysis.

Results

Literature Review

Review of preventive factors. Five major categories including 21 factors and 54 sub-factors were identified through a thematic analysis of selected literature. These are presented in Table 4, as well as in the sections below. The numbers between brackets refer to the identification numbers of the reviewed literature, as presented in Table 1 and Table 2.

Demographic Factors.

Age. Several studies showed that the younger women within populations aged between 15-49 years old, were more in favor of discontinuing FGM/C. A possible explanation that was mentioned is that these women may have had more health education that taught them about the negative health consequences of the practice [11,14,16,19,22]. Two studies reported the association between a low age (i.e. 15-24 years old) and negative attitude towards FGM/C to be significant ($p < .001$) [2,9]. Furthermore, younger women (i.e. 15-24 years old) are less likely to have undergone the practice than older women (i.e. 24-49 years old) [12], show a reduced likelihood to let their daughter undergo the practice [14], and a higher responsiveness to health education interventions [19].

Sex. A positive attitude towards the discontinuation of FGM/C was associated with being female ($p < .001$) [1]. Furthermore, females are more susceptible than men to develop a supportive attitude towards the abandonment of FGM/C after participating in health education, possibly because of their understanding of the topic, due to personal experiences [19].

Residential Status. Urban residence is positively associated with a rejecting attitude towards FGM/C [14,18,19,22]. Two studies reported this effect to be significant ($p < .001$) [1,2]. Individuals living in urban areas also show a reduced likelihood to undergo the practice [9], and a reduced feeling of social pressure to let daughters undergo FGM/C [14].

Marital Status. Unmarried men and women were found to have more positive attitudes towards the abandonment of FGM/C and benefited more from health education interventions [2,19].

FGM Status. Women that have not undergone FGM/C, or had a negative personal experience with the practice, show more positive attitudes towards the discontinuation of FGM/C, as well as a reduced likelihood to let their daughter undergo the cut [2,3,6,8,16,22].

Ethnicity. Ethnicity is associated with the likelihood to undergo FGM/C. For example, in Burkina Faso, females of the Gourounsi and Bissa ethnicity showed a lower prevalence of the practice ($p < .001$) than other ethnic groups within the country [9,12]. Furthermore, among African migrant men in Australia, Somalian men were less likely to support the discontinuation of FGM/C than men of other African ethnicities [17]. Within the Muslim population in Gambia, the Serer and Wolof communities showed less prevalence of FGM/C than other groups [18]. Ethnicity was also considered to be a prevailing factor over professional identity among health care professionals (HCPs) in the Gambia, meaning that even when HCPs understood why they should not carry out FGM/C, HCPs belonging to traditionally practicing groups would still carry out the cutting, based on their traditional values [11]. Finally, ethnicity could also moderate the effectiveness of an anti-FGM intervention, in the sense that interventions showed more positive impact when participants and facilitators shared the same ethnical background [19].

Cultural Factors.

Tradition. Females living in communities that do not traditionally view FGM/C as a prerequisite for marriage or rite of passage, are less likely to undergo the practice [19,22].

Religion. Religion is positively associated with the attitude towards the abandonment of FGM/C, and the likelihood to undergo the practice. That is, Christian and Protestant individuals

are less supportive of, and less likely to undergo, FGM/C than Muslim individuals [8,19]. Two

studies reported this effect to be significant ($p < .001$) [2,9]. The belief that FGM/C is not a

religious requirement determines the extent to which individuals support the abandonment

[6,18]. Several interventions showed that religious leaders can serve as change agents, by

clarifying to the community that no religious scripture prescribes FGM/C [23,24].

      Legislation. Awareness of government policy with regard to the illegality FGM/C is

positively associated with a more supportive attitude towards discontinuation of the practice ($p = $

.002) [3]. Furthermore, anti-FGM legislation serves as a hindering factor for the continuation of

the practice [6,15], as it can lead to direct abandonment due to punitive consequences [20]. For

example, health care providers indicate that one of the main reasons for not performing FGM/C

is that they are concerned about the legal sanctions that might follow when they do perform the

practice [10]. Three reports state that legislation should be accompanied by community

interventions, to combat FGM/C sustainably and prevent unintended consequences (i.e.

practicing FGM/C in secret, or increased medicalization) [20,24,25].

      Social Factors.

      Social Norms. When the dominant social norm rejects FGM/C, HCPs are less likely to

perform it, mothers are less likely to let their daughter undergo the cut, and community members

are more likely to support the discontinuation of the practice [4,10,11,14,15,18]. To change the

social norm towards FGM/C, a supporting environment that enables and supports change needs

to be created. Interventions that involve the community (i.e. children, adults, community leaders,

school teachers, circumcisers, health care providers) have been effective in creating shared

community values and community investment in accelerating positive norm change

[6,7,20,21,22,24,25]. Through providing space for individual and communal reflection (e.g. in

group discussions or community activities, such as alternative rites of passage events or anti-FGM declaration ceremonies), public commitment to end FGM/C can be fostered and gradually diffused throughout social networks [24].

      Socio-Economic Factors.

      Migration. Two studies showed that migration was positively associated with a positive attitude towards the abandonment of FGM/C, in which acculturation served as the mechanism [17,18]. Among a group of Sub-Saharan African migrant men ($N = 67$), residing in Australia, duration of stay was positively associated with their attitude towards FGM/C. This means that the longer men lived in Australia, the more they agreed that FGM/C should be discontinued ($p = .016$), and the more they were willing to marry an uncut woman [17].

      SES. Socio-Economic Status (SES) was found to be positively associated with a supportive attitude towards the discontinuation of FGM/C, meaning that individuals with a higher SES were more rejecting towards the practice (Mberu, 2017; Shabila, 2017). Furthermore, several studies found a high SES to be significantly associated with a reduced likelihood to undergo FGM/C ($p < .002$) [2,12,13,16].

      Media. Media exposure was found to be positively related to the occurrence of FGM/C. To illustrate, Kenyan women that were moderate or highly exposed to media, were at 11% and 30% lower risk of undergoing the practice than women with no or low media exposure ($p < .001$) [2]. Furthermore, it is suggested that media messages can resolve misconceptions, and therefore, contribute to the discontinuation of the practice by influencing the attitude of individuals [15]. Moreover, media can serve as a useful strategy to engage people in (health) education interventions, through reinforcing positive aspects of local culture (e.g. dance) and making it easier for people to understand educative messages [13,19,21,24].

Community Roles. To discontinue FGM/C, it is important to find other sources of income for the circumcisers involved in the practice [22]. Furthermore, encouraging individuals (e.g. girls, circumcisers, HCPs, religious leaders) to become role models or change agents has found to be a successful mechanism in interventions to change community norms towards FGM/C [7,19,21,23,24,25].

Gender Equity. Two studies reported a high level of women empowerment to be associated with a reduced risk to undergo FGM/C [13,15]. Women who show high levels of autonomy, for example regarding household decisions, and do not condone gender-based violence, are less supportive of FGM/C [8]. It is suggested that successful abandonment interventions include attention for women empowerment and gender rights discussion, because they can urge communities to recognize women's rights (i.e. to physical and mental integrity, freedom from discrimination and torture, and the right to life) and collectively change existing inequitable practices such as FGM/C [4,24].

Education. A high educational level is positively related to a less supportive attitude towards FGM/C [1,17,19,22]. Three studies report this effect to be significant ($p < .001$) [2,8,9]. A high educational level is also associated with a reduced risk to undergo the practice [12], and a more accepting attitude towards health education interventions [19]. Furthermore, higher educated women feel less social pressure to let their daughter undergo FGM/C [14]. The more knowledge participants have about the consequences of FGM/C, the less supportive they are of the practice [6,10,18]. However, educative interventions that solely address negative health consequences may only cause positive change in individuals' attitude towards FGM/C, whereas holistic education (e.g. addressing gender rights) can cause promote anti-FGM/C beliefs [7,19,20,21,24].

Intervention Factors.

Funding and Duration. For abandonment interventions to be sustainably effective, long-term investment is necessary [4,21]. Although short-term abandonment interventions can be effective (i.e. provided that they adhere to the mechanism of community-involvement), it is preferable to deliver an intervention over a longer period of time, to guarantee sustainable results [20].

Local Circumstances. For abandonment interventions to be effective, it is important to respond to local circumstances that can mitigate the results. For example, the societal structure (i.e. urban, rural), consistency of attendance at activities, or the (lack of) similarities between facilitators and participants (i.e. language, ethnicity, religion) can influence the impact of the intervention positively or negatively [19,21,24].

Collaboration. To encourage sustainable change, it is important to work towards collaboration and commitment of all parties involved in the norm change process (i.e. government, local leaders, intervention facilitators) [24,25]. For example, transferring the project-ownership to local partners can urge the commitment to end the practice [21,24]. Also, the most sustainable norm changes are achieved by collaborative efforts which combine abandonment interventions with national legislation and policies [24]. Furthermore, interventions seem to have more positive impact when local facilitators have received training, helping them to know their role [7].

Factors overlapping with the Goal programme

With regard to the characteristics (i.e. target group, design, implementation) and content of the Goal curriculum, an analysis of the Goal website and Goal Activity Guide revealed that

several features of the programme overlap with the factors as described in the section above. For an overview of all overlapping factors, see Table 5.

Programme Characteristics.

Target group. The Goal programme aims at reaching girls that might not go to school and are from low-income families, which are factors associated with a higher risk of FGM/C. Furthermore, the programme is targeted at girls, between the age of 12-18 years old, that live in urban communities. However, according to literature, these are individuals that might already have supportive attitudes towards the discontinuation of FGM/C. Also, only reaching the at-risk group, might not cause social norm change, as the community has to be involved to achieve this.

Design. The programme focuses on girl empowerment, promotes social change through encouraging girls to become role models for their community, and offers a holistic education to participants. These are factors that may contribute to the discontinuation of FGM/C.

Implementation. Goal is carried out by trained local partners, over a longer period of time, while being funded for multiple years. Furthermore, local partners are allowed to customize the curriculum, to fit the local circumstances. According to literature, these factors can positively influence the impact of an educative intervention.

Content. In terms of content, the Goal programme addresses the topics of SRHR, EE, GBV and Leadership. Six factors that were identified in the literature review were represented across the four domains. These factors included the encouragement of a (a) high level of autonomy and (b) high SES of individuals, as well as the attention for (c) women empowerment,

(d) gender rights discussion, (e) health consequences of FGM/C, and (f) the potential of individuals to become role models.

Sexual and Reproductive Rights (SRHR). The SRHR module 'Be Healthy' aims at teaching girls about issues related to health and hygiene (e.g. pregnancy prevention or health consequences of HIV), to empower them to make autonomous decisions and know their rights. For example, the session 'Living with HIV' uses demonstration methods, group discussion, and a game around statements to educate girls on what it entails to be HIV-infected, and ways to prevent the spread of the virus. Both education about health consequences of FGM/C and being able to make autonomous decisions seem to help discontinue the practice. Although the module does not yet specifically address the health consequences of FGM/C, it is relevant to assess if the Goal programme is effectively increasing participants' knowledge on similar topics (e.g. HIV), as well as participants' autonomous attitude towards their sexual and reproductive rights.

Economic Empowerment (EE). Literature showed that individuals with a higher socio-economic status (SES) are less likely to undergo FGM/C. The EE module 'Be Savvy' aims at teaching girls how to make money independently and empowering them to manage their finances autonomously, benefiting their SES. For example, the session 'Ways to Make Money' engages girls in a game and discussion around work options in their community.

Gender-Based Violence (GBV). The GBV module 'Be Empowered' evolves around empowering girls to make autonomous decisions according to their rights. For example, in the session 'Stories of Violence', stories stimulate girls to reflect on what to do in abusive relationships. Literature showed addressing the topic of gender rights within interventions is highly relevant when seeking to abandon FGM/C.

Leadership. The leadership module 'Be Yourself' is aimed at personal empowerment, through encouraging girls' autonomy and inspiring them to use their qualities to be a role model or change agent within their community. For example, the session 'Good Leadership' uses group discussions to explore qualities that good leaders and role models possess and reflect on one's own qualities. The literature revealed that individuals with high autonomy are less supportive of FGM/C, and that individuals can serve as a role model or advocate of change, to abandon the practice within their community. Therefore, it is pertinent to analyze to what extent the Goal programme contributes to participants' autonomy and leadership abilities.

As survey data is only available with regard to the Goal programme content, factors related to the programme design, target group and implementation will only be addressed in the discussion section, in which several recommendations for adaptation of the Goal programme will be given. In this section, also the gaps between the Goal programme and the factors associated with the discontinuation of FGM/C will be addressed. In the following section, the effectiveness of the six factors will be assessed.

Survey Analysis

Based on the literature review, four domains (i.e. SRHR, EE, GBV and Leadership) in which the six factors are represented, have been selected for analysis. Paired-sampled t-tests were conducted for thirteen composites associated with the domains (i.e. 3 SRHR, 3 EE, 3 GBV, 4 Leadership), to assess if the Goal programme led to significant improvements. Results are outlined below. Per domain, first the results for all 11 countries that implemented the Goal

Table 4

Thematic Analysis

Category	Factor	Subfactor	ID number source
Demographic	Age	Younger women, less supportive attitude towards FGM/C	2,9 11,14,16,19,22
		Younger women, reduced likelihood to undergo FGMC	12
		Younger women, reduced likelihood to let their daughter undergo FGM/C	14
		Younger populations, more responsive to health care interventions	19
	Sex	Women more susceptible to develop a rejecting attitude towards FGM/C	1,19
	Residential status	Urban residence, less supportive attitude towards FGM/C	1,2,14,18,19,22
		Urban residence, reduced likelihood to undergo FGM/C	9
		Urban residence, reduced feelings of social pressure to let daughter undergo FGM/C	14
	Marital Status	Unmarried (wo)men, less supportive attitude towards FGM/C	2,19
	FGM status	Uncut women, less supportive attitude towards FGM/C	2,8,22
		Uncut women, reduced likelihood to let their daughter undergo FGM/C	16
		Women with negative personal experience, less supportive attitude towards FGM/C	3,6
	Ethnicity	Gourounsi, Bissa females (Burkina Faso) & Serer and Wolof communities (Gambia) & Kenyan, Nigerian, Sudanese, Liberian, Egyptian, and Ethiopian men (Australia) less likely to practice FGM/C	9,12, 17,18
		Interventions more positive impact when participants and facilitators share same ethnicity	19
Cultural	Tradition	When FGM/C is not so much a tradition, reduced likelihood to undergo the practice	19,22
	Religion	Christian and Protestant groups less likely to practice FGM/C	2,8,9,12,19
		Christian and Protestant groups less supportive towards FGM/C	2,8,9,12, 19
		Belief that FGM/C is no religious requirement determines support towards FGM/C discontinuation	6,18
		Religious leaders can support the discontinuation of FGM/C by influencing the community	23,24
	Legislation	More awareness of laws, less supportive attitude towards FGM/C	3
		More awareness of laws, reduced likelihood to practice FGM/C	6,15,20,10
		Combined with interventions, sustainable effects on abandoning FGM/C can be reached	20,24,25
Social	Social Norms	Rejecting community norm towards FGM/C, reduced likelihood to perform it or have daughter undergo the practice	10,11,14
		Rejecting community norm towards FGM/C, more support for discontinuation FGM/C	4,15,18
		Community involvement in interventions can cause social norm change and discontinue FGM/C	6,7,20,21,22,24,25
Socio-Economic	Migration	Migrated individuals, less supportive attitude towards FGM/C	17,18
		Migrated men, more open to marry an uncut woman	17
	SES	Higher SES, less supportive attitude towards FGM/C	16,22
		Higher SES, reduced likelihood to undergo FGM/C	2,12,13,16
	Media-Exposure	Higher exposure, less supportive attitude towards FGM/C	15
		Higher exposure, reduced risk to undergo FGM/C	2,15,19,13,24

		Media can help promote social change, through engaging people in interventions and sharing understandable messages	13,19,21,24
	Community Roles	Alternative occupation for circumcisers promotes the discontinuation of FGM/C	22
		Prompting identification as a role model can contribute to promote social change	7,19,21,23,24,25
	Gender Equity	High women empowerment, reduced risk to undergo FGM/C	13,15
		High autonomy, less supportive attitude towards FGM/C	8
		Interventions that address gender rights can promote social change on FGM/C	4,24
	Education	High education level, less supportive attitude towards FGM/C	1,2,8,9,17,19,22
		High education level, reduced risk to undergo FGM/C	12
		High education level, more accepting towards health education	19
		High education level, reduced feeling of social pressure to let daughter undergo FGM/C	17
		Higher knowledge about FGM/C consequences, less supportive attitude towards FGM/C	6,10,18
		Holistic education effective strategy to change social norms towards FGM/C	7,19,20,21,24
Intervention	Funding	Long-term investment is necessary for interventions to have sustainable effects	4,21
	Duration	Multi-prolonged interventions were effective	20
		Shorter interventions can be effective, when community involvement is addressed	20
	Local Circumstances	Responding to context (facilitation, trust, planning, setting) needed to deliver an effective intervention	19,21,24
	Collaboration	Collaboration between national and local parties can through commitment lead to sustainable results	24,25
		Transfer of project-ownership to local partners can stimulate commitment to end FGM/C	21,24
		Staff training is needed to deliver an effective intervention	7
		Combination of national policy and community interventions promotes sustainable abandonment	24

Note. References matching the ID numbers of sources can be found in Table 1 and Table 2.

Table 5

Overview of overlapping factors

	Goal Programme	Impact Data Available	Theme	Overlap	Gap
Target Group	Girls	n/a	Sex	Less supportive of FGM/C	Not using community-involvement
	Aged between 12-18 years old	n/a	Age	Less supportive of FGM/C & more responsive to interventions	Not using community-involvement
	May or may not be in school	n/a	Education	Higher educated, less supportive of FGM/C	May not reach the lower educated, which are more supportive of FGM/C
	Living in urban communities	n/a	Residential Status	Urban residence, less supportive of FGM/C	No reaching rural areas, which are more supportive of FGM/C
	From low income families	n/a	SES	Lower SES, more supportive of FGM/C	n/a
Design	Aiming at girl empowerment	n/a	Gender Equity	Women empowerment	n/a
	Promoting leadership among girls	n/a	Gender Equity	High autonomy and Role Model Behavior	n/a
	Holistic Education	n/a	Education	Holistic Education	n/a
Implementation	Local customization curriculum possible	n/a	Local Circumstances	Responding to context	n/a
	Long-term Investment	n/a	Funding	Long-term Investment	n/a
	Implementation by local partners	n/a	Collaboration	Project-ownership	n/a
	Weekly sessions within 10 months	n/a	Duration	Multi-Prolonged	n/a
	Facilitators receive training	n/a	Collaboration	Staff training	n/a
Content	'Be Yourself' (leadership)	Yes	Gender Equity	Women Empowerment, Autonomy	n/a
			Community Roles	Role Model/Change Agent	n/a
	'Be Healthy' (SRHR)	Yes	Gender Equity	Women Empowerment, Autonomy	n/a
			Education	Knowledge consequences	n/a
	'Be Empowered' (GBV)	Yes	Gender Equity	Women Empowerment, Autonomy, Intervention addressing gender rights	n/a
	'Be Savvy' (EE)	Yes	Gender Equity	Women Empowerment, Autonomy	n/a
			SES	Higher SES, less supportive of FGM/C	n/a

programme in 2017 are given, and subsequently, possible interesting results for other

individual countries, as well as the results of Kenya (i.e. Nairobi) are highlighted. 'M_{BL}' and

'M_{EL}' are used to indicate the means for baseline and endline composite scores.

Sexual and Reproductive Health and Rights. All three composites within this domain

show positive increases ($p < .001$). At endline, participants show a more positive attitude on

sexual and reproductive rights ($M_{BL} = 2.91$, $M_{EL} = 3.39$, $t = 28.92$, $p = < .001$). For example, more

participants agree that women should have full control over how many children they have and

the spacing of those children. Furthermore, participants' knowledge on prevention of health

problems, sexually transmitted infections (STIs), pregnancy, and HIV has increased ($M_{BL} = 2.53$,

$M_{EL} = 3.38$, $t = 75.47$, $p = < .001$). For example, more participants know that touching your eyes,

nose, and mouth frequently can make you sick, because of bringing germs into your body.

Moreover, an increased number of participants know that hugging someone with HIV is not a

risky activity. Participants also show an increased knowledge on where to find support to discuss

their reproductive health ($M_{BL} = 2.63$, $M_{EL} = 3.40$, $t = 30.67$, $p = < .001$).

All participating countries did also show independent positive increases on the three

composites ($p < .05$). With regard to Kenya (i.e. Nairobi), participants' attitude towards sexual

and reproductive rights increased ($M_{BL} = 3.24$, $M_{EL} = 3.54$, $t = 3.84$, $p = < .001$), as well as their

knowledge on prevention of health problems, STIs, pregnancy, and HIV ($M_{BL} = 3.02$, $M_{EL} = 3.70$,

$t = 10.62$, p $= < .001$), and knowledge on where to find support to talk about health ($M_{BL} = 2.98$,

$M_{EL} = 3.51$, $t = 3.80$, $p = < .001$).

Economic Empowerment. The three composites within this domain show positive increases

($p < .001$). At endline, participants show increased positive behavior with regard to their finances

(i.e. making and managing money) ($M_{BL} = 1.82$, $M_{EL} = 2.64$, $t = 49.75$, $p < .001$). For example,

more participants visited a bank, or edited a budget. Furthermore, participants' knowledge on topics associated with financial management increased (M_{BL}= 2.29, M_{EL}= 3.26, t= 59.85, $p <$ .001), such as knowing what a budget is, and where to get money to start a new business. Moreover, an increased number of participants show a positive attitude towards financial management, and theirs' and other women's ability to do so successfully (M_{BL}=2.99, M_{EL}=3.44, t=48.78, $p < $ .001). For example, more participants indicate that they believe that they will be able to find a job someday, and more participants agree with the statement 'Women should be able to decide how to spend the money that they earn themselves'.

All participating countries did also show independent positive increases on the three composites ($p < $ .05). With regard to Kenya, positive changes in financial management behavior (M_{BL} = 1.83, M_{EL} = 2.03, t = 2.09, $p < $ .001), knowledge on topics related to financial management (M_{BL} = 2.48, M_{EL} = 3.45, t = 11.57, $p < $ .001), and attitude towards financial management (M_{BL} = 3.31, M_{EL} = 3.57, t = 5.09, $p < $ .001) were observed.

Gender-based Violence. All three composites within this domain show positive increases ($p < $ .001). At endline, participants showed increased knowledge on community resources (M_{BL} = 2.69, M_{EL} = 3.47, t = 39.99, $p < $ .001), meaning that they now know a place near their home or school where they feel safe, and where to report violence or abuse of a girl or women. Moreover, an increased knowledge on gender rights was observed (M_{BL} = 2.49, M_{EL} = 3.42, t = 50.78, $p < $ .001). More participants know that verbal insults are a form of violence, and that rich people can also encounter violence. Furthermore, a positive increase in participants' attitude towards gender rights was measured (M_{BL} = 2.65, M_{EL} = 2.86, t = 13.36, $p < $ .001), indicating that at endline, more participants agreed that women should not tolerate beating by their husband to keep the

family together, and that both the man and women are responsible for taking care of the home and looking after the children.

Most of the participating countries did also show independent positive increases on the three composites ($p < .05$), except for the attitude towards gender rights for participants that took part in the Goal programme in Uganda. These participants showed a less positive attitude than at baseline, although this effect was not significant ($M_{BL} = 2.68$, $M_{EL} = 2.67$, $t = -0.22$, $p = 0.83$). With regard to Kenya, positive increases of knowledge on community resources ($M_{BL} = 3.42$, $M_{EL} = 3.78$, $t = 2.09$, $p < .001$), knowledge on gender rights ($M_{BL} = 2.86$, $M_{EL} = 3.70$, $t = 11.57$, $p < .001$), and attitude towards gender rights ($M_{BL} = 2.60$, $M_{EL} = 2.98$, $t = 5.09$, $p < .001$) were observed.

Leadership. The four composites within this domain show positive increases ($p < .001$). At endline, participants showed a more positive attitude towards their own abilities ($M_{BL} = 2.83$, $M_{EL} = 3.36$, $t = 48.72$, $p < .001$). For example, more participants indicate to feel fit and strong, and more able to make decisions about the future. Furthermore, in all countries participants show more communicative behavior ($M_{BL} = 2.81$, $M_{EL} = 3.38$, $t = 50.62$, $p < .001$), indicating that participants are more able to share their personal opinion and boundaries. For example, an more participants dare to stand up if they disagree with friends. Moreover, participants showed increased leadership behavior ($M_{BL} = 1.83$, $M_{EL} = 2.34$, $t = 20.21$, $p < .001$), as at endline, more participants indicated to have fulfilled a leadership position in their school, community, or sports programme in the last six months. Furthermore, at endline, more participants showed a reflective attitude on the social roles within their community, by indicating that they see unequal power relationships in their community ($M_{BL} = 2.18$, $M_{EL} = 2.69$, $t = 16.89$, $p < .001$).

All participating countries did also show independent positive increases on the three composites ($p < .05$). This was also the case for Kenya. At endline, participants showed a more positive attitude towards their own abilities ($M_{BL} = 3.22$, $M_{EL} = 3.48$, $t = 5.19$, $p < .001$), increased communicative behavior ($M_{BL} = 3.10$, $M_{EL} = 3.46$, $t = 6.10$, $p < .001$), and a more reflective attitude on community roles ($M_{BL} = 2.34$, $M_{EL} = 2.88$, $t = 3.20$, $p = 0.002$). Although participants also showed a positive increase on leadership behavior, this effect was not significant ($M_{BL} = 2.11$, $M_{EL} = 2.20$, $t = 0.76$, $p = 0.45$).

Discussion

In the light of international efforts to bring Female Genital Mutilation and Cutting to an end, this study aimed to investigate to which extent the Goal programme of Women Win can help to discontinue FGM/C in North-Eastern Kenya. First, a literature review was conducted to find factors which are positively associated with the discontinuation of the practice. Secondly, the Goal website and activity guide were examined to identify which of these factors were represented in the programme content and characteristics. Factors that were represented across the four content domains (i.e. SRHR, EE, GBV, Leadership) included the encouragement of a (a) high level of autonomy and (b) high SES of individuals, as well as the attention for (c) women empowerment, (d) gender rights discussion, (e) health consequences of FGM/C, and (f) the potential of individuals to become role models. To answer the research question, the six factors were assessed for their effectiveness, using survey data of 11 countries that implemented the programme in 2017.

The Goal programme can be regarded as a promising intervention for the discontinuation of FGM/C in North-Eastern Kenya, as it empowers participants to be role models for their community and make well-informed and autonomous life choices with regard to gender rights,

sexual and reproductive health and rights, as well as financial management. Participants are equipped with a reflective and critical attitude towards existing practices, possibly FGM/C, and are encouraged to stand up for their rights and set a good example for their communities, allowing them to inflict social norm changes.

Despite the potential of the Goal programme, it might still not eradicate the practice in North-Eastern Kenya. This is mainly because the intervention not yet addresses community involvement, which is a key factor for changing the social norm towards FGM/C [24,25]. Furthermore, attention is needed for the contextual applicability of the programme, and support of national and local governments has to be secured to create beneficial circumstances. To increase the potential of the Goal programme, several adaptations are necessary. Recommendations are outlined below. Again, the numbers between brackets refer to the identification numbers of the reviewed literature, as presented in Table 1 and Table 2.

Recommendations.

Adapting existing sessions. Although the SRHR domain positively impacts participants' knowledge on health topics (e.g. HIV and pregnancy prevention), it does not specifically address the health consequences of FGM/C. Therefore, the sessions should be adapted to cover this subject. Merely addressing the consequences of FGM/C could change individuals' attitude, however this could also result in an increased medicalization of the practice, or encourage people to conduct FGM/C in secret [24]. Therefore, it is important to thoroughly address human rights, and link them to local values to lead to a change of norms [4,24]. For example, the GBV sessions could be enriched by linking the right to bodily autonomy to local religious beliefs (e.g. Allah created perfect human beings that do not need alteration). This may cause individual reflection and acknowledgement of the wrongness of FGM/C [6,18].

Adding new sessions. Currently, the Goal programme is built around reaching at-risk girls. However, it therefore overlooks the importance of community involvement in changing social norms. This has recently been confirmed again (Graamans, Ofware, Nguura, Smet, & ten Have, 2018). As described in the literature review, FGM/C is deeply rooted in the existing social norms within communities. To truly change these norms and accomplish community commitment, two things are needed.

First, individual and communal reflection needs to be encouraged, for example by discussion sessions on similarities between human rights and local values, to determine a shared vision and prompt people to take responsibility to commit others through their social networks [24,25]. The programme should continue involving girls, as they can be advocates of change within the community [7,19,21,23,24,25], and because their empowerment is essential in reducing the risk for the following generations of girls [13,15]. However, it is recommended to add sessions for circumcisers, boys, men, school teachers, and community leaders, to start a discussion across the entire community.

Secondly, community members need to feel secured that the social expectations have changed (Boyden, 2012), meaning that it is guaranteed that the marriageability of a girl is not compromised, and no social sanctions will follow when committing to the abandonment of FGM/C [4,10,11,14,15,18]]. Clear public commitment events, such as alternative rites of passage ceremonies, can serve to increase trust and willingness among community members [24,25] to bury the blades forever.

Attention for contextual applicability. Women Win plans to implement the programme in North-Eastern Kenya. In line with literature, this is a highly relevant area, since it is rurally located, inhabited by citizens from mainly Islamic religion with a low SES, showing a high

prevalence of FGM/C based on cultural tradition. However, it is questionable if the positive impact of the programme will sustain when it is implemented here. In 2017, the programme was implemented in mainly the urban areas of the 11 participating countries. Although positive results were also seen in Kenya (i.e. Nairobi), indicating a fit to the Kenyan context, the results have to be interpreted with caution. For example, people living in rural Kenya might experience more difficulties understanding the matters discussed in the programme, due to their lower educational levels. Also, the social pressure to undergo FGM/C is higher in rural areas, because of the traditional character of communities [14]. Therefore, the programme might need to be adapted. For example, a higher intensity of sessions might be needed, as well as adaptation of the content to match local beliefs more. Furthermore, programme activities could use local culture (e.g. dance) and media to engage the lower-educated community in learning about FGM/C in an accessible and easy way [13,19,21,24]. Besides, it is important that the programme facilitators share the same religion and language as the participants, to increase the effectiveness of the programme [19,21,24].

Creating beneficial circumstances. Finally, it is important that the national and local governments invest in the economical welfare of the communities that practice FGM/C, allowing the circumcisers to find a new source of income [22]. Furthermore, investing in the education of girls, as this provides them with knowledge, and skills to find a job and live an economically healthy life, which will in turn could decrease the need for them to marry soon and guarantee a dowry for their families. Furthermore, it may protect their future daughters from FGM/C, as they will be born in a more educated and economically wealthy family [17].

Study Limitations

Results of this study have to be interpreted in the light of several limitations that apply.

First of all, the reliability of the literature review is not optimal, since the quality of studies was not assessed, possibly resulting in the inclusion of low quality studies. Furthermore, there was a lack of longitudinal studies and studies with an experimental design.

Secondly, there are some limitations regarding the survey. It was not specifically designed for this study, limiting the researcher to only measure the effectiveness of six factors that were identified by the literature. Furthermore, some issues arose concerning the composites. Although items shared unity of meaning, the composites showed low reliability. This could be because only a limited number of items was available per composite, and because items used different scales. Another issue related to the scaling of items, was that the high number of binary questions may have prompted the participants to lean towards social desirable answers, since no nuanced options were available.

Lastly, the sample size was relatively low, compared to the total number of girls that participated in the programme in 2017. However, the sample size was still big enough to assess the effectiveness on the composites. Furthermore, no control group data was available, which makes it difficult to say if the effects were entirely caused by the Goal programme. For example, simply the attention girls received could have caused them to feel more empowered.

Conclusion

Regardless of the remarks made, the findings gave important insights in what can be done to abandon FGM/C, and to what extent the Goal programme can be helpful to do this in North-Eastern Kenya. Furthermore, as many studies that examine the abandonment of FGM/C use a qualitative design, this study is a valuable contribution because of its quantitative character. More quantitative evaluations of anti-FGM/C interventions, preferably using an experimental design, are necessary, to expand the knowledge on what best practices are. Furthermore, more

studies are needed to learn more about other contexts in which FGM/C practiced. Currently,

many studies focus on the Sub-Saharan African context. However, FGM/C is also prevalent in

other continents and these may ask for other approaches, due to possible differences in social

dynamics and motives for the practice. Finally, there is a need for practical guidelines, sharing

best practices, for NGOs to use in their programme design. These are currently not available,

complicating the eradication of FGM/C.

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