HOUSE OF COMMONS

International Development Committee

Oral evidence: FCDO's approach to sexual and reproductive health, HC 1216

Tuesday 23 May 2023

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Watch the meeting

Members present: Sarah Champion (Chair); Mr Richard Bacon; Mrs Pauline Latham; Chris Law; Mr Ian Liddell-Grainger; Nigel Mills; Navendu Mishra; David Mundell; Kate Osamor; Mr Virendra Sharma.

Questions 1 - 71

Witnesses

I: Dr Milly Kaggwa, Senior Technical Advisor, Global Medical Team, Population Services International; Caroline Guinard, FCDO Programmes Director, MSI Reproductive Choices; Matt Jackson, Chief of the London Representation Office, United Nations Population Fund (UNFPA); and Dr Sebastian Taylor, Coalition of Health Professional Bodies and Royal Colleges for Sexual and Reproductive Health and Rights.

II: Asenath Mwithigah, CEO, Orchid Project; and Tinebeb Berhane, Country Director, ActionAid Ethiopia.

Examination of witnesses

Witnesses: Dr Milly Kaggwa, Caroline Guinard, Matt Jackson and Dr Sebastian Taylor.

[*This evidence was taken by video conference*]

Q1 **Chair:** I will start this one-off evidence session on the FCDO's approach to sexual and reproductive health with the International Development Select Committee. We are joined by four witnesses today, two in the room and two online. Welcome to all of you. I will ask you to briefly introduce yourselves and your organisations, and then we will get into questions from members.

Caroline Guinard: Welcome, good afternoon. My name is Caroline Guinard. I am the FCDO Programmes Director at MSI Reproductive Choices.

Matt Jackson: Hello, everyone, and thank you for the invitation. I am Matt Jackson. I am Chief of the London Representation Office for UNFPA, the United Nations Population Fund, and we are the UN's sexual and reproductive health agency.

Dr Kaggwa: Hello, everyone. My name is Milly Kaggwa. I work as the Senior Technical Adviser at Population Services International.

Dr Taylor: Hi. My name is Seb Taylor. I work in the global programme at the Royal College of Paediatrics and Child Health, but I am here representing on behalf of a coalition, including the Colleges of Obstetrics and Gynaecology, Nursing and Midwifery as well as the Faculty of Sexual and Reproductive Healthcare and the British Society of Abortion Care.

Q2 **Chair:** Thank you very much. Milly, my first question is to you and it is quite a broad question. Tell us what are the benefits of sexual and reproductive healthcare for women and families?

Dr Kaggwa: Thank you, Caroline. Well, put simply, it is actually the right thing to do. Pregnancy-related causes including abortion, complications before, during and after childbirth, remain one of the leading killers of women globally. Sexual and reproductive health is unlocking the potential of an agency and freedom for women and girls to be able to achieve gender equality.

Access to sexual reproductive health can transform lives and individuals and their societies as well, and is one of the best investments for improving the health, the economy and different development outcomes of people around the world. Access to sexual reproductive health services and strengthening of rights, especially for those whose needs are not met, who have unwanted pregnancies and unsafe abortion, instead allow women and girls to achieve their full potential and be able to take up economic opportunities that they otherwise would not have been able to.

Q3 **Chair:** Thank you very much. Matt, do you have anything to add?

Matt Jackson: Yes, I certainly agree with what Dr Milly said, that investment in sexual and reproductive health and rights is a best buy for development. Certainly, investing in maternal health lowers maternal morbidity. It reduces the likelihood of complications in childbirth, reduces unintended pregnancies, as Dr Milly said, enables girls to stay at school, adolescents to complete training, women to enter society and contribute to the economy. We also know that for every $1 invested in sexual and reproductive health it returns $8 in associated healthcare benefits, and that is a huge win for development for societies, families and the economy.

Q4 **Chair:** When you say it is "a best buy", do you mean that the return on the investment is the best or what do you mean by that?

Matt Jackson: Yes. I mean it is a best buy. SRHR is often called a global public good because of the fact that $1 invested returns $8 in associated healthcare benefits, so the reaping of those benefits may be slightly later, slightly further down the line. You avoid the extra cost of complications during pregnancy and childbirth. Obviously, more maternal lives are saved because of the investment in SRHR and, yes, that is exactly why it is a best buy.

It hits a lot of the population, not just women and girls, but there are greater impacts on those living in rural communities and marginalised and vulnerable communities as well, so the impacts really do hit quite a substantial part of the population.

Q5 **Mrs Latham:** This is a question for Caroline. To what extent do you believe sexual and reproductive health is treated as a priority in the FCDO's international development strategy and its international women and girls strategy?

Caroline Guinard: Thank you for the question. We are very pleased to see the strong emphasis that FCDO puts on women's empowerment in the new women and girls strategies. We welcome the prioritisation of sexual and reproductive health and rights, and the recognition of the critical role that it plays for empowering women and girls. We are also really pleased to have a specific reference to safe abortions in the women and girls strategy, and overall recognition of holdbacks on rights and human rights globally. We feel that there is currently strong support in the women and girls strategies.

Q6 **Mrs Latham:** Are there any improvements or changes that you would like to see made to those strategies?

Caroline Guinard: What we want to emphasise again is to continue to put comprehensive SRHR at the forefront of any funding policies, diplomatic negotiations and really speaking out about abortion. We are also here today to highlight the need for continuity of long-term funding for SRHR, for sexual and reproductive health and rights. The support may

be a more bottom-up kind of approach and design of the sexual and reproductive health programme, involving communities, civil society organisations and access to international development organisation, but having a more bottom-up approach as well.

Q7 **Mrs Latham:** Would you say that FCDO's strategy on sexual and reproductive health lines up with its aid commitments?

Caroline Guinard: Yes. Again, I think we can do much more in future to ensure that there is a longer-term strategy of FCDO funding around SRHR programming. We are delighted to be here today to talk about this.

Q8 **Chair:** Sorry, was that, "Yes, it does line up" or "No, it needs to do more going forwards"?

Caroline Guinard: I think we can do more going forwards, yes.

Q9 **Chris Law:** I will come back to that in a second but, Matt, looking at the women's integrated sexual health programme, which is supposed to be the flagship aid programme of the UK, the cuts have been quite significant over the last couple of years. We had a funding cut of 38% over two and a half years in both areas, leading to huge reductions in total use of family planning, unintended pregnancies averted and so on. How has it impacted the work that the UK aid programme has done on sexual health and what does it mean for women and children on the ground?

Matt Jackson: I should clarify that the women's integrated sexual health programme is MSI. It is one that UNFPA runs as a partnership.

I will talk about the supplies programme partnership, which is made up now of 21 different donors. Since the beginning of the supplies programme with the largest donor to the supplies programme, the cuts that happened in 2021 were very significant. We saw around an 85% cut at that point from UK funds to the supplies programme.

Q10 **Chair:** How much notice did you have of that?

Matt Jackson: There was a lot of talk in the media that the cuts were happening. We knew that the UK had already reduced from 0.7% to 0.5% GNI of ODA. There were lots of rumours and speculation, but we did not have that much notice of the exact—

Chair: Roughly, like a day a week, an hour?

Matt Jackson: A few days but less than a week.

Chair: A few days' notice for an 85% cut?

Matt Jackson: Yes.

Chair: I am sorry for that.

Matt Jackson: Thank you. However, to answer your question, there were very significant cuts from the largest donor to this big global supplies programme. To put it in context, the supplies programme, UNFPA is the largest provider of free voluntary modern contraceptives worldwide. Over 40% of the global market comes from or through UNFPA so, for example, MSI Reproductive Choices. I think about 85% of your contraceptives are via the UNFPA supplies programme. We provide a lot of other implementing partners with this.

We had to do some very quick work initially to figure out what this meant so that we could keep the supplies programme on the road. We did have to cut the commodities that we provide by 30%. We focus on 46 countries, those most in need. We have identified 46. We also had to make cuts across the board to other areas—technical advice, maternal medicines that are provided, management, human resources. We also looked at other donors to fill some of that gap, and some of them did increase their contributions.

Chair: Would commodities—

Matt Jackson: Commodities are contraceptives, different types of—

Q11 **Chair:** A 30% cut in contraceptives around the world that you were able to provide?

Matt Jackson: Yes. Contraception and maternal health medicines as well, so anything that might be needed in family planning or delivery, all of those different component parts. It also meant that some of the innovations we do—so there are new technologies, new types of contraceptives that come on to the market. We try to make sure that there is what is called a method mix, which means that there is a range of contraceptives for individuals to access, so that they have a choice in what they use. It is not just condoms or the contraceptive pill. There are IUDs, injectables, a whole different range. We try to make sure that anyone who comes into one of the clinics that is UNFPA supported, women and girls, that they can have a choice of contraceptives, so what works best for them.

We had to do a lot of quick work to figure out how we could keep the supplies programme running so that we would be able to get through that very harsh cut. I am pleased to say that in 2022—so the following year—the UK returned with a larger contribution to the supplies programme. Last year £60 million was part of the UK's commitment to supply. The work that we did meant we could get through that very difficult patch and we are now getting back on track with everything, thanks to some further funding from the UK.

Q12 **Chair:** Does the uplift take you back to where you were before the cut?

Matt Jackson: No. There is still a deficit based on the commitment. However, there was a five-year commitment period so, in theory, the UK could recoup that over the next few years.

Q13 **Chris Law:** Thank you very much. Caroline, I will ask you the same question very specifically: how has the reduction in spending since 2021 impacted on aid programming and sexual and reproductive health? The numbers look grim from what I am reading here.

Caroline Guinard: Are you talking about the women's integrated and sexual health programme?

Chris Law: Yes.

Caroline Guinard: I am delighted to give more detail on how the budget cuts that we faced following the global Covid-19 pandemic were really devastating for WISH, which is the biggest FCDO-funded programme at MSI in partnership with many different organisations.

The impact is really devasting on women across the countries we serve. To give you a sense of scale, since 2021 our budget has faced a reduction of 78% today. We see that the reduction across the board of 90% of the number of clients we have served in 2020-21, which I call the years of glory of WISH, to now in 2023 where we estimate we have moved from a 2 million client reach to approximately 200,000 this year under the competence of MSI, which manages WISH.

Obviously, this mostly impacts vulnerable groups, particularly adolescents. Again, we will witness a reduction of 90% of adolescents who could reach our service in 2021 compared to nowadays in 2023. We are talking approximately 385,000 young people who will not benefit from any family planning services that they would have benefited from three or four years ago.

Q14 **Chris Law:** Looking at these figures, though, this has resulted in deaths and it seems to be ever increasing because of aid cuts. Maternal deaths averted have been reduced by 34%. We have seen a reduction in child deaths averted by 45% as a result of cuts. Of course, you have lost 300 frontline staff and 1,250 from line delivery sites, so women and unborn children are dying as a result of these cuts. Are the UK Government acknowledging this and taking it very seriously?

Caroline Guinard: I think with our colleagues we have been working closely with FCDO, and WISH of course are facing the same change. We understand that there have been competing priorities. Following the Covid-19 pandemic, savings needed to be made, and what we felt was very damaging, even more than the budget cuts that we faced in 2021, was the unpredictability of funding of FCDO. To give you an example, last year after getting confirmation of our budget quite late in the financial year, around March, we received a budget uplift of £700,000 in the summer to be taken away again in the winter. It means that we have to replan and rebudget and redesign our projects and that has happened quite frequently.

We need to make terrible choices: do we need to close our services in this community or this one? Do we need to stop providing services to

adolescents or to people with disabilities? It is an impossible choice with impossible consequences. This has not been the best time spent redesigning these programmes. We are talking about hours of people time because WISH—the Women's Integrated Sexual Health programme—is such a huge multi-country, multi-partner programme initially across 27 countries, so I think this has been most difficult over the last few years.

We welcome the trust that the Government and the FCDO have given us in delivering this flexi programme but I also think that together with FCDO, in partnership, we can really do better. I think we owe that to the community we serve because there has been so much unpredictability over the last few years. I would like to recommend long-term stability in multi-year funding in sexual and reproductive health.

If we want to implement and deliver the ambitious goals of FCDO, which are around national ownership, sustainability, building and working with national government, health system strengthening, accessing people to the last mile, it takes time. It takes more than six months. It takes years.

Q15 **Chris Law:** I will just ask a follow-up because all of us are aware of the cuts that were made in 2020-21, but you are saying that money has been brought back maybe in small amounts and then taken away again.

Caroline Guinard: Yes.

Q16 **Chris Law:** What explanation has been given to you for that? That is new information for us.

Caroline Guinard: I think it was initially as a result and in the context of just Covid, and then the following year there was a reduction in the overall pots. We are going through global inflation. There is the war in Ukraine and I think there has also been frequent changes in the Government and maybe direction, so I think that has been one of the key challenges.

Again, we were still able to deliver amazing results across the board after five years of this programme. I think that it is because with FCDO we are able to collaborate and find solutions and reimplement the programme, working together to deliver the best, but it has been a challenging few years, yes.

Q17 **Nigel Mills:** Matt, are you saying that, given a 30% reduction, there have been a lot more children being born or has somebody else picked up the slack here and done something different? Does the data show a big rise in childbirth or something?

Matt Jackson: No, we don't look at it that way. With the 85% cut to supplies in 2021, we can work out the full amount of the commitment, which was £425 million over a five-year period. We know what that would have otherwise achieved, which is averting 47 million unintended pregnancies, over 800,000 maternal and child deaths and avoiding 14.4

million unsafe abortions. We know what we would be able to deliver with the money, so we can figure out what would have otherwise happened without that money. There is no correlation between the cuts and fertility rates or childbirth. We don't look at things in that way. At the time as well we said what would otherwise have happened with that contribution.

Now that the UK has started to return to the supplies programme, obviously that data will change and we will be able to look at the success rates. We know that the supplies programme has achieved huge successes, primarily, as I said, with funding from the UK in the 2008-20 period. The UK has contributed significantly to the lives saved through the supplies programme, the unintended pregnancies averted and the avoidance of unsafe abortions.

Q18 **Nigel Mills:** This programme would have avoided 47 million unplanned pregnancies in five years, so 9 million a year, but it is not the case that you can now look at the number of children born in the year we did not fund this and find 9 million more? Isn't that a rather obvious check that your data works?

Matt Jackson: No, it doesn't really work that way. We don't correlate funding to births in the way that you are talking about. As I said, we provide 40% of the world's free, voluntary, modern contraceptives. We are not the only provider and there are other factors that will link into that. What we are interested in is addressing the needs of women and girls, in particular the most vulnerable or those in low income countries, and meeting their sexual and reproductive health needs. That is what we address.

Part of the supplies programme is that we also work with national governments and local governments. We strengthen health systems and we work with those governments. Funding comes from them as well to improve their own national and local health systems, so that the long-term reproductive health for their population, for their citizens, is sustained. Of course, you have different sorts of time lags and everything to do with health systems too.

Q19 **Nigel Mills:** I am slightly intrigued that you put a funding proposal, which says, "We can deliver all these benefits" and then you take the money away but you cannot actually show that those benefits did not stay there because I rather thought that 9 million extra babies would be quite obvious even in some of these countries. When you make the case to get the funding back, does somebody say to you, "Well, what happened when it wasn't there?" and you say, "We just don't measure that"?

Matt Jackson: We measure the results. We can certainly share the results of the supplies programme, but of course it is results in unintended pregnancies avoided and maternal mortality.

Q20 **Chair:** I think Dr Taylor is trying to come in on this. Is that right, Dr

Taylor?

Dr Taylor: Yes. If I may just add a thought. It is an interesting line of questioning, whether there is a direct correlation between reduction of money and the expectable increase in rates of unwanted pregnancy at the rate of 9 million a year. I think the answer is right. It doesn't really work that way, so that qualification would not actually stack up, not least because, rather than absolute numbers changing, you may see changes in the distribution of access to contraception, for example, where people in better economic circumstances are able to shift their point of access to other providers, and it is poorer households who tend not to be able to do that.

Within the context of falling total serviceability in the majority of countries, you may well see changes and a worsening of inequality rather than an absolute change in the total number of pregnancies.

Q21 **Nigel Mills:** Thank you. I think what you are saying is that it is easier for less poor people to find an alternative or find a solution. What you end up with is the most marginalised, maybe disabled people or whatever else, who just have no alternative left. Is that roughly what you are saying? Do we target this spending at the very poorest? Is that what we are trying to do to hit the problem that Dr Taylor was just talking about?

Caroline Guinard: The Women's Integrated Sexual Health programme is a very strong component on reaching the poorest. We have still achieved quite impressively this year, facing the budget cut, 36% of people living in severe poverty across the countries in west and central Africa where we work. We also have a very strong component in strengthening the disability inclusive aspect of our programmes, so reaching more people with disabilities as well as adolescents, as I have already mentioned. In 2022, across our projects, we reached 29% of adolescents in the countries where we work. For example, our gold star is Sierra Leone where 42% of all the clients of WISH are under 20.

Matt Jackson: To add to that on your question, from UNFPA's perspective we use a range of indicators to identify where needs are greatest. We look at the proportion of births attended by skilled health personnel or midwives. We look at the adolescent pregnancy rate, the maternal mortality ratio, the gender inequality index, HIV prevalence and the proportion of modern contraception satisfied already. We use all of those different indicators to produce a picture of where the needs are greatest and then we can focus our resources into those areas.

Q22 **Chair:** Dr Milly, could you tell us how well you think UK aid funding addresses the needs of the most marginalised and the poorest people with disabilities?

Dr Kaggwa: I think that the cuts affected these the most because FCDO funding really does target, through FCDO pilots, adolescents, marginalised women and children, women with disabilities and people who do not have access to healthcare settings. You find, for instance, our

programme in Malawi is an outreach programme that moves beyond the health facility to a village. Our programme in Pakistan is another one where the health provider or community health worker moves to the village. These are women who live very far distances from any health centre, so meeting their needs is very difficult if we are just going to look at the normal health system. Clearly, these cuts have affected those women. For instance, at PSI we saw a reduction that led in some of our programmes to an estimated 40% reduction in major funding in sexual and reproductive health services that are delivered by PSI and our partners.

In some cases we had to drop the partner or we had to scale down, like everybody else has mentioned. In some countries we had to really just close. Yes, it does affect those who are really in need because the programme was set to reach those people.

Q23 **Chair:** I am assuming that the most marginalised groups are also the most expensive to get the support to.

Dr Kaggwa: Yes.

Q24 **Chair:** When you have limited budgets I can see that choices might have been made, which would adversely affect those groups. Is that right?

Dr Kaggwa: That is right, and I think sometimes the impact of this may not be seen in the short term but in the long run. That is when you see the indicators that we are looking at becoming worse than they were, and the gains that we had achieved will be lost because with time you see as with abortions coming up, you see more complications if a woman doesn't have a skilled delivery. Therefore, yes, the impact does definitely impact on those people who cannot afford it, and in addition it may not be right now but we definitely see those impacts in the long term.

Q25 **Mr Sharma:** Dr Milly, what more could the UK do to support access to contraceptives as part of its aid programming?

Dr Kaggwa: PSI are really excited to see the strategies that are being brought on board. We expected to see that the funding for the UNFPA had been improved. We think that there is still a little bit more to see. Perhaps a faint impact is to see commitment that is aligned to the funding and resource bucket that is available sustained in such a way that it is not short term.

One of the biggest challenges for our services is the short-term budget disbursements that they receive. If they knew, for instance, that they have this programme or this amount of money for a year, that helps them to ensure that they have the right things on board. They can actually check to see if these innovations are as impactful as they would be. If you are not sure, that creates an environment of insecurity.

Therefore, the commitment of these strategies and putting that commitment and resources behind that commitment would be a really

good way of making sure that the strategies that have been put in place will actually achieve a good result.

Q26 **Kate Osamor:** I have a question for Dr Seb. In your view, is UK aid programming focusing enough on maternal health?

Dr Taylor: No, not in practical terms. I think probably from the point of view of the rhetoric, yes. I have been through the FCDO statements and they are pretty impressive. They are nicely put together but I think in material terms on the ground, no. I think the data show that maternal mortality was a lag on progress in the millennium development goals. It remains so under the sustainable development goals, and it is a signal—

Q27 **Chair:** Dr Taylor, could I ask you to switch your video off? We are losing the sound a little bit and I would like to grab what you are saying. Can you still hear us now?

Dr Taylor: Yes. Is that better?

Chair: That is much better. Thank you very much.

Dr Taylor: I was just saying that maternal mortality was a lag on progress under the millennium development goals between 2000 and 2015, and it remained so under the sustainable development goals. I think it is just a signal that while there is a lot of rhetorical commitment, it is not converting into the scale of action or the selectivity and prioritisation of actions which are the most impactful. The short answer then is no.

Q28 **Kate Osamor:** Could you describe the scale of action that you have referred to and what it should look like on the ground?

Dr Taylor: I would love to say yes to that. A number of issues have been raised to do with adolescents, access to contraception and access to safe abortion, greater attention to gynaecological disorders—that is a fairly clear one—and concerns around the medicalisation of FGM and cutting. Those are all things that need to be taken forward and need to have the financing behind them.

One of the areas that comes across fairly clearly is that if you want to empower women and girls and you want them to use their education to make choices, sometimes they are going to be making a choice that they want to go through pregnancy and they want to be able to deliver safely and survive. For that to happen, they need to have access to care.

We can talk a lot about enhancing the demand side and helping with education and empowerment but there must be a supply side in the form of meaningful healthcare for women when they become pregnant, when they look for antenatal care services, when they look for safe, good-quality delivery care and for their newborn so they survive the first 28 days. These are the things that need to be in place and I think the

evidence shows that they are not. I can give you a couple of examples if you want but I do not want to take up your time too much.

Kate Osamor: That is okay, you can always send them in to us. We would appreciate that as a Committee.

Dr Taylor: Sure.

Q29 **Kate Osamor:** Dr Milly, I saw you nodding. Do you want to add anything to that?

Dr Kaggwa: Yes. On the point about the healthcare system and the quality of care that women and girls can access, what Dr Sebastian is saying is really true. If a woman goes to a healthcare facility to have that delivery that she really wants and gets complications, we are binding our hands and that is not what we want to achieve. Having a health system that is able to provide a good-quality care service for women for any other health needs that they have, whether they are maternal or gynaecological, is really quite important.

Q30 **Kate Osamor:** I want to touch a little bit on safe abortions. Dr Milly, how important is it for a woman or a girl to have access to a safe abortion?

Dr Kaggwa: It is very important for women to be able to access safe abortion services because this is one of the main killers of women and girls. We have seen, for instance, that around 45% of all abortions are unsafe globally, and of these, 97% will take place in low and middle-income countries. Lack of safe, timely, affordable and respectful sexual and reproductive health that includes abortion care is a critical public health and human rights issue.

Q31 **Kate Osamor:** Could you explain an unsafe abortion, not what it looks like but the impact it could have on a woman's body?

Dr Kaggwa: Yes, unsafe in the sense that that women have gone to great lengths to end a pregnancy when they do not wish it and some of the things that they have done are not really safe. Moving out of the healthcare system to quacks, to those who do not have good information, especially in situations where there are tight restrictions and the law is maybe not so fair, you have women doing a lot of dangerous things that may harm them. It is important for any programme to work within the legal structure of the country that it operates in but we have seen that there is lots of room for women to get safe care, even if it is abortion care.

Safe abortion care is critical in making sure that women do not get complications. The complications that we are talking about in some cases are not mentioned because most of these abortions occur underground, they do not occur in the open. Therefore, even getting a good sense of the magnitude is very difficult in most countries, but we know that this exists. We see the complications that women and girls face when they have an unsafe abortion because eventually they end up in hospital. The

cost of post-abortion care, its impact, and the need for post-abortion care is really high in almost all the countries that we operate in.

Q32 **Kate Osamor:** Thank you. Dr Milly and Caroline, I want to ask you a question. How successful is UK aid in providing safe abortions in lower-income countries?

Dr Kaggwa: UK aid has done a tremendous amount of work to see that safe abortion is integrated within the sexual and reproductive health programmes that it is funding. It is clear that it is an important priority to make sure that women have access to care. We have seen lots of emphasis on the autonomy of the woman and on making sure that women have access to safe abortions. I think that FCDO has been very deliberate in making sure that it is addressing safe abortion programming in the different countries that it operates in.

Caroline Guinard: When we talk about unsafe abortions, there is a number of deaths annually that result from unsafe abortions. All of those deaths are preventable with the provision of low-cost medical interventions. It is a solution to reduce maternal mortality.

On your second question, in the WISH programme we work in a very restricted environment and we are always providing safe abortions only when the legal context allows us to do so, but we also provide post-abortion care, which is legal, to save a woman's life following an unsafe abortion. We are operating in quite a restrictive environment but in countries such as DRC and Nigeria we work closely with the national government and organisations to support policies that are pro-safe abortion and sexual and reproductive health.

Q33 **Kate Osamor:** Caroline, you spoke about Nigeria. I do not know if you have heard that since 2013 there have been reports of the Nigerian military conducting a secret system where over 10,000 women and girls have been forced to have abortions. This is out there; I am not just making it up. I just wanted to know if you or Dr Milly had heard about this. This is something that is out there. I do not know if it has been picked up. If it has been picked up, what assistance is in place for those women, who are mainly internally displaced as well?

Caroline Guinard: Who are forced to—

Kate Osamor: Yes, by the military.

Caroline Guinard: Personally, I have not heard about that.

Kate Osamor: Dr Milly, have you heard about these reports?

Dr Kaggwa: I also personally have not heard about those reports. It is really sad that such a thing is happening.

Q34 **Mr Sharma:** Dr Taylor, what are the biggest drivers of newborn deaths in lower-income countries?

Dr Taylor: Asphyxia, sepsis and complications relating to prematurity. There was a report brought out earlier in the month that prematurity is now the leading cause of death among under-fives globally. To fill that out a little bit, most newborn deaths happen within the first few days after delivery and most maternal deaths happen on the day of delivery. That tells us that the place where the mother delivers and the newborn arrives needs to be a place of considerable safety and quality of care. We know that that is not yet the case and that investment needs to be made in ensuring that high-quality perinatal care is delivered around the world.

If you look at the neonatal survival rates in Sierra Leone in west Africa and then in Rwanda in east Africa, two quite different countries in their economic trajectory, you find that in both cases neonatal mortality reduction has started to flatten since around 2015-16. That means that countries are much less likely, in the absence of better investment in perinatal care, to hit their SDG targets by 2030.

One final thought, we have seen UK aid for health rising fairly consistently over the last 20 years up until what happened in 2020, but if you break it down by areas of expenditure you find that expenditure on health personnel development, medical education and training, and basic health infrastructure—three core elements of what a health system needs to be sustainably good—together total just under 1% of UK aid spending. That does not seem to me to be a recipe for investments that will leave behind lasting, sustainable healthcare that will save both mothers and newborns.

Q35 **Mr Sharma:** Do you think that the FCDO's strategy on ending preventable deaths of mothers, babies and children by 2030 tackles the key challenges?

Dr Taylor: Again, I do not want to be unnecessarily negative but on balance the answer probably needs to be no, not because FCDO is not making suggestions and positive advances but because I think there are signal gaps in the strategic approach it is taking. The gap for me is investment in health workers.

We know that in low-income countries, health workers are adequate to deliver about 40%, 41% of essential care needs. There is a significant gap just in the basic numbers of midwives and nurses, who are instrumental in maternal and newborn survival, in almost all of the countries that I am familiar with. Unless we see a more meaningful approach to health worker development, particularly in the context of UK policy to recruit health workers internationally—there has to be a quid pro quo about this—and that element of strategy being strengthened somewhat, I have doubts that we will see the kind of progress that we need.

Q36 **Mr Sharma:** I know you have touched on it but I will still ask the question. Is this strategy being implemented in practice?

Dr Taylor: It is slightly difficult to tell. To quote from one FCDO document, it says, "We seek to build inclusion, resilience and sustainability into our investments—often taking a systems-strengthening approach—to ensure impacts are far-reaching and long lasting". My problem with that is that I do not know quite what it means and I am absolutely certain it is difficult to measure it. I think you need to see more clarity in the numbers around money and what those numbers are going to be put into as specific, concrete actions.

Q37 **David Mundell:** Caroline, does the UK focus enough on including adolescents in its aid programming?

Caroline Guinard: Yes, according to my experience. Again, managing the Women's Integrated Sexual Health programme, WISH, there is a huge component around accessing adolescents and, as I mentioned earlier, we achieved really impressive results this year. Only 29% of our clients were adolescents. Throughout the time of the project, we increased our reach and now we are seeing the success of a few years of programming and targeting young people and trying to focus on continuing to reach adolescents.

However, we need, again, long-term stability of programming because reaching adolescents, designing services that are user-friendly, designing also some generation campaigns on social media, with schools, and developing partnerships with youth organisations take time. If we cut the project in one community to then start it all over again a year later, we will lose a lot of precious time in doing so. If we want to design projects and activities that are bottom-up, together with communities, again they take time and a long-term strategy. Particularly with adolescents, despite our strong achievement in reaching this category of young people, with long-term strategy and planning we could do better.

Q38 **David Mundell:** Where does tackling STIs and HIV fit in with all of that? We have not heard any mention of either of those in the discussion and yet they are huge impactors on sexual health. STIs can lead to infertility and lots of other complications. HIV is growing very fast among young women, particularly in sub-Saharan Africa. How is that encompassed in your work?

Caroline Guinard: In our work, we are first and foremost a family planning organisation, we deliver a family planning service and where we can, with the appropriate funding, we provide a set of various services such as STI testing, referrals, HIV testing and so on.

In 2021 there was a strong push by FCDO to increase service integration across the WISH project and we were looking at how to respond to this ambition and rolling this out across the countries where we are working. I just want to say that it costs quite a lot of money. There is a trade-off to service integration because if you serve a client who comes for a family planning service and then you add other services such as HIV and STI testing, suddenly you take more time with your client. Time, productivity

and costs need to be taken into account. As a result of the budget cut that we face, service integration was deprioritised by FCDO. We continue to implement—

Q39 **David Mundell:** Was that a conscious decision?

Caroline Guinard: It is a decision more to continue to do what we are doing in service integration, but we cannot start anything new because the funding had been reduced in 2021. That was the direction that we were given at the time.

Q40 **David Mundell:** Matt, obviously there is a balance in dealing with adolescents with safeguarding them but at the same time providing the services that they need. How do you deal with that balance, particularly in the context of STIs and HIV as well as the possibility of pregnancy?

Matt Jackson: On the connecting point, linking to STIs, like Caroline was saying, we provide integrated services. From the perspective of the individual, you go somewhere like a one-stop shop. That is what you want to have. Just as family planning conversations often happen after delivery of a baby, we look at integrating sexual health, STIs and all of those checks as well.

There are different parts to safeguarding. There is obviously the safeguarding of the individual, of the adolescent. We certainly work with a lot of implementing partners and that means that we have due diligence checks and we have a zero tolerance, but on the other side we also provide technical advice on safeguarding to those we work with and to local governments. We do a lot of work on peer support, that is youth-to-youth peer support groups, and we also have a safeguarding young persons programme that runs in sub-Saharan Africa, the region you are talking about. That is where we work on national legislation, policy, promoting respect and the rights of adolescents. There is quite a wide range of activities and work that happens as part of those services.

Q41 **David Mundell:** I will ask Dr Taylor if he has a view on the need to integrate support on STIs and HIV with the general sexual health issues that we have been discussing.

Dr Taylor: It is not my area of expertise but it seems to me that, as Matt says, there is a confluence of interest and engagement at particular moments, for example around delivery, where you get quite a lot of traction in associated discussions and conversations. Yes, I think the more that can be done the more efficient the process will be.

Q42 **Chair:** Matt, I love my Rotherham sexual health clinic because they tend to pick up modern slavery, trafficking, child sexual exploitation and domestic violence and they are networked in to get the support around the individuals that they find. When we are talking about safeguarding, is that a role that your colleagues carry out, is that something that you are funded for, or are you very strict on where you can and cannot offer support?

Matt Jackson: A lot of it will depend on the programme and the country context but safeguarding is a key part of everything we do. We have very strict rules on safeguarding. They are part of a lot of our MoUs, our agreements with our donors for bilateral projects that we run in countries. It runs through everything.

Like your example of the Rotherham sexual health clinic, we will often work to integrate other areas into this, safeguarding in other senses, not just protecting the individual but also social norms aspects as well, for example technical advice or other advice on female genital mutilation or on tacking the stigma of menstruation. We apply a life cycle or life course approach to everything, from the onset of menstruation, menarche, through to menopause and the ageing population. We are seeing lately that there is a greater need in ageing populations for their sexual and reproductive health needs and other needs as well.

Chair: Even in the UK?

Matt Jackson: Same in the UK.

Chair: Sorry, David, I interrupted.

Q43 **David Mundell:** No, it is fine. I will just give a shoutout for opt-out testing here in the UK, which I am a great advocate of, to track HIV among those people who are not aware that they have it. We could easily do that on a much greater level.

Caroline, how do you ensure that aid programming and sexual and reproductive health is LGBT+ inclusive?

Caroline Guinard: The inclusivity of our programming is paramount at MSI Reproductive Choices. We have our new strategy, MSI 2030, which puts strong emphasis on leaving no one behind and serving the most vulnerable, adolescents, people with disability, and the poorest. As I mentioned earlier, we have demonstrated under WISH that we can reach some particularly vulnerable groups.

On LGBTQI+, we do various initiatives, first partnering with organisations that work with communities from an LGBTQI+ background. Recently in Nepal we partnered with two organisations called Blue Diamond Society and Unity for Change. We also ensure that all our staff across MSI, from service providers on the ground to HQ, are trained on how to ensure that those communities are listened to and that, especially in the clinics and services that we provide, they are treated with respect and confidentiality. We also have developed some workshops around value clarification and working with our staff and providers again on that aspect.

Q44 **David Mundell:** There was some suggestion that MSI had in the past funded some clinics that had promoted conversion therapy. Are you able to tell us what steps have been taken on that?

Caroline Guinard: All those steps that I have just mentioned. We relate it to—

Q45 **Chair:** Were those steps brought in as a reaction to the allegations about conversion therapy or were they in place before and did not work?

Caroline Guinard: To respond to the allegation that openDemocracy made on just one country, which was Marie Stopes Tanzania, we were first shocked and quite appalled by those allegations. We immediately investigated, working with openDemocracy to look at those allegations. I want to reiterate that our internal investigation did not corroborate those allegations.

As a result of this, we reviewed our policies. It was the opportunity that allowed us to review our safeguarding policy and to reiterate to all our staff what methods and services we provide and the ones we do not provide. We again built up on skills and training of our service providers and staff and reinforced the policy across the board.

Q46 **David Mundell:** Are you satisfied that that could not happen now? Are you satisfied that nobody you fund is promoting conversion therapy?

Caroline Guinard: Yes.

Q47 **Mrs Latham:** This is a question for Dr Taylor. What are the challenges that gynaecological issues pose to women and girls in low-income countries?

Dr Taylor: Again, I should say that this is not an area of expertise for me so I do not want to comment too far, but I am speaking on behalf of the coalition that includes the Royal College of Obstetrics and Gynaecology, as well as the Royal College of Midwives and the Faculty of Sexual and Reproductive Healthcare.

A short summary of the view of that coalition is that there is a range of gynaecological disorders that are, broadly speaking, marginalised in their importance and impact and receive less attention from clinical to social levels. In one of the analytical reports that I have seen, gynaecological disorders writ large have a larger effect on morbidity globally than TB, malaria and HIV together at this point. That seems to me, therefore, to be a very large amount of inattention to a very significant set of problems. I would like to leave it there because, as I say, this is not an area of expertise for me.

Q48 **Mrs Latham:** It is interesting. Gynaecology is a big subject and I know that one of the issues in some lower-income countries is fistulas, which need surgery. Are there sufficient surgeons around to deal with the various gynaecological issues that women have, or is that one of the problems?

Dr Taylor: Again, I can speak briefly to the range of surgical services and the answer is that they remain extremely limited and inequitably distributed, much more easily available to higher-income households and

communities, much more easily available in large urban settlements and much less so in rural ones. *The Lancet* did a commission a few years back looking at bellwether surgical functions, which should take a lead in expanding provision of these services. I do not think fistula was in there but to a large extent there are people who argue that it should be.

Of course, you have to remember that in expanding surgical capability, it is not just about the surgeons, it is about the anaesthetists, the theatre nurses who are the ones who manage the structural elements of care delivery, and it is about infection prevention and control efficiently being delivered into those hospitals so that you do not come out with post-operative infection, which you take home and which kills you. There is an ecosystem that needs to be invested in. It goes back to my earlier point about broader investment in health system strengthening. There is an ecosystem around good surgical care for fistula.

Q49 **Mrs Pauline Latham:** To what extent does UK aid focus on gynaecological health as part of its aid programming and do you think that that focus is sufficient? From what you have said already, you do not.

Dr Taylor: No, with limited evidence—I can talk about the trajectories of money because, as you will probably know, the OECD Creditor Reporting System tracks fairly carefully, with quite a good breakdown, the kinds of expenditures that each of the major bilateral donors makes. If you look at that, you see that UK aid allocated to reproductive health has been on a declining trend since 2014.

Q50 **Chair:** Dr Taylor, I am sorry to interrupt you but it would be really helpful if you could supply that document to us, please.

Dr Taylor: Yes, absolutely. It is not a document, it is a website, but I have just been looking at the numbers and I can send you the analysis that I have done.

Q51 **Chair:** That would be very helpful. Dr Milly, did you have anything to add on this point about gynaecology?

Dr Kaggwa: I just want to add to the question, "Do we have enough gynaecological specialists or surgeons to address this?" That is a clear no. The doctor-patient ratio in most of the countries in sub-Saharan Africa is very limited. That already is a gap in the human resourcing for health. It has been mentioned before in this discussion that that is a big gap. Strengthening the health system, including providing skills for the available health workers to be able to tackle surgical interventions, is definitely a gap in most places and especially in gynaecological disorders as well.

Q52 **Chair:** Matt, did you want to come back in?

Matt Jackson: Connecting your question with the earlier discussion on maternal mortality, we know that over 800 women die every day in

pregnancy and childbirth. That is a woman every two hours. In countries like Afghanistan and Yemen, that is nearly one death every two minutes.[1] The humanitarian crisis setting is relevant here as well.

On the morbidity that Dr Sebastian Taylor mentioned, and fistula, as you said, we know that it is very cheap to perform an obstetric fistula repair. It is about $500 per operation. That restores dignity, which is hugely important to anyone. We know what happens during fistula and it can happen for decades. You are ostracised, left outside or on a mattress in a relative's house. That dignity is an important thing that a simple fistula repair can give back to someone.

It connects, very importantly, to midwifery and training programmes. We know that in many places around the world, midwives are not valued as much and not seen as important enough. We run midwifery schools and we know that other organisations like RCOG do as well. Having trained, skilled birth attendants is hugely important in averting maternal mortality.

On other gynaecological disorders, obviously cervical cancer is something that is hugely important that we have not talked about here. Building that into reproductive health programmes as well is something that we all need to keep thinking about. There is work looking at the HPV vaccine, for example, and how that can be rolled out in countries, similarly to how it has been rolled out in the UK but making sure that we take local contexts into account. For example, some cases would not like to follow the UK, where we gave the HPV vaccine to girls for a number of years before it was given to boys. We need to look at that context as well.

Q53 **Mr Sharma:** Dr Milly, what diplomatic steps can the UK take to support sexual and reproductive rights for women and girls in lower-income countries?

Dr Kaggwa: That is a great question. Already there is a lot of commitment from the UK Government to address this issue and to promote sexual and reproductive health rights. It is making sure that the strategies that have been put in place and the funding commitments or resourcing that is in place are adequate and sustained over time to make sure that these programmes can be implemented.

I think that in most cases, there is very good will and good discussions with Government, MoH, to make sure that there is alignment in sexual and reproductive health and rights. In the countries where FCDO has funding programmes we have seen that discussion and dialogue taking place, and we have seen partners as well working to see that alignment between the commitments, the strategies for sexual and reproductive health, implementation and, in some cases, funding and resourcing. We

[1] Matt Jackson's office contacted us after the session to clarify that he meant to say "That is a woman every two *minutes*. In countries like Afghanistan and Yemen, that is nearly one death every two *hours*."

would love to see that. If that were available, the UK would see the impact of having these strategies in place.

Chair: Thank you very much. Witnesses, those are all of our questions to you. You have given us loads of evidence and lots of things to think about and indeed Google in some cases. Thank you very much for your time. I will pause this session and ask our second panel of witnesses to come forward, please.

Examination of witnesses

Witnesses: Asenath Mwithigah and Tinebeb Berhane.

[*This evidence was taken by video conference*]

Q54 **Chair:** This is our second panel of witnesses. I will ask you to introduce yourselves and then the panel will have specific questions for you. Asenath, could you introduce yourself and your organisation, please?

Asenath Mwithigah: Thank you for having me. My name is Asenath Mwithigah. I am the CEO of Orchid Project, a British charity working to end female genital mutilation. Thank you.

Chair: Thank you very much. We have a bit of a problem with your sound and I might have to ask you to switch your camera off if it continues, but let us see how we get on. Tinebeb, could you introduce yourself and your organisation, please.?

Tinebeb Berhane: Thank you very much for having me. My name is Tinebeb Berhane. I am the Country Director for ActionAid International in Ethiopia.

Chair: Thank you very much. In this session we are going to be focusing on FGM, female genital mutilation, and the first questions are from Pauline Latham.

Q55 **Mrs Latham:** This is for Tinebeb. How prevalent is female genital mutilation in lower-income countries?

Tinebeb Berhane: Thank you very much for that question. Our studies indicated that in the 31 countries that we collected and published data on FGM prevalence, one in three girls are cut. I can draw on a specific example in Somalia. It has one of the world's highest prevalence rates, with 98% of women and girls being cut and 85% experiencing infibulation, which is a severe form of FGM. The same is true for many countries in Africa and in others of the global south.

Q56 **Mrs Latham:** What are the short-term and the long-term impacts of FGM?

Tinebeb Berhane: On an individual basis, of course this is practised at a lower age of girls and children. They will experience a severe form of bleeding and a severe form of infection that will have a long-term health

impact. Of course, in the future, in their life, they will experience a lot of challenges during childbirth and in their sexual route in general. It will also have a very high level of emotional damage in itself because it is a violation of dignity and of human rights in general. The implication and the impact is in the short and long term. I would say that it is a lifetime.

Q57 **Mrs Latham:** You are based in Ethiopia. When I went over there a few years ago with the Select Committee, we saw a British-funded programme where grassroots people were being trained to train communities, including religious leaders. Is that continuing or has that stopped?

Tinebeb Berhane: It has continued. I can speak from ActionAid experience because we have the FCDO grant that we are implementing across various countries with other partners as well. We are employing that approach because this is a deeply cultural issue and communities have to be aware and empowered to make an informed decision on this act. It has continued somehow but the funding situation also has a great impact on this long-term intervention.

Q58 **Mrs Latham:** Has it made an impact on the cultural view about FGM, particularly in Ethiopia?

Tinebeb Berhane: Yes, somehow. In Ethiopia, for instance, the demographic health survey that was conducted in 2019 showed that the prevalence rate has somewhat decreased from 90% to 65.2%. That indicates that there is some cultural shift in our communities, but this number is a significant number, especially looking at the population, where 51% of the population are women and girls. This is still a high prevalence rate.

Q59 **Mrs Latham:** Asenath, what are the drivers of FGM and how do these drivers differ between communities?

Asenath Mwithigah: Thank you so much for that question. We need to understand that FGM is a manifestation deeply entrenched in gender inequalities. It is a social and a gender norm. We also need to understand that there are social expectations that surround it and there are reward and sanction mechanisms.

One of the drivers that continues the practice of FGM is religious practice. Although it is not endorsed by any religion, communities continue to hold it on religion. There are Islamic communities, for example, saying that it is upheld by religion.

There are cultural and social norms that drive the practice whereby it is assumed that the girl is moving from childhood to adulthood. It is a process of her getting to marriageability and there are cultural and social norms that affect that.

Of course there are socioeconomic aspects that drive or motivate the practice of FGM and that is the bride wealth. Communities see a girl as a

commodity and out of that, they recommend that she undergo FGM and then she is married off at a tender age.

There are sociosexual drivers as well, whereby it is controlling women's sexuality and it is deeply rooted in power imbalances. Of course it varies in different communities based on ethnicity, the type of practice of FGM and so on.

Q60 **Mrs Latham:** There is increasing medicalisation of FGM. Do you think you know what is causing this?

Asenath Mwithigah: According to the WHO, they are defining medicalisation as when a healthcare provider performs FGM. One of the reasons that could be causing an increase in medicalisation may be that communities think that it is a safer way to practise FGM, but there is no safe way to practise FGM. There is no safe FGM because there is no documented evidence that medicalised FGM is safe. It is a human rights violation and therefore the healthcare providers should not be using their medical equipment or their medical expertise, if any, to perform the practice. Also, healthcare providers have signed an oath that they should not do any harm and we all know that female genital mutilation is a grievous harm to women's and girl's rights. Therefore, they are indeed in contempt of the oath that they take.

Q61 **Mrs Latham:** What would you say are the most effective methods of preventing FGM and does the UK aid utilise the most effective methods?

Asenath Mwithigah: Female genital mutilation and cutting are underpinned by social and gender norms, as I said, and therefore there is no one way that cuts across. Of course there is a number of ways that support us in ensuring that we end the practice. Looking at the legal policies and frameworks that have been put in place, they have supported countries, for instance, to be able to develop mechanisms to protect women's and girls' rights. It shows a commitment by the government to hold them to account, for communities to be held to account. Even the national government's work ratified some of those international treaties.

The other thing is raising awareness, especially of frontline organisations in communities where the practice is happening. They need to understand that FGM has no benefit whatsoever, it is a human rights violation, and so locating sensitisation programmes through educating the communities and the whole duty bearer system, that supports.

Also it is looking at data on what works, because the practice has been with us for the longest time. It is good to have an evidence base whereby we can collect and document what is working and what interventions then have helped. For instance, with medicalisation, I always say that maybe it is because of some fear strategy where FGM was linked with HIV and AIDS and therefore communities thought that maybe when you medicalise it, it is safe. That is my own opinion. It is not documented

anywhere. How do we analyse? How do we collect evidence based on the interventions that are working and, through that, how do we share knowledge with other programmes for that to be effective moving on?

Q62 **Chair:** Asenath, I thought you very powerfully made the argument about how this is a subjugation of women and girls and I completely agree with your analysis of that. You say it is a human rights violation; I agree and I think it is straight child abuse, to be quite honest. However, a lot of people argue that it is a cultural practice, it is a tradition and it should be respected as such. Are you finding that that argument is being made by governments around the world, by local organisations, or do you think that that argument is now dead?

Asenath Mwithigah: It is still surprising when we are doing our interventions that they will claim that it is our culture, it is our tradition, it is our way of life. We encourage our partners, when they are talking to the community members, to explain that cultures are not static, they are dynamic. Back in the day there were some cultural practices that were being done but now they are no longer happening because they are extinct.

We cannot have that basis because maybe they were not aware it is a human rights violation. Now that we know, can we just turn a blind eye to that? We have to continue sensitising the communities. They will forever hold, of course, but it is upon the campaigners and the organisations that are working on the elimination of this practice to create awareness and to shed some light so that they understand. That is why it is necessary to do no harm.

There is a UNICEF report that says that communities where FGM is practised do not see it is as dangerous, but for us, we know it is a human rights violation. When we go into the communities, how do we build a rapport? How do we have non-judgmental conversations, dialogues and discussions so that we have that buy-in? It is not that we are there to condemn them but we are there to enable them to understand that this is a human rights violation—

Chair: Asenath, your line is dropping out. If you can still hear me and can switch off your video, that would be very helpful.

Asenath Mwithigah: Sorry about that. The ones that are not progressive—can you hear me now?

Q63 **Chair:** Yes, and we will come back to you with another question if that is okay. Tinebeb, in the UK, FGM tends to be discovered when women are going for gynaecological examinations, whether that is through maternal health or whatever reason. It is frustrating that quite often health professionals will not raise it when they so obviously see it. Are you working in Ethiopia to make sure that medical practitioners do recognise the signs and do report that in, so that the woman can get the help in later life that she will need?

Tinebeb Berhane: Thank you for that question. First of all I would like to say that culture is usually used to undermine gender equality and women's rights across the world. When people are mobile and travel, they travel with their culture. They continue to practise that regardless of their location and where they are.

In Ethiopia, in our experience, FGM by law is not allowed but it is customary law, which is what makes it very unique and deeply entrenched to people's culture and somehow related to their religion. One of the problems that girls face in this practice is that they do not have a proper referral system, not only when this is imposed on them but even during the after-effects of that.

It is very difficult to say that there is medical attention to that because it is not recognised by the law. Medical practice here does not recognise female genital mutilation. If they face that, the medical doctors are expected to report it because it is against the policy of the country, but what is expected and the reality might be different. The enforcement of the law is very crucial, I would say. That is a common problem that we have.

Chair: I agree.

Q64 **Mr Bacon:** You mentioned that it is widely regarded as a human rights violation. You also said just a moment ago that it is against the law. Can you just clarify, in how many countries is FGM against the law?

Tinebeb Berhane: It is very difficult for me to say that because in this project ActionAid works in four countries: Ethiopia, Kenya, Somalia and Senegal. The fact that we have this project in place implies that at least in the countries in which we are operating, FGM is just a customary law and is not legally recognised. I can say that this is the case in most countries. I do not have the figure now but that is something that I think.

Q65 **Mr Bacon:** In quite a few countries the law is silent on FGM; is that right?

Tinebeb Berhane: That could be true. The lawmakers are also part and parcel of the situation in general. The policymakers and people in the government are also from the same society and that belief can be reflected in the system. It can be very silent because the customary laws are as powerful as the other laws and the legal frameworks that countries have.

Q66 **Mr Bacon:** In March 2021 there was a case in the High Court of the Republic of Kenya in which a medical doctor challenged the prohibition of FGM. He argued that it limited women's choice and right to uphold their culture. The court dismissed the case. I will not go into the detail, but basically the court found in favour of upholding the law that prohibits FGM. An obvious route for any NGO is to pressure more countries to pass laws that prohibit it and if it is a human rights violation, presumably cases could be brought in front of the African Court of Justice and Human

Rights in Arusha in Tanzania as well. Has that happened?

Tinebeb Berhane: If you are asking me if that happens in those countries, I am not sure if I can answer that. As civil society, international NGOs and non-governmental organisations in general, one of our roles is to challenge these laws so that human rights in general are respected and that, specifically, the gender lens is applied in applying these legal frameworks, but it is a process. The law has to change in the due course of time, and advocacy at different levels by mobilising communities, survivors and people who are affected by this situation is very critical, which is also part and parcel of our work across these countries as ActionAid.

Chair: Tinebeb, I will just say that it has been against the law in the UK for over 30 years, I think, and we have had a handful of prosecutions, only one successful. Having the law and actually implementing it, all around the world tend to be two very different things, unfortunately.

Q67 **Mr Bacon:** FGM is often associated with Islam but just to confirm, it is correct, is it not, that FGM takes place in many different faith communities of different religions, not just Islam?

Tinebeb Berhane: Yes, that is right.

Q68 **Mr Liddell-Grainger:** Following on from what Richard was saying, what you are saying is interesting, and Sarah made a very good point: you can have as many laws as you want, it does not actually mean anything is going to particularly change. It is interesting from our point of view that the international community, through the SDGs, wanted to get rid of FGM by 2030. Are we in any way in line to be able to achieve that?

Tinebeb Berhane: Coming from the global south, that is one of the biggest commitments that every government should comply with. That is why my Government in Ethiopia has the FGM road map as a policy. The ministry that is mandated to abolish this practice has a clear direction. Of course, as one of the global SDG-committed countries, that is what is expected.

Like I said, when you look at the prevalence rate we are not there yet, but the commitment is there and the support that is being provided by different stakeholders, including organisations like ours, is crucial to meet that goal in general. Whether we are in the right direction or not from the various countries will need to be studied, but it is a struggle that we need to see in the future.

Q69 **Mr Liddell-Grainger:** What do we have to do to try to hit this SDG target by 2030? You quite rightly point out that you cannot speak for every single country, I understand that, but just where you have knowledge, what do we need to do to improve?

Tinebeb Berhane: The commitment that we see as very useful is to continue to provide sufficient and reliable funding to countries that are

undergoing this kind of problem, whether it is bilateral or through different mechanisms like financing NGOs, civil society groups in general and groups and movements who are organised to challenge that. Consistent and long-term financial support is very important, and also supporting governments to have a proper road map and policy in place, and of course a legal framework as well. A proper system should be in place for communities to comply with where it is practised.

The funding is very important because we are dealing with structural and cultural issues that do not change in a short time. That is why it is very important for donors like FCDO to continue their support to countries.

Q70 **Mr Liddell-Grainger:** I will follow on from that and from what Sarah said, which is that you can have as many laws as you want but it does not mean it will happen. Do you think that the UK aid programmes, and we fund adequately, reflect our commitment as the United Kingdom to try to stop FGM in lower-income countries? Are we providing what is required to be able to do that?

Tinebeb Berhane: Not sufficiently, given the current reality that we have. Between when we applied for this grant a few years back and now when we get it, it has been cut by 80%. What remains is only 20% of the total grant that we have applied for. This grant is invested in four countries and other countries through other local partners. Commitment is tested by the amount of funding that is allocated to support this kind of initiative. We are so grateful that FCDO is still supporting us but I would say that it is not sufficient when you look at the huge budget that has been cut since we started this project.

Mr Liddell-Grainger: I think that is pretty clear. Thank you very much indeed.

Q71 **Chair:** I was always incredibly proud of the work FCDO or DfID did internationally on FGM. I think it was a world leader on that. Are we still a world leader on tackling FGM?

Tinebeb Berhane: We are also very proud that FCDO is supporting us in countries because we know the funding that is coming to these countries, regardless of the amount. I am not really sure whether your FCDO is a world leader in financing that, given the complexity and given the fact that it requires consistent, reliable funding because we deal with cultural issues.

I am not quite sure whether FCDO is a world leader but still I believe that it is significantly important for countries in the global south. For instance, for now we have only FCDO grants for this FGM programme. I can say that had you not funded us, this challenge would prevail in our communities and the suffering of girls would continue. We acknowledge the significant support that we have been receiving but still there is a lot of potential not to cut the fund, to reinstate what has been cut and also increase the funding amount so that we address this deeply entrenched

situation. Countries like Ethiopia are very big—120 million, like I said—and the problem is very significant; 62% is a huge number. This does not go away overnight. It requires commitment, diligence and a proper policy and legal framework in place. That needs financial resources.

Chair: Thank you. I keep my pride and I hear very well your plea to not step away from the projects that we are funding. Ladies, thank you so much for your time today. That has been really informative for us. Any more questions from members? No. I call this session to a close. Thank you all very much for your participation.