USAID
FROM THE AMERICAN PEOPLE

LEARNING AGENDA

ENDING FEMALE GENITAL MUTILATION/CUTTING

Female genital mutilation/cutting (FGM/C) is a global human rights abuse occurring in more than 90 countries.[1] At least 200 million girls and women alive today in 31 countries have undergone FGM/C, and more than 4 million are at risk annually. An estimated additional 2 million girls and women per year are at risk due to the COVID-19 pandemic. Governments and other stakeholders have committed to ending the practice by 2030, recognizing that it has multiple harmful and negative consequences in the lives of women and girls, including severe medical, psychological, emotional, and social problems, and even death. Girls subjected to FGM/C may also be at risk of child marriage; school dropout; and reduced opportunities for growth, development, and sustainable incomes. According to the World Health Organization, preventing FGM/C can save communities and countries an estimated $1.4 billion each year in health care costs alone.[2]

This learning agenda builds on a theory of change that describes how engagement by the United States Agency for International Development (USAID) in efforts to end FGM/C can contribute toward a more gender-equal world in which girls and women are equitably valued and empowered. It offers a set of strategic questions around which USAID intends to produce evidence and findings to support the Agency and the broader global community of stakeholders working to end FGM/C.

The FGM/C Learning Agenda will contribute to expanding USAID's understanding of how and where to invest for maximum impact, with a focus on inclusive interventions that are rights-based and survivor-centered. Developed through an iterative consultative process with diverse stakeholders within and outside of the U.S. Government, the learning agenda consists of questions in key areas for which USAID intends to disseminate existing data, generate new evidence, and produce recommendations on how to improve the design and implementation of interventions. This learning agenda will build on evidence from other USAID investments and learning agendas, such as those for ending gender-based violence, advancing sexual and reproductive health, and promoting the rights and well-being of adolescent girls.

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[1] End FGM European Network, US End FGM/C Network, and Equality Now. *Female Genital Mutilation/Cutting: A Call for a Global Response*. Equality Now, 2021. https://d3n8a8pro7vhmx.cloudfront.net/equalitynow/pages/2280/attachments/original/1587032303/FGM_Global_-_ONLINE_PDF_VERSION_-_07.pdf?1587032303.

[2] "Female Genital Mutilation Cost Calculator," World Health Organization, accessed June 3, 2022. https://www.who.int/news/item/06-02-2020-economic-cost-of-female-genital-mutilation.

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At the same time, USAID recognizes that many other actors, including other funders, host-country governments, the academic community and, increasingly, survivors and civil society organizations, are generating evidence and knowledge that will advance our collective efforts to answer the questions prioritized in this document. We should, therefore, seek to collaborate and coordinate with these global, regional, and local actors, including through joint research activities, so that our efforts are complementary and avoid duplication.

The FGM/C Learning Agenda recommends the use of a variety of data sources and analytic methods to produce evidence and findings and allows for flexibility in how USAID may address the questions in this document. It reflects work currently being carried out by USAID and its partners and colleagues, the results of which will inform programs supported by USAID, as well as the broader global research agenda. At the same time, the learning agenda will serve as a guide for potential questions to include in new research, impact and performance evaluations, and other analyses conducted under future investments and programming.

Learning agenda questions were selected and developed by working with technical experts from USAID, conducting a literature review of peer-reviewed publications and grey literature, reviewing questions and research gaps identified by other global actors, and discussing evidence gaps with external partners, including survivors. Particularly useful for understanding and prioritizing existing evidence gaps were the research priorities identified by the United Nations Population Fund (UNFPA)-UNICEF Joint Programme to Eliminate Female Genital Mutilation (FGM) and the report of the United Nations High Commissioner for Human Rights expert group meeting on the elimination of FGM, which took place in 2020.

LEARNING AGENDA QUESTIONS

HOW CAN USAID CONTRIBUTE TO THE COLLECTION OF MORE DETAILED FGM/C PREVALENCE DATA IN ALL COUNTRIES WHERE FGM/C IS PRACTICED?

The U.S. National Strategy on Gender Equity and Equality recognizes that improvements in gender-related data collection are integral to advancing equity worldwide. There are significant geographical gaps in data on the prevalence, context, drivers, and incidence of FGM/C. While FGM/C is known to take place in at least 90 countries,[3] the Multiple Indicator Cluster Surveys (MICS) and Demographic and Health Surveys (DHS)—nationally representative surveys that are critical tools for the design and implementation of targeted FGM/C programming—as well as other national surveys, collect data on FGM/C in only 31 countries. A focus on national-level estimates may be misleading in understanding the actual prevalence of the practice because in many countries, FGM/C may be concentrated in certain geographic locations.[4] The data are also collected and presented in ways that do not allow for the disaggregation (i.e., by community, age, type of FGM/C, who performs the cutting, and drivers) needed to design appropriate programming to address FGM/C.

Global attention to FGM/C has increased significantly in the past decade. The global community has agreed to eradicate FGM/C by 2030 and to assess progress toward this goal by measuring the proportion of girls and women ages 15–49 who have undergone the procedure. This is a globally standardized measure that the MICS and DHS already use in the countries where FGM/C is measured.

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[3] End FGM European Network, US End FGM/C Network, and Equality Now. *Female Genital Mutilation/Cutting: A Call for a Global Response*. Equality Now, 2021. https://d3n8a8pro7vhmx.cloudfront.net/equalitynow/pages/2280/attachments/original/1587032303/FGM_Global_-_ONLINE_PDF_VERSION_-_07.pdf?1587032303.

[4] "Data: a Generation to Protect," UNICEF, accessed June 3, 2022. https://data.unicef.org/resources/a-generation-to-protect/.

Data must be analyzed and interpreted in light of the extremely delicate and often sensitive nature of the issue of FGM/C, including illegality of the practice in some countries. Self-reported data on FGM/C may be underreported, as women may be unwilling to disclose having undergone the practice. Also, many women may be unaware that they experienced FGM/C or of the extent of the cutting, particularly if FGM/C was performed at an early age.

Information on the FGM/C status of daughters is generally regarded as more reliable than women's self-reports because mothers and fathers usually would have been involved with or aware of the event. However, even these data need to be interpreted with the understanding that parents may be reluctant to disclose the FGM/C status of their daughters for fear of repercussions, especially in countries where the practice has been the target of campaigns or legal measures to prohibit it.[5]

One challenge in evaluating the prevalence of FGM/C is the degree to which the practice and the interventions to prevent it are localized. Changes in prevalence often happen at a level more localized than is disaggregated by the DHS and MICS. Disaggregating data by smaller geographic units could help monitor changes in prevalence over time. However, experimental and quasi-experimental research studies are needed to assess the effectiveness of interventions to reduce FGM/C.

Despite these limitations, the MICS and DHS are important tools for informing the design of targeted FGM/C programming, particularly as they allow for understanding correlations and trends with other indicators, such as education level and wealth quintile.

USAID could lead on efforts at mission level, nationally, and globally, to include questions about FGM/C in the DHS in all countries and encourage UNICEF to do the same with the MICS. The questions asked must reflect the local context, and data should be disaggregated at the national, subnational, and local levels to allow for better understanding of where "hot spots" exist within and across countries. DHS and MICS design and implementation could be updated to include changes in sampling frames, questionnaire content, structure, and terminology used to refer to the practice, as well as questions to better understand the context within which FGM/C is taking place, including medicalization of the practice, and the short- and long-term physical and mental health implications. While the DHS already includes questions around attitudes toward FGM/C, these could, with survivor input, be expanded and improved to elicit more detailed information around the local drivers of the practice. More granular data could inform more context-specific interventions. Research should be contextual and survivor-centered.

Questions:

- What are the geographic locations where FGM/C takes place? (Disaggregated at the lowest possible geographic level)
- In what settings, facilities, and places does FGM/C occur?
- At what age are girls being cut? (Disaggregated by five-year age bands)
- Who is performing FGM/C?
- Are community attitudes about FGM/C shifting, and among whom?
- What survey questions can effectively elicit information on the drivers of FGM/C in the local context?

[5] "Data: Female Genital Mutilation (FGM)," UNICEF, accessed June 3, 2022. https://data.unicef.org/topic/child-protection/female-genital-mutilation/.

HOW CAN EFFORTS TO END FGM/C BE INTEGRATED ACROSS SECTORS EFFECTIVELY?

Evidence indicates that interventions are most effective at ending FGM/C when both multisectoral and holistic strategies are integrated into multiple sectors and coordinated across different levels of the socio-ecological framework. FGM/C is deeply connected with other manifestations of gender inequality and has effects across many sectors; thus, addressing the practice in a broader, multisectoral manner is critical.

Integrating FGM/C into interventions designed to advance USAID's goals in health; water, sanitation, and hygiene; gender-based violence; democracy, rights, and governance; crisis and conflict; education; economic growth; and other sectors should be a priority for the Agency. (See *Implementation Plan for Female Genital Mutilation/Cutting* for more on this topic.) Further, multisectoral and comprehensive approaches to ending FGM/C should include expanded partnerships at the local, subnational, and national levels while Agency responses are being built across sectors. Partnership and collaboration among actors across multiple sectors will serve as a "force multiplier" holding governments accountable for eliminating FGM/C.

Questions:

- In which countries and sectors is USAID working to reduce FGM/C? What are the interventions and funding sources?
- What are examples from different sectors of successful interventions to reduce FGM/C?
- What kind of information can help USAID staff and implementing partners working across sectors (e.g., health; water, sanitation, and hygiene; gender-based violence; democracy, rights, and governance; crisis and conflict; education; and economic growth) understand and actively work to reduce FGM/C?
- What are the institutional barriers or challenges to collaborating and working across sectors to reduce FGM/C?

WHAT STRATEGIES CAN PREVENT FGM/C IN UNDERSTUDIED COUNTRIES AND CONTEXTS?

Much of the rigorous evidence generated to date on effective response to FGM/C comes from geographically localized programs, primarily from 17 countries in sub-Saharan Africa. The response strategies identified from these programs have shown greater effectiveness when implemented in combination and when multisectoral and holistic approaches are implemented and coordinated, as noted above. The strategies include those that seek to foster enabling environments and advance more equitable social norms, empower survivors and girl advocates, and engage health professionals in FGM/C prevention and response.

It is important to note that these high-level strategies are aggregated from lessons learned across programs implemented in different contexts and settings; therefore, program design and impact may differ from one context to another. Not enough is known about which strategies and combinations of strategies work best in which contexts. It can be useful to review successful approaches from other sectors and issues, including child, early, and forced marriage and early unions (CEFM), and apply them to FGM/C.

USAID can support an expanded evidence base through implementation research and innovative methods to develop and evaluate interventions to end FGM/C within and across sectors and across diverse contexts. These interventions should be context-specific, survivor-centered, practical, effective, and cost effective. More knowledge around intervention effectiveness is needed in the following areas:

A. Policy and legal approaches to create enabling environments. There is a consensus that enacting legislation that prohibits FGM/C and offers protection and redress options for women and girls is critical to signal that the practice is unacceptable. Specific laws or legal provisions against FGM/C often operate as a declaration of political will and demonstrate government commitment toward ending FGM/C. Developing a provision to address FGM/C, as an official acknowledgment of the issue, is arguably the first step toward putting in place comprehensive policies and establishing adequate services at a national level to take on this harmful practice. However, adoption of comprehensive legislation alone is insufficient to address the practice effectively. Anti-FGM/C legislation should be part of a comprehensive approach that includes measures to foster more gender-equal social norms. Implementation of laws can face challenges around enforcement gaps, including narrow conceptualization and interpretation by judges. Experts agree more research is needed on consent, bodily autonomy, and choice, and the human rights implications of policy and legal approaches to addressing FGM/C, particularly for adult women.

Questions:

- What type of support can help policymakers and judicial systems develop and implement effective policies and laws to end FGM/C?
- How can legal approaches to end FGM/C most effectively address issues of consent, bodily autonomy, choice, and harm, including in relation to medicalization of the practice?
- Aside from criminalization, what policy and legal strategies exist to successfully address, prevent, and end the practice of FGM/C? What types of incentive structures could reduce the practice?
- What successful approaches and experiences from other sectors might be applicable to reducing FGM/C?

B. Social and behavior change. In countries where national data are collected on FGM/C, seven in ten girls and women report believing that the practice should end. Among women and girls who have already been cut, five in ten.[6]

Sustainable social change must be driven by local communities. Social norms are diverse and complex and do not lend themselves to simple interventions.[7] Their transformation is only possible through sustained action at all levels of the socio-ecological system—individual, family, community, and institutional. While some successes have been documented related to local campaigns and actions that increased public awareness and condemnation of FGM/C, the evidence that they reduced FGM/C is scant and largely anecdotal. Despite strong public opinion against the practice, not enough is known about how to translate changes in attitudes to reductions in the number of girls and women who get cut.

[6] "The UNICEF Approach to the Elimination of Female Genital Mutilation," UNICEF, accessed June 3, 2022, https://www.unicef.org/media/88751/file/FGM-Factsheet-2020.pdf.
[7] "Evidence to End FGM/C: Reflections from Five Years of Research," Population Council, accessed June 3, 2022, https://www.popcouncil.org/uploads/pdfs/2020RH_FGMC_ReflectionsFiveYears.pdf.

Questions:

- What strategies are effective in translating changes in knowledge and attitudes around FGM/C into a reduction in the number of girls and women who get cut?
- How can families, communities, local organizations, faith and traditional leaders, and men and boys be engaged effectively to reduce FGM/C and advance gender equality?
- What are the reasons that some women who have undergone FGM/C support the practice?

WHAT HEALTH CARE SERVICES CAN MOST EFFECTIVELY MEET THE NEEDS OF GIRLS AND WOMEN WHO HAVE EXPERIENCED FGM/C?

Girls and women who undergo FGM/C often experience long-term health consequences, including scarring, cysts, abscesses and other tissue damage, fistula, infertility, and increased susceptibility to infections. They may have difficulty and pain when they menstruate, urinate, or have sexual intercourse. Women who have undergone infibulation, where the labia are cut and sewn together to drastically narrow the vaginal opening, must be cut open again to enable sexual intercourse and childbirth. According to UNFPA, FGM/C can cause serious and even life-threatening complications during childbirth. Scar tissue may not stretch enough to accommodate a newborn, making delivery even more painful and making it more likely that the woman will need a cesarean section or other emergency interventions.[8] In addition, some women who experience urinary retention, a common side effect of infibulation, have likened the excruciating pain every time they urinate to the feeling of salt being rubbed into an open wound.

The risk of prolonged, obstructed labor is heightened for women who have undergone FGM/C. Without timely medical intervention, obstructed labor can cause debilitating obstetric fistula and put the mother and baby at risk of death or long-term injury. While several countries with high prevalence of FGM/C also have among the highest maternal mortality rates, research demonstrating a direct connection between medicalization of FGM/C and maternal mortality has been insufficient. Such research could be useful for advocacy to end the practice.

Girls and women who have undergone FGM/C also present with unique emotional issues. While the evidence base is more limited in this area, it indicates that FGM/C can have lasting consequences for the mental health of girls and women. Girls may feel deeply betrayed by the parents who insisted they be subjected to FGM/C. In young children, that loss of trust and confidence can lead to behavioral problems in addition to psychological pain. As girls grow up and marry, the sexual dysfunction caused by FGM/C may put stress on their marriages. Over the long term, FGM/C can leave serious psychological scars and may cause anxiety, depression, memory loss, sleep disorders, and post-traumatic stress disorder.

The health sector can play several roles in ending the practice. First, many girls and women do not associate their often extreme and painful health symptoms with FGM/C. In most countries, an increasing percentage of women are attending a first antenatal care visit and delivering in health facilities. These are opportunities to provide prevention services (for daughters) and care services (for mothers), and to discuss a range of sexual and reproductive health and rights issues, including harmful practices like FGM/C.[9] For example, during these visits providers can prepare patients who are survivors of FGM/C for the additional pain and complications they may experience during delivery. They may discuss medical treatments for complications related to FGM/C, and they can counsel their patients on why they should not perpetuate FGM/C with their daughters.

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[8] "5 Ways FGM Undermines the Health of Women and Girls," Somaliland.com, accessed June 3, 2022, https://www.somaliland.com/health-fitness/5-ways-fgm-undermines-the-health-of-women-and-girls/.
[9] "Compendium of Indicators on Female Genital Mutilation," UNFPA and UNICEF, accessed June 3, 2022, https://www.unfpa.org/publications/compendium-indicators-female-genital-mutilation.

FGM/C has become increasingly medicalized, though there is no medical justification for it. Medicalizing the practice does not make it safer, as it still removes and damages healthy, normal tissue and interferes with the natural functioning of girls' bodies. About one in four FGM/C survivors (26 percent, or 52 million women and girls) were cut by health care personnel. The proportion is twice as high among adolescents (34 percent among survivors ages 15–19) as older women (16 percent among survivors ages 45–49 years), which indicates a growth in medicalization.[10] Trained health professionals who perform FGM/C violate girls' right to life, physical integrity, and health, in contravention of the fundamental principles of medical ethics.[11]

Financial gain also plays a role. FGM/C can bring in income for health professionals and a higher bride price/dowry for parents when their daughter is married. Medicalized FGM/C may be a major source of income for those who perform it, as fees can be high, especially in countries where FGM/C is illegal.[12]

Efforts to engage all types and levels of health care workers have included training birth attendants, community health workers, and other health care providers to recognize, prevent, and treat FGM/C in a respectful and professional manner. This increasingly includes providing an adequate response to the mental, psychological, and physical health needs of millions of women and girls who have undergone FGM/C. Other strategies include devising and sharing survivor-centered guidance with health care personnel, such as community-based health workers and birth attendants, on how to address social norms and use legal provisions to respond to social pressure to perform medicalized FGM/C; strengthen the development of curricula; and engage students in conversations about the ethical and legal aspects of FGM/C. Knowledge of laws and policies can be a powerful tool for parents and health care workers in efforts to prevent FGM/C, especially when responding to pressure from extended family. For example, parents have reported that invoking the U.S. federal law on FGM/C, which makes it illegal to take a child outside the U.S. for the purposes of FGM/C, has been useful to rebut social pressure to have their daughters cut when they visit their country of origin.

Evidence on the effectiveness of building the capacity of the health care system to address FGM/C, including the integration of FGM/C into health services, is needed. Because many of these strategies have not been appropriately evaluated, little is known about their effectiveness from the perspective of providers and survivors.

Questions:

- What physical and psychological needs have women and girls who have experienced FGM/C identified? What health care services are most effective for responding to those needs? Specifically, what strategies are effective for understanding, learning from, and responding to the short- and long-term physical and psychological consequences of FGM/C?
- How many maternal deaths result from FGM/C, and what is the proportion of maternal mortality associated with FGM/C?
- What is the burden of child morbidity and mortality associated with a mother who has experienced FGM/C?

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[10] "Female Genital Mutilation: A New Generation Calls for Ending an Old Practice" UNICEF, last modified 2020, https://data.unicef.org/resources/female-genital-mutilation-a-new-generation-calls-for-ending-an-old-practice/.
[11] "The UNICEF Approach to the Elimination of Female Genital Mutilation," UNICEF, accessed June 3, 2022, https://www.unicef.org/media/88751/file/FGM-Factsheet-2020.pdf.
[12] Els Leye, Nina Van Eekert, Simukai Shamu, Tammary Esho, Hazel Barrett, and ANSER, "Debating Medicalization of Female Genital Mutilation/Cutting (FGM/C): Learning from (Policy) Experiences Across Countries," *Reproductive Health* 16, no. 158 (November 2019), https://doi.org/10.1186/s12978-019-0817-3.

- What is the prevalence of women who seek care for fistula related to FGM/C? What are the barriers to women receiving care for FGM/C-related fistula?
- What strategies are most effective for health care providers and the health system in the prevention of FGM/C, particularly ending medicalization of the practice?

HOW CAN FGM/C BE MOST EFFECTIVELY ADDRESSED ACROSS NATIONAL BORDERS?

Girls are sometimes taken across national borders to undergo FGM/C in a country where laws against the practice are lightly enforced or nonexistent, a phenomenon known as cross-border FGM/C. Cross-border FGM/C is poorly documented and difficult to detect, in part because of its clandestine nature. Experts have highlighted the need for effective prevention strategies and international collaboration, cooperation, and harmonization of such strategies to combat FGM/C in countries with communities affected by the practice.

Questions:

- What strategies are effective for identifying countries affected by cross-border FGM/C?
- How can effective cross-border and regional strategies be developed and tested for communities that straddle two or more countries?

HOW CAN USAID MOST EFFECTIVELY SUPPORT GRASSROOTS, SURVIVOR-LED, YOUTH-LED, WOMEN-LED, AND OTHER LOCAL ORGANIZATIONS TO PROMOTE AND MEASURE POSITIVE OUTCOMES FOR GIRLS AND WOMEN, INCLUDING ENDING FGM/C?

> *"If we truly want to make aid inclusive, local voices need to be at the center of everything we do. We've got to tap into the knowledge of local communities, and their lived experiences. Otherwise, we risk reinforcing the systemic inequities that are already in place."*
>
> USAID Administrator Samantha Power, November 2021[13]

While interventions designed and implemented by international and large national nongovernmental organizations can certainly be effective, it is possible that they are not as effective, cost-effective, or sustainable as those implemented by local organizations. USAID is increasingly committed to strengthening local leadership and accountability as is required for sustainable, structural change. At the same time, little is known about the impact, cost effectiveness, and sustainability of work led by grassroots level organizations.

Increasing evidence confirms the critical importance of understanding local context and engaging local communities in efforts to end FGM/C. USAID should expand support for community-driven, survivor-centered, survivor-led, multistakeholder approaches to meaningfully engage survivors, young people, parents, service providers, and policymakers, as well as community, religious, and traditional leaders. This also calls for providing support and measuring success differently than in the past. Sustainability can be encouraged beyond single-funder programs by providing core funding and investing in the growing capacity of grassroots and local organizations, particularly in finance, administration, and evaluation.

[13] "Administrator Samantha Power on a New Vision for Global Development," USAID, accessed June 3, 2022, https://www.usaid.gov/news-information/speeches/nov-4-2021-administrator-samantha-power-new-vision-global-development.

USAID can help local organizations continue to expand their capacity, establish self-sufficiency, and set their own effective priorities for their country and local contexts, while answering the following questions:

- How can USAID most effectively foster partnerships that promote ethical and promising interventions to reduce harmful practices?
- How can USAID most effectively support the sustainability of grassroots and local advocacy organizations to promote positive outcomes for girls and women?
- What strategies are most effective in reaching the most marginalized girls?
- What is the impact of survivor-led, youth-led, and women's rights organizations and movements on changing social norms around FGM/C, sexuality, and the rights of girls?
- Which aspects of the work of survivor-led, youth-led, and women's rights organizations and movements are most effective in advocating for policy change and social norms change in local communities?

HOW CAN FGM/C INTERVENTIONS BE EVALUATED TO MEASURE PROGRESS FLEXIBLY AND IN WAYS THAT MEET THE NEEDS OF THOSE AT RISK, WHILE ALSO PROMOTING ACCOUNTABILITY AND RIGOR?

Practices that are deeply connected to gender inequality, poverty, and social norms and taboos cannot be changed overnight. The returns from investing in the many strategies designed to end FGM/C and advance more gender-equal societies—such as supporting girls' education, providing adolescent-responsive sexuality education and sexual and reproductive health services, and developing, passing, and implementing gender-equal laws—may take many years to be realized.

Measuring intermediate outcomes, such as shifts in knowledge, attitudes, and beliefs, and doing so in innovative, context-grounded, and mixed-methods ways, is an important means to check that interventions are not only doing no harm, but are also on the path to achieving success. At the same time, as noted in the U.S. National Strategy on Gender Equity and Equality, greater investment is needed in rigorous evaluations of interventions to determine what works, where, and under what conditions.

In supporting the implementation, monitoring, and evaluation of gender-transformative approaches that "address the underlying, structural inequalities that drive girls' vulnerability," and that respond to the "holistic and multifaceted nature of girls' lives,"[14] USAID increasingly must become comfortable with diverse methods of evaluation and measures of success. These should go beyond simply tracking FGM/C incidence and prevalence to testing and measuring change in the attitudes and the practice of FGM/C among community members, faith leaders, and health care practitioners. Other factors that should be measured are the societal roles of girls and women, girls' agency, girls' outlooks on the future and the opportunities they envision beyond marriage, changes in the distribution of power and resources, and other indicators of social transformation and empowerment.[15, 16]

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[14] Suzanne Petroni et al., "Understanding the Relationships Between HIV and Child Marriage: Conclusions from an Expert Consultation," *Journal of Adolescent Health* 64, no. 6 (June 2019): 694-696, https://doi.org/10.1016/j.jadohealth.2019.02.001.
[15] "Tackling the Taboo: Sexuality and Gender-Transformative Programmes to End Child, Early and Forced Marriage and Unions," Plan International, accessed June 3, 2022, https://plan-international.org/publications/tackling-taboo-ending-child-marriage#download-options.
[16] "Research Strategy for Phase II: The UNFPA–UNICEF Global Programme to End Child Marriage," UNICEF, accessed June 3, 2022, https://www.unicef.org/media/104126/file/Child-marriage-research-strategy-2021.pdf.

Measuring the effectiveness of gender-transformative approaches and synthesizing evidence on social norms change to end FGM/C would further benefit future work. USAID can build on past investments that defined the nature and scope of the problem to also assess intervention effectiveness. Work supported by USAID through the Social Norms Learning Collaborative, for example, is an excellent start to advance such novel measures, but more could be done to study and define new measures of change and disseminate findings.

Questions:

- What opportunities exist for investment in innovative yet rigorous evaluations of interventions to prevent and respond to FGM/C?
- What innovative, context-grounded, survivor-centered methods are effective and achievable to measure program success while doing no harm and spurring country-level reporting?

WAYS TO ADDRESS THE LEARNING QUESTIONS

ANALYSIS AND UTILIZATION OF EXISTING DATA

As current data show, the complexity of FGM/C, the experience of this practice, and how to address it vary significantly within and across countries and communities. As noted, the global community has collected DHS and MICS data on the prevalence of FGM/C from a limited number of countries, but the expansion of data collection in South and East Asia and Latin America, among others, is urgently needed.

DHS and MICS data, as well as other large datasets, can typically be disaggregated at the subnational level (i.e., district or county) and by wealth quintile, among other factors, but more nuanced segregation is necessary to identify populations of interest or "hot spots," as well as to design appropriate interventions.

Understanding these differences, as well as the differences in FGM/C prevalence and trends disaggregated by factors such as religion, ethnicity, education level, age, household and community characteristics, and prevalence of the medicalization of FGM/C, may assist in the design of interventions targeting those most at risk. Existing datasets can be better mined, for example, to produce vulnerability profiles that identify subnational regions with the greatest need, based on some of these characteristics. While some implementers and researchers develop such profiles prior to designing programs, many respond to funder desires for interventions in given settings that do not necessarily include individuals most at risk. Program designers may also be forced to propose locations and interventions in response to requests for proposals, without sufficient time or funding to design the most suitable interventions for the contexts with greatest need.

Appropriate analysis of existing datasets can further explain the relationships between shifts in age at FGM/C and other factors, such as medicalization, education levels, health, nutrition, mobility, and other experiences of gender-based violence. There is increasing evidence that FGM/C affects sexual and reproductive health and maternal and child health, and strategies should be identified to integrate FGM/C prevention and response into these sectors. Analysis of existing datasets may shed light on the following questions:

- How many maternal deaths result from FGM/C, and what is the proportion of maternal mortality associated with FGM/C?
- How many stillbirths result from FGM/C, and what is the proportion of infant mortality among children born of a woman who has experienced FGM/C?

- What is the burden of child morbidity associated with a mother who has experienced FGM/C?
- What is the prevalence of women who seek care for fistula related to FGM/C? How many women need care for FGM/C related fistula but do not receive it? What are the barriers to women receiving care?

Far less is known about how FGM/C may contribute to other health and development outcomes, such as mental health and well-being, and how to adequately meet these needs. More evidence is needed regarding how to effectively engage health practitioners in preventing FGM/C and ending medicalization of the practice.

A better understanding of these impacts, as well as the determinants and drivers of FGM/C in specific contexts, could be helpful to inform the design of powerful, locally relevant advocacy campaigns and interventions to prevent and respond to FGM/C. This understanding could result from quantitative analyses, qualitative work, or other means.

In the short term, however, there are numerous opportunities to expand data collection and better use existing datasets related to adolescent girls, add survivor-centered questions to surveys and evaluations, share existing data more widely, and make better use of existing programmatic and administrative data.

QUALITATIVE RESEARCH

A growing body of qualitative research in recent years has helped build a better understanding of girls' and women's experiences with FGM/C. Some survivors of FGM/C report experiencing discrimination and trauma from programs to end FGM/C. Research that includes local survivors and activists throughout the design and implementation processes can help avoid such unintended consequences and lead to better programs. Moreover, well-conducted qualitative research is critical for grounding quantitative results in local contexts.

Qualitative research and discussions with survivors across the United States, Africa, United Kingdom, and South Asia have begun to reveal the racism, Islamophobia, colonialism, and anti-immigration sentiments inherent in some efforts to address FGM/C.[17] Research conducted by Sahiyo, an advocacy organization in Asia, used participatory storytelling for survivors to share their experiences. This research has generated qualitative data that highlight how FGM/C drivers are rooted in deeply entrenched gender inequality and patriarchal norms related to female sexuality. Sahiyo also identified tensions at the familial and community levels about the rights and expectations of girls and women, particularly adolescent girls, regarding FGM/C.

Qualitative research on the Saleema Initiative[18] suggested that including women—particularly survivors of FGM/C—in program design and implementation processes can reduce the stigmatization of the women and girls who have survived FGM/C as well as those who have not undergone FGM/C. Including survivors of FGM/C in development can lead to more gender-responsive programs.

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[17] "Critical Intersections: Anti-racism and Female Genital Cutting," Sahiyo.com, accessed June 3, 2022, https://sahiyo.com/2021/07/05/addressing-critical-intersections-anti-racism-and-female-genital-cutting/.
[18] "FGM Elimination and COVID-19: Sustaining the Momentum," UNFPA and UNICEF, accessed June 3, 2022, https://www.unicef.org/media/107721/file/FGM%20data%20and%20evidence%20for%20impact%202020.pdf.

Qualitative research can also provide compelling examples for advocates and policymakers, such as stories told from the perspectives of girls and women that demonstrate the effects of FGM/C on their lives.

Qualitative research can be used to answer learning agenda questions such as:

- What physical and psychological needs have women and girls who have experienced FGM/C identified?
- How can families, communities, local organizations, faith and traditional leaders, and men and boys be engaged effectively to reduce FGM/C and advance gender equality?
- How can efforts to address FGM/C avoid reinforcing racist, Islamophobic, colonial and anti-immigrant tropes?
- Which aspects of the work of survivor-led, youth-led, and women's rights organizations and movements are most effective in advocating for policy change and social norms change in local communities?

EXPERIMENTAL AND QUASI-EXPERIMENTAL STUDIES

Rigorous testing using experimental and quasi-experimental designs can provide valuable data on what interventions—or combination of interventions—are effective at preventing FGM/C and improving related outcomes. Investment in rigorous evaluations of interventions in various geographies and settings could help identify promising and evidence-based approaches to be scaled up. Rigorous evaluations should be preceded by formative qualitative research to contextualize and adapt interventions to the setting and population and should include qualitative research in the evaluation component to help explain the quantitative evaluation results.

This approach can be used to answer learning agenda questions such as:

- What strategies are effective in translating changes in knowledge and attitudes around FGM/C into a reduction in the number of girls and women who get cut?
- What is the effect of survivor-led, youth-led, and women's rights organizations and movements on changing social norms around FGM/C, sexuality, and the rights of girls?
- What strategies are most effective for health care providers and the health system in the prevention of FGM/C, particularly ending medicalization of the practice?

CLOSING

FGM/C is a human rights abuse. Encouragingly, eliminating the practice is now on local, national, regional, and global development agendas, especially where national data are collected and reported. However, much more work is needed to expand understanding of what FGM/C is; where, how, and by whom it is practiced; and how prevention and response efforts can be effectively integrated within and across existing program areas. More survivors are speaking out about their experiences and challenging the norms that allow FGM/C to continue. This document is a first step toward determining how to fill gaps in the evidence base. However, it will be important to learn from, collaborate with, and otherwise engage with other funders, advocates, policymakers, implementers, and researchers—along with survivors themselves—to inform USAID's prioritization of high-impact interventions that accelerate progress toward a sustainable end to FGM/C.

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The goal of the Collective Action to Reduce Gender-Based Violence (CARE-GBV) activity is to strengthen USAID's collective prevention and response, or "collective action" in gender-based violence (GBV) development programming across USAID. For more information about CARE-GBV, click here.

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