

A photograph of a woman with a purple and orange headwrap, wearing a blue t-shirt, smiling warmly while holding a young child. The child is wrapped in a light-colored cloth. The background is a soft-focus outdoor setting with greenery.

RETHINKING END FGM/C WORK

**A GUIDE TO DESIGNING EFFECTIVE
SOCIAL-NORMS-CHANGE PROGRAMMES**

January 2022

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ABOUT 28 TOO MANY

28 Too Many is an international research organisation created to end female genital mutilation (FGM) in the 28 African countries where it is practised and in other countries across the world where members of those communities have migrated. Founded in 2010 by Dr Ann-Marie Wilson and registered as a charity in the UK in 2012, 28 Too Many aims to provide a strategic framework where evidence-based knowledge and tools enable both policymakers and in-country anti-FGM campaigners to be successful and make a sustainable change to end FGM.

The vision of 28 Too Many is a world where every woman and girl is safe, healthy and lives free from FGM and other human-rights violations.

28 Too Many carries out all its work thanks to donations and is an independent, objective voice unaffiliated with any government or large organisation.

All reports and resources published by 28 Too Many are available to download for free at www.28toomany.org.

ABOUT PLAN INTERNATIONAL

We strive to advance children's rights and equality for girls all over the world. We recognise the power and potential of every single child. But this is often suppressed by poverty, violence, exclusion and discrimination. And it's girls, who are most affected. As an independent development and humanitarian organisation, we work alongside children, young people, our supporters and partners to tackle the root causes of the challenges facing girls and all vulnerable children. We support children's rights from birth until they reach adulthood and enable children to prepare for and respond to crises and adversity. We drive changes in practice and policy at local, national and global levels using our reach, experience and knowledge. For over 80 years we have been building powerful partnerships for children, and we are active in over 75 countries.

Plan has positioned itself clearly against the practice of FGM/C and recognises that its elimination is crucial for achieving the organisation's objectives, because of the important role FGM/C plays in perpetuating gender inequality in practicing communities. The organisation has been working on FGM/C in more than ten affected countries for over twenty years and aims to both scale up and improve the effectiveness of its end FGM/C interventions going forward.

More information on Plan's work to end FGM/C can be found at:

www.plan-international.org/sexual-health/fgm-female-genital-mutilation.

LIST OF ABBREVIATIONS

ARP	Alternative rite of passage
DHS	Demographic and Health Surveys Programme
FGM/C	Female genital mutilation/cutting
GBV	Gender-based violence
K-A-P	Increasing knowledge, changing attitudes and shifting practice
MEA	Men Engage Africa
MICS	Multiple Index Cluster Surveys
SRHR	Sexual and reproductive health and rights
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
WHO	World Health Organization

FOREWORD

Female Genital Mutilation/Cutting (FGM/C) is the practice of altering or removing the external female genitalia for non-medical reasons and it currently affects at least 200 million girls and women in 31 countries alone where systematic data is available. The practice is known to occur in at least 96 countries worldwide, most of which lack national data. It is internationally recognised as a human rights violation and poses serious risks to girls' and women's health, well-being and future aspirations. FGM/C is a cultural practice and, in many cases, a deeply entrenched social norm, rooted in gender norms often aimed at controlling female sexuality. As such it is a manifestation of gender inequality and a form of gender-based violence. Ending this harmful practice is part of the Sustainable Development Agenda.

FGM/C prevalence is declining in many countries where it is practiced, but due to high rates of population growth and the impact of COVID-19, the absolute number of affected and at-risk girls continues to grow despite decades of end FGM/C efforts, with 4.6 million girls expected to be cut annually by 2030. Many different strategies and approaches to end FGM/C have been tried and tested over the past 20 years by various organisations and actors, including Plan International. Some have proven effective, at least in some contexts, while others have

been shown to be ineffective or even to contribute to unintended negative outcomes, such as increased medicalisation. It is widely recognised that many interventions have failed to take full account of the cultural and social context in which they occurred. There is growing consensus that a more effective approach to reducing FGM/C would be through culturally sensitive, community-based programmes that lead to a change in the deeply embedded social norms that uphold the practice. This entails recognising that there is no one-size-fits-all strategy, that the specific beliefs and values of each community must form the starting point of any intervention, and that the key decision-makers and influencers in each community must be engaged from the start, along with girls and young people.

The following guidelines are meant to support programme staff at all levels to act on this learning and design more effective end FGM/C interventions, by providing a step-by-step approach that ensures the right questions are asked and locally relevant strategies are developed.

We hope that everyone working towards ending FGM/C will find the guidelines inspiring and useful and that it will therefore contribute to achieving this important objective.



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INTRODUCTION

Background

Over the past few decades, many strategies to reduce FGM/C have been developed. Although there has been a decline in prevalence rates in many countries, it has not been keeping up with population growth resulting in continued rise of absolute numbers of girls and women affected. In addition, it has long been felt that most of the interventions that have been tried failed to take full account of the cultural and social context in which they occurred.

There is a growing consensus that a more effective approach to reducing FGM/C would be through culturally sensitive, community-based programmes that lead to a shift in the deeply embedded social norms that uphold the practice. This would entail recognising that there is no one-size-fits-all strategy, that the beliefs and values of each community have to be addressed individually, and the key decision-makers and influencers in each community must be engaged from the start.

The following guidelines for operationalising a social norms approach to ending FGM/C have been produced jointly by Plan International and 28 Too Many. They should be read alongside 28 Too Many's paper [FGM and Social Norms](#), which sets out the theoretical concepts on which these guidelines are based.

Summary of the Social Norms Approach

Social norms are expectations or informal rules shared by people in a group or society as to how people should behave. Norms shape what people believe are typical and/or appropriate behaviours. Gender norms are a significant sub-set of social norms. They are the unwritten rules about how men and women, often of a particular age, should behave. Gender norms reflect hierarchies of power and privilege which often discriminate against women and girls.

A social norm comprises a number of elements, as follows:

1. A reference group: the group of others whose actions and expectations affect an individual's choices.
2. What is typical: beliefs about what others in the community do (also called *descriptive norms* or *empirical expectations*)
3. What is expected: beliefs about what others in the community expect one to do (also called *conjunctive norms* or *normative expectations*)
4. Sanctions: the consequences of not behaving accordingly.
5. Social benefits: the benefits associated with conforming.¹

For example, a mother may perceive that all girls in her community are cut and therefore decide to cut her daughter. In this case, she acts on a *descriptive norm* or her *empirical expectation*: she conforms to a behaviour she thinks that most people in her reference adhere to; she does what she thinks others do.

Her behaviour may also be influenced by an *injunctive norm* or a *normative expectation*: She believes and expects that her daughter will not receive as much respect from others in the community if she is not cut; she tries to avoid the social sanctions applied by the reference group as a consequence of not conforming to the norm. By cutting her daughter she therefore does what she thinks people in her reference group expect her to do.

In this example, even if for personal reasons a mother (or father) strongly disapproves of cutting and would like not to cut their daughter, they may conform to the social norm of cutting their daughter. Not conforming may result in negative reactions from the people who matter to them, and conforming is likely to be rewarded by feeling that their daughter is welcomed and respected.²

As this example demonstrates, **changes in personal attitudes towards FGM/C don't necessarily lead to changes in the practice of FGM/C**. This is because, while attitudes might change at an individual level, a more communal process is needed to achieve a change in practice. Critically, 'enough people have to believe that enough people are changing'.³ This in turn should result in a shift in expectations, a reduction in sanctions and, ultimately, a change in what is typically practised.

But social norms don't occur in a vacuum: strategies to end FGM/C also need to take account of moral norms that govern what people feel is right or wrong, and legal norms, which are those institutions and formal rules put in place by the state. These facets have to work together to create a shift in normative behaviour, and several strategies likely need to be operationalised in tandem; for example, the introduction of a law against FGM/C can make a strong statement about what is acceptable at state level, but this will only be enforceable in communities if those who have to uphold the law and those affected by the law believe it is the right thing to do. Collectivist values are therefore as important as individual values in transforming norms and changing behaviour.

Developing programmes aimed at catalysing change in deeply structured systems of normative behaviour therefore need to take into account four dimensions:

- Norms – attitudes, values and beliefs;
- Resources – economic capital, human capital, social capital, and cultural resources;
- Regulations – enforcement mechanisms (e.g. laws, policies, social sanctions or rewards); and
- Decision-making – decision-making processes and power dynamics.⁵

While these four dimensions contribute to the causes of FGM/C, they are also levers that can be used to catalyse change across the whole system.

Focusing on Women’s Empowerment and Gender Equality

FGM/C is a form of GBV and a violation of the rights of girls and women that is rooted in gender norms and stereotypes. It is important, therefore, for anti-FGM/C programmes to be situated within a broader gender equality, rights-based context that addresses issues such as control of bodily integrity, female sexuality and women’s empowerment and aims at shifting the underlying harmful gender norms. However, these issues are often controversial. In the opening stages of community dialogue, to encourage engagement, it may be more helpful to begin with facilitated discussion on the less controversial aspects of girls’ and women’s reproductive health. Your approach needs to be sensitive, integrating discussion on rights into the social realities of the community; for example, how educating girls brings benefits to the family and community, and if FGM/C signposts an end to girls’ school attendance, those benefits will be lost.



Resource: UNICEF’s guide to Gender Transformative Approaches for Elimination of FGM makes clear the intersectionality and distinction between gender norms and social norms, and how together these sustain the continuation of FGM. This relationship is summarised by UNICEF in Table 5, and the guide is available at:

<https://www.unicef.org/documents/gender-transformative-approaches-elimination-female-genital-mutilation>

Gender Norms	Social Norms
<ul style="list-style-type: none"> ▪ Gender norms are in the world, embedded in institutions and reproduced by people’s actions. ▪ Gender norms are produced and reproduced through people’s actions and enforced by powerholders who benefit from people’s compliance with them. ▪ Gender norms are often studied as shaping people’s individual attitudes. ▪ People follow the gender norms of their culture, society or group, the boundaries of which are usually blurry. ▪ Changing gender norms requires changing institutions and power dynamics. Often this will happen through conflict and renegotiation of the power equilibrium. ▪ Changing gender norms is a political project that leads to equality between women and men. 	<ul style="list-style-type: none"> ▪ Social norms are in the mind; people’s beliefs are shaped by their experiences of other people’s actions and manifestations of approval and disapproval. ▪ Social norms are equilibria that maintain themselves, not necessarily benefitting anyone. ▪ Social norms are often studied as diverging from people’s individual attitudes. ▪ People follow the social norms of their reference group, the boundaries of which are usually well defined. ▪ Changing social norms (at its simplest) requires changing people’s misperceptions of what others in their reference group do and approve of. ▪ Changing social norms is a health-related project that leads to greater wellbeing for women and men.

Table 5: Relationship between gender norms and social norms⁴

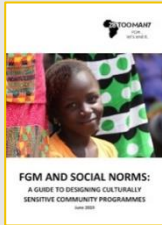
The UNICEF guide recommends conducting gender and contextual analyses of the type described in the first, Scoping, section of this guide, aimed at understanding how gender roles, power and decision-making roles and relationships between women and girls, and men and boys, perpetuate FGM/C. The UNICEF guide also contains a framework for a gender analysis in the context of FGM/C programming; further guidance on how to evaluate gender-transformative approaches is available at

https://www.unicef.org/evaldatabase/files/UNICEF-Guidance_on_Gender-LR.pdf.



Overview of These Guidelines

These guidelines suggest that changing the social norms related to FGM/C may be achieved through three distinct phases: increasing knowledge, changing attitudes and shifting practice (K-A-P).



Resources: These three phases align with both 28 Too Many's underpinning theory of change as set out in FGM and Social Norms and that of the United Nations Population Fund (UNFPA) as set out in How Changing Social Norms is Crucial in Achieving Gender Equality.⁵



The guidelines comprise four stages:

1. **Scoping Phase** – context is critical, and this section takes you through the questions you need to ask, and the data to be gathered, in order to fully understand the social environment in which FGM/C is taking place in a specific location:

- Where and why is it happening?
- How old are the girls or women when they undergo FGM/C?
- What type of FGM/C do they experience?
- Who decides if/when girls should be cut?
- Who influences that decision?
- Who undertakes the cutting?

2. **Programme Analysis and Design Phase** – this section takes you through the process of designing your strategy/ies on the basis of the context you have researched:

- Describing your target community: who you are trying to reach, where they are located, their age(s), the type of FGM/C they experience, the attitudes of their community towards FGM/C, and who makes and influences the decision on whether or not a girl should be cut.
- Deciding and describing what you hope to achieve with the programme: what are your anticipated outcomes and impact?
- Deciding what tactics and interventions to employ. Interventions that have been tried are summarised here, with suggestions about the context for which they are most suited in the social-norms-change process.

3. **Implementing Your Plan** – this section looks at some of the features that have been found essential for delivering the social norms approach through the K-A-P components (increasing knowledge, changing attitudes and shifting practice):

- The process of implementing a social-norms-based programme to ensure effective transformation and, eventually, shifts in behaviour;

- The role and skills of staff required to facilitate community-based dialogue;
- Your duty of care to safeguard your staff from stress and abuse; and
- How to integrate an ‘End FGM/C’ message into a broader human-rights approach, focusing on girls’ and women’s empowerment and gender equality.

4. Assessing Programme Impact – in this section we look at what sort of monitoring and evaluation system, based on the social norms approach, would help you answer the following questions:

- Is knowledge increasing?
- Are attitudes changing?
- Is practice shifting?

And, following on from these questions:

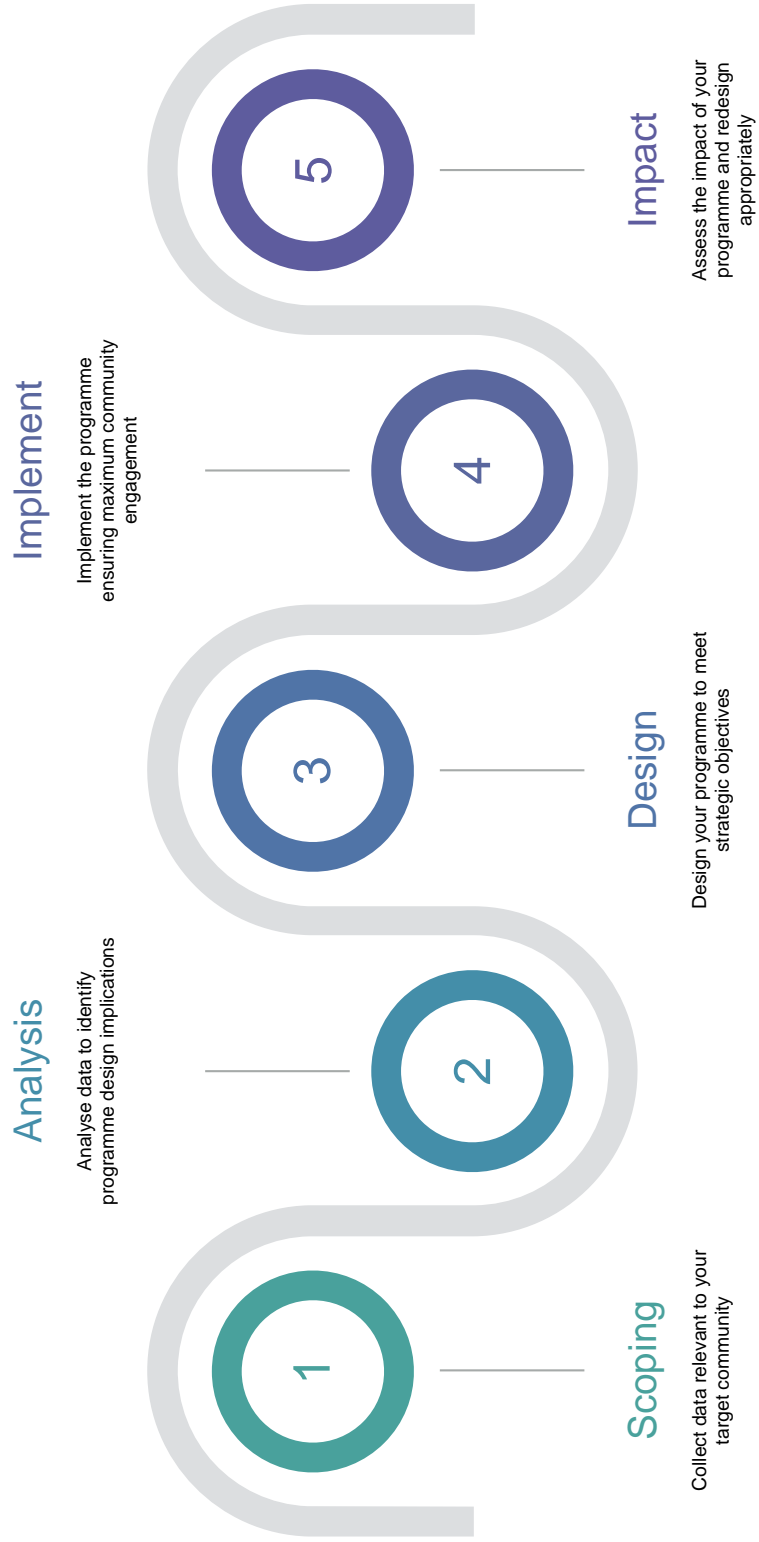
- What have we learnt?
- What can we build on to extend impact?
- What didn’t work and why?
- How can we reduce or mitigate these aspects?

5. Resource Section – this section lists the documents and websites mentioned in these guidelines, where you can get further help and support.



Community members attend the official FGM abandonment ceremony in their community in Central Manfran, Forested Guinea in 2018.

Photo: Plan International / Johanna de Tessières



1. SCOPING PHASE: CONTEXT IS CRITICAL

The Purpose of This Phase

Before embarking on programme design, you need to understand the context in which FGM/C is taking place:

- Where and why is it happening in certain areas?
- How old are the girls or women when they undergo FGM/C?
- What type(s) of FGM/C do they experience?
- Who decides if/when girls should be cut?
- Who influences that decision?
- Who undertakes the cutting?

The type of intervention you put in place will only work if you have a thorough understanding of who you're targeting and how they are likely to respond to messages about ending FGM/C in their community. For example, a strategy that focuses on empowering adolescent girls will not have much impact in a context in which girls are cut at a very young age and the decision to cut them is taken by elder family members.

There is no one-size-fits-all-approach, and it is unlikely you will be attempting to achieve social change across a whole country or region in one swoop. More likely you will want to test an intervention in a few villages or a province of a particular country, learn from that experience and then move forward, taking the programme to a wider area. Just because a programme was successful in one community does not mean it will be successful in another. **Achieving social change depends upon firstly identifying and taking into account the range of variables surrounding FGM/C within the defined area.**

1.1 Sources of Data for This Phase

A document review is the place to start your scoping process.

28 Too Many: For an overview of the 28 African countries where FGM/C continues to be practised, see 28 Too Many's Country Profiles at <https://www.28toomany.org/research-resources/>. This site has a short section containing the key features of FGM/C in each country, with summaries of the data from the Demographic and Health Surveys Programme (DHS) and Multiple Index Cluster Surveys (MICS) (see below), and in-depth analyses of 14 of these. There are also continent-level summaries of the practice of FGM/C, including the Americas, Asia and Europe, and thematic reports that look in detail at specific issues related to FGM/C, such as medicalisation of the practice and laws against it in African and other countries.

DHS: Demographic and Health Surveys have been carried out across various African countries for the past three decades. Many of the early country surveys did not include questions about FGM/C, but as interest in this topic grew through the 2000s, so questions were added to give an indication of prevalence, the age(s) at which it is carried out, where it is most/least prevalent (for

example, in villages or urban areas; which province or region), why it is performed, and peoples' attitudes towards it. There are concerns about the quality of some of the data, however; for example, most of the surveys only cover women between 15 and 49 years of age, who may be reluctant to say whether they have experienced FGM/C if it happened when they were an infant or if it is illegal in their country. A list of countries where DHS surveys have been carried out is available at <https://www.dhsprogram.com/Publications/Publications-by-Country.cfm>.

MICS: Other useful sources of data are UNICEF's Multiple Indicator Cluster Surveys for affected countries (see https://www.unicef.org/statistics/index_countrystats.html). Sometimes these overlap with, or are conducted instead of, the DHS surveys, and the same limitations apply to the quality of the data, but they are another place to source basic information about FGM/C prevalence, often according to age, locality and type of FGM/C.

1.2 Identifying and Understanding Characteristics of FGM/C in Particular Contexts

The aspects on which you will need to gather data before you start your programme design are the W issues: Where, What (type), When, Why, and Who (who decides to cut and who does the cutting). It is also important to understand the intersectionality between all these factors, how they relate to, and impact on each other.



Resource: Verifying these assumptions: Although the DHS's and 28 Too Many's reports will give you an overview of the practice, for greater understanding of the particular group of villages or urban areas in which you plan to work, and in order to conduct a baseline and meaningfully evaluate programme success, you should carry out your own survey. A tool for this is available at <https://28toomany.org/survey-toolkit/>.

1.2.1 Where is FGM/C Happening?

The first task is to identify the geographic focus of your intervention.

Country-level prevalence data is not going to give you the full picture, as can be seen when comparing the below Figure 1 (National-level prevalence) and Figure 2 (Administrative-region-level prevalence).

Regional prevalence: the 28 Too Many website provides national prevalence maps (based on the latest DHS and MICS datasets) that give an indication of the parts of a country where it is most commonly practised.

For example, in Kenya FGM/C prevalence is over 90% in the north-east, but less than 10% in the coastal region.

Having identified a target geographic area, you should also consider the following:

Urban and rural dynamics: in general, FGM/C is more widely practised in rural areas, where traditions are strongest, but this is not always the case (DHS data often provides this urban/rural split).

For example, in Nigeria and Egypt FGM/C is more frequent in urban areas, where the practice is increasingly being medicalised (i.e. carried out by medical professionals in clinics and hospitals).

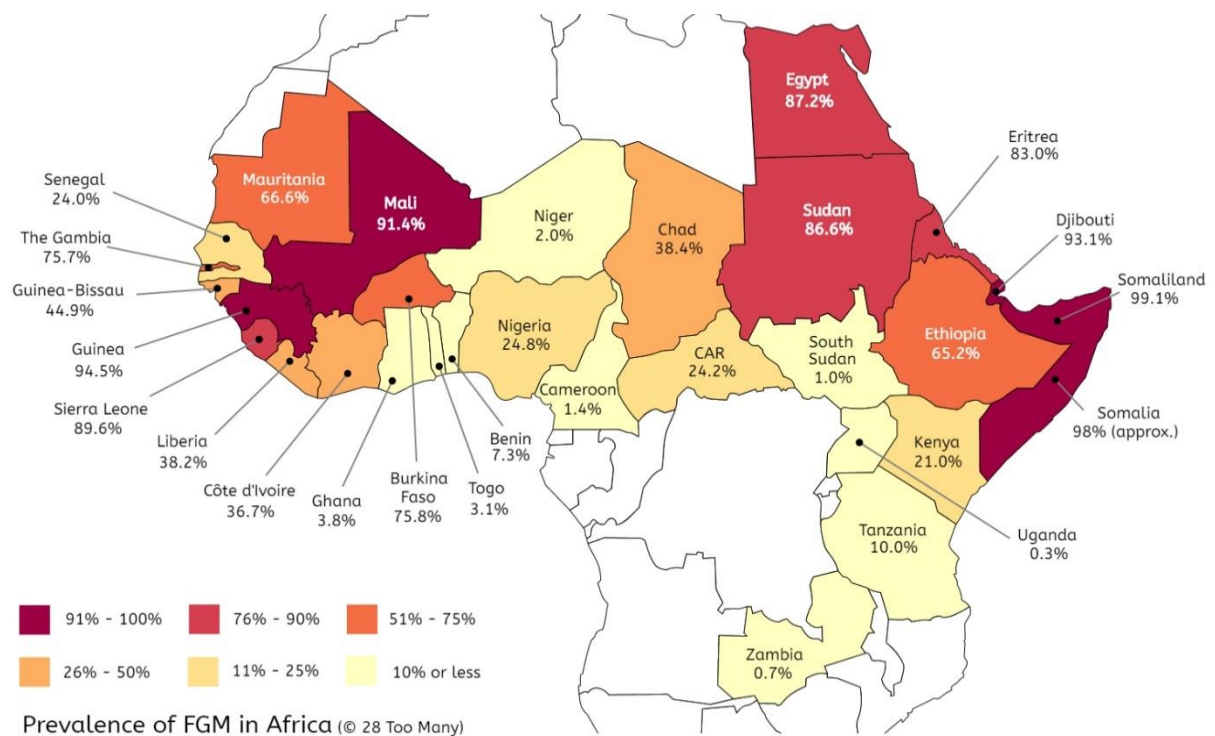


Figure 1: National-level FGM prevalence

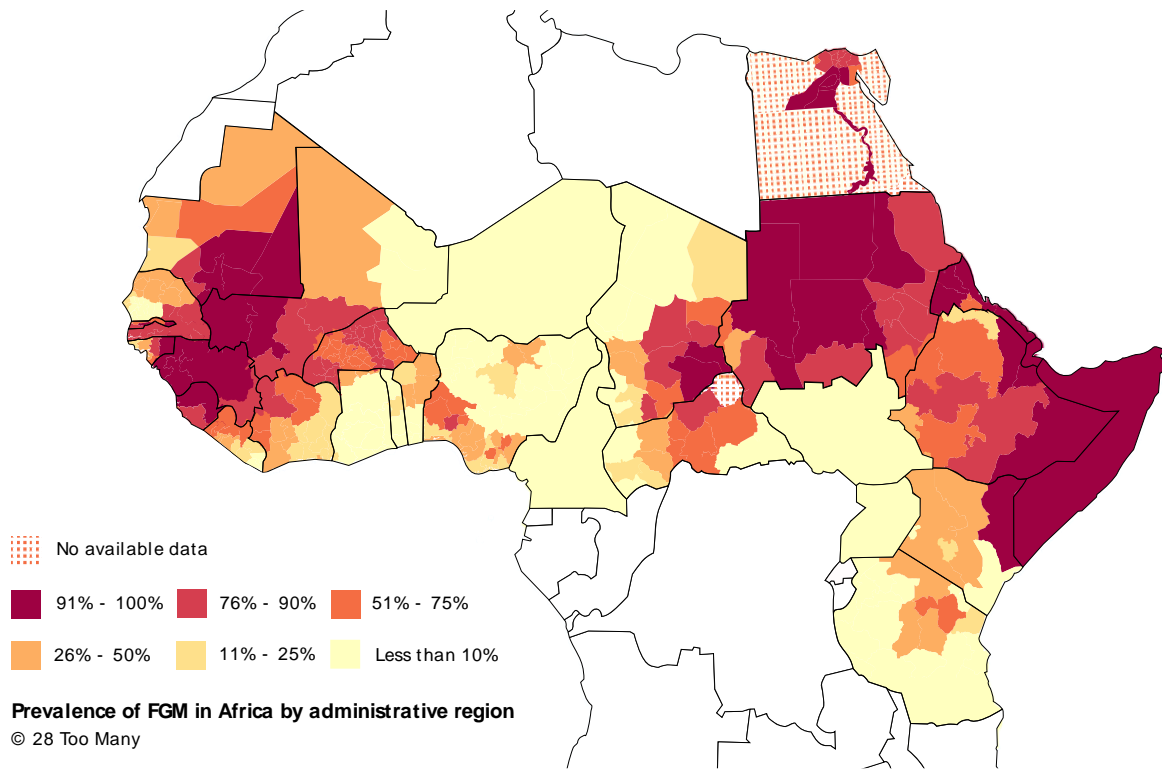


Figure 2: Administrative-region-level FGM prevalence

Ethnicity and religion: regional prevalence may be linked to social and cultural factors in a particular area; for example, a dominant ethnic group or religion.

Neighbouring communities: prevalence in neighbouring communities may influence local practices. This is especially important for those regions near the border of another country, where FGM/C laws and law enforcement differ, creating the potential for cross-border movement of cutters and/or girls.

Venue: ‘Where’ should also include the premises where cutting actually takes place. Is it mainly in clinics, carried out by medical professionals? Or is it carried out by grandmothers or traditional cutters in the homes of the girls, or at a village location as part of a ceremony for girls ‘becoming women’?

Looking more broadly at Figure 2, we can see that the almost universal prevalence of FGM/C in Somalia crosses the borders into north-east Kenya and eastern Ethiopia. Likewise, a band of midrange prevalence runs from central Tanzania north through central and western Kenya and up into south-west Ethiopia. Similar trends are evident in central and West Africa.

1.2.2 What Type of FGM/C is Practised?

The World Health Organization (WHO) has four classifications of the types of FGM/C (see also Figure 3):

- **Type 1** involves partially or totally removing the external clitoris, and is referred to as sunna in some countries (for example, Somalia and Sudan); it is the least invasive of Types 1–3.
- **Types 2 and 3** involve cutting away some of the labia and surrounding flesh, and stitching up (in Type 3, this is sometimes known as the Pharaonic cut) to leave only small openings to the urinary tract and vagina.
- **Type 4** includes any other form of non-medically required damage to a girl's genitals, including cauterisation and scraping (e.g., in Nigeria, these other forms may be referred to as angurya or gishiri cuts).⁶

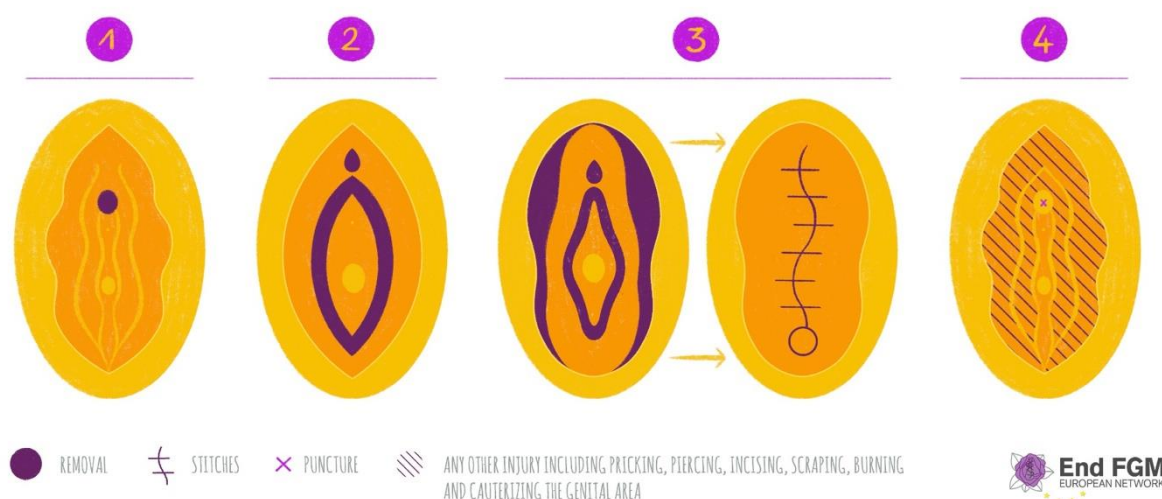


Figure 3: The World Health Organization's FGM-type classifications⁷

The DHS uses a different classification system that does not completely match the WHO's:

- **Cut, no flesh removed:** this is closest to Type 1 or 4 under the WHO's classifications;
- **Cut, flesh removed:** this is closest to Type 2 but could include some Type 1 under the WHO's classifications; and
- **Sewn closed:** this is closest to Type 3 under the WHO's classifications.

Prevalence by FGM/C type is often included in the DHS and MICS datasets and summarised in 28 Too Many's country profiles. It is important to know which type is principally practised in your defined area or region, as type is sometimes linked to the reasons for FGM/C and the age at which it is carried out, as discussed further below.

Country	Cut but No Flesh Removed (%*)	Cut and Flesh Removed (%*)	Sewn Closed (%*)
Benin	5.6	68.9	12.5
Burkina Faso	16.6	76.8	1.2
Cameroon	3.7	84.8	4.6
Chad	39.2	42.5	9.4
Côte d'Ivoire	4.7	71.1	8.7
Eritrea	46.0	4.1	38.6
Ethiopia	2.6	73.0	6.5
The Gambia	0.2	85.2	–
Guinea	11.0	57.7	9.7
Kenya	1.6	87.2	9.3
Mali	25.4	40.7	8.2
Niger	7.2	78.4	6.3
Nigeria	9.6	40.7	5.6
Senegal	8.5	58.3	6.9
Sierra Leone	0.5	75.2	9.0
Somaliland	17.8	–	82.2
Sudan	2.2	16.3	77.0
Tanzania	3.2	81.1	6.6
Togo	12.2	62.6	15.4

* NB: All percentages are of women aged 15–49 who have undergone FGM.

Table 1: Prevalence of types of FGM/C among women aged 15–49 who have undergone FGM/C, according to country of residence⁸

1.2.3 When Does it Happen?

The age at which girls undergo FGM/C varies within and between countries, and the differences are usually associated with local beliefs and culture. Therefore, in order to understand why a girl is cut at a certain age, it is important to understand why it takes place at all.

Determining the age of cutting is critical in identifying if your target cohort is at risk of, or already living with, FGM/C. This will impact on the specific tactics employed and on the choice of beneficiaries. For example, a programme aimed at older primary-school girls might be effective at preventing harm in some communities, but completely miss the mark in other communities.

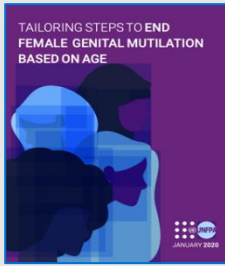
The age ranges for cutting and the associated cultural norms can be roughly categorized as shown in table 2 below. However, it is important to note that these are generalisations that mask the significant degree of variation across different regions and ethnic groups within countries. Furthermore, keep in mind that age of cutting is decreasing in many countries, either to avoid

detection in countries where the practice is criminalized or as a harm-reduction strategy often resulting from anti-FGM/C interventions with a strong focus on the physical and sometimes mental harm associated with the practice. Confirming these general trends through a baseline in the specific project area is therefore always recommended.

Age of Cutting	Associated Cultural Norm	Type of FGM/C Often Practised
< 1 Year	<p>Cutting in infancy is often part of recognising the girl as being a part of the community.</p> <p>Country examples: Mauritania, Yemen, Nigeria, Indonesia</p>	Typically Type 1 or Type 2.
1–4 Years	<p>Again, cutting at this time may be associated with belonging to the community.</p> <p>Country examples: Niger, Guinea Bissau, Mali, Senegal, Burkina Faso, Côte d'Ivoire, Ethiopia, The Gambia, Maldives</p>	Typically Type 2. There is evidence that some girls are being cut at this age, rather than in the 5+ range, since the introduction of laws against FGM/C, so that the girls cannot inform authorities of the practice and because it is believed there are less health risks than at a later age.
5–9 Years	<p>At this age, the reason for FGM/C is a mix of confirming their belonging to the community and anticipating them becoming sexually aware.</p> <p>Country examples: Iraq, Egypt, Sudan, Benin, Chad, Guinea, Tanzania</p>	All types of FGM/C are practised at this age. Girls may be circumcised in this age range before they become sexually aware.
10–14 Years	<p>Cutting pre-puberty and at puberty is often part of the ritual and recognition of the girl becoming a woman.</p> <p>Country examples: Kenya Sierra Leone, Central African Republic, Somalia</p>	Typically Type 2 and Type 3 FGM/C. This is often linked to the family's and community's concern that the girl <u>remain</u> pure to improve her marriage chances.
15–49 Years	<p>FGM/C after 15 years of age is uncommon. It may occur, however, if a girl/woman from a non-FGM/C community marries a man from a different community in which FGM/C is practised, or a woman may undergo re-infibulation after the birth of each child</p>	Re-infibulation may be undergone to ensure continued fidelity to the spouse. Health risks continue throughout life, and are increased at each occasion of re-infibulation.

Table 2: Age ranges of cutting and associated cultural norms

DHS and MICS reports often give breakdowns of when those surveyed experienced FGM/C. Carrying out your own survey, or raising the age issue in discussion with the community, may confirm the most likely age they undergo FGM/C.



Resource: A useful document setting out the dynamics of age in relation to type of programme intervention is Tailoring Steps to End FGM based on Age by the UNFPA (2020, available at:

<https://www.unfpa.org/resources/tailoring-steps-end-female-genital-mutilation-based-age>

1.2.4 Why Does it Happen? (Beliefs About FGM/C)

Women surveyed for the DHS and MICS surveys give a range of reasons as to why they underwent FGM/C. **Understanding the reasons for supporting the continuation of FGM/C is critical to determining the type of programme intervention that will be most effective.** The most common reasons given for its continuation are as follows.

- **Religion:** although it is not required by any major religious text, FGM/C is often believed to be required by religion.
- **Purity and cleanliness:** it may be seen as cleansing a girl of unpleasant genital secretions and odours, or as a beautifying procedure.
- **Family honour and a pre-requisite to marriage:** ensuring the girl is a virgin when she marries; some communities believe men's sexual pleasure will be enhanced by FGM/C.
- **Health:** that it will reduce vaginal and urinary tract infections. In fact, FGM/C has the opposite effect, frequently creating problems with menstruation, passing urine and giving birth.
- **Other myths:** for example, that, during labour, if the baby's head touches the mother's clitoris, he/she will die or be blind.

Some of these reasons are easier to refute than others, but each must be treated with respect in the discussions held with communities, as they will have developed from some aspect of cultural history or spiritual belief. **Practising communities do not set out to harm their girls; rather, they want to ensure the security of their daughters' futures in the community.**

1.2.5 Why Does it Continue? (Attitudes Towards FGM/C)

Many country surveys also include data about whether respondents support the continuation of the practice, whether they will have their daughters cut, and, if so, why/why not. In recent years some DHS surveys have also asked men/partners of the women whether they support the continuation of the practice and whether they expect their wives and/or daughters to undergo FGM/C.

A community's readiness to change and move towards ending FGM/C will depend upon its members' knowledge of the practice and its impact on girls and women, and their attitudes to its continuation, both of which are included in some of the countries' DHS and MICS datasets.

In some communities it is the women who feel more strongly than the men that it should continue, usually because they see it as essential for the girl to make a 'good' marriage. It is also worth finding out, perhaps by local survey, what boys and girls think about its continuance, as it is their futures that are to be challenged by any intervention. Many girls think they should be cut because that is what will make them a woman; they fear being ridiculed by their peers and continuing to be treated as a child. Boys may fear being ridiculed if they marry a girl who has not been cut, as she may be marked out in their community as being 'over-sexed' and, therefore, likely to commit adultery.

1.2.6 Who Decides Whether Girls and Women Should Be Cut, Who Influences That Decision, and Who Does the Cutting?

Answering these 'Who?' questions depends upon having a clear understanding of various peoples' roles and ranks within the target community. A thorough analysis of stakeholders and their interests in the FGM/C process is critical. This stakeholder analysis will need to take account of the following actors:

Female stakeholders	Male stakeholders	Professional stakeholders
The girl	Fathers	Health workers
Mothers	Other male relations	Education staff/teachers
Grandmothers	Future husband	Community leaders
Other women in family and community	Other men in the community	Religious leaders
The girl's peers	Boys in the family and community	NGO staff
		Donors

(NB There may be other stakeholders, depending on the context of your target community.)

It is important to consider whether there are any stakeholders in the community who will lose, or feel they do, if FGM/C ends, and how they may be a barrier to the success of your intervention. Think about arguments to show them what they, too, might win to bring them onside.

There are a wide selection of stakeholder-analysis frameworks available on the web, or your organisation may have its own template.



Resource: A useful template is provided by Tools for Development, which can be adapted to meet your project needs:
<http://www.tools4dev.org/resources/stakeholder-analysis-matrix-template/>

Headings you will need when analysing actors in an FGM/C-intervention design will be as follows (you may want to add others; these are the minimum necessary):

The stakeholder	What is important to the stakeholder about intervening to reduce FGM/C?	What level of impact will ending FGM/C have on them – high/medium/low?	What level of influence do they have on the continuation of FGM/C – high/medium/low?	Could they block anti-FGM/C interventions? How? What needs to be done to mitigate or prevent blocking?	Could they contribute to the project/intervention? How could they be engaged to contribute?
Girl	<p>Her lifelong health and well-being</p> <p>Her identity as belonging to the community, being recognised as becoming a woman and marrying well within the community.</p> <p>The socio-economic support network provided by family and community.</p> <p>Her education – may lose time at school if she experiences serious damage to her health</p>	<p>High</p> <p>If she is not cut she could avoid lifelong damage to her physical and mental health, impacts on her education and economic empowerment.</p> <p>But she may reduce her marriage chances and/or be stigmatised by her peers and the community.</p>	<p>Medium</p> <p>Others will make the decision about her own FGM/C and continuation of the practice, especially when girls are cut at a very young age. In contexts where girls are cut around puberty, they sometimes support the decision or even ask to be cut as a result of peer pressure and social norms stigmatizing uncut girls.</p>	<p>No</p> <p>She will not be able either to support or block any intervention to reduce FGM/C against the will of older community members.</p>	<p>Yes, though with difficulty because she has little power to influence.</p> <p>She could be given a voice (an opportunity to express her feelings and points of view) through open community dialogue.</p>
Grandmother	<p>Her status and reputation as a custodian of tradition and a guardian of family honour, which is often strongly linked to ensuring that the family's daughters are cut.</p>	<p>High</p> <p>Will lose status and reputation, which are important factors ensuring social security for older women who depend on their family's support for their livelihood.</p>	<p>High</p> <p>In patrilineal and patrilocal societies, the paternal grandmothers often wield significant influence on family matters, especially those related to girls and women, even if patriarchal norms mean that this influence is often exercised "behind the scenes".</p>	<p>Yes.</p> <p>As key decision makers with regards to cutting the girls in their families they could work directly against the project's intentions.</p> <p>They could also block or counter any attempts to influence key male decision makers at the community level, using the influence they have, particularly on their sons.</p>	<p>Yes.</p> <p>Interventions can build on the traditional influence of (paternal) grandmothers by engaging them in non-directive discussions on girls' issues and rights, and by strengthening their traditional role in the community while at the same time using their reach and influence to diffuse new ideas.</p>

Traditional cutter	Her status as a custodian of tradition and the income she makes from cutting.	High Will lose status and income.	Medium Cutters are not necessarily the ones who decide whether a girl is cut or not. They can encourage families to cut their daughters, but if they decide to stop cutting, families might find other ways of having their daughters cut.	Yes Cutters who feel that an intervention threatens their status, income and maybe even identity, can turn into opponents. The level to which they could actually block the project will depend on their level of influence in a given context.	Yes, If interventions address their concern for maintaining cultural identity and heritage and help them identify strategies to remain valued and respected members of the community without performing FGM/C.
Religious leader	Retaining authority in the community and providing “good” religious guidance.	Low It will have little personal impact on them, but they may feel like losing part of their cultural and religious heritage. When higher level religious leaders continue to support FGM/C they may also risk conflict and loss of influence among their peer religious leaders.	High Religion is one of the most commonly cited reasons for continuation of FGM/C, and communities look to their religious leader for guidance.	Yes They could block any anti-FGM/C project if they see it as being anti-religious and as undermining their authority.	Yes, If they can be persuaded of the benefits of ending FGM/C, they would be a strong ally. Arguments linking human rights, as well as girls’ and women’s rights to religious values like respect of god’s creation as well as clarification of misinterpretations of religious scripts can help win religious leaders as supporters to ending FGM/C.
Men & Boys	Maintaining the principle of male authority in the household and village. Maintaining the family honour which depends on ensuring that the daughters of the family fulfil the local standards for respectable women, including being cut. Ensuring the future of the family’s daughters, which includes marrying them well.	Medium. May feel their authority is eroded, and fear their daughter will be rejected for marriage	Medium, if it is a culture in which men are the final decision makers at household and community level. However, even in these cases they may be strongly influenced by the grandmothers’ guidance.	Yes, If they feel that ending the cutting endangers their authority and their cultural identity. Boys and young men as a group can oppose a project by refusing to marry girls who have not been cut.	Yes, encourage them to recognise the human rights of women and girls and the benefits to the family and community that this will bring, e.g. girls’ education and economic employment. Boys and young men could be encouraged to accept uncut women by explaining how they and their wives will gain more sexual pleasure if uncut. But careful not to create stigma for cut girls.

Table 3: Example stakeholder analysis

2. PROGRAMME-DESIGN PHASE

The Purpose of This Phase

Having conducted a thorough scoping process, you will now be able to design your programme on a firm basis, fully understanding the context in which you will be working. The purpose of this section is to provide guidance on how to take forward the design of your programme on the basis of your scoping research, in a way that supports social norms change.

This design phase comprises three parts, and we will look at how you can operationalise each of them:

- **Describe your target community:** who are you trying to reach? Where are they located? What are their ages, the type of FGM/C they experience, and the attitudes of their community to FGM/C? Who decides and influences decisions about whether or not a girl should be cut? Draw out the linkages between these factors and how they impact on each other.
- **Analyse the data collected** in your research of your target community.
- Decide on and describe what you hope to achieve with the programme: what are your objectives, anticipated outcomes and impact?
- **Decide what tactics and interventions to employ** to achieve your desired impact. Interventions that have been tried are summarised below, with suggestions about the context for which they are most suited in the social-norms-change process.

2.1 Describing the Target Community

The first task, based on your scoping research, is to **describe your target community**.

What will be your geographic area? Will it be urban or rural? Will you start in an area (village/ suburb/ province) where prevalence is high and the practice firmly embedded in the community? Or will you start in an area where prevalence is lower and the community has already shown an interest and a willingness to end the practice? Sometimes it can help to start with a community where there is already some willingness to change in order to test your tactics, and get some feedback on and recognition for your approach.

'Where' might also involve decisions on whether to take an approach that deals with cross-border FGM/C or an ethnic group that spans several countries, rather than focusing on one location in one country. For this, you will need to take into account the differing anti-FGM/C laws in the various countries and the attitudes of their governments.

Having decided on **where** to focus your programme, revisit your initial scope (see previous section) to clearly understand:

- **what** type of FGM/C is practiced in the selected area;
- **when** girls are most vulnerable to FGM/C taking place in the selected area;
- **why** FGM/C of that type, at that time, happens in that place;

- **attitudes** towards FGM/C and its continuation in the selected area – these will shed light on why FGM/C continues and on a community’s readiness to change; and
- **who** to target based on your stakeholder analysis – who decides, who influences and who cuts?

2.2 Analysis of The Community Scoping Data

Having gathered data on the community, you need to analyse that data in order to understand its importance in programme design.

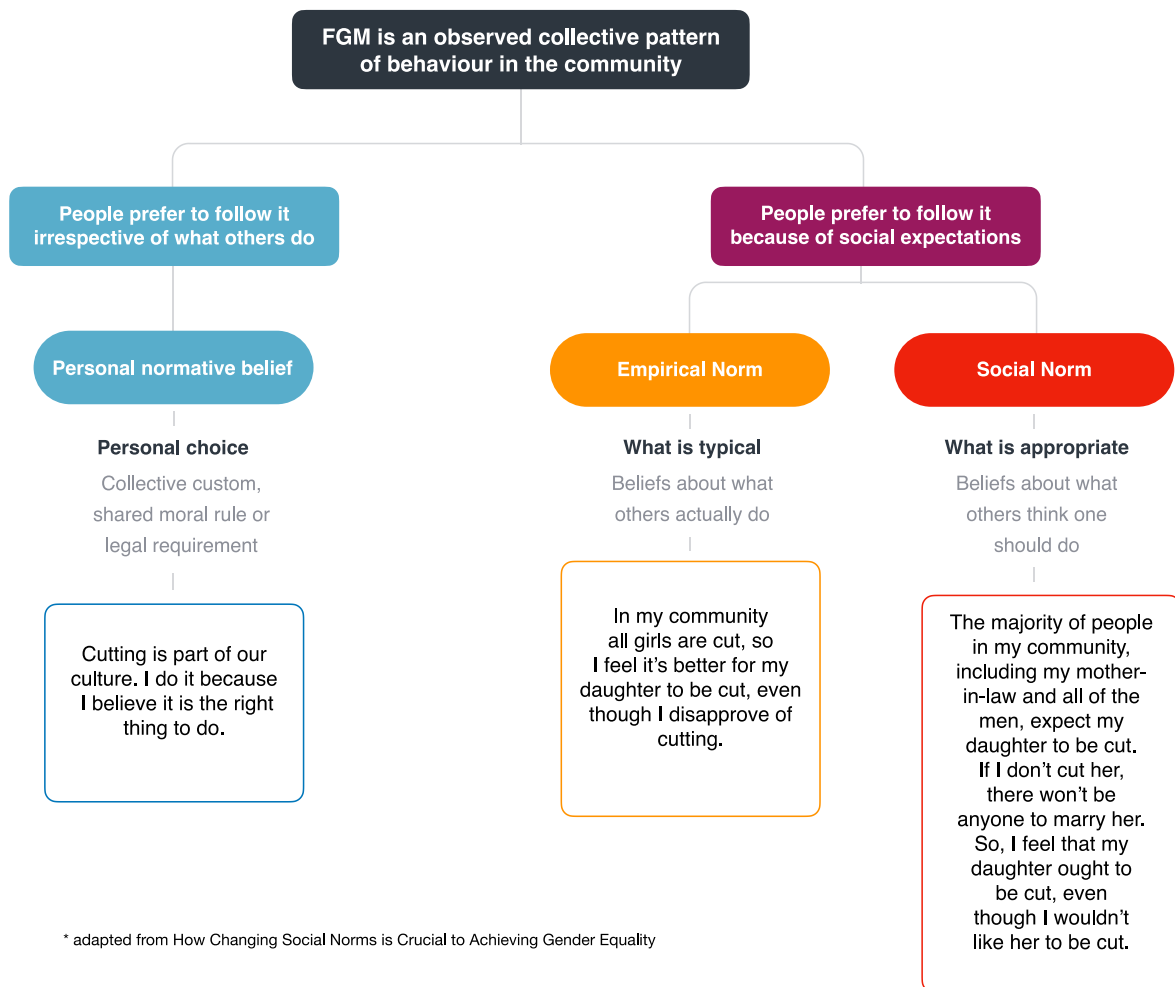


Figure 4: Diagnosing social norms

2.2.1 Is FGM/C a social norm in this community? How does that influence programme design?

In many practising communities, FGM/C is an embedded social norm. This makes it necessary to do more to change behaviours than simply changing the personal beliefs of the individual. One also needs to work towards a shift in the communal expectations that enable the social norm to persist.

2.2.2 Do attitudes align with prevalence? How does that influence programme design?

The graph below shows the prevalence of practice in many of the FGM/C-practising countries compared with the percentage of survey respondents who think FGM/C should continue.

Where support for continuation of the practice is low compared to its prevalence, it raises the question, 'If so many people do not believe the practice should continue, why then does it continue?' An opportunity is created to build on that majority support for abandoning the practice.

Conversely, where support for continuation of the practice is high compared to its prevalence, those in the minority who oppose its continuation need to be supported, and the emphasis should be on challenging the deeply held beliefs and/or myths on which that high support for continuation is based.

This analysis is important for deciding where you need to start on the K-A-P spectrum.

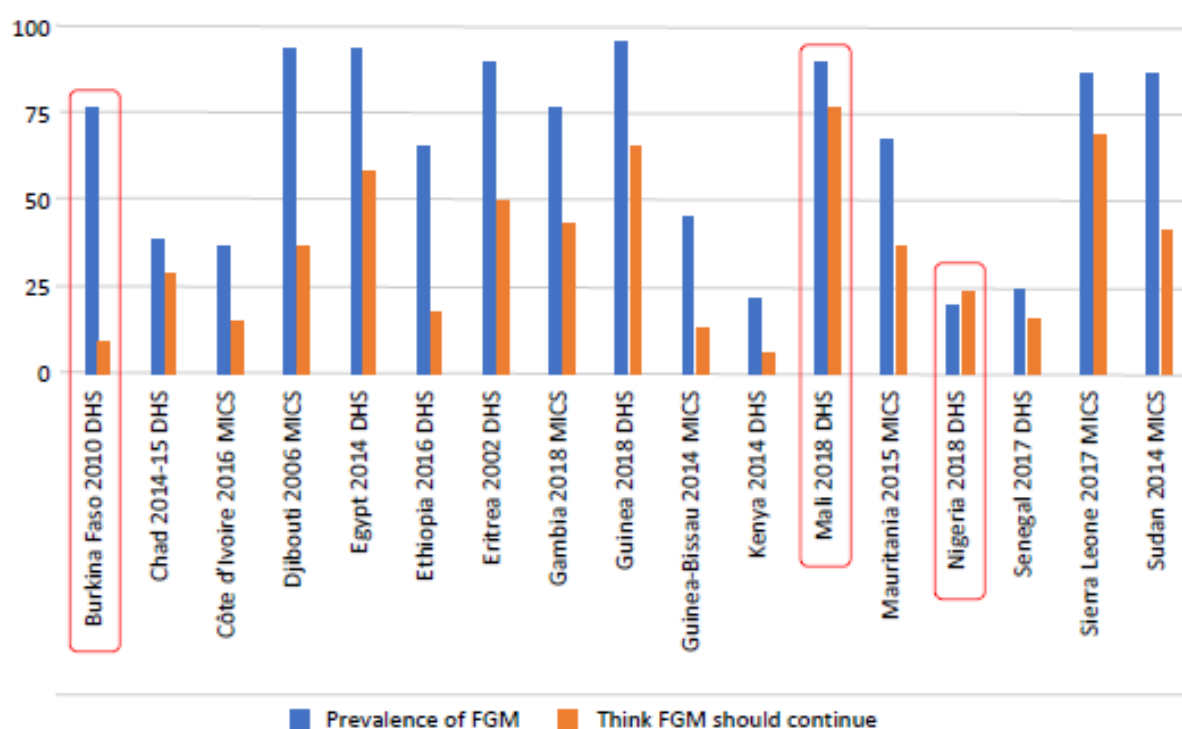


Figure 5: Prevalence of FGM in various countries compared to support in each for continuing the practice

Let's look at some examples.

Figure 5 shows that in Burkina Faso FGM/C prevalence is around 75%, yet only 12% of those surveyed think it should continue. This would suggest that people already have knowledge of the impacts, but they continue to put their daughters through the experience because the sanctions imposed for not cutting them outweigh these concerns (perhaps by reducing their chances of obtaining a 'good' marriage, or triggering peer pressure and stigmatisation by other members of the community).

On the other hand, in Mali prevalence is also high, at about 85%, but a majority (over 75%) think the practice should continue. This suggests that FGM/C is a deeply embedded social norm that few are willing to abandon.

In Nigeria, the number who think the practice should continue slightly exceeds the prevalence, suggesting there is a need to ascertain why so many think it should continue, yet don't actually expose their daughters to FGM/C.

Another important aspect when considering the prevalence of FGM/C in relation to support for it is whether it is most strongly supported by men or women. Not every DHS deals with this distinction, but an interesting country to look at is Sierra Leone, where 69.2% of women aged 15–49 think FGM/C should continue, as compared to 46.3% of men. Here FGM/C is a rite of passage for girls to womanhood that enables them to enter the exclusively female Bondo secret societies. This suggests that the sanction of not being able to join Bondo society is immensely influential on a family's decision to cut their girls, and that the principal upholders of this difficulty are the women in the family.

In all cases, however, you need to think about the prevalence of FGM/C versus the level of support for its continuation in the context of the specific location and community in which you will be working.

2.2.3 Is prevalence changing over time? How does that influence programme design?

Another critical influence on your programme design is whether or not prevalence is declining over time. Are girls less likely to be cut than their mothers and grandmothers?

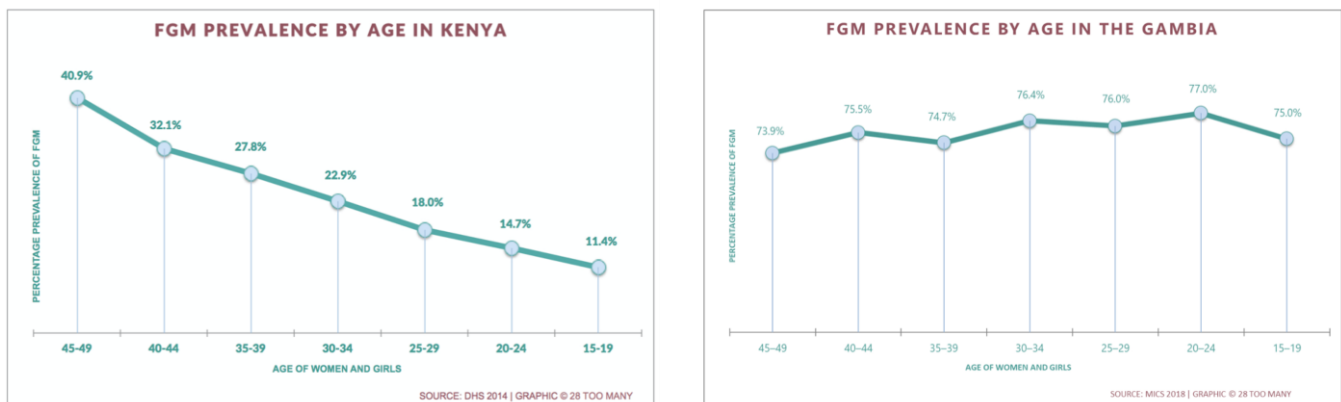


Figure 6: Prevalence of FGM/C according to women's ages in Kenya and The Gambia

From the above graphs we can see that, in Kenya, mothers are twice as likely to have been cut (20 years ago) than their daughters are today. Grandmothers are almost four times as likely to have been cut. There appears to be real momentum towards ending the practice. Your programming could thus focus on how you can build on that momentum by encouraging a sustainable change in attitudes and practice.

There has been very little decline in FGM/C in The Gambia: roughly the same number of girls are entering womanhood (at 15) having been cut as their grandmothers (now aged 49), who were cut nearly four decades ago. This suggests there is still a lot of work to do to increase

people's awareness and knowledge of the harms of FGM/C before we are likely to see any change in attitudes or practice.

Again, you need to look at the age trends specific to your selected region and communities, which may vary from the broad national picture.

2.2.4 How do religious beliefs influence programme design?

The dominant religion and its influence on the practice of FGM/C in your selected community is another key aspect to take into account when designing your strategy. Although FGM/C is not a requirement of any religion, or mandated by any religious text, many communities mistakenly associate the practice with religion.



Figure 7: The role of religion in FGM/C programming

As depicted in Figure 7, working with religious leaders and treating them as key influencers is only going to be important and effective in a community where people believe FGM/C is a requirement of their religion.

For example, Somalia and Eritrea are both Muslim countries, and in both FGM/C prevalence is above 85%. But in Eritrea only 1% of women who have experienced FGM/C believe it is a religious requirement, while in Somalia 87% of women who have undergone FGM/C believe it is a requirement of Islam. Engaging with religious leaders in Somalia and bringing them onside to end FGM/C is therefore critical. However, they are unlikely to have much impact on your interventions in Eritrea.

2.2.5 How do power dynamics influence programme design?

The critical features of the stakeholder analysis that need to be considered further are:

- who decides whether girls should be cut; and
- who has the power to influence that decision?

This involves understanding the power dynamics in the community.

It is helpful to conduct a paradox matrix for each of the key stakeholders, based on the stakeholder analysis and plotting how they will be impacted by the intervention against their power to influence the decision to continue FGM/C.

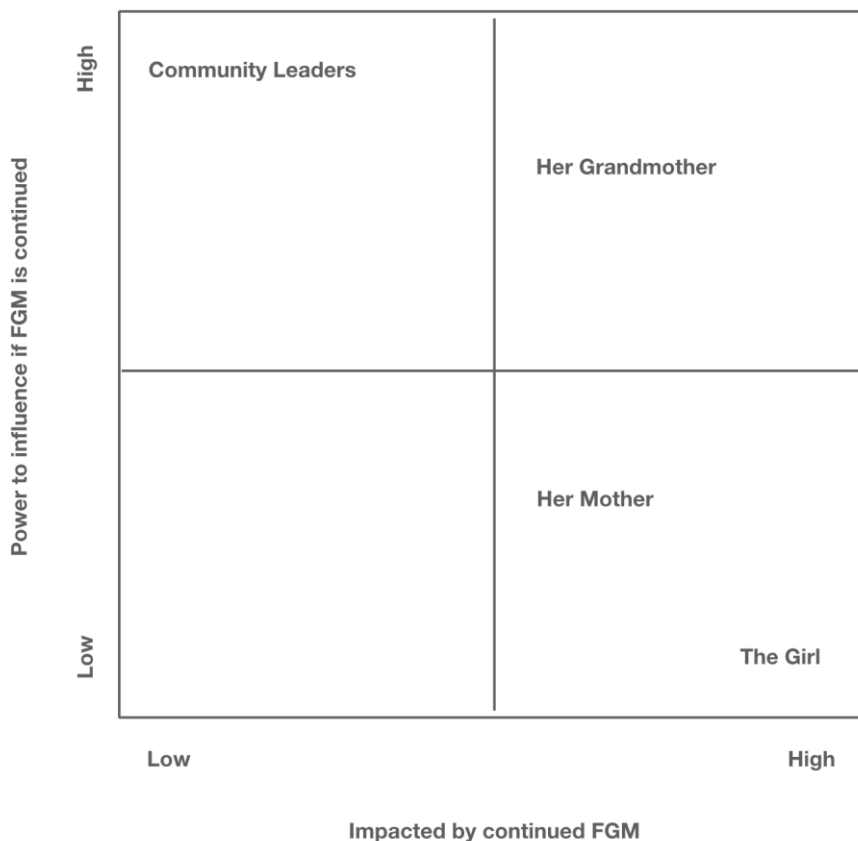


Figure 8: Sample Paradox Matrix

For example, in our analysis (above) of a particular community, we see that the girl typically has no real power to influence the decision and yet she is obviously the most highly impacted. Her mother might have some influence, but probably not as much as her grandmother. Both these women would potentially be negatively impacted if the girl were not cut, since they could be stigmatised. Grandmothers are often the cutters, and this may be their only source of income and status within the community, because in some communities, unlike old men who are often regarded as sage and wise, old women past their reproductive age have very low status. If this is the case in your target community you will need to think how you can bring the grandmother's onside and ensure they retain an independent income and do not lose status.

Community leaders (in this example, all men) might have the most influence and yet be the least impacted by the practice.

28 Too Many's *FGM and Social Norms* discusses the likely role and rank of stakeholders in an FGM/C-practising community with regard to decision-making, influence and authority, and concludes that:

When you are designing a programme to shift social norms around FGM/C, it is essential to both:

- **work with the full range of stakeholders** who have experienced FGM/C as well as those who play roles as decision-makers, influencers and performers in shaping FGM/C practice in a given community (which is likely to include most community groups as well as relevant categories of professionals who have contact with the community); and
- **authority** to shape the practice (which is likely to include elders, and female elders in particular).⁹

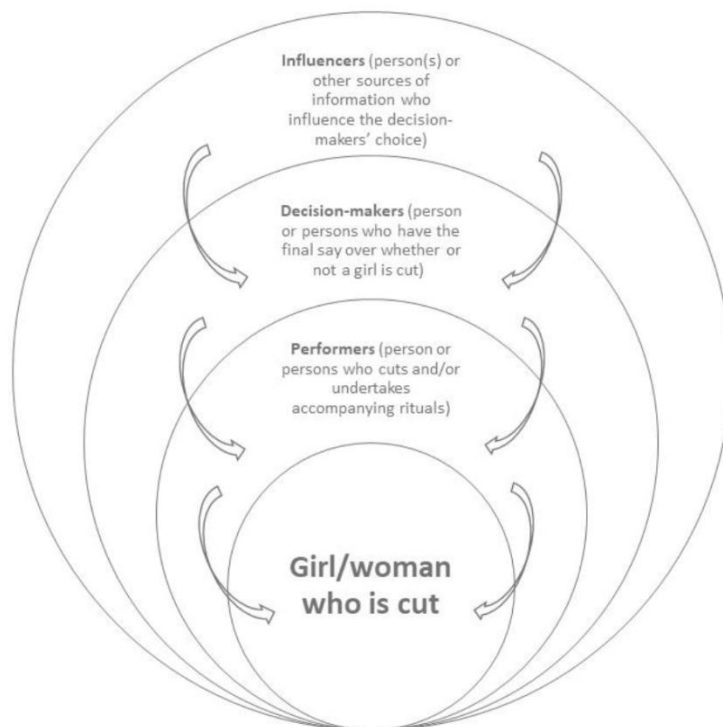


Figure 9: Key actors in the practice of FGM/C

When looking at potential impact of an intervention it is important to identify potential negative impacts as well as the desired outcomes, and understand the fears of those actors who may lose out. If not taken into account, they may become barriers to achieving the desired aim of ending FGM/C in the community. For example, grandmothers may block your efforts in communities where they will lose income and status; men (as husbands, fathers or religious and community leaders) may fear a loss of their authority and present barriers. Consider how their losses can be mitigated so they can be brought onside to support the intervention. (This is discussed further at 2.4.2 C.)

Also, don't forget the important role men and boys, as fathers and prospective husbands, can have on the outcome of your intervention, in the short and long term; they need to be brought onside from the start if they are not to become barriers by refusing to marry uncut girls.

2.3 Deciding on Anticipated Outcomes and Impact

What you hope to achieve with your programme will largely depend on how ready the target community/communities are to engage with you. Typically, three impact possibilities are considered:

- **knowledge:** increased knowledge of FGM/C (know what FGM/C is and understand its impacts);
- **attitude:** decreased acceptance of FGM/C (believe FGM/C should stop); or
- **practice:** decreased prevalence of FGM/C (actually stopping FGM/C).

There is a progressive logic to these three impacts/outcomes: as knowledge increases, so attitudes shift over time. Attitudes are expressed in statements like 'I believe one should . . .' For example, if one believes that FGM/C is a religious requirement, then new knowledge that shows it is in fact not a religious requirement (especially from a trusted source) will slowly shift that belief/attitude. As that belief shifts (together with other supporting beliefs), one might come to a point where FGM/C shifts from being desirable to being unacceptable.

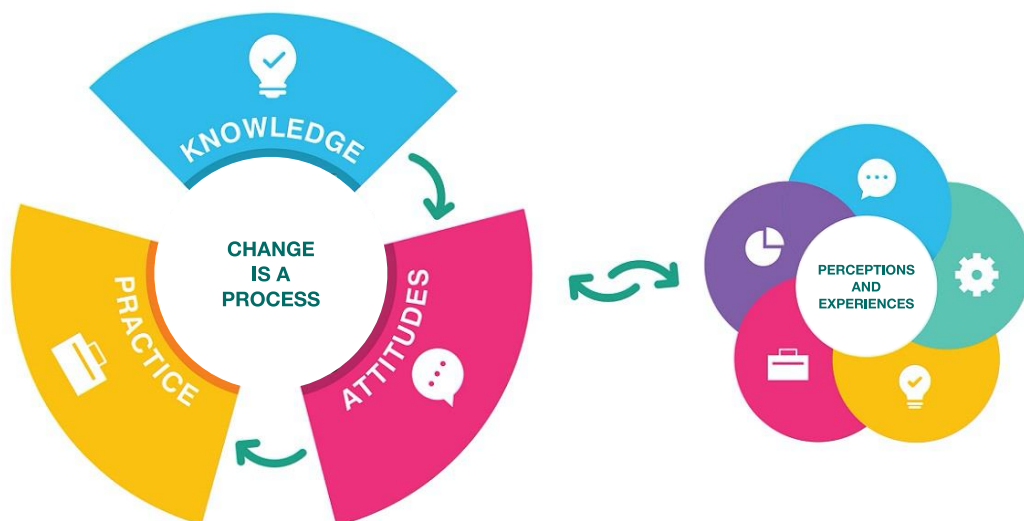


Figure 10: The K-A-P Process¹⁰

However, a shift in personal **knowledge** and **attitude** (belief) does not necessarily translate into a shift in **practice** (behaviour). This is because FGM/C is often upheld by expectations that we believe others have of us. In order for us to change our **practice** (behaviour), we need to know that everyone else in our social group has also changed their **attitudes** towards the practice. This calls for transparent communication and community dialogue.

2.3.1 Progressive Change

Change typically follows this process:

- a. Learning new **knowledge** from a trusted source.

- b. One often discounts this new knowledge (as 'fake news') if it comes from an untrusted source and/or if it undermines and challenges one's existing beliefs.
- c. Repeatedly acquiring new knowledge from a number of different trusted sources should lead to a change in beliefs and **attitudes** over time.
- d. However, new (dissonant) beliefs are risky. We often feel like we are the only ones in our community to hold this new belief. The sanctions in the community are often high for those who rebel and so we keep our beliefs to ourselves.
- e. Over time, however, there is a growing awareness that others in our social group are going through this same shift. This awareness is almost always only achieved through some kind of facilitated community dialogue.
- f. At that point, we (the community) can jointly imagine shifting our expectations of each other (social norms). The key to change is believing that everyone is on board with the change and that there will be no negative sanctions as a result of the change.
- g. Once we are all convinced of that, an agreement to change our **practice** (behaviour) is possible. It is only at this point that actual changes in behaviour take place.

This process is well illustrated by UNFPA:

Figure [13] shows that although knowledge and attitude might move in the same direction – 'I acquire knowledge and more or less in an interactive way I gradually change my attitude' – attitude and practice, when a decision is more 'interdependent', may not change in an interactive way. Instead, it can be a coordinated behavioural change, quite slow, and then sudden: enough people have to believe that enough people are changing – seeing others manifest change is often the best way of being sure of it. In one way, social norms are very easy to change (or establish), but in another way they are very hard to change because of the need to get enough people to coordinate on making the change.¹¹

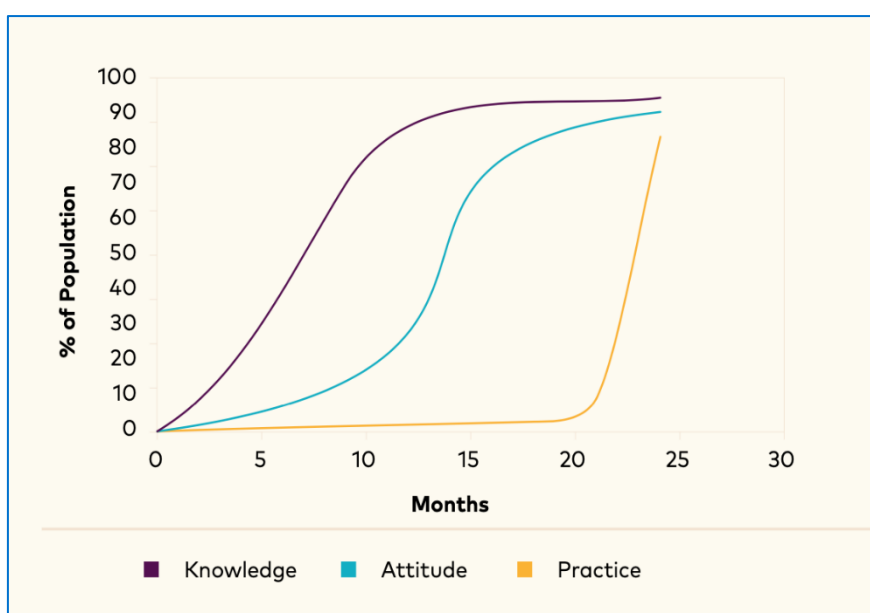


Figure 11: Interactive shift of attitude and coordinated shift of practice¹²

2.3.2 Three Possible Outcomes

Based on your scope of the community, you should have a good sense of what the underlying reasons for FGM/C are and what community attitudes towards its continuance are. It is critical to diagnose where the community is at in the K-A-P cycle before deciding on your programme outcomes/impacts and the tactics you wish to employ.

Ultimately, you will need to decide which of the following three outcomes are most appropriate for this programme cycle:

Increasing knowledge in the community. This could include:

- increasing understanding about what FGM/C is and its impacts;
- discovering that there are no religious requirements for FGM/C;
- debunking myths that support FGM/C; or
- raising awareness of prevalence and attitudes in the broader community and looking at examples of communities that have abandoned the practice.

Key questions to answer for increasing knowledge are:

- What knowledge does the community already have?
- Do we need to share existing community knowledge more broadly?
- What additional knowledge is required?
- Who needs to know what?
- Who needs to deliver that information? Who will be trusted by the community?
- In what format should that information be delivered?
- Over what timeframe should that information be delivered?
- How will we know when the appropriate knowledge is common knowledge?

Changing attitudes in the community towards:

- the marriageability of uncut girls;
- the 'purity' of uncut girls;
- gender empowerment and gender equality;
- the value of girls' education; and
- early marriage.

Key questions to answer for changing attitudes are:

- Whose attitude needs to change?
- Do they have the knowledge/information required to support that change?
- Do they have permission/power to effect changes in attitude across the community?
- What support do they need to shift their beliefs (attitudes)?

Agreeing to shift **practice (behaviour)** in the community. This should lead to:

- an agreement to end the practice completely.

Key questions to answer for shifting practice are:

- Is there broad community buy-in/readiness for ending the practice?
- Is the community ready to reduce the sanctions associated with the desired change in practice?
- What are the other potential (negative) consequences of a change in practice? How will these be mitigated?
- By what process will the community decide to change this practice? Who needs to be included in that process?
- How will the community memorialise this change in practice?
- How will this change in practice be sustained?

Having decided on the outcome, we can now turn to the different tactics (see below) that could be employed, noting that each tactic will be more effective at supporting one of these impacts rather than others.

2.4 Deciding on Tactics to Employ to Achieve Your Outcome

The overarching tactic recommended for effective social-norms change is catalysing community dialogue and collective problem-solving.

Community dialogue and collective problem-solving, including intergenerational dialogue, are not new to the development sector. These strategies are commonly used in other development programmes. These same strategies need to be employed in your FGM/C programming. Within that broad framework, we present some specific tactics related to FGM/C that might be considered in your programme design, based on the specifics of your context. We have divided these tactics broadly across the K-A-P spectrum.

2.4.1 Specific Tactics for Increasing Knowledge

The tactics for increasing knowledge will obviously take into account:

- **Audience:** who are we seeking to communicate with?
- **Message:** what are we seeking to communicate?
- **Messenger:** who should deliver the message?
- **Medium:** what medium (radio, social media, word of mouth) should we use to deliver the message?

In deciding on your approach, you should also consider the following specific tactics related to the message, messenger and medium:

A. Knowledge of the impacts of FGM/C

Promoting messaging that focuses solely on the physical health impacts of certain types of FGM/C has been shown to lead to a shift from more physically extensive cuts (e.g. Type 3) to Types 1 and 2, rather than the abandonment of all type of cut. This tactic is also associated with increasing medicalisation of the practice, whereby medical professionals perform the cut as communities believe it will be 'safer'.

To effectively introduce new knowledge about the short- and long-term complications of FGM/C to a community the most effective way is to work with those members of the community who have the authority over tradition and culture, which in many cases will be elders, in many cases grandmothers. To this end the formal and informal leaders of these groups of community members should be identified; the individuals that the others listen to. If the information sharing is undertaken in a dialogue-based, non-directive way that builds on peoples' own experiences, raising awareness about risks can contribute to changes in views and behaviour.

Such an approach takes into account that women are often aware of the health risks and side-effects but continue the practice for other reasons. For example, in some communities, withstanding the initial pain of the procedure is often highly valued, while in the longer-term women can gain social advantages from undergoing the procedure.

B. Religious leaders speaking out against FGM/C

The purpose of this approach is to demonstrate that FGM/C is not compatible with the religion of a community.

This strategy would only be relevant in communities where religion is considered to be a key driver of the continued practice of FGM/C. Analysis of DHS data suggests that this approach might be appropriate in Egypt, Guinea, Mali, Mauritania, Sierra Leone, Somalia and practising countries across Asia and the Middle East.

It must be noted that while this data refers to the belief that FGM/C is a religious requirement across the country, there will be differences within the country between various localities and ethnic groups. Your scoping study should have indicated how relevant it is in your selected communities.

C. Designing media campaigns

Your programme is almost always going to include a mix of various media. In most African countries radio is the most common form of media used by the majority of the rural population. In recent years African countries have also developed strong social media networks, and a large majority of the urban population own or have access to mobile phones. Both are important tools in the campaign to abolish FGM/C and can contribute to an enabling environment for discussing taboo subjects that contribute to social norms change.

Where possible, it is always better to seek to enable dialogue (two-way communication) rather than simply broadcasting your message to the community. On radio that might mean a phone-in show or a discussion between a number of guests in the studio, while a poster campaign would be best supported by a facilitated dialogue about the poster's message.

2.4.2 Tactics Aimed at Changing Attitudes

Community-dialogue and collective-problem-solving strategies for shifting attitudes should primarily be driven by your stakeholder analysis. It is important to identify both those stakeholders who influence the continuation of practice in the community and those who decide if a specific girl should be cut. The following tactics should be considered where appropriate:

A. Involving traditional gatekeepers such as grandmothers

Grandmothers may play a significant role in the retention of the tradition and even be the main cutters in a village. If this is the case arising from your stakeholder analysis, engaging them in dialogue about ending FGM/C is critical. FGM/C may be their main source of income and status in the community and in the family, and they are likely to be reluctant to give that up.

The **Girls' Holistic Development Programme** implemented in Senegal by the NGO Grandmother Project – Change through Culture aimed to promote positive family and community values in support of various aspects of girls' development, including access to education and prevention of early marriage, adolescent pregnancy and FGM/C. It depended on intergenerational dialogue that recognised the status of grandmothers as norm-setters and advisers to younger generations.

Over time the programme expanded to 70 rural communities, whose activities include intergenerational forums, Days of Praise for Grandmothers, non-formal education training and Grandmother Leadership training aimed at encouraging their collective action to support adolescent girls and abandon FGM/C.

Community elders interviewed about the project said they felt obliged to follow the advice of the grandmothers; for example, *'We could not refuse the advice of the grandmother leaders to stop the practice, given their authority and our respect for them.'*

More Information on the Grandmother Project can be found at www.grandmotherproject.org

B. Active engagement of traditional authority figures

Since the aim is to achieve broad community buy-in for the abandonment of FGM/C, it is critical to include community leaders and village elders in the dialogue from the beginning, alongside religious leaders, as they are likely to hold considerable influence.

Modernity is feared by many in remote rural locations as it appears to undermine traditional values such as respect for elders, which is a cornerstone of many traditional African societies.¹³ Similarly, 'NGOs can be seen as outsiders bringing a subtle form of cultural colonialism disguised as development. The state is often seen to be corrupted by the international community.'¹⁴ This stance allows FGM/C to become a symbol of resistance; thus, prevalence remains high.¹⁵

C. Engaging men and boys

Changing social traditions should involve all members of the community, not just women and girls. Some programmes explicitly include men and boys, but it is important to recognise that

this strategy needs to be tailored to the specific community, with clear understanding of the role men play in FGM/C decision-making and their knowledge and beliefs about FGM/C. This should have emerged from your scoping process and stakeholder analysis.

An example of such a programme is **Men Engage Africa (MEA)**, which is the regional network of the Men Engage Global Alliance (<http://menengage.org/regions/africa/>). MEA has members from 22 countries, including ten that practice FGM/C (Ethiopia, Kenya, Liberia, Mali, Nigeria, Sierra Leone, Tanzania, Togo, Uganda and Cameroon.)

MEA members work collectively towards advancing gender justice, human rights and social justice in key thematic areas including sexual reproductive health and rights (SRHR), GBV, and HIV prevention, child rights and positive parenting and promoting peace on the continent.

They have produced an SRHR Advocacy Toolkit to assist Men Engage Africa Youth structures to design, develop and implement advocacy strategies focused on SRHR. It is a collection of tools and information sourced from established organisations working in the fields of youth, advocacy and SRHR. The toolkit is designed for organisations that work with men and boys towards gender equality and the empowerment of women and girls, but can be used by any group that is interested in SRHR advocacy. (See <http://menengage.org/resources/srhr-advocacy-toolkit-for-young-people/>) The toolkit includes a discussion of how men can advocate for ending FGM/C.

Another example of bringing men into the dialogue is in high-prevalence Kenyan communities where men are becoming agents of change as they find the courage to share their stories of standing up to their families' expectations and holding fast to their beliefs in the rights of women and girls. By declaring that they will marry or have already married uncut women, their voices translate into action – teaching other men and boys in their families and communities about the harms of the practice and the benefits of educating girls and protecting their health.¹⁶

D. Supporting positive deviants (high-risk strategy)

Positive deviants are individuals who have challenged or 'deviated' from societal expectations by abandoning FGM/C. These individuals are often held up as role models.

The positive-deviance approach is more likely to be effective in shifting attitudes towards FGM/C if the role models carry authority within the community. This approach is also more likely to be successful if there are no social sanctions on either deviants or those who follow them; hence, the need for a collective process of community-level norms change, whereby everyone agrees to a shift in behaviour.

These strategies can often lead to confrontational approaches, however, which are often harmful when it comes to dealing with issues within communities themselves. This is because the approach divides the community into different groups with divergent interests and, therefore, is likely to undermine the cohesion, consensus and collective problem-solving ability that is key to improving community health.

Indeed, confrontational encounters over FGM/C may protect girls from immediate risk but make them vulnerable in new ways. Girls who have spoken out can become estranged from their families and dependent on the support of others for their basic needs, which in turn makes them vulnerable to sexual abuse and exploitation, among others. This approach also leaves few options open to girls and women who oppose harmful practices but are not ready to sacrifice the wellbeing, security and sense of belonging that comes with their conforming to dominant cultural norms.

Programmes of this type have had variable success. Those that showed positive results did so because they built on locally relevant reasons for abandonment and recognised that the solution to the problem already existed within the community.

Youth education and forums are more likely to work than individual positive deviants as this may give young girls the protection of collective deviance. **There may be a place for 'role models', but it has to be said that this is a high-risk strategy and may endanger girls.**

2.4.3 Tactics that Demonstrate a Change in Practice

It is vital that we don't deploy tactics designed to demonstrate a change in practice too early in the process. These tactics should only be used once there is broad-based agreement to change. When these tactics are deployed too early, they create a false sense of impact and almost always only result in short-lived change. An example of the need to take the long view is that of a survey undertaken in 2019 of Tostan's work in Senegal, in which 32 communities, where declarations to end FGM/C had been made between 2008 – 2013, were surveyed. The study concluded¹⁷:

- in 20% of the communities that participated in the declarations there is evidence that FGM/C has been abandoned;
- in 35% of the communities there is some evidence of abandonment;
- in 45% of the communities who participated in the declaration there is no evidence of abandonment.

This shows the need to recognise that social norm change takes time and thinking in terms of short-term project timescales is unlikely to produce lasting change.

A. Alternative rites of passage (ARPs)

Alternative rites of passage have been developed by NGOs since the mid-1990s as part of programmes to end FGM/C in communities where cutting forms part of the initiation of girls into womanhood, typically at puberty (for example, among the Maasai and Samburu in east Africa). ARPs can take various forms, but essentially aim to replicate traditional initiation rituals for pubescent girls who are transitioning to womanhood, but without FGM/C.

While some programmes proposing ARPs have been successful in certain contexts, particularly when accompanied by extensive, community-based dialogue that involves the community as a whole and promotes a consensus to abandon the practice, success is by no means widespread.¹⁸

It is increasingly being recognised that, as ARPs are usually imposed from 'outside', rather than being community-led, they often overlook kinship and deeper social norms at work within

FGM/C-affected communities. This raises questions as to whether ARPs do lead to long-term abandonment of FGM/C or simply represent a postponement of the practice.

A survey to assess a 2017 ARP intervention among the Maasai community of Kajiado in Kenya found that, while successfully committing the community to girls' education and thus delaying early marriage, none of the girls interviewed post-ARP considered themselves to be a woman in any traditional sense, neither were they considered as such by community members. It can be supposed that the ARP is not an alternative rite of passage (into womanhood), but a rite that signifies an extension of childhood. Preventing school dropout and buying time through education is, however, no guarantee that girls will not be cut at some later stage if what it means to be a woman is not redefined and embedded in daily life.

The evidence increasingly suggests, therefore, that ARPs are only an appropriate strategy when tailored to the specific cultural and local context in which they are used and are combined with community-wide dialogue to effect social-norms change.¹⁹

B. Public declarations of abandonment and establishment of FGM/C-free villages and areas

Public declarations may be effective in supporting a momentum of change in villages where a majority of the influential formal and informal leaders, including (depending on context) grandmothers, have already changed their attitudes as a result of intensive community dialogue. They are less effective as a means to creating a change in attitude, because this is rarely achieved through pressure but rather through reflection and dialogue. They therefore rather mark the end of the change process, then support its initiation.

2.4.4 Other Tactics to Consider

While these tactics don't specifically fit into the K-A-P framework, some of them might be considered important in your specific context.

A. Advocating for anti-FGM/C legislation and law enforcement

Laws alone will not eradicate FGM/C. Nevertheless, anti-FGM/C laws are important because they are a statement of intent and they demonstrate a commitment to eradicating FGM/C. Lack of a law also makes a strong statement!

Based on 28 Too Many's research, 23 African countries (out of the 28 that practice FGM/C) have national legislation criminalising FGM/C. Five (Somalia, Sierra Leone, Liberia, Chad and Mali) remain without laws, meaning that FGM/C is effectively still legal in these countries. In most countries with anti-FGM/C laws, however, the legislation is failing to protect women and girls from FGM/C because laws are rarely enforced.

Significantly, of the 55 million girls (aged 0–14) who have experienced or are at risk of FGM/C across the 28 countries:

- 60% of them are in four countries that have anti-FGM/C laws (Egypt, Ethiopia, Nigeria and Sudan); and
- 20% of them are in the countries without current anti-FGM/C laws.

28 Too Many and Plan International believe all countries need to fully protect women and girls from FGM/C through their national legislative frameworks. In particular, if Egypt, Ethiopia, Nigeria and Sudan were to tighten and fully implement their existing anti-FGM/C legislation, and if the five countries without it were to introduce national laws, this would potentially have an impact on 80% (44 million) of girls under the age of 15 in FGM/C-practising countries across Africa.

The legal approach is most effective when accompanied by awareness-raising and community dialogue. If anti-FGM/C laws are introduced before society has changed its attitudes and beliefs, or is not accompanied by the requisite social support, it may drive the practice underground, encourage people to cross borders to undergo FGM/C in neighbouring countries, and prevent people from seeking medical treatment for health complications.²⁰



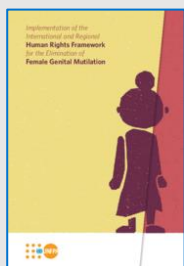
Resources: 28 Too Many has produced reports on anti-FGM laws in 29 African countries, alongside a summary report, *The Law and FGM*, and an *FGM Model Law*. All of these reports are available at

<https://www.28toomany.org/thematic/law-and-fgm/>



B. Building capacity in government structures

Associated with the passing of legislation is the importance of building capacity and developing institutions to support that legislation. For example, Kenya's legislation establishes an Anti-FGM/C Board, which is responsible for coordinating efforts to end the practice, including setting up helplines and supporting community dialogues.'



Resource: A UNFPA paper that aims to address FGM/C in its context as a violation of human rights. It also discusses the duty of governments under international human-rights laws to abolish the practice. The paper is available at

<https://www.28toomany.org/thematic/law-and-fgm/>

In many countries with laws, there is poor coordination between the government and civil society. For example, in Egypt, coordination is poor (and therefore the law is not taken seriously at the community level), reportedly due to different and even conflicting visions around the most effective ways to end FGM/C. As a result, progress is hindered and remains a challenge.

C. Promoting girls' education

In many of the countries covered by DHS data, there is evidence of a correlation between education and the prevalence of FGM/C and attitudes towards its continuation. There is also a strong link between FGM/C and early marriage among some ethnic groups.

(For further information on the links between FGM/C and early/child marriage, see <https://www.28toomany.org/thematic/fgm-and-child-marriage/>.)



Resource: Published by the Population Council, this is a meta-study of existing research into the links between FGM and child marriage. The study is available at <https://www.28toomany.org/thematic/fgm-and-child-marriage/>

In these communities, girls are cut prior to getting married and often drop out of school after being cut. Promoting girls' education encourages girls to remain in school and, in some cases, encourages them to speak out against FGM/C. However, as with the alternative rites of passage approach, this may be seen as a delaying strategy. Girls and their communities may feel they are staying children by remaining in school and that they are not women until they have left school and been cut.

2.4.5 Less Effective Tactics

There are a couple of tactics we would suggest avoiding, or at least not making a primary focus of your strategy.

A. Alternative income-generation for traditional cutters

A popular strategy over the last few decades has been to educate traditional practitioners about the health risks associated with FGM/C, provide them with alternative means of income as an incentive to abandon their work, and train them as change agents in their communities.

There is much scepticism around this approach. While alternative income-earning activities may address the economic benefits of performing FGM/C, they do not solve the potential loss of status and community recognition that often accompanies the traditional practitioner's role. Cutters (who may often be the grandmothers) need to be empowered to become anti-FGM/C advocates, not just paid to learn a different skill. Also, cutters may not necessarily be the community members with the most authority to convince others to abandon the practice.

Without an accompanying strategy that works to shift social norms in the wider community, such programmes often have little effect. Demand for FGM/C continues.²¹

B. Establishing safe houses

There are organisations in some countries that aim to protect girls from early marriage and/or FGM/C as well as, sometimes, enabling young girls to continue their education. They may also facilitate the reconciliation of the girls and their families and their re-integration with the community. In isolation, however, safe houses are unlikely to have a significant impact because they are unlikely to be accessible to girls in remote villages and can only work where there are the structures and funding in place to maintain them. It is also argued that this approach simply delays FGM/C, as girls need the support of others if they have run away from their families, and girls remain at risk or may even break up with their families for good.

3. IMPLEMENTING YOUR PLAN

The Purpose of This Phase

Having conducted your scope and decided on a strategy and the approaches you intend introducing, you next need to think about how best to deliver your plan. This section looks at some of the features that have been found to be essential for delivering the social norms approach through the K-A-P components – increasing knowledge, changing attitudes, and shifting practice.

Whichever tactics you choose, the social norms approach depends upon developing intergenerational dialogue and collective decision-making with key stakeholders. This is not something that will happen overnight, nor does it involve plunging into a community with an up-front anti-FGM/C message.

First you must gain the trust of the community. This means putting the whole community, including those who appear to be the ‘obstacles’ to ending FGM/C, right at the front of your programme. Too often ‘the vast majority of people in recipient societies report they do not feel included in the critical decisions about assistance they receive’.²² The role of an external agency in the social norms approach is to catalyse and facilitate rather than impose or direct the process of change.

3.1 Components of Implementing a Social-Norms-Based Programme

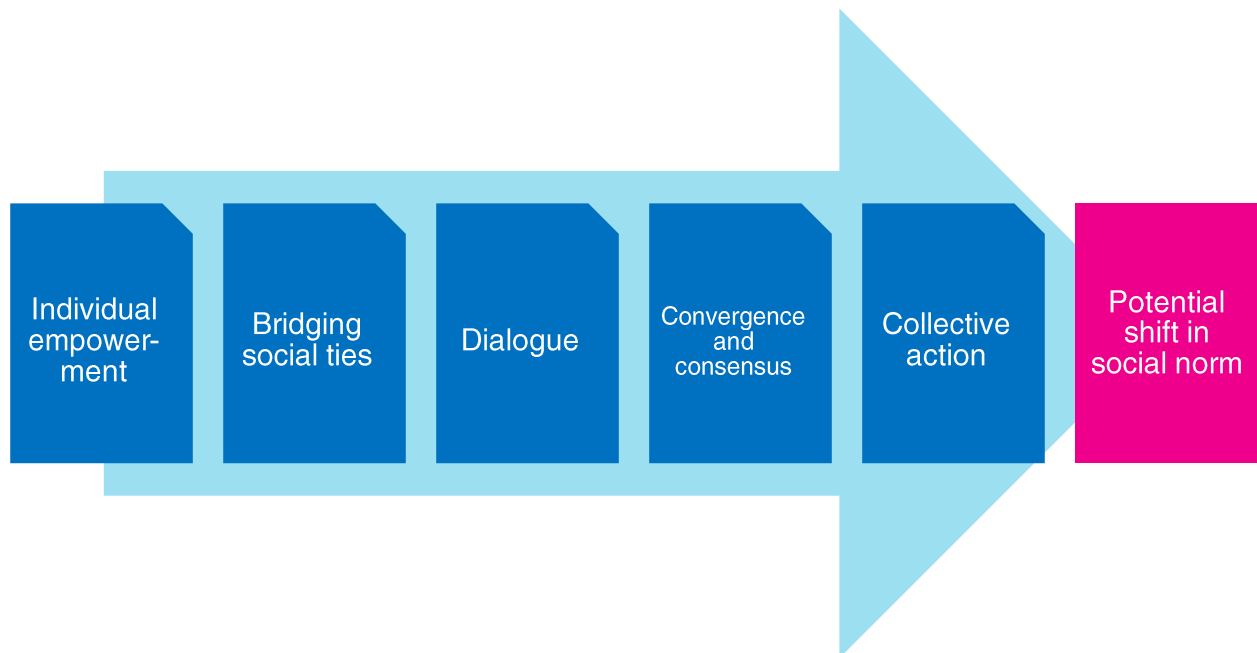


Figure 12: Processes required to enable collaborative problem-solving

The social norms approach involves working through, by collaborative facilitation, **five key processes to ensure an effective social norms transformation.**

- **Empowering individuals in the community by facilitating their participation in the process.** This means ensuring that even the most marginalised voices are listened to and their views taken into account; it means ensuring certain parties don't dominate or influence the discussions, and that priorities are not defined by outsiders or powerful stakeholders. All participants must be treated equally and their views respected.
- **Building social bridges** between different groups in the community, finding and sharing connections between people, and developing trust between stakeholders. It helps to bring together groups of people who would not normally spend much time together in specific activities, so they have the opportunity to share experiences and get to know each other. The aim is to build cohesion by focusing on what groups have in common, their shared values, rather than what divides them.
- **Achieving non-judgemental dialogue** by creating opportunities for varied groups of people, encouraging them to discuss sensitive topics and build on the diversity and ambivalence that will exist in the community in relation to FGM/C. Dialogue is more than just talking: it is also about listening and sharing information so that people can reach a shared understanding and mutual agreement. It is also about language: use the terms that the community uses to describe FGM/C, being respectful and aware that it is not always seen as mutilation which implies harmful and wilful damage. It may be done as an act of love by families who want the best future for their daughter in terms of marriage opportunities and acceptance by the community.
- **Achieving convergence and consensus** so that people with different views gradually come to understand others' views and beliefs and eventually reach mutual agreement around ideas and strategies. Consensus depends upon respecting each other's views, the equality of participants and the sharing of power within the community. The outcome should be recognition of the problem to be addressed, a shared common vision for the future and a way forward to resolve the problem.
- **Achieving collective action** at the community level for the implementation of the agreed solution. Following up on the actual implementation and support the resolution of any problems or conflicts coming up along the way.

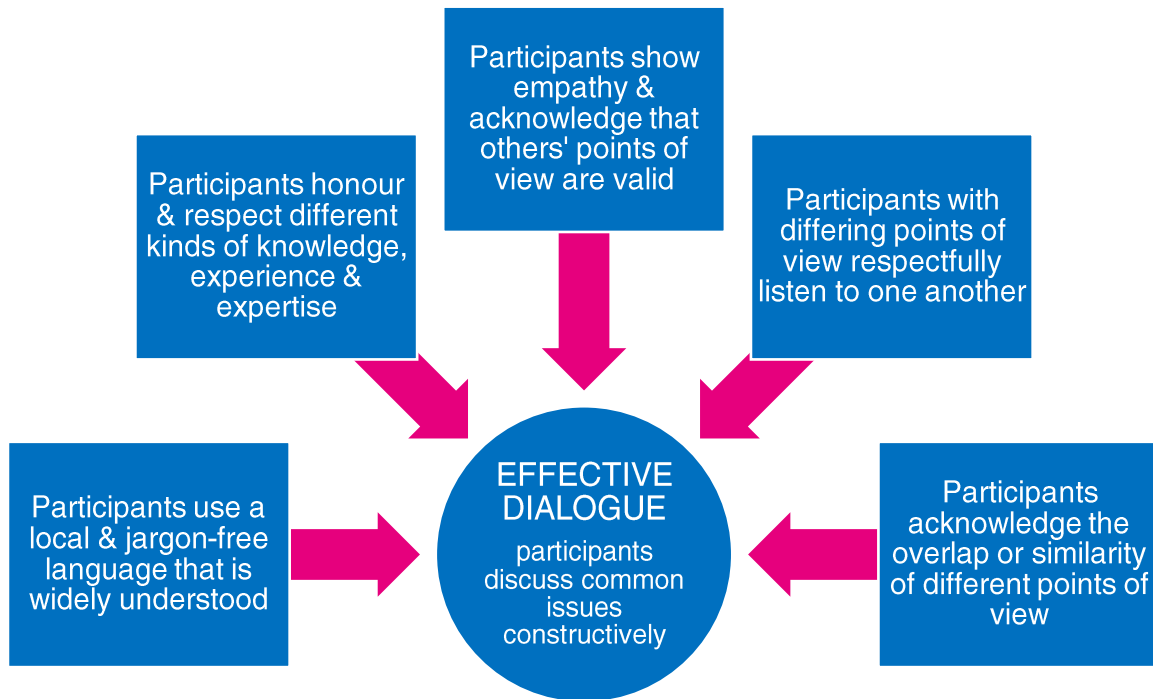


Figure 13: Factors required for effective dialogue²³

The above process is cyclical and iterative – it never ends but is constantly being renewed as new ideas and challenges emerge. By developing this process, the community becomes empowered to tackle new problems and take ownership of the outcomes.

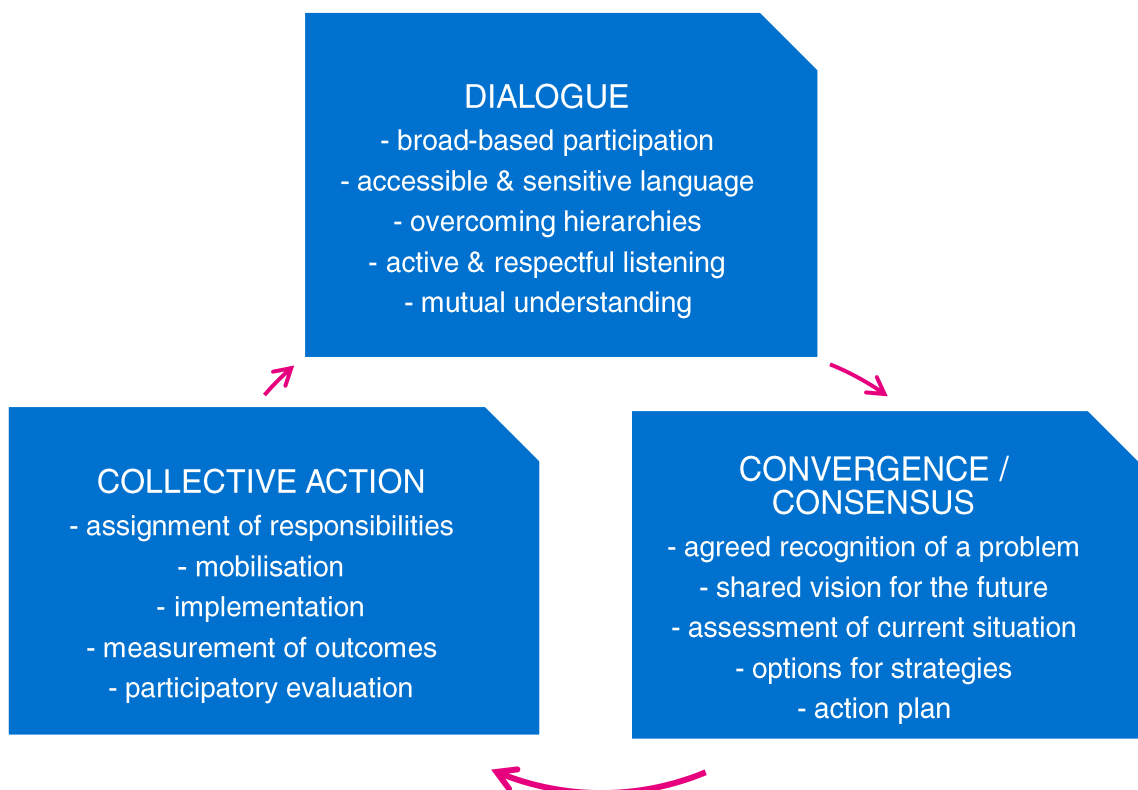


Figure 14: The cyclical process of dialogue, collaborative problem-solving and collective action²⁴

3.2 Project Staff

3.2.1 Role and Skills of Staff

The role and skills of staff in the dialogue process are critical. Among the issues you will need to consider are:

- Using local, community-level staff to lead the way (rather than national or international staff).
- Whether they should be male or female – probably you will need both. Women and girls may be more comfortable talking to women, and/or they may not be allowed to speak to men without their male spouse or a family member present. Conversely, men are more likely to prefer discussing such a sensitive issue as FGM/C and its impact on sexual relations with a man. Additionally, they may not respect women as leaders and teachers.
- It is important that the facilitators speak the local language or vernacular, so there is no confusion about terms and to ensure members of the community can speak freely.
- Your facilitators have to be respected by local people, so they will probably need to be older with life experience and have a reasonable level of education. They also need a humble attitude, have empathy for the community and faith in their capacities to solve their own problems.
- Staff should be facilitators and catalysts of dialogue, not tellers delivering a message.

28 Too Many's *FGM and Social Norms* sets out the facilitation skills needed to promote learning and change:

Community Development	Adult Education	Group Facilitation	Participatory Communication
<ul style="list-style-type: none"> ▪ Focuses on community assets rather than deficits ▪ Identifies formal and informal community leaders ▪ Develops rapport and collaboration with community leaders ▪ Develops community autonomy in decision-making ▪ Strengthens skills of community leaders in participatory problem-solving 	<ul style="list-style-type: none"> ▪ Understands characteristics of adult learners ▪ Uses a problem-solving approach, not a banking approach, to education ▪ Uses facilitation, not instruction ▪ Creates a learning environment that facilitates learning ▪ Develops critical-thinking skills ▪ Stimulates group learning 	<ul style="list-style-type: none"> ▪ Takes on the role of facilitator in group activities ▪ Has strong listening and questioning skills ▪ Gives and receives feedback ▪ Has strong verbal and non-verbal communication skills ▪ Restrains group members who dominate the discussion 	<ul style="list-style-type: none"> ▪ Develops and uses a variety of these methods: <ul style="list-style-type: none"> ○ stories ○ songs ○ role plays or skits ○ community theatre ○ community meetings ○ games ○ discussions ○ pictures ○ case studies

Community Development	Adult Education	Group Facilitation	Participatory Communication
<ul style="list-style-type: none"> Builds up the ability of community actors to communicate and collaborate effectively Helps community groups to link with outside organisations and institutions to access resources 		<ul style="list-style-type: none"> Encourages shy group members to contribute their ideas to group discussions Has conflict-resolution skills 	

Table 4: Knowledge and skills needed by community-health-development workers to promote change in communities²⁵

3.2.2 Safeguarding Project Staff

Organisations implementing end-FGM/C programmes have a duty of care to their staff, and a requirement to safeguard them from physical and mental abuse and trauma. Staff engaged on the frontline of delivering anti-FGM/C projects may find themselves experiencing psychological stress if they come from affected communities or have undergone FGM/C themselves. Listening to survivors' stories or re-living their own experiences can be distressing and traumatic. They may also fear for their own physical safety, working in practising communities, as they may receive threats and abuse for doing so. Losing skilled staff to burn-out or trauma is also damaging to the project, as it means recruiting new staff and disrupting the continuity of work with communities.

It is important, therefore, to consider how you are going to support staff through this stress, protect them from physical and verbal abuse, and generally safeguard their wellbeing. Among the support methods to consider are:

- training in self-care approaches (helping the individual to recognise signs of stress in themselves know when they need support, and have the confidence to ask for that support);
- creating 'safe spaces' such as shared-learning events, support networks and time-out social events during which the individual can express their concerns and share with others in similar situations;
- setting up a 'buddy' mentoring system by pairing workers or creating small 'buddy circles'; and
- ensuring senior staff are aware of the potential stress and harm that front workers may come up against, that they recognise signs and they can either be a non-judgemental listening ear themselves or direct them to counselling or other support services.

Don't forget your male staff. They may come from affected communities and be ridiculed or threatened for working for an organisation that supports women's rights and campaigns against local traditions that support patriarchy. Ensure safeguarding procedures include them.

Conversely male staff can have an important part to play in implementation as role models and advocates of the end-FGM/C message, particularly if they have wives and daughters who have not been cut.

Keep in mind that using an approach that values local culture and is embedded in the communities' social structures minimises the risk of push-back and resulting stress and risk for the staff working at community level.



Resource: The Girl Generation's Emotional Wellbeing Project includes slides for a training session in wellbeing. It is available at

<https://www.thegirlgeneration.org/resources/emotional-wellbeing-resources>

3.3 Timing of The Programme

A problem with many development programmes is that change is expected to occur within 18 months (for a mid-term review) and be embedded by the three-year mark (conveniently in time for an end-of-project review). **Transforming social norms, which may go back centuries, does not work so slickly. You need to think long-term** – that your programme will be multi-phase, multi-year, even multi-generational, to achieve the shift in practice that heralds a community abandoning FGM/C and maintains that abandonment.



Zainab is an outspoken advocate against FGM/C in Sierra Leone.

Photo: Plan International / Quinn Neely

4. PROGRESS AND IMPACT OF YOUR PROGRAMME TO END FGM/C

The Purpose of This Phase

The social norms approach is not a quick-fix, one-size-fits-all approach. You will have tailored your strategy and tactics to meet the specific social context and environment in your selected location and target group. It is now important to set in place ways of measuring the progress and impact of these strategies – and to design indicators and methods of measurement as part of the design process, before the programme starts.

One of the problems with the strategies and interventions listed in Phase 3 is that there has been little in the way of testing and measuring their impacts from a social norms perspective that focuses on change and transformation in practice, rather than on short-term outputs.

The purpose of this section is to consider what sort of monitoring and evaluation system, based on the social norms approach, would help you to answer the following questions:

- Is **knowledge** increasing?
- Are **attitudes** changing?
- Is **practice** shifting?

Evaluation and impact assessments are carried out with the aim of learning from what has happened so far in the programme, so that in future you can build on what worked and remove or mitigate aspects that do not work (Figure 17).

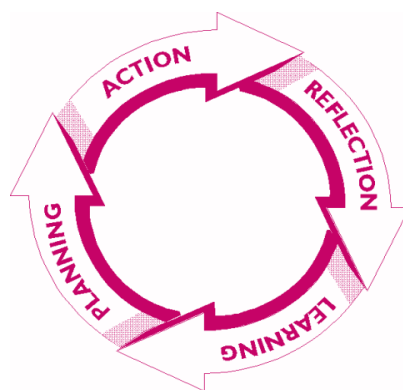
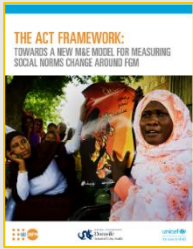


Figure 15: The action-reflection planning cycle

4.2 The ACT Framework (UNFPA)



Resource: UNFPA have produced a model framework for measuring social norms change in relation to FGM/C. The underpinning principal of the ACT Framework is the tracking of people's beliefs and knowledge in relation to FGM/C, through changes in theirs and others' feelings and attitudes, towards an eventual shift in reducing or abandoning FGM/C (i.e. similar to the K-A-P model). Available at

<https://www.unfpa.org/resources/act-framework-towards-new-me-model-measuring-social-norms-change-around-fgm>

- 'A' is for **assessing** and **ascertaining** what individuals know, feel and do;
- 'C' is for **considering** and **exploring the context** of the power dynamics surrounding gender roles and norms relating to decision-making and influencing FGM/C practice; and
- 'T' is for **tracking** individual and social change over time and **triangulating** data from multiple sources and perspectives.

These features are summarised in Table 6 below.

AGGREGATED ACT MEASURES/INDICATORS		
COMPONENT OF THE ACT FRAMEWORK	SOCIAL NORMS CONSTRUCT/CONCEPT	AGGREGATED MEASURE/INDICATOR
Assess what people know, feel and do	Know	Change over time in knowledge of FGM
	Feel	Change over time in beliefs about FGM
		Change over time in intentions not to practise FGM
	Do	Proportion of girls and women who have undergone FGM
Proportion of households moving along the continuum of change		
Ascertain normative factors	Descriptive norms	Change over time in perceived prevalence of FGM
	Injunctive norms	Change over time in the approval of FGM by self and others
	Outcome expectancies	Change over time in individuals' identification of benefits and sanctions related to FGM
		Change over time in intention to give rewards and impose sanctions related to FGM
Consider context	Empowerment	Change over time in agency
		Change over time in decision-making power
	Gender	Change over time in gender role beliefs
		Change over time in egalitarian beliefs about men and women
Collect information on social support and networks	Social Networks	Change over time in interpersonal communication about FGM
		Change over time in spousal communication about FGM
	Social support	Change over time in informational social support for FGM abandonment
		Change over time in instrumental social support for FGM abandonment
Track individual and social change over time	Individual and social change	Proportion of the intended audience participating in individual and social change communication programming on FGM abandonment
		Proportion of the intended audience exhibiting encoded exposure to individual and social change communication programming on FGM abandonment

Table 6: UNICEF's aggregated ACT measures, indicators²⁶

4.3 UNFPA-UNICEF Compendium of Indicators on FGM



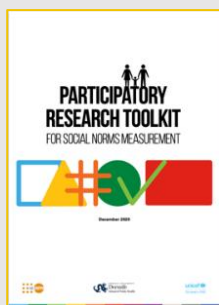
Resource: In Dec 2020, the Joint UNFPA-UNICEF Programme, Accelerating Change, published a list of indicators with explanation as to how they can be applied in the field. The aim is to develop a robust approach to measuring and monitoring the progress of end-FGM/C strategies, to identify what works or not, and why, at global, national and local levels. It is also hoped that using standard indicators will allow cross-country and cross-programme comparisons, thereby advancing global knowledge about FGM/C practice. Available at:

https://www.unfpa.org/sites/default/files/pub-pdf/026_UF_CompendiumOfIndicatorsFGM_21-online_F.pdf

4.4 A Participatory Approach

Operationalising the ACT Framework or any other framework that aims to assess social norms change should encompass a participatory approach, whereby the impacted individuals themselves assess their progress towards the programme goal. Participatory methods can be useful ways of generating dialogue between impacted groups, facilitating reaching a consensus on ways forward.

There are many sources for guidelines on how to carry out participatory evaluations. The Institute of Development Studies (IDS Sussex) has a long-held reputation for developing these, and many examples are available to download at <https://www.participatorymethods.org/>.



Resource: Another useful resource for carrying out evaluations and impact assessments is the UNFPA/UNICEF Participatory Research Toolkit for Social Norms Measurement. Available at:

<https://www.unfpa.org/resources/participatory-research-toolkit-social-norms-measurement>

This Toolkit brings together participatory research tools that can be used in a variety of in community led approaches to social norm change, but which have been found to be particularly helpful for sensitive issues such as harmful practices. They can be used at all stages of the programme cycle, starting with community identification and consensus building of issues on which to work, through to tracking changes in attitudes and shifts in practice over time.

The Toolkit comprises nine participatory research tools, each of which is described in detail with suggestions for its practical application within the community. These tools include body mapping, complete-the-story, and social network mapping. They can be adapted to be relevant to different groups in the community, including girls who are vulnerable and at risk of FGM/C.

The Toolkit also shows how the outcomes of the participatory research can be analysed and used to shape future discussions and activities.

4.4 Reflection and Learning

Interventions won't always achieve all your planned objectives. Sometimes there are unexpected, unplanned impacts, both positive and negative. It is important to take the time to look out for these and to learn from them, so you can go back to your programme design and adjust it to mitigate negative impacts or build upon positive ones.

The authors of *Alternative Rites of Passage in FGM/C Abandonment Campaigns in Africa: A Research Opportunity* reviewed some 20 evaluations of interventions aimed at ending FGM/C, many of them involving ARPs. They concluded that most of the evaluations lacked rigour in their methodologies, and they highlighted in particular the following shortfalls:

- **lack of a baseline measurement** of FGM/C in the communities for which the impact of the intervention could properly be assessed;
- in the few studies that had undertaken a baseline study, there was no comparison group, making it impossible to assess whether change would have occurred anyway without the intervention;
- where interventions included other empowerment aspects (for example, promotion of girls' education, sexual health information, community sensitisation on women's rights, etc), it was not possible to disaggregate or separate the impact of the end-FGM/C or ARP components; and
- there is usually no long-term follow-up with girls and women in participating communities to assess whether the impact of the intervention (in particular ARPs) has been sustained.

Design of a monitoring, evaluation and impact-assessment process should therefore be built into your programme design and put into place before implementation, so you can properly assess its impact and learn from your work as you proceed.

5. KEY RESOURCES

The following resources are referenced throughout this document:

Introduction

United Nations Population Fund (2020) How Changing Social Norms is Crucial in Achieving Gender Equality. Available at <https://www.unfpa.org/social-norms-change>.

Dr Anneke Newman and 28 Too Many (2019) FGM and Social Norms: A Guide to Designing Culturally Sensitive Community Programmes. Available at <https://www.28toomany.org/thematic/social-norms-and-fgm/>.

1. Scoping Phase: Context is Critical

FGM Research and Survey Toolkit: <https://28toomany.org/survey-toolkit/>.

UNFPA (2020) Tailoring Steps to End FGM based on Age. Available at <https://www.unfpa.org/resources/tailoring-steps-end-female-genital-mutilation-based-age>.

Tools for Development – Stakeholder Analysis Matrix Template: <http://www.tools4dev.org/resources/stakeholder-analysis-matrix-template/>.

2. Programme-Design Phase

28 Too Many's reports on anti-FGM laws in 29 African countries: <https://www.28toomany.org/thematic/law-and-fgm/>.

UNFPA (2014) Implementation of the International and Regional Human Rights Framework for the Elimination of Female Genital Mutilation. Available at <https://www.28toomany.org/thematic/law-and-fgm/>.

UKAID and Population Council (2017) Exploring the Association Between FGM/C and Early/Child Marriage: A Review of the Evidence. Available at <https://www.28toomany.org/thematic/fgm-and-child-marriage/>.

3. Implementing Your Plan

The Girl Generation (2016) Emotional Wellbeing Project. Available at <https://www.thegirlgeneration.org/resources/emotional-wellbeing-resources>.

UNICEF (2020) Gender Transformative Approaches for Elimination of FGM. Available at <https://www.unicef.org/documents/gender-transformative-approaches-elimination-female-genital-mutilation>.

4. Progress and Impact of Your Programme to End FGM/C

UNFPA-UNICEF Joint Programme on Eliminating Female Genital Mutilation (2020) The Act Framework: Towards a New M&E Model for Measuring Social Norms Change Around FGM. Available at https://www.alignplatform.org/sites/default/files/202004/act_fgm_framework_summary_finalforprint_1.pdf.

Feinstein International Center (2009) Participatory Impact Assessment: A Design Guide. Available at https://fic.tufts.edu/wp-content/uploads/PIA-guide_revised-2014-3.pdf.

Endnotes

- 1 United Nations Population Fund (2020) How Changing Social Norms is Crucial in Achieving Gender Equality. Available at <https://www.unfpa.org/social-norms-change> (accessed 29 September 2020).
Gerry Mackie, Francesca Moneti, Holly Shakya and Elaine Denny (2015) What are Social Norms? How are They Measured?, p.12. UNICEF/University of California, San Diego, Center on Global Justice. Available at <http://globalresearchandadvocacygroup.org/wp-content/uploads/2018/06/What-are-Social-Norms.pdf> (accessed 12 January 2021).
- 2 United Nations Population Fund, op. cit., p.24.
- 3 Ibid., p.30.
- 4 UNICEF (2020) Gender Transformative Approaches for the Elimination of Female Genital Mutilation. Available at <https://www.unicef.org/media/86391/file/FGM-Mainstreaming-Gender-Equality-2020-v2.pdf>
- 5 United Nations Population Fund, op. cit.
Dr Anneke Newman and 28 Too Many (2019) FGM and Social Norms: A Guide to Designing Culturally Sensitive Community Programmes. Available at <https://www.28toomany.org/thematic/social-norms-and-fgm/>
- 6 World Health Organization (2016) WHO guidelines on the management of health complications from female genital mutilation, pp.2–4. Available at <http://www.who.int/reproductivehealth/topics/fgm/management-health-complications-fgm/en/> (accessed 29 September 2020).
- 7 End FGM European Network (2009–2020) What is FGM? Types of FGM. Available at <https://www.endfgm.eu/female-genital-mutilation/what-is-fgm/> (accessed 29 September 2020).
- 8 Taken from the current DHS and MICS surveys for each country.
- 9 Dr Anneke Newman and 28 Too Many, op. cit., p.46.
- 10 Adapted from Ponts'o Letuka, Sebolelo Nkhebenyane and Oriel Thekiso (2019) 'Assessment of Food Safety Knowledge, Attitudes and Practices among Street Food Vendors and Consumers' Perceptions of Street Food Vending in Maseru Lesotho', Preprints, 2009 (2019050257). Available at <https://www.preprints.org/manuscript/201905.0257/v1> (accessed 29 September 2020).
- 11 United Nations Population Fund, op. cit., p.30.
- 12 Ibid., p.29.
- 13 Liselott Dellenborg, 'A reflection on the cultural meanings of female circumcision: Experiences from fieldwork in Casamance, southern Senegal' in Signe Anfred (ed.) (2004) Rethinking Sexualities in Africa. Uppsala: Nordic Africa Institute.
Sarah O'Neill (2012) Defying the law, negotiating change: the Futanke's opposition to the national ban on FGM in Senegal. Doctoral thesis, Goldsmiths, University of London: Goldsmiths Research Online.
- 14 Sarah O'Neill, op. cit.
- 15 28 Too Many (2015; updated 2018) Country Profile: FGM in Senegal, p.29. Available at <http://www.28toomany.org/Senegal/>
- 16 28 Too Many (2016) Kenya: Country Profile Update, p.29. Available at <http://28toomany.org/countries/kenya/>
- 17 Ministère de la Femme, de la Famille et Genre, République du Sénégal (2019) Analyse qualitative pour documenter les dynamiques communautaires relatives à la surveillance et au respect des déclarations publiques d'abandon de l'excision dans la région de Kolda.
- 18 Laurence Droy, Lotte Hughes, Mark Lamont, Peter Nguura, Damaris Parsitau and Grace Wamue Ngare (2018) Alternative Rites of Passage in FGM/C Abandonment Campaigns in Africa: A research opportunity', LIAS Working Paper Series Vol. 1. University of Leicester. Available at <https://journals.le.ac.uk/ojs1/index.php/lias/article/view/2820> (accessed 3 December 2020).
- 19 Dr Anneke Newman and 28 Too Many, op. cit., pp.23 and 24. A successful example of this strategy is the Loita Rite of Passage created by SAFE Maa in Kenya. For more information see <https://www.sciencedirect.com/science/article/pii/S2667321521000160>
- 20 28 Too Many (2018) The Law and FGM. Available at [https://www.28toomany.org/static/media/uploads/Law%20Reports/the_law_and_fgm_v1_\(september_2018\).pdf](https://www.28toomany.org/static/media/uploads/Law%20Reports/the_law_and_fgm_v1_(september_2018).pdf)
- 21 Dr Anneke Newman and 28 Too Many, op. cit., p.23.
- 22 Mary B. Anderson, Dayna Brown and Isabella Jean (2012) Time to Listen: Hearing People on the Receiving End of International Aid, p.68. Cambridge, MA.
- 23 Adapted from:
Maria Elena Figueroa, D. Lawrence Kincaid, Manju Rani and Gary Lewis (2002) Communication for Social Change: An Integrated Model for Measuring the Process and Its Outcomes, pp.4 and 5. New York, NY: The Rockefeller Foundation and Johns Hopkins University Center for Communication Programs.
Roz D. Lasker and Elisa S. Weiss (2003) 'Broadening Participation in Community Problem Solving: A Multidisciplinary Model to Support Collaborative Practice and Research', Journal of Urban Health: Bulletin of the New York Academy of Medicine 80(1), pp.14–60.
- 24 Adapted from Maria Elena Figueroa et al. (2002) op. cit., pp.5 and 10.
- 25 Adapted from Judi Aubel (2014) Involving Grandmothers to Promote Child Nutrition, Health and Development: A Guide for Programme Managers and Planners, p.27. Toronto: Grandmother Project and World Vision International.
- 26 The UNFPA-UNICEF Joint Programme on the Elimination of Female Genital Mutilation (2020) The ACT Framework: Towards a New M&E Model for Measuring Social Norms Change Around FGM, p.6. Available at https://www.alignplatform.org/sites/default/files/2020-04/act_fgm_framework_summary_finalforprint_1.pdf (accessed 29 September 2020).