Female Genital Mutilation among non-Syrian Refugees/migrants IN JORDAN
Female Genital Mutilation among non-Syrian Refugees/migrants in Jordan
A situational analysis and recommendations for future programming

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Acronyms

- CMR  Clinical Management of Rape
- CS   Cesarean Section
- CVT  Center for Victims of Torture
- CSO  Civil Society Organization
- DHS  Demographic Health Survey
- FGD  Focus Group Discussion
- FGM  Female Genital Mutilation
- FPD  Family Protection Department
- GBV  Gender-Based Violence
- GBV IMS  Gender-Based Violence Information Management System
- GBV WG  Gender-based Violence Work Group
- GoJ  Government of Jordan
- IEC  Information, Education and Communication
- INGO  International Non-Governmental Organization
- IPV  Intimate Partner Violence
- JRP  Jordan Response Plan
- KAP  Knowledge, Attitudes and Practice
- MECI  Middle East Children Institute
- MoE  Ministry of Education
- MOH  Ministry of Health
- MoSD  Ministry of Social Development
- MoY  Ministry of Youth
- NGO  Non-Governmental Organization
- ORA  One Refugee Approach
- PSS  Psychosocial Support
- SDHS  Somali Demographic Health Survey
- UN   United Nations
- UNFPA  United Nations Population Fund
- UNHCR  United Nations High Commissioner for Refugees
- UNICEF  United Nations International Children’s Emergency Fund
- WFP  World Food Programme
- WHO  World Health Organization
Executive Summary

This report presents findings from a situational analysis on Female Genital Mutilation (FGM) in Jordan among non-Syrian refugees/migrants, especially Sudanese and Somali communities, providing a case study for possible dynamics of FGM and migration of communities from high to low prevalence countries.

Anecdotal evidence and media reports suggest that FGM practice in Jordan is very low and highly localized. However, the results of this analysis show that FGM is still being practiced among Sudanese and Somali refugees/migrants in Jordan and is subjected to different positive and negative scenarios influencing its patterns. The report aims to identify the current FGM practice in Jordan, evaluate the unmet needs and flag the gaps, challenges, and opportunities existing regarding GBV programming including for FGM, and finally, to provide recommendations and way forward for FGM programming as well as GBV related service provision targeting non-Syrian refugees in Jordan/migrants. The report uses data collected through Focus group discussions (FGDs) with the community, an online survey for organizations, and a review of relevant literature.

Findings of the report show that Sudanese and Somali women and girls can access various GBV related services both for prevention (e.g. awareness, raising, education and public campaigning) and response (e.g. psychosocial support, cash assistance, shelter and referral) provided by a multitude of actors ranging from small grass-root organizations to governmental entities like the Family Protection Department (FPD) and public hospitals.

However, service providers are not well aware and trained on FGM; more likely, survivors/-women and girls at risk receive such services under more generic areas, if they were at all aware of available support.
Gaps in the current GBV services and challenges to potential FGM services include, but are not limited to, the exclusion of Sudanese and Somali refugees/migrants from systematic assistance schemes which aggravates the burden of reporting and help seeking for women and girls, fear of reporting by women and girls, poorly adapted services and low awareness of service providers regarding FGM, and the research gap in understanding accurate trends and determinants of FGM practice among those communities. Women/-girls as well as service providing organizations have identified several opportunities to build on regarding FGM programming in Jordan such as: the perceived successes of current GBV programming and community-based interventions, involvement of community leaders, youth networks and youth led initiatives (e.g. Y-PEER) and existing knowledge sharing mechanisms and partnerships between stakeholders.

Recommendations for FGM programming address actors at all levels with specific action areas for different actors, and focus on legislation, strengthening the capacity of the relevant professionals to effectively address the practice through training and guidelines, as well as awareness-raising among targeted communities. The recommendations refer to several guidelines and considerations while working on FGM among migrant/refugee communities as well as the host community such as adopting a rights-based approach, involving men and boys as well as capitalizing on partnerships including with community, youth and religious leaders.

The recommendations stress on the need for considering the overall context of service provision for Sudanese and Somali communities, adopting an evidence-based approach to programming and highlighting the need for long term investment (financial and capacities building) in service providers at all levels, e.g. governmental, international and grass root organizations.
Box 1: Types of FGM

(The world health organization (WHO) classification):

**Type 1:** this is the partial or total removal of the clitoral glans (the external and visible part of the clitoris, which is a sensitive part of the female genitals), and/or the prepuce/ clitoral hood (the fold of skin surrounding the clitoral glans).

**Type 2:** this is the partial or total removal of the clitoral glans and the labia minora (the inner folds of the vulva), with or without removal of the labia majora (the outer folds of skin of the vulva).

**Type 3:** Also known as infibulation, this is the narrowing of the vaginal opening through the creation of a covering seal. The seal is formed by cutting and repositioning the labia minora, or labia majora, sometimes through stitching, with or without removal of the clitoral prepuce/clitoral hood and glans (Type I FGM).

**Type 4:** This includes all other harmful procedures to the female genitalia for non-medical purposes, e.g., pricking, piercing, incising, scraping, and cauterizing the genital area.

Deinfibulation refers to the practice of cutting open the sealed vaginal opening of a woman who has been infibulated, which is often necessary for improving health and well-being as well as to allow intercourse or to facilitate childbirth.
Introduction

Female genital mutilation (FGM) is a form of gender-based violence (GBV) and a violation of human rights that refers to

“All procedures involving partial or total removal of the female external genitalia or other injury to the female genital organs for non-medical reasons.”

The Arab world has 50 million cases of FGM accounting for one-quarter of the global cases with Somalia as the highest prevalence in the world

Data about FGM in other Arab states like Jordan is scarce and the evidence on the practice is based on sporadic studies and/or media reports.
Since 2012, Jordan - the second highest share of refugees per capita in the world - has received asylum seekers from countries with high FGM prevalence rates, such as Sudan (6,024) and Somalia (718). Sudanese and Somali refugees/migrants mostly reside in East Amman and in neighborhoods such as Jabal Amman, Jabal Hussein and Sahab area in Amman. Recently, grass-root non-governmental organizations (NGOs) serving the Sudanese and Somali refugee communities started receiving requests from women who had undergone FGM asking for FGM related services like counseling. Moreover, these NGOs have carried some focus group discussions (FGDs) with community members who all had known at least one person among their networks who had been a survivor of FGM.

In Jordan, evidence about FGM is only anecdotal or derived from media reports. In 2003, a news report mentioned that FGM was being practiced in the town of Rahmah (a town with a population of 500). The same report mentioned that younger generations of tribe’s women in Rahmah said they were aware FGM was not an obligation of Islam. Others that had undergone the practice complained of “sexual frigidity”, prompting their husbands to take second and third wives. In Rahmah, FGM is considered “halal” (allowed by Islam), and the drivers for the practice are based on misconceptions about honor, hygiene, and religion.

Women in Rahmah, like many women who undergo FGM, are deprived from many rights due to the society structure that prevents women from decision making, leaving them to elders and husbands to decide what would be done to their bodies. More complexity is added to this context by the lack of education and lack of access to basic information, particularly on health and the body, which leaves room for misconceptions around FGM to persist.
A more recent study in 2013 was conducted online with 992 participants from 11 countries to investigate opinions, motives, and prevalence of FGM among Internet users in the Middle East. The study results revealed that 7.4% of female participants from Jordan reported having undergone FGM, but the total number of Jordanian participants was not known.

Recently, Jordan represents a special context regarding FGM being a low prevalence rate country that has received refugees/migrants from high prevalence rate countries. This model has been studied in the literature as one of the scenarios explaining the dynamics between FGM and migration (explained later in this report).

Scope and purpose

This study was conducted to highlight the situation of FGM among non-Syrian refugees/migrants in Jordan. More specifically the objectives were to:

1. Identify the occurrence and patterns of practicing FGM among non-Syrian refugees in Jordan along with exposure to other forms of GBV;
2. Flag the gaps and challenges as well as the opportunities existing regarding GBV programming targeting non-Syrian refugees/migrants in Jordan including any existing or potential FGM programming;
3. Identify the unmet needs for GBV related services (including FGM) among non-Syrian refugees/migrants in Jordan; and
4. Provide recommendations and way forward for FGM programming as well as GBV related services provision targeting non-Syrian refugees/migrants in Jordan.
Methodology

Given the current gap in information regarding FGM practice in Jordan, and the sporadic nature of evidence, different data collection tools were used and adapted to capture all the possibly available data from all parties concerned, namely: affected community members (women/girls), and the organizations that provide services for them, complemented by a thorough review of available literature, to provide the intended situational analysis and inform recommendations for future actions.

Desk review

The purpose of the desk review was to carry out a situational analysis of FGM in Jordan among host and migrant/refugee communities to identify the occurrence of FGM, gaps and challenges that might be faced by FGM programming and opportunities for programming, and to assess the current services related to GBV including FGM. The desk review also informed the construction of the FGD guide and questions. The review was done for around 20 publications which varied between official reports, scientific papers, internal NGO reports and media links.

The reviewed documents were produced by different entities, e.g. governmental and non-governmental websites, the United Nations (UN) and local and international non-governmental organizations. The reviewed documents included information about non-Syrian migrants/refugees in Jordan and their exposure to GBV including FGM as well as their various needs and services provided. The reviewed documents also included information about FGM within the migration context.
Focus group discussions

Three FGDs were held virtually (via Zoom meetings) with 35 women and girls aged 15-50 years from the non-Syrian migrant/refugee communities in Jordan (Sudanese, Somali and Yemeni). One of the three FGDs was conducted with adolescent girls (aged 15-18).

The FGDs were moderated in Arabic. Consent to participation, note taking and audio recording of the FGDs was obtained from all participants (or the parents of adolescent girl participants) through the community leaders of the organization “Sawiyan”. Participants’ confidentiality and voluntary participation was assured.

An FGD guide was developed prior to the sessions and reviewed by community leaders to ensure cultural sensitivity.

The core of the FGD consisted of questions about general information about FGM practice among the targeted communities, FGM practice trends in Jordan and assessment of services related to GBV including FGM targeting non-Syrian migrant/refugee communities in Jordan. The questions were informed by resources from the desk review focusing on tools of qualitative research on FGM and trends of FGM within migrant communities.
Stakeholders’ survey

An online survey targeting members of the GBV work group in Jordan and other partners was undertaken first, to assess their knowledge about the situation of FGM in Jordan, both in host and non-Syrian migrant/refugee community and secondly, to map any services currently provided for GBV and FGM survivors or high-risk groups and the extent to which such services are customized to the needs of non-Syrian migrant/refugee community.

The questionnaire was structured with three main sections: the first covered information about the organizations’ profiles including their country, names, types, and primary and secondary targets. The second section targeted details about the organizations’ knowledge of FGM in Jordan.

The last section covered the organizations’ strategies regarding work on the elimination of FGM (e.g. main mandate, activities and provided services, needs and challenges, opportunities, and good practices). The questions alternated between closed-ended multiple-choice questions and open-ended questions where more details were required.

Where relevant, some questions were informed by previous mapping exercises done on GBV services in Jordan and other tools from the desk review adapted to the objectives of the study.

A total of 24 organizations participated in the online survey. Around 42% of the participating organizations described themselves as local non-governmental (local NGOs), 29.2% as International NGOs (INGOs) and 25% as UN organizations.

There was only one participating government entity, namely the Ministry of Social Development (MoSD).
Limitations

Due to the current circumstances related to COVID19- pandemic restrictive measures, the FGDs were held virtually with the participants joining from different locations.

This was challenging as some of them might have found difficulty to access the internet. In addition, and as stated in the objectives, this report aims at providing an overall picture about FGM in Jordan, a topic that has very limitedly been addressed by literature.

Both points were overcome by ensuring a high level of detail during the FGDs and by frequently using probing questions until saturation of information was reached.

Also, the proactivity and enthusiasm of the participants provided important insights, especially when contradicting and/or complementary points of view existed within one group. Finally, the participation of adolescent girls added an important perspective to the discussions and results.
FGDs participants’ profile:

Three FGDs took place with 24 women and 11 girls aged 15-45 years. Participants were from Sudan (86%), Yemen (8%) and Somalia (6%). The groups were highly heterogeneous in terms of the participants’ age groups (Figure 1), occupations and marital statuses.

Many of them worked previously as registered nurses, gynecologists and in other medical specialties or were volunteering with initiatives and/or organizations that supported the refugee/migrant communities.

Regarding the adolescent girls, all were enrolled in formal education. Most of the participating adult women were married with children (%97.2), and two pregnant women were present within the groups as well. There was a significant participation of specific groups such as:

1. Adolescent girls: their participation was crucial to this research being the primary group at risk of exposure to FGM. It was necessary to reflect their experiences including their perceptions about FGM, their rights, their worries, their points of view and the role they could play in the elimination of the practice.

2. Pregnant women (2 women) and medical practitioners (4 doctors and nurses) in the field of gynecology and reproductive health highlighted the hazards that FGM poses on women’s reproductive health throughout their lives. The personal experiences of both exposed women and medical practitioners of the same community captured the suffering FGM survivors endure and provided powerful insights about service provision for these women including the needs, challenges, and good practices.

3. Community leaders and volunteers (4 women), who supported their communities through organizations or informal activities, provided a high level of detail and allowed for the discussions to be community-oriented, creating links between FGM practice and the different societal factors including social norms, migration, living conditions, relevant needs and provision of services.
The diversity in the groups’ composition resulted in strong group dynamics where both agreements and contradictions enriched the discussions and ultimately resulted in informative, complementary, coherent and women/girls-centered output.

*Figure (1): Distribution of FGDs participants by age groups (or Did not reply)*
Stakeholders survey participants’ profile:

Primary beneficiaries targeted by the organizations were categorized in terms of: Gender, age groups, nationality (including migration status), place of residence and level of education.

Only 21% specified the gender of the beneficiaries they targeted primarily as women, while the remaining majority reported targeting “Any” gender with their services. Regarding age groups 37.5% of the participants included all age groups in their responses.

Adults and adolescents were mentioned equally (87.5% of all responses each), followed by children (79.2%) and finally the elderly by 54.2% of all responses.

Regarding the nationality of the primary beneficiaries, Syrian refugees/migrants were the most frequently reported group to be included in all the responses (83.3% of all responses), followed by Jordanian (host community) by 79.2% of all responses. Sudanese, Iraqi and Yemeni nationalities were equally mentioned as primary beneficiaries (45.8 % of all responses each) followed by Somali (41.7% of all responses).
Three organizations mentioned “other” nationalities among their responses with no further clarification about those groups. (Figure 2)

![Figure 2: Primary targets of organizations by nationality.](image-url)
All organizations mentioned targeting beneficiaries living in urban areas. In addition to that, 50% of the responses referred to targeting beneficiaries in rural areas and about 42% of the responses referred to targeting beneficiaries in refugees’ camps as well. One organization, the Middle East Children Institute (MECI), mentioned that their work takes place mainly in school settings affiliated to the Ministry of Education (MoE).

Regarding education of primary beneficiaries, 70.8% of the responses included the whole range of education levels (from people who never received an education to people with university or postgraduate education). The least frequently reported level of education targeted was for those who never received an education (5% of the total responses).

Regarding secondary beneficiaries, most responses included targeting small local community-based groups. Also, equal responses included targeting other civil society organizations (CSOs), women groups and community leaders (Figure 3).

![Figure 3: Secondary targets of organizations](image-url)
FGM in Sudan, Somalia and Yemen:

Sudan and Somalia are considered two of the highest FGM prevalence countries worldwide (88% and 98% among women aged 15-49 years respectively).

Somalia

In Somalia, the practice is concentrated in rural areas, but the prevalence is universally high in all other areas. Trends of FGM practice in Somalia have been greatly affected by the COVID-19 pandemic where lockdown measures, closure of schools and economic pressures on traditional practitioners have led to a surge in the practice which was performed door to door.

Girls in Somalia are usually cut between ages 10-14 years by traditional practitioners. However, resort to medicalization has been recently increasing. About 80% of girls and women have undergone Type III FGM (infibulation/’sewn closed’), which is also known as Pharaonic FGM.

According to the Somali Demographic Health Survey (SDHS) of 2020, the FGM practice in Somalia is supported by women aged 15-49 years where 72% believe it is a religious requirement (religion is the main driver of FGM in Somalia). However, FGM is less supported among more educated and wealthier women.
Sudan

In Sudan, the practice is the highest in the North West of the country, where girls are usually cut between the ages 5-9 years largely by medical practitioners (the medicalization rate is around 75%). Type III is the most common type of FGM practiced in Sudan. More than 40% of Sudanese women aged 15-49 support the continuation of the practice. The support for continuation is less among the more educated and wealthier women, also the level of support declines in big cities like Khartoum (71% are in favor of abandoning the practice). The main drivers of FGM in Sudan are ‘purification, cleanliness and hygiene, acceptability within the group and reducing the sexual desire’.

Yemen

Yemen is not considered a high FGM prevalence country in comparison to Somalia and Sudan. However, it is estimated that 18.5% have undergone FGM in Yemen, mainly localized in the eastern parts of the country. Almost 84% of the girls are cut during the first week of birth by traditional practitioners. However, recent data show a rise in the process of medicalization of FGM in the past years. Type I and II are the most performed. Unlike Somalia and Sudan, the majority (75.4%) of Yemeni women support the discontinuation of the practice. The main driver of such an attitude is their belief that it is “against religion”.

Sudanese and Somali women’s view of the practice in their countries of origin:
The FGDs included women and girls who had undergone FGM in their countries of origin. Women and girls agreed that in all their countries of origin (mainly participants from Sudan and Somalia), it took place at a very early age under very poor hygienic conditions which poses dangers to the girls’ lives from bleeding to life-time complications and disability and even death. Some un-exposed girls mentioned that their families refused the practices and were aware that it was not related to religion, health, chastity or honor. However, they had never spoken to their girls about it or the reasons behind their attitudes.

“FGM is a nightmare to young girls” Sudanese female, 16 years.

“My mother made me go through this experience then she regretted doing it. Nothing bad has happened to me so far but I am always afraid that something bad will happen to me in the future” Somali female, 15 years.

Findings from the FGDs suggest that the decision that a young girl undergoes FGM in the three communities is usually taken by elderly female family members. However, even if some girls may escape FGM because their families decided that they will not do it to her, these girls choose to undergo FGM when they are older because of social pressure. Some families believe that Sunnah (Islamic recommended practice) (Type I) is a fair choice that allows them to conform to the traditions and “save the girls” at the same time.
Description of FGM practice among Sudanese and Somali refugees/migrants in Jordan and factors affecting it

Current FGM practice

Evidence from literature, FGDs findings and inter-organizational communications strongly suggest that FGM is practiced among Sudanese and Somali refugees/migrants in Jordan. Recently, grassroot NGOs that support the Sudanese, Somali and Yemeni refugee/migrant communities - among others - in Jordan have started receiving requests from women who had undergone FGM or asking for FGM related services like counseling.

According to these NGOs, an FGD was held with female community members who all had known at least one person among their networks who had been a survivor of FGM.

In our study, women’s observations were that generally the rates of practicing FGM have declined since they arrived in Jordan. However, they mentioned specific occasions where FGM was practiced collectively among their communities in Jordan.

“A midwife would arrive from Sudan to Jordan to visit her family and then people would become aware of her presence by word of mouth and they would pay her to “cut” their girls. This midwife then returns to Sudan after “cutting” a large number of girls in strict secrecy as members of the community know it is illegal to perform FGM in Jordan.”

Sudanese female, 30 years.
The participants mentioned two specific years when this incident happened in 2008 and 2019, but they mentioned that it may have been repeated occasionally during that interval or even before. This means that there are currently adolescent girls and young adult women who survived FGM and might need support. However, Sudanese, and Somali adolescent girls seemed to be less aware about the occurrence of FGM among their communities in Jordan.

This may support the assumption that FGM rates have declined among these communities that is why the younger (adolescent girls) do not hear about it often among their close circles, unlike older women who may have heard about it or witnessed it take place during their presence in Jordan or know some women who have already undergone FGM before in their countries of origin and need relevant services at this point.

Among Yemenis, FGM is reported much less than the Sudanese and Somalis, which can be attributed to the already lower prevalence and localization of the practice in Yemen.
Current GBV practice

Findings of the FGDs suggest that Yemeni women are subjected to many other forms of GBV including Intimate partner violence (IPV), domestic violence and deprivation from the right to work or even leave the house. Similarly, among the Sudanese community, the Center for Victims of Torture (CVT) in Jordan reports that many Sudanese women approach them for help with intimate partner violence (IPV). Sudanese women and men, also, complain of sexual harassment by strangers.

In its 2020 annual report, the GBV IMS provided a thematic focus on the analysis of GBV status among non-Syrians.

The analysis showed that certain types of GBV are more prevalent among some communities than others. For example, forced marriage is more reported by Yemeni survivors, while rape is highly reported in other communities like Somali, Sudanese, and other nationalities, especially rape in country of origin reported by men in the context of detention or persecution.

Sudanese and Yemeni communities experience GBV in the community and in the workplace due to informal working arrangements and lack of work permits.

Other forms of exploitation and abuse are experienced by Sudanese and Yemeni communities on their housing quest where they must deal with forced evictions and lack of rental agreements.
Factors that can influence FGM practice in Jordan

Jordan represents a case of “migration from FGM practicing countries to countries with low FGM prevalence”. Important assumptions are made about this category and supported by input from women and girls who participated in the FGDs regarding the enablers and hinderers of FGM in such context.

Factors that may increase FGM practice include: a) adherence of the migrant community to cultural traditions which is further exaggerated by closed-knit migrant community settings, b) resistance to change that is complicated by inappropriate community-based initiatives that aim at raising the awareness of community members or transforming their attitudes, as they can be perceived as offensive, discriminatory or judgmental, and c) challenges faced by non-Syrian migrants/refugees regarding multiple basic needs including food insecurity, highly limited healthcare coverage and complicated healthcare related procedures (e.g. slow referrals, appointments and high cost of investigations and medication).

Non-Syrian refugees also must pay full education enrollment fees and possess proof of residency or a parent’s work permit to register, leading to barriers in accessing education.

“\[ The biggest problem is still that people are convinced that FGM is necessary. No progress will be achieved without changing the social norms. \]”

Sudanese female, 27 years

“Wait till I die then cut her”- Sudanese woman about her daughter responding to her mother’s repetitive requests to “cut” the granddaughter.
Hinderers of FGM practice in this context include: a) escaping the tremendous social pressure in countries of origin, b) the effect of being in new culture where comparisons to “un-cut” women are made and used to convince husbands/other family members to abandon the practice, c) better community learning and awareness opportunities about the dangers of FGM, d) more involvement of men in the help seeking journey of their wives which made them more aware of women’s suffering, e) relatively difficult access to traditional methods of practicing FGM (outside medical facilities) as the practice is not common within the host community, f) change of social dynamics (e.g. marriage of Sudanese men to Jordanian women who do not approve the practice, and g) more timely and effective management of FGM consequences due to better availability of services.

“Migrating to Jordan can lead to a psychosocial revolution that influences husbands and the community”  
Sudanese female participant.
GBV related services including FGM:

Description of current services:

Jordan has made great progress regarding GBV response over the past decades. The government of Jordan (GoJ) shows commitment to responding to GBV by putting the necessary policies and strategies in place. Several Jordanian entities are keeping with their institutional mandate to address GBV; for example the Ministry of Health (MOH) has established specialized committees in health facilities and developed internal guidelines and a clinical management of rape (CMR) protocol to guide service provision. Likewise, the police and justice sector has specialized Family Protection Departments (FPD), specialized judges, and fast track courts to handle urgent GBV cases. FPD provides free security and protection GBV services on a 24/7 work basis at national level.

In its 2020-2022 strategy, the gender-based violence work group (GBV WG) chaired by UNHCR and UNFPA in Jordan committed to continuing the provision of GBV related services and gave special attention to case management services from non-Syrian, non-Arabic speaking migrants and refugees, in addition to addressing specific risks of these communities (e.g. FGM) and potential barriers of accessibility to these services.

In our stakeholders’ survey, a rapid review of services provided by each organization showed that 75% of the responses mentioned GBV to be considered as “main mandate of action” followed by 66% mentioning women empowerment, 62.5% for each of adolescent girls’ empowerment and child protection, and finally 16.7% (4 responses) mentioned FGM as a main mandate of action. In addition, individual responses reflected other mandates like social protection and mental health while the World Food Programme (WFP) mentioned that they ensured protection and gender are mainstreamed in their services as a referral organization.
Types of services provided in these mandates included:

A - **Prevention activities** (ordered from most to least frequently mentioned responses): raising community awareness (87.5%), trainings and workshops for both community members and service providers (83.3%), women groups (66.7%), raising awareness of medical practitioners (62.5%), activities targeting adolescents and youth in schools, universities, and youth clubs (62.5%), education (58.3) and finally, men and boys’ groups (52.4%). Other specific examples of prevention services mentioned by respondents were raising awareness of community-based organizations and implementation of educational programmes on GBV in cooperation with (MoE).

B - **Response activities** (ordered from most to least frequently mentioned responses): psychosocial support (PSS) (75%), legal assistance (41%), safety/security, livelihoods, cash assistance (33.3% each), health/medical services (29.2%), shelter (4.2%). Some organizations that limit their intervention to prevention activities mentioned that if they come across GBV survivors in need of specific help, they refer these persons to specialized services as needed be that health, shelter, or PSS. Organizations whose main mandates do not include GBV (although mainstreamed in their programming) can do alterations to the service when it comes to their knowledge that a beneficiary is a GBV survivor. For example, they refer these persons for case management and provide cash assistance. Also, if they were informed that someone in the household was being deprived of this organization’s assistance, the organization blocks the assistance and issues a “new card”.


**C - Advocacy and public campaigning** (ordered from most to least frequently mentioned responses): Almost all respondents participate in multi stakeholder roundtables/meetings/working groups. Organizations mentioned to a lesser extent participating in public campaigns, performing community outreach approaches (e.g., wall painting, posters and community theatre) and engagement with the media.

*Figure 4: distribution of organizations by provision of GBV services to non-Syrian refugee/migrants.*
Sudanese, Somali, and Yemeni women who took part in the FGDs generally described GBV related services to be available and complementary to each other. This was in line with the results of organizations’ responses regarding the nationalities of their primary targets. Most respondents (67%) addressed non-Syrian refugees/migrants by services related to the mentioned mandates, 25% did not and 8.3% mentioned that they may have offered related services to these communities on the course of their work without specifically targeting them (Figure 4). Further disaggregation of the nationalities of primary targets of each organization revealed that Sudanese, Iraqi, and Yemeni nationalities were equally mentioned as primary beneficiaries (45.8% of all responses each) followed by Somali (41.7% of all responses).

“The ministry of youth organized a health camp which I participated in. We visited girls of the same age as ours who live in remote areas in Jordan and had limited access to technology and tough conditions. We made presentations and gave sessions to these girls about GBV.”

Sudanese female, 16 years.

“Sometimes we were asked to do a research in school about GBV and present it to our colleagues.”
Adolescent girls:

There are many organizations that support children, adolescents, and youth of the non-Syrian refugee/migrant communities in Jordan. On top of these is the Jordanian Ministry of Youth (MoY).

Results from our survey showed that most organizations (87.5%) include adolescents as primary targets of their work. These organizations reach out to adolescents and youth mostly at **schools where they give sessions** to raise their awareness about GBV and related services, or through the production of information, education, and communication (IEC) materials like stories that address GBV in terms of its definition, types, hazards, and services. They also operate **hotlines** through which these youth can communicate their needs/exposure to GBV and receive the necessary **support through specialized centers**.

Girls considered services to be generally accessible as they can reach even children who are not enrolled in schools or those who reside in remote areas from Amman.

Services targeting adolescent girls have the lion’s share of innovative activities that enhance the outreach to the girls especially in areas/times where it is hard to access information or difficult to report incidences, and this was evident from the input of girls during the FGDs. Adolescent girls mentioned the “Amaali” application created by members of the GBV WG as one of these approaches.

It is a mobile application that provides the girls with information on services to seek help or to join group activities to improve their skills, release stress and improve their social network.

Also, it enables the girls to share risk points if they could identify areas generally unsafe for women and girls.
FGM specific services:

Sudanese and Somali women mentioned that there were no FGM specific services provided to the community. Sudanese women sometimes convene in social groups that target other women of their communities to raise their awareness about the hazards of FGM and provide support if needed.

This was consistent with findings from the stakeholders’ survey where only one-quarter of the organizations confirmed that they provide services to women/girls exposed/at risk of exposure to FGM.

However, by looking into these services, they should not be considered as “a special programming” on FGM, more likely the services mentioned were offered to women/girls with/at risk of FGM as part of the community receiving these services and not as being specifically targeted with them.

Examples of these services are case management, PSS, and referral. One FGM specific activity mentioned was community-based research activities (e.g. FGDs) to help explore the situation of FGM in the community.

Sudanese community leaders believe that there is currently a weak role of organizations towards the elimination of FGM. Women believed that due to unawareness about the magnitude of FGM among their communities, there are not enough grassroot organizations to support survivors or girls at risk.

They also believed that the abundance of service providers on such levels can help with timely interference to prevent or respond to GBV exposure including FGM, and will compensate/cover up for the lengthy procedures of “bigger” organizations until they are able to act.
Gaps and challenges with current services

1-The overall context of service provision for non-Syrian refugees/migrants:

Unlike Syrian refugees, who already have their own share of challenges and difficult living conditions, Sudanese and Somali refugees/migrants are not included in the Jordan Response Plan (JRP) or similar frameworks that systematically plan and fund service provision, like the Jordan Compact, and multi-donor accounts. Conversely, they receive comparatively less attention from actors in the humanitarian field. For example, 67% of non-Syrian refugees/migrants suffer from food insecurity. Near a quarter of this group are Sudanese and Somali. Despite being covered through health multi donor accounts, non-Syrian communities still face difficulties in making appointments, dealing with external referrals and affording medications. The accessibility of children and adolescents to education opportunities is highly undermined by the full enrollment fees that their families must pay in addition to having proof of residency or work permits (which has been highly limited by the cessation of refugee registration of Sudanese, Somali, Iraqi and Yemeni refugees since 2019).

Regarding GBV, the results of our survey show that although some organizations provide GBV related services to the Sudanese and Somali communities, these services’ sustainability is threatened by the challenges to getting non-Syrian focused programming approved, and the poor funding received by these organizations, especially smaller/grass-root ones. Small local NGOs have a very effective role in community outreach, and ability to mobilize community leaders and the expansion of their activities was stated by the community members to be of great value.
2-Fear of reporting on GBV and threatened community outreach:
Both women and adolescent girls groups mentioned that the biggest challenge to seek help among women/girls exposed to any form of GBV was the women and girls themselves who fear the reaction of their husbands/families if they knew about it. In the Yemeni community, women seeking help regarding such “private” issues would risk their reputation.

“I know a woman who was hit by her husband. She did not seek help here, instead she escaped back to Yemen with her baby and resided in a city other than where her family lived because they would harm her had they known that she left her husband. It is to that extent that Yemeni women would not seek help when exposed to such things (referring to GBV)”

Yemeni female, 38 years - community leader

Similarly, adolescent girls reported that they fear the threats imposed by their parents and families if they tried to communicate with any service provider upon exposure to GBV. According to the girls, their families see these services as a kind of “incitement” for the girls to disobey them.

“If the girl finds herself in a bad situation; she is obliged at this moment to choose between the service and her own family”

Sudanese female, 16 years.
The situation may become more complicated when families are provoked sometimes by inappropriateness of some services. For example, a father may be outraged if a male facilitator gives a session about GBV to the girls. This fear from reporting from the survivors as well as the reactions from their families/communities can mislead the attempts to estimate the occurrence of the practice due to under reporting, and also form an obstacle to service providers who expressed their concern regarding reaching out to the community to address FGM being a culturally sensitive issue addressed under the umbrella of the already delicate GBV topic. Such sensitivity also affects participation of community members/leaders themselves during programming and implementation thus threatening both the design and the execution of an FGM elimination programme.

3-Low awareness of service providers on FGM causes, consequences, and related services:
Results from our Stakeholders Survey suggest that organizations that identified non-Syrian refugees/migrants to be among their targeted communities still need to educate themselves more about FGM. Organizations’ knowledge level was acceptable regarding the definition of FGM (more than two thirds of the participants mentioned they knew the definition of FGM), and that it is a type of GBV and a violation of human rights (95%, and 100% respectively). However, around 30% of the participants were not sure if there were different types of FGM, and most participants (75%) mentioned that FGM does not exist in the Jordanian community, while 25% mentioned it “may be” existent. Additionally, almost 80% of the participants mentioned that they were either not sure if FGM existed in refugee/migrant communities in Jordan or that it did not exist. The remaining 20% of organizations that confirmed that FGM is practiced among refugee/migrant communities believed that it is mostly practiced among Sudanese, Somali, Egyptian and Iraqi, and “African” communities.
Regarding consequences of FGM, all participating organizations were aware of at least one health consequence of FGM. Complications during intercourse, mental health illness, complications during delivery and recurrent/chronic infections were most frequently mentioned. Regarding their knowledge about the possible drivers for FGM practice, all participants were able to identify more than one driver e.g. (in order of frequency of responses): psychosexual reasons (to control women’s sexuality), sociocultural reasons, the belief that it was a religious requirement, beliefs about hygiene, and finally economic reasons.

This lack of knowledge about some aspects of FGM can be attributed to the conviction that FGM has not been practiced in Jordan before. FGM survivors and women/girls at risk of exposure to FGM need a spectrum of services provided by these organizations which, without enough knowledge and awareness, may fail to assist those in need with some already existing services like medical referral for management of short term or long-term complications, protection, PSS and community awareness. Not only low levels of knowledge about FGM affect the provision of services to those in need, but it also hinders the process of “change” that is necessary in order to eliminate the practice. Both the organizations and women from the community agree that the belief that FGM is not very prevalent or that it is localized within specific communities will not allow the formation of a critical mass of advocates and supporters for FGM elimination. Moreover, organizations find that their lack of experience in working on the topic may prevent building bridges of trust and understanding with the community.
Examples of low awareness of service providers:

- Medical services providers:

Adding to the fact that FGM specific medical services are not currently in place, participants of the FGDs mentioned that a major gap in receiving medical services is the poor level of knowledge of medical practitioners about the medical consequences of FGM and their unawareness about the cultural background (and the practices emerging from it) of patients from non-Syrian refugee/migrant communities, which results in poor or no medical management of the case and complicates the already burdened life of refugee/migrant women at many levels.

For example, most Sudanese women who experienced FGM and had to give birth in Jordan had to undergo a cesarean section (CS) operation for delivery. The decision to have a CS is most of the time imposed on women due to “fear of complications” or “incompetency to deal with an FGM case” by the medical practitioners. In addition to being subjected to major surgery like CS (referenced), women reported that such a decision delayed their recovery from delivery and affected their ability to care for themselves, the newborn and their families.

This is particularly challenging for refugee/migrant women who may have little support from few family members or women who contribute to household income either fully or partially. As with physical health, FGM may represent a major mental health consideration for women exposed to it. However, it is often missed by psychiatrists and mental health specialists during history taking, as one of the participants reported.

“I know a woman who had to explain to the gynecologist how FGM was done to her so that he can help her with her complaint”

Sudanese female, 17 years.
In addition to poor medical management, low awareness of medical practitioners of the risk factors (including cultural background) and signs and complications of FGM will lead to lack of identification of survivors or those at risk, therefore interrupting the pathway of services that could be provided to this woman/girl like protection, PSS and other services.

**Protection service providers**

Participants from the adolescent girls group mentioned that one of the organizations taught them “signals” that they can use to tell individuals (could be the public, police officers, doctors ...etc.) that they are exposed to a form of GBV and that they need help. These signals are intended to allow girls to reach out for help without having to visit certain centers and without being prevented or threatened by their families. A major challenge to this service is that the persons intended to be “helpers” are either unaware of the signals or unwilling to help.

**4-High cost of some medical/protection services:**

Non-Syrian refugees/migrants in Jordan experience economic challenges and pay extra expenses than those who live in camps. Therefore, they are obliged to accrue debts and undermine their food and health services quality to cope with the increased demands. This is complicated, according to the participants, by their obligation sometimes to pay for some services that are not covered by the aided services like the cost of some medical investigations or procedures (which makes most women non-compliant with the prescribed medical management), and some administrative procedures when reporting incidents to the local police.
“I know someone who suffered from problems in the sexual relationship with her husband because of FGM. She could not afford having a major operation to solve this problem, so she resorted to another illegal procedure to solve it. She had to endure the pain and suffering twice.”

Sudanese female, 27 years.

Unmet basic needs aggravate the financial burden of getting some related medical/protection services (medications, investigations, administrative procedures).

5-Some services must be provided through slow and bureaucratic pathways:
UNHCR was mentioned frequently by the participants as the first place they would seek for help on exposure to GBV. However, participants agreed that the process of receiving protection services at UNHCR was rather slow and bureaucratic due to the large number of beneficiaries they needed to support. UNHCR provides direct PSS to survivors, complemented with emergency cash assistance and partnerships with local NGOs who provide specialized support to survivors in safe spaces across Jordan. Survivors are referred to health, legal, safe shelter options, and to other services. UNHCR also implements prevention activities such as women empowerment workshops, self-defense classes led by refugee women and various awareness activities within communities.

“I do not know where to go or what to do until the protection section helps me.”

Sudanese female, 17 years.
6-The COVID-19 pandemic:

Just like in many parts of the world, women and girls in Jordan suffered from the increased exposure to GBV during the pandemic because of the preventive measures like curfew, schools’ closures, limited livelihood opportunities and loss of jobs which increases the tension leading to more incidents of domestic violence. Migrant women, adolescent girls and survivors of GBV were more vulnerable to discrimination and abuse during crises like this pandemic.

Moreover, disruption in service provision affecting all communities has caused decreased access to services as well as decreased reporting. For Sudanese and Somali refugees/migrants, some services continued during the lockdown like those provided by the FPD, while others like CMR were available only in camps. In urban settings CMR services were only available on call due to closure of the primary healthcare centers. It is safe to assume that Sudanese and Somali refugees/migrants face the same challenges regarding access to services like the host community and refugees in camp settings, e.g. not knowing how to reach services during lockdown, having to use the husband (who can be the perpetrator of violence), having no phone for reaching remote assistance in life threatening conditions.

Globally, pandemic lock down measures, including school closures have led to disruption of prevention and response services especially in hard-to-reach areas. According to aUNFPA global study and report on the impact of COVID-19 on FGM, a 30% reduction in the progress towards ending FGM by 2030 is anticipated, and as many as 2 million FGM cases could occur over the next decade that would otherwise have been averted.
7-Poor adaptation of services:
Organizations were asked to mention adaptations made in their services to meet specific needs of an FGM exposed/at risk beneficiary. The majority (71%) of respondents either did not make any adaptations or were not sure about them, while only 29% of the respondents mentioned that they made specific adaptations. By looking at those adaptations, they were mostly generic falling under the umbrella of bigger categories of services e.g. referral, support services, cash assistance and life skills programmes. Some organizations mentioned adapting the geographical scope and timing of their services (mainly cash assistance) to reach as many beneficiaries as possible.

8-Absence of supportive laws and legislations on FGM
Generally, Jordan has established legal and policy frameworks on GBV laws. Addressing GBV in Jordan falls under criminal or personal status laws. Laws that are strengthened and achieve gender justice in the Jordanian law are related to domestic violence, rape (other than by spouse), human trafficking and dismissal from jobs on pregnancy. However, there is no specific legal prohibition of FGM.
Results from our survey reflected good knowledge of the organizations about this fact where almost all participants either mentioned it did not exist or were not sure if it did.
9-Research gap:

There is still a research gap to be filled regarding the needs of non-Syrian refugee communities in Jordan. Recent studies and advocacy papers highlight the situation of non-Syrian refugee communities, but even the studies that address details about the conditions of non-Syrian refugees in Jordan in almost all aspects of their life in asylum do not give the same degree of detail about their GBV experiences and never mention the topic of FGM.

In low FGM prevalence countries like Jordan, data about FGM are usually obtained from small scale surveys or indirect estimates rather than nationally representative surveys e.g. DHSs or MICs. Indirect estimates depend on FGM prevalence in countries from which refugees originates (which are high prevalence countries where estimates are made through national surveys). This may be problematic as estimates will assume that FGM is only practiced in the country of origin and not taking into consideration the changes in practice due to migration. Current research activities carried out by various organizations are more related to programming than to knowledge generation. Most organizations draw on monitoring and evaluation frameworks of their projects as evidence for further GBV programming (83.3%). They only perform, to a lesser extent, baseline, and impact evaluation studies. Few examples of community-based surveys (e.g. Knowledge, attitudes and practices (KAP) surveys) (62.5%) were mentioned. More specifically, UN Women also mentioned performing gender analyses while Sawiyan mentioned facilitating FGDs with the community members for programming purposes or as part of bigger research activities, like in the preparation of this report.

The scarcity of robust data on FGM practice among Sudanese and Somali communities prevent organizations from finding proper defense assessments to showcase FGM elimination as a potential area of action that needs attention.
1-Community based interventions:

GBV programming capitalizes on community-based interventions, social networks and mutual trust between community members and serving organizations. The Sudanese refugee/migrant community in Jordan is privileged with such strong social bonding and relations through which the community members help each other and support the most vulnerable and form reliable links with the serving organizations.

This is particularly important to enhance accessibility to GBV related services including FGM by all community members. Community members rely on local organizations at grass-root level to provide timely and accessible services.

There is currently an increased involvement of local NGOs that support non-Syrian refugees/migrants and the establishment of referral mechanisms between these organizations and other service providers. This involvement helps in increasing both disclosure of GBV incidents and awareness about the available services.

Moreover, some organizations have expanded in terms of physical existence to cover many parts of Amman and the country, reaching hard-to-access areas.
2-Existing GBV programming:
GBV programming in Jordan has been sustained and even improved over the past years including at government, service providers and community levels.

It would be useful to build on the momentum created by of GBV programming in various areas by including FGM related activities/services within the existing plans. FGM should not be addressed as a standalone problem that affects small communities in Jordan. More importantly, established relations with other stakeholders and the targeted communities can be used as a channel to communicate this new scope thus encouraging their future support and cooperation. Actors, also, have experience with addressing GBV from a human rights perspective.

Including FGM when using the same narrative for advocacy or for community awareness can both leverage the current efforts against GBV and pave the road for programming to eliminate FGM within the practicing communities.

3-Community insiders:
Some organizations working on GBV have succeeded in building the capacities of some Sudanese and Somali community members (mostly women) and had them lead on community outreach to raise awareness on GBV, women rights and child protection. Community leaders were able to help service providers deliver services using their expertise, orientation about their communities and the discussion groups they host to mobilize other women. Engagement of community leaders has also allowed some organizations to go for innovative interventions such as "Generations for Peace" that uses sports and art to convey messages about GBV.
4-Existing Youth-led initiatives:
Youth constitute a great capital for countries while working on social transformation. The Y-PEER network can be a great source to capitalize on youth leadership in their communities. In Egypt, Y-PEER works on FGM by adopting innovative approaches like community theatre, in addition to preparing training guides on peer education. Y-PEER Jordan can use their regional network to get on knowledge and experience sharing activities from their peers in Sudan and Egypt, for example.

5-Partnerships and multi-stakeholder approach:
It has been evident through the previous sections that there are well established partnerships between the government, international actors and local organizations working on the GBV mandate in Jordan. Results from our stakeholders’ survey showed that partnerships were most prevalent between participating organizations in the form of taking part in protection/GBV work groups, joint programming with other community-based organizations, UN organizations, NGOs, and government departments and to a lesser extent with the private sector. FGM programming depends on partnerships for mobilizing funds, joint programming, knowledge dissemination, achieving collective advocacy and dissemination of good practices.
Also, working with the formal actors through workshops and roundtable discussions (Criminal Judges, FPD, MoSD, etc.) achieves better coordination, raises the awareness of decision makers and supports sustainability.
Some organizations are already involved in advocacy dialogue to achieve better results and respond to the status of Sudanese and Somali refugees in Jordan. The One Refugee Approach Work Group (ORA WG) is one of these initiatives. The ORAWG advocacy centers around the ‘principles of impartiality and non-discrimination’ prioritizing vulnerability as determinant for service provision rather than nationality, in addition to pushing to make refugee and humanitarian response framework in Jordan more inclusive and in line with humanitarian principles. FGM (as issue of big concern for the communities of concern to the ORA WG) can be brought to the table during such discussions building on evidence of the practice from this report and other resources and clarifying the dynamics of FGM both among migrant and host communities.

6-Knowledge generation and sharing:
Gender sensitive research/assessments and policy papers are carried out by some actors. Also, with smaller steps community-based research approaches are starting to take place regarding FGM. In addition to expansion on the current research activities, organizing knowledge sharing platforms with countries that have been working on the issue for decades now can inform the next steps of FGM programming in Jordan in terms of planning, expected challenges and how to overcome them, opportunities in the Jordanian context and finally planning and funding. Actors can also make use of consultations from specialists and organizations that have in-depth experience in developing/funding community-based approaches to this issue.
The UNFPA-UNICEF Joint Programme to eliminate FGM:

The UNFPA-UNICEF Global Joint Programme to eliminate FGM (initiated in 2008 and currently working in its Phase III) provides an opportunity for knowledge sharing and exchanging experience. Through publications, conferences, trainings and the development of an online platform, it supports the sharing of best practices and lessons learnt across communities and countries. The Programme brings together experiences of 17 countries where it has achieved outstanding progress through adopting a comprehensive approach, enhancing policy development, evidence-based programming, improving access to prevention and response services, ensuring community engagement and working on social norms transformation.
Recommendations and the way forward

Measures to address FGM among minority communities should focus on legislation, strengthening the capacity of relevant professionals to effectively address the practice through training and guidelines, as well as awareness-raising among targeted communities.

Recommendations to all actors:

1. Awareness raising of community members, service providers and other stakeholders:

   Awareness raising activities should target community members and service providers to address the gaps in knowledge about FGM including its drivers, consequences and services. More importantly, activities should aim at educating community members and service providers about women’s and girls’ rights to healthy lives, intact bodies and protection.

   Additionally, these activities should emphasize the importance of help seeking on GBV, including FGM, especially in situations that threaten women’s physical and/or mental health.

   Targeted community members ideally include: women and girls, right holders, men and boys as agents of change and community religious and youth leaders who will form a critical mass ensuring the initiation and sustainability of community awareness.

   This can be done through sessions in women and community groups, youth centers, technical webinars for service providers, the use of media channels (TV, Radio, Social media) and public campaigning such as “16 Days of Activism against GBV” and innovative community outreach (e.g. community theatre, arts, sports...etc.).
Raising awareness of service providers on FGM drivers and consequences will allow for better understanding of the context where FGM takes place and more efficient, relevant and culturally sensitive prevention and response services.

2. Capacity building of service providers:
Persons providing services to FGM survivors or women/girls at risk in all sectors, e.g. health and protection, should have the capacity to:

a) Identify when a girl (including an unborn girl) or young woman may be at risk of FGM and respond appropriately to protect them;

b) Identify when a girl or young woman has had FGM and responding appropriately to support them; and

c) Take part in measures that can be implemented to prevent and ultimately help end the practice of FGM.

Examples of capacity building of service providers include but are not limited to:

1) Training medical service providers on the latest tools and guidelines on diagnosis and management of FGM, providing specialized quality health, psychosocial and reproductive/sexual care for the FGM survivors;

2) Building the capacity of GBV case managers to include FGM in their assessment tools and provide guidance for referral and service provision for FGM survivors/at risk women and girls;

3) Building the capacity of government staff by equipping relevant officials with the needed personnel, financial, technical and other resources; and

4) Building the capacities of local and international organizations’ staff making use of their expertise in community engagement and development. This can be done through more collaboration and technical partnerships to work together on designing interventions aiming at staff training, research and ultimately, improved programming.
3. Well-adapted services:

The most accurate methodology to adapt/reform current services or develop new ones is by obtaining feedback from the targeted communities about the necessary adaptations needed through satisfaction surveys, needs assessments and mapping of current activities, however few. An effective way to achieve customization of services is by having FGM specific programmes (can be included as an outcome of existing GBV programming) covering all areas like health, protection, awareness … etc.).

Examples of FGM specific health programming include integrating FGM examination and management in ongoing reproductive health programmes, flexibility regarding the settings, the method and the service providers. To elaborate more, FGM related health consultations can be offered through schools instead of medical institutions if necessary, also to consider female nurses and doctors the main service providers in this specific area. Regarding protection services, it could be useful to have focal points for FGM in the different protection organizations or even in FPD. This can make a major difference in the willingness of women to report to authorities.

A low hanging fruit of well-adapted services is the orientation and awareness created for both community members and service providers. The availability of specific services/pathways provided for FGM survivors or women/ girls at risk paves the road for other service providers e.g. to identify those in need of FGM related support and more importantly be able to guide them. Also, community members start to observe that the practice is receiving increasing attention from service providers which can positively influence their help seeking behaviors.
4. Research:
Extensive quantitative and qualitative research is needed to map-out more accurately the magnitude of FGM among both migrant and the Jordanian host community. It is important to investigate the drivers and hinderers of the continuation of the practice specifically for Sudanese and Somali communities after migration. Moreover, needs assessments, satisfaction surveys, gender analyses and operational research should run alongside planning and implementation. In addition to evidence-based programming, knowledge sharing platforms should be created to disseminate evidence and gain experiences at national, regional and global levels. Although reliable data collection in countries where only minority groups practice FGM is a challenge, evidence produced by FGM programmes around the world (e.g., the UNFPA-UNICEF Global Joint Programme on FGM elimination) can provide substantive guidance on data collection tools and data analysis for programming and advocacy.

Recommendations to decision makers at national level:

Creating an enabling environment to work on FGM among Sudanese and Somali communities:

FGM has diverse and multi-dimensional drivers, that is why it should never be addressed in isolation from its predisposing factors. Therefore, holistic approaches that include advocacy, policy-level work and community level transformation of social norms have been adopted in many countries and have succeeded so far to bring the practice into decline. For example, a holistic approach to promoting girls’ health and well-being that addresses all facets of their growth and development is more acceptable to communities than one that narrowly addresses a single problematic aspect, such as FGM.
Investigating the situation of FGM and its related services among the Sudanese and Somali communities in Jordan puts a spotlight again on the influence of exclusion of these communities’ assistance frameworks, like the JRP. FGM and deprivation from basic needs should be tackled together; they cannot be reduced in isolation.

Collaboration between the GoJ and relevant partners is needed to assess the needs of these communities and create a response strategy that includes possible fund-raising mechanisms to support GoJ in extending basic services to non-Syrian refugees/migrants including those from Sudan and Somalia.

Ensuring food security, cash assistance and further bolstering community-based protection services should be prioritized in any such response strategy or planning.

Additionally, allowing these communities a legal pathway to obtaining work permits that will significantly improve the economic status of the Sudanese and Somali families should be prioritized, thus addressing the economic driver of FGM as a precursor for early marriage.

Also, access to basic health and education services is essential. Response framework and local policy should be set up in such a way that allows these communities access to both services. Doing so can lead to increased educational, social and potentially economic empowerment of women and adolescent girls who can, in turn, have greater capacity to stand up for their rights in future.
Moreover, it is important to work with government entities e.g. the National Council of Family Affairs (NCFA) and the Jordanian National Commission for Women (JNCW), FDP, MOH and MoSD to revise the national SOPs and guidelines to make sure FGM related principles are well integrated (e.g. guidelines for clinical management of FGM to be integrated in relevant medical guidelines), and to even go as far as forming a national taskforce/programme/council working on FGM to ensure services for refugees of other nationalities are well reflected, as well as developing new and enhance existing GBV-related policies and legislation to include legislations against FGM.

Guiding principles for FGM programming:

A) Address FGM as a type of GBV from a rights-based perspective
Adopting a positive narrative based on rights and being “intact” has proven its success in some FGM high prevalence countries (e.g. the “Saleema” campaign in Sudan). Messages conveyed to both communities and actors should focus on gender equality, respect for girls and their rights, their aspirations and decisions that have an impact on their lives.
B) Community engagement

**Community leaders** should be dealt with as “owners” of the community-based programming. Their involvement is a key to initiate the work on FGM, sustain it and succeed in it. At all levels of programming, community leaders can provide guidance on feasibility and applicability of interventions, ensure that interventions are culturally appropriate and relevant and most importantly help build the bridge of trust between organizations and the community. Collaboration with refugee/community leaders on creative approaches towards community-based advocacy, participatory research and prevention are other areas where community leaders can help.

**Religious entities and leaders** as well influence the beliefs, attitudes, and behaviors of communities. In many countries that have worked on FGM elimination for decades, commitment and support from religious authorities and religious public figures had positive influence on the progress of work through issuing fatwa (religious opinion) or making declarations prohibiting the practice, as well as serving in community mobilization for the high credibility they enjoy within their communities.

**Men and boys** are critical change agents to abandon FGM at community level. As a prerequisite for marriage in the Sudanese and Somali communities, transforming the attitudes of husbands/potential husbands can lead to great progress. Men and boys should be targeted with comprehensive sexual and reproductive health education, so they understand the consequences of FGM and the rights of the girls and women in their community.
C) Youth as agents of change
There is an inevitable need to work with youth leaders and utilize youth education, youth-led initiatives and youth groups to tackle FGM. Evaluation of previous interventions showed that the investment in dedicated girls and youth programming contributed to stronger policy advocacy on girls’ and women’s rights. Also the emerging focus on youth engagement and education ensures sustainability and continuous work on social norms change among future generations.

D) Multi-stakeholders approach
FGM elimination requires complex multisectoral strategies involving all sectors of government and the wider public, including the media, civil society groups, the private sector, community leaders, medical professionals and teachers. It also requires addressing and engaging with beliefs and social attitudes and norms within the communities where FGM is practiced. All stakeholders, including affected people, should be part of programming in all stages.
Work groups include organizations with extensive expertise on various mandates. Expanding collaboration within these work groups as well as between them and the government and community members will be crucial to development of quality programming and can play a role in channeling these experiences into productive activities. Strengthening lines of communication and collaboration between work groups such as the SGBV, ORAWG, Protection Work Group, and Basic Needs Work Group should be important focal points in establishing inter-sectorial coordination, advocacy and collaboration on the aforementioned issues.
The Jordan INGO Forum, ‘Leave No One Behind’ Committee, and multi-donor groups should also be seen as important focal points for coordination and awareness-raising in any effort to develop affective, multi-sector, principled programming related to the issues at hand.

An arm of a multisectoral/multi-stakeholders approach is collective advocacy that can be used to reinforce discussions with key donors and government representatives.
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WFP: Comprehensive Food Security and Vulnerability Assessment, 2018 (April 2019)


World Food Programme (WFP) Jordan, Comprehensive Food Security and Vulnerability Assessment, 2018 (April 2019)

## Annex II: Summary of GBV services provided by participating organizations

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<tr>
<th>Organization</th>
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<th>Prevention Services</th>
<th>Response services</th>
<th>Research</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anonymous</td>
<td>NGO</td>
<td>GBV, Child protection, Adolescent girls’ empowerment, Women empowerment</td>
<td>Jordanian, Syrian, Sudanese, Somali, Iraqi, Yemeni</td>
<td>Awareness raising, Education, Trainings and workshops, Women groups, Education to children and young people in schools, Youth clubs and universities, Men, and boys’ groups</td>
<td>N/A</td>
<td>M/E framework</td>
</tr>
<tr>
<td>UNICEF</td>
<td>UN</td>
<td>GBV, Child protection</td>
<td>Jordanian, Syrian, Sudanese, Somali, Iraqi, Yemeni</td>
<td>Awareness raising, Education, Education to children and young people in schools, Youth clubs and universities, Men, and boys’ groups</td>
<td>N/A</td>
<td>M/E framework, Impact Evaluation</td>
</tr>
<tr>
<td>Syrian American medical Society</td>
<td>INGO</td>
<td>GBV, Mental Health</td>
<td>Jordanian, Syrian, Sudanese, Somali, Iraqi, Yemeni</td>
<td>Trainings and workshops, Women groups, Education to children and young people in schools, Youth clubs and universities, raise awareness for the health service providers and other service providers on GBV, raise awareness for the CBO's service providers</td>
<td>PSS</td>
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<tr>
<td>WFP</td>
<td>UN</td>
<td>Adolescent girls' empowerment, Women empowerment, mainstreaming of gender and protection during referral</td>
<td>Syrian</td>
<td>We train our staff to be aware of the referral pathways and how to spot GBV related issues</td>
<td>We refer these cases for case management and provide cash assistance if we know that the beneficiary is a GBV survivor (if we come across the information). In cases that we are informed that someone in the household is being deprived of our assistance we take action to block the assistance and issue a new card</td>
<td>N/A</td>
</tr>
<tr>
<td>Middle East Children Institute - MECI</td>
<td>INGO</td>
<td>Education and under MoE umbrella</td>
<td>Jordanian, Syrian, Sudanese, Somali, Iraqi, Yemeni</td>
<td>Education</td>
<td></td>
<td>N/A</td>
</tr>
<tr>
<td>UNHCR</td>
<td>UN</td>
<td>GBV, Child protection, FGM, Adolescent girls' empowerment, Women empowerment</td>
<td>Syrian, Sudanese, Somali, Iraqi, Yemeni, Other</td>
<td>Awareness raising, Education, Trainings and workshops, Women groups, Education to children and young people in schools, Youth clubs and universities, Men, and boys’ groups, Raise awareness for the health service providers and other service providers on GBV</td>
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<td>Jordanian women’s union</td>
<td>NGO</td>
<td>GBV, Child protection, FGM, Adolescent girls’ empowerment, Women empowerment</td>
<td>Syrian, Sudanese, Somali, Iraqi, Yemeni, Other</td>
<td>Awareness raising, Education, Trainings and workshops, Women groups, Education to children and young people in schools, Youth clubs and universities, Men, and boys’ groups, Raise awareness for the health service providers and other service providers on GBV</td>
<td>PSS, Health/Medical Services, Legal Assistance, Livelihood, Cash assistance, Shelter (specific for GBV and human trafficking)</td>
<td>KAP Surveys, Baseline studies, M/E framework, Impact Evaluation</td>
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<tr>
<td>TDH Terre des Hommes</td>
<td>INGO</td>
<td>GBV, Child protection, Women empowerment</td>
<td>Jordanian, Syrian</td>
<td>Awareness raising, Education, Trainings and workshops, Women groups, Men, and boys’ groups</td>
<td>PSS, Legal Assistance</td>
<td>KAP Surveys, Baseline studies, M/E framework, Impact Evaluation</td>
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<tr>
<td>International medical corps</td>
<td>NGO</td>
<td>Child protection, Adolescent girls’ empowerment</td>
<td>Jordanian, Syrian, Sudanese, Somali, Iraqi, Yemeni, Other</td>
<td>Awareness raising, Education, Trainings and workshops, Education to children and young people in schools, Youth clubs and universities, Raise awareness for the health service providers and other service providers on GBV</td>
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<tr>
<td>IFH</td>
<td>NGO</td>
<td>GBV, Child protection, Adolescent girls’ empowerment, Women empowerment</td>
<td>Jordanian, Syrian, Sudanese, Somali, Iraqi, Yemeni</td>
<td>Awareness raising, Trainings and workshops, Women groups, Education to children and young people in schools, Youth clubs and universities, Men, and boys’ groups, Raise awareness for the health service providers and other service providers on GBV</td>
<td>PSS, Health/Medical Services, Safety/Security, Cash assistance</td>
<td>KAP Surveys, Baseline studies, M/E framework, Impact Evaluation</td>
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<tr>
<td>ActionAid</td>
<td>INGO</td>
<td>GBV, Adolescent girls’ empowerment, Women empowerment</td>
<td>Jordanian, Syrian</td>
<td>Awareness raising, Trainings and workshops, Women groups, Education to children and young people in schools, Youth clubs and universities, Men, and boys’ groups, Raise awareness for the health service providers and other service providers on GBV</td>
<td>PSS</td>
<td>KAP Surveys, M/E framework, Impact Evaluation</td>
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<tr>
<td>Anonymous</td>
<td>UN</td>
<td>GBV, Child protection, FGM, Adolescent girls’ empowerment, Women empowerment</td>
<td>Syrian, Sudanese, Somali, Iraqi, Yemeni, Other</td>
<td>Awareness raising, Education, Trainings and workshops, Women groups, Education to children and young people in schools, Youth clubs and universities, Men, and boys’ groups, Raise awareness for the health service providers and other service providers on GBV</td>
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<tr>
<td>NRC</td>
<td>INGO</td>
<td>Child protection, Adolescent girls’ empowerment</td>
<td>Jordanian, Syrian, Iraqi</td>
<td>Awareness raising, Education, Trainings and workshops, Education to children and young people in schools, Youth clubs and universities</td>
<td>PSS, Legal Assistance, Referral</td>
<td>We don’t do GBV/FGM programming</td>
</tr>
<tr>
<td>Jordan River</td>
<td>NGO</td>
<td>GBV, Child protection, Women empowerment</td>
<td>Jordanian, Syrian, Sudanese, Somali, Iraqi, Yemeni, Other</td>
<td>Awareness raising, Trainings and workshops, Women groups</td>
<td>PSS</td>
<td>KAP Surveys, M/E framework, Impact Evaluation</td>
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<tr>
<td>Foundation</td>
<td></td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>MoSD</td>
<td>Government</td>
<td>GBV, Child protection</td>
<td>Jordanian</td>
<td>Awareness raising, Trainings and workshops, Women groups, Education to children and young people in schools, Youth clubs and universities</td>
<td>PSS, Safety/Security</td>
<td>KAP Surveys, Baseline studies, M/E framework, Impact Evaluation</td>
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<tr>
<td>Siren</td>
<td>INGO</td>
<td>حماية مجتمعية</td>
<td>Other</td>
<td>Awareness raising, Trainings and workshops</td>
<td>Safety/Security</td>
<td>KAP Surveys, Baseline studies, M/E framework, Impact Evaluation</td>
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<tr>
<td>Anonymous</td>
<td>NGO</td>
<td>GBV, Women empowerment</td>
<td>Jordanian, Syrian</td>
<td>Awareness raising, Education, Trainings and workshops, Women groups, Education to children and young people in schools, Youth clubs and universities, Men, and boys’ groups, Raise awareness for the health service providers and other service providers on GBV</td>
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<td>UNRWA</td>
<td>UN</td>
<td>GBV, Child protection, Women empowerment</td>
<td>Jordanian, Other</td>
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<td>PSS, Health/Medical Services, Livelihood, Cash assistance</td>
<td>KAP Surveys, Baseline studies, M/E framework, Impact Evaluation</td>
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<tr>
<td>Islamic Relief Worldwide - Jordan Office (IRW-Jordan)</td>
<td>INGO</td>
<td>GBV, Child protection, Adolescent girls’ empowerment, Women empowerment</td>
<td>Jordanian, Syrian</td>
<td>Awareness raising, Trainings and workshops, Women groups</td>
<td>PSS, Health/Medical Services, Livelihood, Cash assistance</td>
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<tr>
<td>UN Women</td>
<td>UN</td>
<td>GBV, Adolescent girls’ empowerment, Women empowerment</td>
<td>Jordanian, Syrian</td>
<td>Awareness raising, Education, Trainings and workshops, Women groups, Men, and boys’ groups, Raise awareness for the health service providers and other service providers on GBV</td>
<td></td>
<td>KAP Surveys, Baseline studies, M/E framework, Impact Evaluation</td>
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<tr>
<td>Save The Children</td>
<td>NGO</td>
<td>GBV, Child protection, Adolescent girls’ empowerment</td>
<td>Jordanian, Syrian</td>
<td>Awareness raising, Education, Trainings, and workshops, Raise awareness for the health service providers and other service providers on GBV</td>
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<td>JRF</td>
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<tr>
<td>Saiyan</td>
<td>NGO</td>
<td>FGM, Adolescent girls’ empowerment, Women empowerment</td>
<td>Sudanese, Somali Yemeni</td>
<td>Awareness raising, Women groups, Raise awareness for the health service providers and other service providers on GBV</td>
<td>Referral only</td>
<td>in the early stages of facilitating FGDs with community leaders with UNFPA for their inception report</td>
</tr>
<tr>
<td>Arab Women Organization of Jordan (AWO)</td>
<td>NGO</td>
<td>GBV, Adolescent girls’ empowerment, Women empowerment</td>
<td>Jordanian, Syrian</td>
<td>Awareness raising, Education, Trainings and workshops, Women groups, Education to children and young people in schools, Youth clubs and universities, Men, and boys’ groups, Raise awareness for the health service providers and other service providers on GBV</td>
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Female Genital Mutilation among non-Syrian Refugees/migrants IN JORDAN