

NUMBER 03

# CMI REPORT

OCTOBER 2020



Photo: DFID on Flickr (CC BY 2.0)

## **AUTHORS**

**Mari Norbakk**

**Liv Tønnessen**

Prevalence, drivers, and review of the literature on the effects of interventions to reduce the prevalence of female genital mutilation

**Prevalence, drivers, and review of the literature  
on the effects of interventions to reduce the prevalence  
of female genital mutilation**

CMI Report, number 3, October 2020

This report is the result of a research pilot and collaboration between CMI,  
Save the Children and Norwegian Church Aid funded by strategic funds  
from the Norwegian Research Council.

**Authors**

Mari Norbakk and Liv Tønnessen

ISSN 0805-505X (print)

ISSN 1890-503X (PDF)

ISBN 978-82-8062-758-2 (print)

ISBN 978-82-8062-759-9 (PDF)

**Cover photo**

DFID - UK Department for International Development  
on Flickr (CC BY 2.0)

## Table of content

|  |           |
|--|-----------|
| <b>1. Introduction.....</b>  | <b>3</b>  |
| <b>2. Background.....</b>  | <b>4</b>  |
| 2.1. Terminology .....   | 4         |
| <b>3. Prevalence and trends .....</b>  | <b>5</b>  |
| 3.1. Decline in prevalence.....  | 6         |
| 3.2. Shift to less severe types of FGM.....                                    | 7         |
| 3.3. Medicalization.....   | 7         |
| <b>4. Drivers of FGM.....</b>  | <b>8</b>  |
| 4.1. Constructing the ideal girl and woman .....                               | 8         |
| 4.2. FGM and shared group identity.....  | 9         |
| 4.3. Religion.....   | 11        |
| <b>5. Criminalization.....</b>   | <b>12</b> |
| <b>6. Criteria for study inclusion .....</b>                                   | <b>15</b> |
| <b>7. Interventions: What we know about what works and does not work .....</b> | <b>18</b> |
| 7.1. Health education interventions .....                                      | 19        |
| 7.2. Village empowerment interventions .....                                   | 21        |
| 7.3. Advocacy interventions.....   | 23        |
| 7.4. Communication interventions.....  | 24        |
| 7.5. Social norms interventions.....   | 26        |
| <b>8. Discussion and take away points .....</b>                                | <b>27</b> |
| 8.1. Context matters .....   | 29        |
| 8.2. A flawed measurement of change?.....                                      | 30        |
| 8.3. Combined messages.....  | 31        |
| 8.4. Readiness to change?.....   | 32        |
| <b>References .....</b>  | <b>33</b> |

## 1. Introduction

We have conducted a review of studies looking at the effect of interventions to abandon female genital mutilation/cutting (FGM) in Africa. Although there has been an overall decline in the prevalence FGM, we know surprisingly little about what has caused this decline, to what extent interventions to abandon FGM in Africa have contributed to this positive development, and which types of interventions work the best.

In this review, we have only included studies looking at the *effect* of interventions to abandon FGM in Africa. The scope of studies is thereby limited to those with an approach designed to evaluate effect using a controlled before and after methodological design. We found only 10 studies from Sudan, Egypt, Mali, Burkina Faso, Senegal, Nigeria, Kenya, and Ethiopia that met our inclusion criteria.

The low number of intervention studies meeting our inclusion criteria reflects the fact that interventions have to a scant degree been properly documented and evaluated (Johansen et al. 2013; Berg and Denison 2012). Most of the prevailing literature on FGM in Africa focuses on prevalence, attitudes, and health consequences of the practice, not on the effects of interventions to abandon it (Obiora, Maree, and Nkosi-Mafutha 2020). Among the writings on interventions, few specifically evaluate effect using the collection of baseline and end line data. It is thereby difficult to clearly state what works based on this scant literature available. The lack of studies is partly related to the high economic cost of such studies, but perhaps more importantly to the types of complex interventions with a holistic, integrated, and multisectoral approach that are currently recommended by the UN and followed by many international and national NGOs (Hashi and Sharafi 2007). In such complex interventions, it is difficult to determine the interplay and relative efficacy of the different components.

Therefore, the main finding in our review is that there are few studies that can inform us about the key question of interest: the effects of the various interventions on actual abandonment of the practice. The majority of the intervention studies included in this review focus primarily on changing knowledge and attitudes regarding FGM, postulating that this will lead to reduced FGM in the long run. But because of the low number of studies, weak methodology in those studies, and scant information about the actual content, quality, and implementation of the interventions examined, it is difficult to draw conclusions about what works best to increase knowledge of FGM and change attitudes towards FGM. Although these intervention studies were within hugely varying cultural contexts in Africa, there are some important common take away points:

- Interventions should be carefully based on preintervention mapping of types of FGM and local context specific drivers to pinpoint messages and target groups. For example, if men are the main decisionmakers regarding FGM, an intervention targeting only women may be off target.
- Interventions may be most effective in contexts showcasing a readiness to change, that is, where there are already active debates regarding FGM abandonment.

- Exposure to a message from multiple sources and combined anti-FGM messages seem to be the most effective.

Even if the scientific literature on the effects of interventions is scant and the methodological quality is low, this does not necessarily reflect on the quality or number of interventions. Interventions may very well be working, but we simply do not have robust scientific studies to document their effects.

The background of this study discusses relevant terminology before addressing the prevalence, trends, and drivers of FGM. It then elaborates on the growing trend of criminalization of FGM in Africa and what evidence we have of its effect. Following this introduction, we describe the inclusion criteria for studies assessed in this paper. We then analyze how the studies measure intervention effects and what lessons we can learn from them. The last section assesses important points for discussion and further research

## 2. Background

### 2.1. Terminology

Female genital mutilation/cutting (FGM) refers to “all procedures involving partial or total removal of the female external genitalia or other injury to the female genital organs for nonmedical reasons.”<sup>1</sup> FGM is recognized as a harmful practice which violates human rights. FGM violates a series of well-established human rights principles, norms, and standards, including the principles of equality and non-discrimination on the basis of sex, the right to life (when the procedure results in death), the right to freedom from torture and cruel, inhuman, or degrading treatment or punishment, and the rights of the child. It is prohibited by law in several African and Western countries.

The current classification describes four types of FGM<sup>2</sup>:

- Type 1, clitoridectomy, involves partial or total removal of the clitoris and/or the prepuce.
- Type 2, excision, involves partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora.

---

<sup>1</sup> Fran Hosken first used the term “female genital mutilation” to replace the term “female circumcision” in her work, *The Hosken Report: Genital and Sexual Mutilation of Females* (1979). African feminists later approved the term in 1990 at the <sup>1</sup> Fran Hosken first used the term “female genital mutilation” to replace the term “female circumcision” in her work, *The Hosken Report: Genital and Sexual Mutilation of Females* (1979). African feminists later approved the term in 1990 at the third conference of the Inter-African Committee on Traditional Practices Affecting the Harm of Women and Children (IAC) (Raafat 2017; 28 Too Many 2020). The World Health Organization (WHO), United Nations Children’s Fund (UNICEF), and United Nations Population Fund (UNFPA) adopted the term in a joint statement in 1997. In 2008, UN agencies adopted the term “female genital mutilation/cutting” (with the addition of “cutting”) in a joint statement (OHCHR et al. 2008, 3). This was also the year when the UNICEF-UNFPA Joint Program on Female Genital Mutilation/Cutting: Accelerating Change was launched (see UNICEF and UNFPA 2008), which is the largest global program to on FGM/C abandonment to date.

<sup>2</sup> See WHO’s fact sheet on female genital mutilation/cutting:  
<https://www.who.int/reproductivehealth/topics/fgm/prevalence/en/>

- Type 3, infibulation, involves narrowing of the vaginal orifice with creation of a covering seal by cutting and appositioning the labia minora and/or the labia majora, with or without excision of the clitoris.
- Type 4, “other,” involves all other harmful procedures to the female genitalia for nonmedical purposes, for example: pricking, piercing, incising, scraping and cauterization.

All types of FGM are potentially harmful. The magnitude of both short- and long-term risks increase with the severity of the cutting performed (Berg et al. 2014).<sup>3</sup>

### 3. Prevalence and trends

While the exact number of girls and women worldwide who have undergone FGM remains unknown, UNICEF estimates that at least 200 million girls and women have been cut, typically before the age of 15. In some contexts where type 3 is common, adult women are also commonly re-infibulated after childbirth (UNICEF 2020a).

FGM is practiced mainly in Africa as well as in some parts of the Middle East and Asia, but prevalence and type of FGM varies widely among countries. The countries with highest prevalence are concentrated in north (Sudan, Egypt), eastern (Somalia, Eritrea, Djibouti) and western Africa (Sierra Leone, Mali, Guinea), all of which have prevalence rates over 80%. The type of procedure performed also varies between and sometimes within countries. Around 90% of FGM cases include either type 1 (mainly clitoridectomy), 2 (excision), or 4 (particularly “nicking” without flesh being removed). About 10% have undergone the most severe form of FGM, infibulation (type 3), which is mostly practiced in the northeastern regions of Africa (Djibouti, Eritrea, Ethiopia, Somalia, and Sudan).

UNICEF’s estimates build on representative data on FGM prevalence, which is based on large scale national surveys such as demographic and health surveys (DHS) and multiple indicator cluster surveys (MICS). The data is based on self-reporting: females from 15 to 49 years old are asked if they themselves or their daughters have been cut. The data collected also varies between countries, as in some contexts only women who have ever been married are included (Yoder and Khan 2008).

There are several obvious weaknesses in such data (see for example Elmusharaf, Elhadi and Almroth 2006). The actual numbers might be higher because (a) women are not always aware that they have undergone FGM, especially if the type of FGM is in the less severe category of, for example, symbolic

---

<sup>3</sup> In the longer term, women who have undergone the most severe types of FGM are at greater risk of adverse obstetric outcomes, including caesarean sections and postpartum hemorrhaging. Infants born to mothers who have undergone FGM are more likely to require resuscitation immediately following birth and have higher rates of stillbirth and neonatal mortality (Banks et al. 2006). FGM can also have a profound impact on women’s sexual wellbeing. Two recent systematic reviews concluded that women who have undergone FGM experience reduced sexual desire and satisfaction and are more likely to experience dyspareunia (painful sexual intercourse) (Berg and Denison 2012; Berg et al. 2014). These practices may also negatively affect women’s mental health (see, e.g., Behrendt and Moritz 2005; Kizilhan 2011; Knipscheer et al. 2015).

“nicking” of the clitoral hood and (b) in countries where the practice is outlawed, respondents are likely to give the “politically correct” answer, as they may be afraid of criminal prosecution.<sup>4</sup>

UNICEF’s database does not cover all countries where FGM is practiced, but rather includes the 31 countries (most of which are in Africa) where the practice is most prevalent. UNICEF’s estimate made a big jump from 125 million to 200 million when Indonesia was included in the database after 2013. According to UNICEF, nearly half of the girls under the age of 12 have undergone FGM in Indonesia, which has a population of 267 million.

Finally, it is important to note that FGM prevalence is just an estimation. The numbers vary greatly, as the available data has expanded and methods for calculation of estimates have become more sophisticated (Yoder and Khan 2008).<sup>5</sup>

Nonetheless, the increased availability of nationally representative data on FGM, including repeat surveys in several countries, allows for at least a general analysis of some trends in the prevalence of and attitudes towards the practice.<sup>6</sup>

### 3.1. Decline in prevalence

There has been a significant overall decline in the prevalence of the practice of FGM over the last three decades, but progress has been unevenly distributed (UNICEF, 2020b; see also Koski and Heymann 2017). According to UNICEF, around one in three girls ages 15–19 in the 30 countries with nationally representative FGM prevalence data have been subjected to the practice—down from one in two in the mid-1980s. In some countries, there is hardly any change at all; for example, in Guinea, the prevalence of FGM has only declined from 98.6% in 1999 to 96.8% in 2016.

Overall, there is a decline in FGM among girls ages 15–19 across countries, including those targeted by the UNICEF-UNFPA Joint Program on Female Genital Mutilation/Cutting: Accelerating Change (Accelerating Change). Breaking down the most recent data by age group in Ethiopia, for example, shows

---

<sup>4</sup> A study conducted in northern Ghana (Jackson et al. 2003) provided data concerning the consistency of FGM/C self-reporting among 15- to 49-year-old female respondents (n = 2,391) across surveys administered in 1995 and 2000. About 15% of respondents gave an answer in 2000 that differed from their answer in 1995: 4% of respondents switched from “no” to “yes,” and 11% switched from “yes” to “no.” The researchers note that a small number of women may not have known whether they had experienced FGM/C and that some of those who denied being cut in the second survey may have done so because of the law banning FGM/C. Another study conducted in Tanzania compare self-reported data with data from medical exams using relatively small samples. The study found that 66% of those interviewed reported that they had experienced FGM/C, whereas the medical exam found that 73% had been cut. The researchers note that some women may have been cut only minimally and at an early age and, thus, did not realize they had undergone the procedure (Klouman, Manongi, and Klepp 2005).

<sup>5</sup> One of the earliest efforts was made in 1982 in The Hosken Report: Genital and Sexual Mutilation of Females, where the number was estimated to be over 110 million women and girls worldwide.

<sup>6</sup> However, please note that there is a lack of data in many countries (for example, the most recent data on Cameroon and Somalia is from 2004 and 2006, respectively) and data might not be reliable for a number of reasons, including the number of data surveys conducted in each country, survey design and implementation etc.

that the prevalence for women ages 45–49 fell from 75.3% in 2005, to 65.2% in 2016. However, the overall prevalence alone may not fully reflect the progress among the youngest age cohorts. Breaking down the most recent data from 2016 by age group shows that the prevalence for women aged 45–49 is 75.3%, while for the youngest age group this has fallen to 47.1% (28 Too Many, Ethiopia). Despite the fact that a small proportion of women may be cut after the age of 15, the lower prevalence among younger women suggest that the practice is declining. However, we also see this trend among countries that have not been targeted by Accelerating Change, such as Liberia where the prevalence of FGM among adolescent girls aged 15 to 19 has halved within the last three decades (UNICEF, 2020b).

For girls below the age of 15 the picture looks even more encouraging, with significant decline in FGM prevalence in east, north, and west African countries. Looking at the period 1990–2017, we find a decline in prevalence in east Africa from 71.4% in 1995 to 8.0% in 2016; for north Africa, prevalence has plummeted from 57.7% in 1995 to 14.1% in 2015; and for west Africa, the prevalence decreased from 73.6% to 25.4% in 2017 (Kandala et al. 2018).<sup>7</sup>

### 3.2. Shift to less severe types of FGM

Another trend identified in the literature is a shift to less severe types of FGM. According to Koski and Heymann’s study based on DHS data from 22 African and middle eastern countries (2017), there is little evidence of a substantial shift in the severity of the procedures performed. However, some countries not part of Koski and Heymann’s study have seen a shift from infibulation to non-infibulating types of FGM.

For example, in Sudan there has been a shift from “pharaonic” FGM (type 3, infibulation) to Sunna FGM (type 1, clitoridectomy) in some parts of the country and among various ethnic groups. Sunna cuts, being of lesser severity, are believed to avert the health risks associated with more severe forms of the practice (Bedri et al. 2019). It is believed that the focus of anti-FGM campaigns on the health risks of FGM may have played a key role in driving this change, combined with religious discourses (including from state institutions) and encourage the abandonment of pharaonic and the adaptation of Sunna as a religious obligation (ibid.; Tønnessen and al-Nagar forthcoming). A similar trend can be observed in Somaliland (Bergom Lunde and Sagbakken 2014) and among the Somali and Harari people of eastern Ethiopia (Abathun, Sundby, and Gele 2016).

### 3.3. Medicalization

Although the majority of girls are still cut by traditional midwives, we see a trend in some countries towards “medicalization” of FGM. Medicalization of the practice may mean that girls and women are increasingly

---

<sup>7</sup> These numbers must be approached with some caution as in some cultures, women are not cut until after age 15, and the estimates are based on parents’ reporting (Yoder and Khan 2008).



cut by medical personnel with sterile blades in medical facilities, perhaps lessening the risk of sepsis or death. Factors motivating medicalization include, but are not limited to, safety.

Among women exposed to medicalized FGM, 93% live in just three countries—Egypt, Nigeria and Sudan (Kimani and Shell-Duncan 2018; Shell-Duncan, Moore, and Njue 2017). More than half of them reside in Egypt alone. Notably, UNICEF's figures do not include Indonesia, where medicalized FGM is performed as part of the package of services for newborns in health facilities.

The health risk approach (including education on the negative health effects of unsterile tools, which was typical of the first wave of interventions to prevent FGM) may have unintendedly contributed to this trend. Concerns over potential health complications motivate parents to seek medicalized FGM (Doucet, Pallitto, and Groleau 2017; Modrek and Sieverding 2016; Bedri et al. 2019; Kimani and Shell-Duncan 2018). At times, medicalized cutting has been driven by policies restricting traditional midwives but allowing health professionals to do so (Egypt in the 1990s and more recently Indonesia). Some studies suggest that financial gain also is a factor, although seldom the primary motivating factor (Doucet, Pallitto, and Groleau 2017). Attitudes supporting FGM among health professionals and a lack of knowledge among such professionals about laws and professional guidelines that ban or criticize the practice are also factors highlighted in the literature (*ibid.*). There is a growing consensus that defining FGM should be described as a human rights violation, which underscores that concerns about the practice are not limited to minimizing health risks.

## 4. Drivers of FGM

The most cited reason for FGM is “cultural tradition” functioning both as a form of social control and identity for women (see Berg and Denison 2013a). In looking at underlying norms and beliefs that perpetuate adherence to this tradition, some general themes emerge. However, it is important to remember that the causes of FGM vary across contexts and sometimes even between ethnic and religious groups within the same country. Therefore, there is no universal recipe in terms of changing what are considering to be “sticky” social norms. Instead interventions should be carefully designed to accommodate local drivers of FGM.

In particular, three interrelated normative themes underpin the practice of FGM: (a) the linkage of the practice to ideals about femininity and women's sexuality, (b) the role of the practice to a shared group identity, and (c) a belief that the practice is required by religion. This section discusses each of these themes in turn.

### 4.1. Constructing the ideal girl and woman

The practice of FGM is linked to traditions and other cultural norms about femininity and women's sexuality. For example, the relationship between FGM and sexual morality is the most recurring theme in

studies identifying causes and drivers of FGM (see the systematic review of Berg and Denison 2013a, see also the literature review of Alcaraz, Siles González, and C. Solano Ruiz 2013, and the Systematic Review and Meta-Ethnography by Elamin and Mason-Jones 2020). FGM, and especially infibulation, is believed to reduce sexual desire and help women resist “illicit” sexual acts, that is, to ensure a young woman’s virginity and a wife’s fidelity (Johnsdotter et al. 2009; Philips 2016; Ahlberg et al. 2004).

This view is particularly prominent in cultures where premarital virginity is seen as a proof of morality and where women are seen as promiscuous and hypersexual if they are left uncontrolled (Fahmy, El-Mouelhy, and Ragab 2010; Johansen 2017). In a study from Kersa District, East Hararge, Oromia region, Ethiopia, preventing premarital sex and reducing female hypersexuality were stated as reasons to continue the practice of FGM (Yirga et al. 2012)

Additional factors related to constructs about femininity include the importance of maintaining good health and permitting male sexual enjoyment. FGM is associated with “cleanliness” and “purity,” while the clitoris is seen as dirty, male organ. Cultural norms suggest that women must remove or trim it to become beautiful and truly feminine (Izette and Toubia 2000). Cultural beliefs also suggest that keeping the clitoris may cause negative health consequences (Dotimi 2016). Among the Maasai in Kenya there is a belief that if a baby’s head touches a woman’s clitoris during birth, the baby will suffer (Van Bavel, Coene, and Leye 2017). The perception that men prefer cut women for sexual enjoyment is also mentioned, specifically the belief that men gain sexual pleasure from the tight vagina of an infibulated woman, although this view seems to be more widespread among women than men, at least among immigrant communities in the West (Johansen 2017; looking at views of Somali and Sudanese immigrants in Norway). These notions of ideal femininity ultimately perpetuate gender roles and stereotypes that view a woman as a vessel for reproduction and deny her a role as a sexual being (Izette and Toubia 2000).

However, there are studies suggesting that men increasingly are ambivalent about the practice (for an overview see Varol et.al 2015). For example, one study finds that, while Egyptian men want their wives to have the procedure for its perceived beneficial effects on women’s sexual morality, the men also perceive and lament a negative effect on sexual pleasure (Fahmy, El-Mouelhy, and Ragab 2010). Studies from Sudan suggest that husbands express empathy with the pain and suffering penetration can cause on re-infibulated wives after childbirth, the lack of sexual pleasure, and the lack of wife’s sexual pleasure is potentially damaging to their masculinity (Berggren et al. 2006).

## 4.2. FGM and shared group identity

FGM is seen as a social convention that plays an important role in consolidating communal, ethnic, and kinship ties, contributing to a shared group identity. On a societal level, FGM promotes social cohesion. Community-based interventions, including public declarations, often address this social aspect of the practice by suggesting that individuals in a community can achieve social cohesion through other means or that they can create new social norms around the importance of protecting girls and women from the

negative outcomes of the practice. The most known and widely recognized such initiative in this context is the work of Tostan, an NGO established in Senegal in the early 1990s. Tostan's work has been replicated by a number of NGOs working in Africa.

#### 4.2.1. Marriageability

According to Gerry Mackie, FGM is a self-enforcing social convention that is perpetuated first and foremost by concerns about marriageability (Mackie 1996; 2000; 2009). Although the practice of FGM is enforced through a variety of social, moral, or religious norms marriageability is considered the "main engine of continuation," which means that any change to the practice requires coordination among intermarrying groups (Mackie 2000, 265). Mackie predicts that if a critical mass of people in a community were to agree to stop the practice and publicly declared this, it could spread to other communities and lead to a shift in social conventions that would "help bring female genital mutilation to an end" (Mackie 1996, 999).

FGM is thought to increase a girl's chance of finding a suitable husband and having a family (Elamin and Mason-Jones 2020). Marriageability has been identified as the major reason for practicing FGM, for example, in the Somali region of Ethiopia (Abathun, Sundby, and Gele 2016). Being uncut may cause severe social sanctions from the ethnic group; women who are uncut may be seen as not eligible for marriage, which may bring shame to the family and damage the social standing of any future husband (Elamin and Mason-Jones, 2020).

The FGM ceremony is often celebratory and accompanied by certain rituals, such as a ceremony or gift giving, which help create a sense of belonging to the ethnic group (Dotimi, 2016). In some contexts (such as Kenya), FGM is performed as a part of coming of age or initiation ceremonies that take place as girls become closer to marrying age and link the cutting to becoming "good" potential wives. In societies where FGM is part of a rite of passage, elaborate ceremonies and lessons on the role of a wife and mother are often part of the procedure.

#### 4.2.2. Social capital

Other studies have redirected focus away from the marriageability convention towards an intergenerational peer convention. In their study on Senegambia, Shell-Duncan et al. (2011) find that that expectations regarding whether other girls in the community will be cut or whether potential marriage partners will prefer cut wives were not listed among the major considerations in the decision-making process regarding FGM. Rather, gaining entry to a women's peer network is a driving factor. First, FGM is considered part of a family's obligation to its daughters. Second, uncut girls and women face substantial harassment from

cut women.<sup>8</sup> Finally, uncut women are excluded from participating in, or even being present for, some activities (most commonly listed were FGM ceremonies and wedding ceremonies) and from collective (family or community) decision making. Therefore, undergoing FGM allows young women to expand their social capital, and, as they age, to benefit from the deference and obedience of younger women, thus gaining personal power in the community. To gain entry to a network, young women use circumcision to signal a willingness to participate in the hierarchy of power.

### 4.3. Religion

There are both Christian and Muslim communities that believe FGM is required by religion. Although it is often said that the Quran or the Bible do not mention FGM, it is still widely viewed as a religious obligation among practitioners. Nonetheless, women who live in the diaspora are beginning to refute the association between and religion (Ogunsiji, Wilkes, and Chok 2018; Ahlberg et al. 2004).

Most of the countries with the highest prevalence of FGM worldwide have a Muslim-majority population.<sup>9</sup> The use of religious terms to refer to the practice has given it an Islamic identity and strengthened the belief that Islam requires FGM.<sup>10</sup> Nonetheless, “pharaonic” (type 3) FGM is regarded as a cultural practice predating Islam, while “Sunna” (an Islamic term referring to the teachings and actions of the Prophet Mohammed) is employed to legitimize type 1 FGM. Although the Quran makes no mention of FGM, the Sunna reference the practice in several hadiths.<sup>11</sup> Since the practice of FGM predates Islam, it is difficult to separate culture and tradition on the one hand from Islam on the other, especially given that control of women’s sexuality is often embedded within both custom and religion (Gruenbaum 2001).

In summary, FGM derives from a complex belief system. Drivers of the practice must be understood in specific local contexts and may vary widely between communities, even within the same country (as is the case in Ethiopia). Interventions must therefore carefully take into account and analyze local drivers of FGM.

---

<sup>8</sup> As Hernlund (2000) has found, those who are not circumcised in Senegambia are contemptuously insulted by being labeled *solima*, meaning not only uncircumcised, but also rude, ignorant, immature, uncivilized, and unclean; women who are *solima* are told they know nothing and are harassed and excluded by other women for not knowing how to behave properly.

<sup>9</sup> The literature on Christian views on FGM is scarce (El-Damanhoury 2013). Coptic Christians perform FGM/C in Egypt, orthodox Christians in Ethiopia, and some Christian groups throughout coastal West Africa (Hayford and Trinitapoli 2011). The only contemporary examples of Christians practicing FGM are in Africa.

<sup>10</sup> Nonetheless, even within Islam there is a lack of consensus about the practice. For example, of the four law schools in Sunni Islam (Shafi’i, Maliki, Hanafi, and Hanbali), only the Shafi’i law school regards Sunna FGM/C as obligatory for both men and women.

<sup>11</sup> A range of hadiths justify FGM, including the hadith of Ummu-Attiya, the hadith of al-Hajjaj ibnu Arta, the hadith of Abdalla ibnu Umar, the hadith of Aisha, and the hadith of Abu Hureira.

## 5. Criminalization

The increased focus on FGM as a human rights violation has resulted in an increased focus on the use of criminalization as one appropriate response to eradicating FGM. National women's movements in many African countries, as well as the international community, have pushed for legal protection against this harmful practice. Since the Beijing Platform of Action of 1995 called for governments to "Enact and enforce legislation protecting girls from all forms of violence, including . . . genital mutilation" (UN 1995, 175), 28 of the 29 countries in Africa that practiced FGM/C have enacted laws prohibiting the practice, at least in part, compared to only 2 in 1995 (see table below for overview). Nonetheless, it should be mentioned that these laws vary widely in strength, including whether they criminalize all forms of FGM (see, e.g., Tønnessen, al-Nagar, and Bamkar 2017; discussing Sudan). Furthermore, while most laws set forth measures to investigate, prosecute and punish perpetrators, many of them do not include preventative measures and support for victims of FGM (see, e.g., Kandala and Komba (2015); pointing out that legislation in Senegal does not offer adequate protection to potential victims of FGM).

### Criminalization of FGM by country, as of September 2020

| Country <sup>12</sup>    | Year of criminalization | Comments   |
|--------------------------|-------------------------|--|
| Benin                    | 2003                    |  |
| Burkina Faso             | 1996                    |  |
| Cameroon                 | 2016                    |  |
| Central African Republic | 2006                    |  |
| Chad                     | 2002                    | Lacking implementation decree  |
| Côte D'Ivoire            | 1998                    | Banned in the constitution   |
| Djibouti                 | 1995                    |  |
| Egypt                    | 2008                    |  |
| Eritrea                  | 2007                    |  |
| Ethiopia                 | 2004                    |  |
| Gambia                   | 2015                    |  |
| Ghana                    | 1994                    | The 1960 law forbids "circumcision," but no prosecutions were brought until 1994.  |
| Guinea                   | 2008                    |  |
| Guinea Bissau            | 2011                    |  |
| Kenya                    | 2011                    |  |
| Liberia                  | 2018                    | A national executive order on the domestic violence law addressed FGM, but was only valid only one year and expired in 2019. |
| Mauritania               | 2005                    |  |
| Niger                    | 2003                    |  |

<sup>12</sup> Draws on resources from the Vinois et al. (2018) and Hurn and Pinder (2018).

|              |      |  |
|--------------|------|--|
| Nigeria      | 2015 | The 2015 federal law was only effective in one territory; however, some states have separate laws        |
| Senegal      | 1999 | Banned in the constitution   |
| Sierra Leone | 2007 | There is no national ban on FGM, but memorandums of understanding in some chiefdoms outlaw the practice. |
| Somalia      | 2012 | Banned in the constitution, but no national legislation.   |
| South Africa | 2005 |  |
| Sudan        | 2020 |  |
| South Sudan  | 2008 |  |
| Tanzania     | 1998 |  |
| Togo         | 1998 |  |
| Uganda       | 2010 |  |

The evidence from the research on the effect of criminalization of FGM is extremely weak, simply because there are few studies with a robust methodology equipped to measure effect. A literature review on the topic concludes, “While the majority of countries have adopted legal frameworks prohibiting FGM, these measures have been ineffective in preventing and/or accelerating the abandonment of the practice” (Muthumi et al. 2015, 32). However, the body of literature the article builds upon is scarce and consists mainly of UN reports (34 of 47 references) that gather data on the implementation of law where effect is largely thought of in terms of the number of cases reported and prosecuted. Several articles on efforts to end FGM contain the words “effect” or “impact” (of the law) in the title, but they do not actually measure the effect of a law prohibiting FGM or even awareness of and attitude towards the new legal requirement. Several of these articles point out that, despite enacting a law prohibiting FGM, prevalence is not reduced (see, e.g., Hassanin and Shaaban 2013; Alkhalileh et al. 2018). Rasheed, Abd-Ellah and Yousef (2011) support this finding by stating that, irrespective of the fact that FGM has been criminalized in Egypt, the incidence is still high in Upper Egypt. In addition, Aberese Ako and Akweongo (2009) report through a qualitative study in Ghana that the political will to enforce the law prohibiting FGM is lacking and local communities remain determined to maintain the practice because of tradition, thereby posing a huge challenge for effective intervention by the state (see also Obiora, Maree, and Nkosi-Mafutha 2020). One unpublished working paper with econometric design from Burkina Faso finds a decline in prevalence before and immediately after the introduction of a law prohibiting FGM; however, the authors acknowledge the weakness of the data, which consists of self-reporting by females ages 15–49 years, who are asked if they themselves or their daughters have been cut (Crisman et al. 2016).

In analyzing whether laws can help accelerate abandonment, it is important to note that expectations of effects emerge from at least two different theoretical perspectives within the field of law and social transformation. From a law and economy perspective, legal sanctions will deter crime. This perspective

rests on the assumption that if individuals are aware of the law, they will calculate the risks and benefits of continuing the practice and the risk of prosecution will deter them from continuing. From a law and society perspective, social norms supporting FGM may generate resistance to implementation of a new legal norm. From this perspective, to be effective, laws must be more or less in step with social norms, so they can nudge behavior in a desired direction. If the laws are too divergent from social norms, they are likely to simply be rejected (thereby forcing the practice underground) or to be a source of countermobilization that potentially derails grassroots efforts to abandon the practice (Tønnessen and al-Nagar, forthcoming).<sup>13</sup> Other negative effects have also been noted in the literature: Camilotti (2016, 134) observe a decrease in age at cutting in Senegal as a consequence of the induced secrecy of the practice.

Bettina Shell-Duncan and Ylva Herlund (2013) explore responses to a 1999 anti-FGM law in Senegal in an article entitled “Legislating Change? Responses to Criminalizing Female Genital Cutting in Senegal.” Although the article does not establish causality and thus, strictly speaking, cannot say anything about the “effect” of the law, it provides interesting insights about the potential impact of criminalization of FGM. The article draws on data from a mixed method study, collected in a rural region of the country where other abandonment efforts were being implemented and where FGM was being actively contested. The study is thus not based on a national representative sample. Data was collected during a three-year period beginning in 2004, starting with qualitative interviewing from which an ethnographically grounded survey was developed. The authors evaluate associations between individuals’ readiness to change and the perceived power of the law and explore both the law and economy and the law and society perspectives. Individuals readiness to change was delineated into “willing adherents,” “reluctant adherents,” “contemplators,” “reluctant abandoners,” and “willing abandoners.”

Shell-Duncan and Herlund’s findings suggest that fear of prosecution and belief in the power of the law is significantly lower among willing adherents of FGM, compared to all other groups. This suggests that imposing legal regulations in communities where there is unanimous support for FGM may have little effect. However, where there are active debates and divergent opinions about the continuation of FGM, legislation may provide added strength to those individuals in favor of abandonment. Furthermore, it can create an enabling environment for NGOs to do awareness raising among practicing communities.

It is also important to note that Senegal is not among the countries with the highest prevalence of FGM. Therefore, if this study were replicated other places the results could be very different. Nonetheless, the study brings an important insight into the debate on the potential effect of criminalization by demonstrating that within the same rural context in Senegal there are great variations in fear of prosecution and belief in the power of the law.

---

<sup>13</sup> Dan Kahan’s (2000) discussion of “gentle nudges” and “hard shoves” points out that if a new legal norm imposes harsh penalties against a widely accepted social norm, police will become less likely to enforce the law, prosecutors less likely to charge, and juries less likely to convict, with the effect of reinforcing the existing norm that was targeted for change, thus undermining progressive condemnation and abandonment of the “sticky” norm.

However, the fact that there is a lack of studies on effect of law does not mean that law cannot be an effective tool in abandonment of FGM. It merely means that there is a scant scientific literature to document the material and symbolic effects of legal changes. It is inherently difficult to measure the effect of law on FGM, especially if data is self-reported, because people may not answer truthfully when asked whether they have cut their daughters in a legal context where they might put themselves at risk of persecution. Nonetheless, based on the scant scientific literature available, it seems that criminalization might work best in a context where abandonment is already underway, and communities and individuals show a readiness to change. It is also worth noting that laws prohibiting FGM might have different effects depending on the content of the laws themselves. For example, laws that only prosecute perpetrators may operate differently in practice than laws that also aim to prevent and protect victims of FGM.

## 6. Criteria for study inclusion

The scientific literature on effect of interventions into the practice of FGM is scarce because very few interventions have been properly documented and evaluated (Johansen et al. 2013). The literature on FGM and interventions is growing, but there is a lack of studies with a sufficiently methodologically rigorous design. A systematic review (SR) from 2012 found only seven interventions that were deemed sufficiently rigorous to be included in the review, and even those are described by the authors as having weak methodology (Berg and Denison 2012, 1). Berg and Denison included studies that scientifically determined effect based on a controlled before-and-after design analysis, including three non-peer reviewed publications commissioned by the Population Council.

For our current review, we searched both the Cochrane and Campbell libraries for more recent SRs. In addition, we ran searches in Pubmed (Medline)<sup>14</sup> and Web of Science<sup>15</sup> to screen for studies published since Berg and Denison's 2012 SR. Titles and abstracts for inclusion were then screened. Our inclusion criteria were (a) studies that focus on the effect of interventions to reduce the prevalence of FGM (b) in Africa (c) that had controlled before-and-after designs and (d) were in peer reviewed publication outlets. Only one of the selected studies is randomized (Vogt et al. 2016). We found only three intervention studies that met the inclusion criteria. As this review has taken place under time and resource constraints, there may be studies available that the authors are not aware of, especially as we chose not to include further searches of "grey literature" databases.

---

<sup>14</sup> Specifically, we used the following search string: (("Circumcision, Female"[Mesh] AND (2013:2020[pdat])) AND ((interventions) AND (effect))). This yielded 116 results, and screening on titles led us to six potentially relevant studies, which were reduced to three relevant studies based on reading the abstracts.

<sup>15</sup> We started with the following search string: TOPIC: (female genital mutilation). We then refined it by "(intervention AND effect)" and applied a timespan of 2013–2020. We applied these search criteria to the indexes SCI-EXPANDED, SSCI, A&HCI, ESCI, which yielded 24 hits. Further screening of titles led us to four potentially relevant studies. Two of these studies overlapped with findings from Pubmed (and one of those had already been selected for inclusion). The other two studies were not included because they were missing control groups.



Combined with the seven publications from Berg and Denison's systematic review, we include and summarize results from ten intervention studies. See the overview of included studies in the table below.

### FGM intervention studies, sorted by author

| Citation   | Country          | Implementor  | Type of intervention                     | Source                    |
|--|------------------|--|--|---------------------------|
| Babalola, S., A. Brasington, A. Agbasimalo, A. Helland, E. Nwanguma and N. Onah. 2006. "Impact of a Communication Programme on Female Genital Cutting in Eastern Nigeria." <i>Tropical Medicine and International Health</i> 11, no. 10: 1594–1603.  | Nigeria          | Health Communication Partnership, NAWOJ, WARO, & USAID   | Communication (supplemented by advocacy) | SR, Berg and Denison 2012 |
| Chege, J., I. Askew, S. Igras, and J. Mutesh-Strachan. 2004. "Testing for the Effectiveness of Integrating Community-based Approaches for Encouraging Abandonment of Female Genital Cutting into CARE's Reproductive Health Programs in Ethiopia and Kenya." FRONTIERS Final Report. Washington: Population Council. | Ethiopia & Kenya | CARE with local partners (governmental and non-governmental)   | Advocacy                                 | SR, Berg and Denison 2012 |
| Diop, N.J., M.M. Faye, A. Moreau, J. Cabral, H. Benga, F. Cisse, B. Mane, I. Baumgarten, and M. Melching. 2004. "The TOSTAN Program: Evaluation of a Community Based Education Program in Senegal." FRONTIERS Final Report. Washington: Population Council.  | Senegal          | Tostan   | Village empowerment                      | SR, Berg and Denison 2012 |
| Diop, N.J., F. Traore, H. Diallo, O. Traore, A.H. Toure, Y. Diallo, M. Sangare, F.T. Keita, and A. Toure. 2007. "Study of the Effectiveness of Training Malian Social and Health Agents in Female Genital Cutting Issues and in Educating Their Clients." Final Report. Bamako: Population Council.                  | Mali             | Ministère de la Santé, des Personnes Agées et de la Solidarité (MSPAS) and the Association de Soutien au Développement des activités de Population (ASDAP) | Health education                         | SR, Berg and Denison 2012 |
| Easton, P., R. Miles, and K. Monkman. 2002. "Final report on the evaluation of the Tostan/IEP village empowerment program pilot project in the republic of Mali." Tallahassee: Florida State University.   | Mali             | Tostan   | Village empowerment                      | SR, Berg and Denison 2012 |
| Evans, W.D., C. Donahue, J. Snider, N. Bedri, T.A. Elhusein, and S.A. Elamin. 2019. "The Saleema Initiative in Sudan to Abandon Female Genital Mutilation: Outcomes and Dose Response Effects." <i>PLoS ONE</i> 14, no. 3: e0213380.   | Sudan            | Saleema  | Social norms                             | Pubmed                    |
| Mahgoub, E., M. Nimir, S. Abdalla, and D.A. Elhuda. 2019. "Effects of School-based Health Education on Attitudes of Female Students towards Female Genital   | Sudan            | Implemented by the authors   | Health education                         | Pubmed/Web of Science     |

| Citation  | Country      | Implementor                | Type of intervention | Source                    |
|---|--------------|----------------------------|----------------------|---------------------------|
| Mutilation in Sudan.” Eastern Mediterranean Health Journal 25, no. 6: 406–412.  |              |                            |                      |                           |
| Mounir, G.M., N.H. Mahdy, and I.M. Fatohy. 2003. “Impact of Health Education Program about Reproductive Health on Knowledge and Attitude of Female Alexandria University Students.” Journal of the Egyptian Public Health Association 78, no. 5/6: 433–466. | Egypt        | Implemented by the authors | Health education     | SR, Berg and Denison 2012 |
| Ouoba D., Z. Congo, N.J. Diop, M. Melching, B. Banza, G. Guiella, and I. Baumgarten. 2004. “Experience from a Community-based Education Program in Burkina Faso: The Tostan Program.” FRONTIERS Final Report. Washington: Population Council.               | Burkina Faso | Tostan                     | Village empowerment  | SR, Berg and Denison 2012 |
| Vogt, S., N.A.M. Zaid, H.F. Ahmed, E. Fehr, C. Efferson. 2016. “Changing Cultural Attitudes towards Female Genital Mutilation.” Nature 538: 506–509.  | Sudan        | Implemented by the authors | Communication        | Pubmed                    |

There are several reasons why scientific literature on FGM intervention is scarce. First, contemporary interventions to abandon FGM—often described as holistic, integrated, or multisectoral—are inherently difficult and costly to evaluate. In particular, no scientific studies to date document the effects of the interplay between different components of interventions. Furthermore, the most commonly collected data (self-reported data) has major weaknesses. From a research ethics point of view, biological data can only be collected within the frame of health interventions at medical facilities. In addition, changes in attitudes towards and the prevalence of FGM cannot be reliably measured in a short time period; long-term follow up of several years is desirable (Berg and Denison 2012, 53). All these factors combined make studies of the effects of interventions to abandon FGM less attractive for specialists engaging in impact evaluations.

Importantly, “This is not for a lack of robust interventions, but rather a lack of robust studies evaluating these interventions” (Esho, Karumbi, and Njue 2017, 7). In other words, the prevalence of scientific literature does not necessarily reflect on the number or quality of interventions. However, it does mean that we know surprisingly little about what works. Although we see a decline in FGM prevalence, we do not know whether this is caused by interventions or development changes more broadly, including economic development and women’s empowerment (Engelsma, Mackie, and Merrell 2020).

## 7. Interventions: What we know about what works and does not work

We have grouped the 10 intervention studies into the following categories: (a) health education interventions (three studies, in Mali, Sudan and Egypt), (b) village empowerment interventions (Senegal, Mali and Burkina Faso), (c) advocacy interventions (Ethiopia/Kenya), (d) communication interventions (Sudan, Nigeria), and (e) social norms interventions (Sudan). This does not reflect all interventions, but the universe of studies that have a methodological design equipped to measure effect.

With two exceptions, the intervention studies measure effect on knowledge, attitudes, and intentions regarding FGM rather than whether parents have cut their daughters. Some studies include measurement in terms of discussing FGM in the family and community. Only the studies in Senegal and Burkina Faso provide evidence of the effect of interventions on actual abandonment of the practice.

A huge disadvantage in assessing effect of the studies included in this review is that we learn very little about the content and quality of the intervention. This is a limitation that has been noted in other literature. For example, according to Esho, Karumbi, and Njue (2017, 7),

Many published reports assessing or evaluating FGM interventions describe the interventions poorly, so readers are unable to fully understand what was implemented, why, and for what effect, limiting their abilities to replicate or adapt these interventions.

Generally, we also receive little information about the theory of change relied upon for the intervention, although in some cases we have been able to determine this based on other publications by the same authors or by the organization implementing the intervention. Based on how these studies evaluate and measure the effects of intervention, it seems that the majority of these studies place great emphasis on increased knowledge as a gateway to changing attitudes and behavior. According to Berg and Denison (2013, 333), who evaluated seven of the 10 studies included in this review,

A change mechanism underpinning all interventions was that providing information about FGM would increase knowledge. Thus, it seems that the driving force for changing FGM-related behaviour was thought to be the dissemination of information. On the whole, this reflects local efforts which have historically concentrated on education and advocacy.

This might reflect the fact that many of these studies are from the late 1990s and early 2000s, and the theories of change regarding FGM abandonment interventions have changed since that time.

The initial phase of the global campaign framed opposition to FGM as a health problem, “an impediment to development that can be prevented and eradicated much like any disease” (Hosken 1979, 85). Interventions focused on (both formal and informal) education on the adverse health effects of FGM and assumed that if people were made aware of the risks, they would be motivated to abandon the practice

(Herlund and Shell-Duncan 2007b). However, several weaknesses of this approach have been identified, including the medicalization of FGM and, more importantly, that communities may be aware of the negative health effects, but continue to practice FGM because the social, religious, and cultural benefits outweigh the risks (Mohamud, Radeny, and Ringheim 2006; Shell-Duncan and Herlund 2000; 2010).

Recent years have seen a shift away from the health risk approach towards a rights-based approach, which acknowledges that the practice is a violation of human rights (Shell-Duncan 2008). The current ideal intervention is holistic, rights-based, culturally sensitive, and participatory. Under the current approach, FGM is seen as deeply embedded in social norms, understood as rules of behavior that members of a community are expected and motivated to follow through a set of rewards and sanctions. Key to this approach is community empowerment and participatory deliberation, which allows members of the community to themselves conclude that FGM causes harm and violates girls' and women's rights and to decide to declare its abandonment. Laws and policy can create an enabling and supportive environment for such changes to take place within practicing communities.

## 7.1. Health education interventions

As explained by Waigwa et al. (2018: 2), a health education intervention

. . . involves different learning experiences designed to help individuals and communities improve their health by increasing their knowledge or influencing their attitude. [. . .] It is vital for health education interventions to aim at long-term changes to the health behaviour and the norms that are attributed to a health problem.

Addressing the social norms driving FGM is thus seen as important in such interventions, considering that research points in the direction that among practicing communities “health risks are considered a lesser danger than the dangers associated with abandoning FGM” (Johansen et al. 2013, 4; capitalization omitted). This type of intervention targeting health workers is particularly relevant in contexts where FGM is medicalized.<sup>16</sup> Where FGM may be a taboo topic, rarely discussed in public; or even within families; educating girls and women about the harmful effects of FGM can be especially relevant.

Three included studies focus on “classroom” health education interventions. The target groups include health workers in Bamako, Mali (Diop et al. 2007),<sup>17</sup> female university students in Alexandria, Egypt (Mounir, Mahdy, and Fatohy 2003), and female pupils ages 14–17 in Khartoum, Sudan (Mahgoub et al. 2019). Each of the studies had a controlled before and after methodological design.

---

<sup>16</sup> A systematic review on health interventions for healthcare providers to improve treatment and prevention of FGM found only two studies, including the study from Mali elaborated above and a study from the United States (Balfour et al. 2016). In other words, the research on this topic is scarce not only in an African context.

<sup>17</sup> This study was originally published in French in 1998 and was translated into English in 2007.

The theory of change that is explicitly or implicitly formulated in these three studies suggests that increased knowledge of harmful health effects of FGM will change attitudes towards the practice. In the Mali and Sudan studies, there is also an expectation that those receiving health education will become change agents. In the Mali case, health workers are expected to use this new knowledge to educate patients seeking to perform FGM and thereby to persuade them not to cut their daughters (Diop et al. 2007). In the case of Sudan, the recipients of the intervention are expected to object if someone in the family wants to practice FGM and to join activists seeking to discontinue FGM (Mahgoub et al. 2019).

The interventions consisted of (a) a four-day educational session on the harmful health effects of FGM that included visual aids and role play activities (Mali); (b) two one-hour educational sessions on reproductive health that included a component on the negative health effects of FGM (Egypt); and (c) an 80-minute health education session that included a lecture, video, and group work (Sudan). Two of the studies combined education on harmful effects with a discussion of local drivers of the practice (Mali and Sudan). The studies provide only little information about the content and quality of these education sessions or the competency of the trainers. Therefore, we do not know whether the sessions were based on a pre-intervention mapping of harmful health effects specific to the local context or whether the identified social norms driving FGM were tailored to those localities.

Notably, the overall literature emphasizes that health education interventions are less likely to work than other types of interventions and may even lead to medicalization rather than to abandonment of FGM. This is particularly the case if they merely present a “laundry list” of the harmful health effects of the most severe type of FGM that is likely to be disconnected from the local context and personal experiences of the communities (Banks et al. 2006). For example, in local contexts where harmful health effects of FGM are attributed to witchcraft or evil spirits, a general introduction of health risks detached from the local context may not accelerate abandonment (Johansen et al. 2013).

All three studies that examine the effect of health education interventions report a positive change in knowledge and attitude, which suggest that health education interventions may work well to change attitudes. However, the Mali case also finds increased knowledge in the control group, which suggest that any new knowledge gained might have come as a result of larger societal changes, rather than through the intervention itself (Diop et al. 2007). The Mali study finds a positive effect of the intervention on health workers’ attitudes towards medicalization and finds that the intervention led to a reduction in the share of workers who regarded FGM carried out in a health facility as safe (from 35 to 17%) (ibid., 28). Since “safety” is found to be a key motivator for health workers to perform FGM in medical facilities (see, e.g., Leye et al. 2019), this attitudinal change may be a step in reversing the trend of medicalization.

The expectation that health workers in Mali and school students in Sudan will become change agents is only partially fulfilled. In Sudan, the percentage of school students who indicated that they intend to join activists seeking to discontinue FGM or say they will object if someone in their family wants to practice

FGM increased following the intervention (Mahgoub et al. 2019). On the other hand, in Mali, the percentage of health workers who regarded anti-FGM advocacy as necessary after the intervention increased, but the percentage of health workers who indicated a willingness to participate in such advocacy *decreased*, something the authors attribute to health workers seeing this as an added work burden (Diop et al. 2007).

The studies only measure secondary outcomes in terms of increased knowledge and attitudes towards FGM. The authors of the Sudan study make clear that they do not see this as sufficient in and by itself to change behaviors, since decision making takes place in a family and wider community setting, especially considering the patriarchal context in which schoolgirls must maneuver:

[T]his positive attitude change towards FGM might not be translated into a decrease in the level of FGM practice in the future. Many studies have shown that a health education intervention programme alone usually is not sufficient to achieve the kind of behavioural change that will lead to discontinuation of a complex practice such as FGM (Mahgoub et al. 2019, 410).

## 7.2. Village empowerment interventions

Three studies address what could be termed “village empowerment” interventions: one in Kolda region, Senegal (Diop et al. 2004), another in Mali (Easton, Miles, and Monkman 2002), and a third in Burkina Faso (Ouoba et al. 2004). All three studies evaluate the effect of an intervention by the Senegalese NGO Tostan, which was established by Molly Melching. All three studies collect baseline and end line data and have intervention and control villages. They also all have a mixed method approach that includes participant observation as a method during the intervention. The program uses informal educational modules and problem-solving activities in local communities to foster transformative learning, rather than passive assimilation of information. The educational modules relate to topics such as community hygiene, reproductive health, and women’s rights and target both men and women. FGM-abandonment is explicitly addressed as part of the modules is also feature in a three-day seminar offered towards the end of the intervention.

The approach is considered “participatory” or “empowering,” as participants themselves are encouraged to identify local issues of concern, including the harmful effects of FGM (Monkman, Miles, and Easton 2007). The approach is also considered “rights-based,” since human rights are talked about using culturally sensitive language. The idea is that “learning about the human right to voice one’s opinions in public discussions opened the possibility for women to articulate their health concerns in village meetings and to the press” (Gillespie and Melching 2010, 478–479).

Gillespie and Melching argue that, if introduced at a stage when the community displays readiness for change, the intervention will lead the community to declare abandonment. Community members will not only stop cutting their daughters, but will also become advocates of change within the community. This

theory of change acknowledges that increased knowledge may only have an effect if there is a readiness for abandonment or at least active discussions about abandonment taking place before the intervention. Because of this emphasis on “readiness to change,” there seems to be a selection bias of villages. For example, related publications by the authors of the Senegal study suggest that in some cases participants reported having been asked about their willingness to abolish FGM during the village selection process, suggesting that if the village did not express such willingness, a different village would have been selected for the intervention (Diop, Moreau, and Benga 2008, 8; Diop and Askew 2009, 315). This suggests that there may be bias in estimating the effects of the program.

All the three Tostan interventions followed the same approach. “The change mechanisms revolved around education affecting knowledge, skills, public discourse and empowerment” (Berg and Denison 2013b, 329). It is unclear to what extent the interventions, which lasted between six and eight months, catered to local differences and whether pre-intervention mappings were conducted to establish local drivers and harmful effects based on the type of FGM most commonly performed. It seems from the studies that pre-intervention mapping was conducted mostly in order to identify which villages would receive the intervention, and, indeed, the Mali study acknowledges implementation challenges with regards to embedding the intervention (originally designed for a Senegalese context) in the local context in Mali (Easton, Miles, and Monkman 2002). The fact that the relationship between FGM and religion/tradition is not included as a measurable indicator (except for men in Senegal), although it is perceived to be an important driver of FGM in these countries, may suggest that the pre-mapping was not conducted to establish the social embeddedness of FGM in the local contexts (Berg and Denison 2013b). Religious belief was included in the survey for men in the study on Senegal, and the intervention seemed to have a negative impact, since more men believed FGM was an Islamic practice after the intervention:

The proportion of men who thought that FGC was supported by religion increased significantly among all groups in both the intervention and comparison villages. [. . .] This increase was probably due to the declarations by an important Pulaar spiritual leader made in response to the introduction of the law forbidding and punishing FGC in 1999 (Diop et al. 2004, 19).

Although the same Tostan intervention is evaluated in three countries, the studies measure effect in different ways. The effect of the intervention on prevalence (primary outcome) was only measured in Senegal and Burkina Faso, and only the Senegal study finds a significant effect: “The prevalence of FGC among girls decreased significantly in the intervention groups, while it stayed at the same level in the comparison group” (Diop et al. 2004, 31). The Burkina Faso study finds no significant effect on prevalence, although the percentage of mothers who reported having cut their daughters was low even before the intervention started (Ouoba et al. 2004).

The Tostan program is reported to have positively affected knowledge and attitudes, so-called “secondary outcomes.” In Mali, the only outcome reported is that a greater proportion of intervention participants

than comparison participants opposed FGM (Easton, Miles, and Monkman 2002). The Senegal and Burkina Faso studies report an increase in knowledge about the harmful consequences of FGM among men and women, disapproval of FGM, and regret (among women in Burkina Faso) for having cut their daughters (Ouoba et al. 2004; Diop et al. 2004). However, no indicators measure outcomes on the human rights components of the education modules, which is a major weakness of these studies, although qualitative data from the Mali study suggests that the human rights component was the central turning point in the educational modules for participants to decide to oppose FGM (Easton, Miles, and Monkman 2002).

### 7.3. Advocacy interventions

Only one study examines what can be characterized as an advocacy intervention, but that intervention was executed in two countries (Chege et al. 2004). The FGM intervention had a duration of 18 months and was integrated into a larger reproductive health program administered by CARE in Kenya and Ethiopia. The intervention targeted a refugee camp for Somalis in Kenya and the Afar people in Ethiopia, with an objective to “increase interest and ability of communities, NGOs and the Ministry of Health (MOH) and other local Ministries to address FGC issues appropriately and effectively” (ibid., 2). The intervention included community level educational outreach activities and community level advocacy in these two Muslim communities in which FGM prevalence is almost universal. Outreach activities included information and educational sessions, community meetings, theatre group performances, video sessions, mass media activities, and support of advocacy.

Influential individuals who could serve as advocates (especially religious leaders) were targeted. Specific training and messages were constructed for each group, for example, religious leaders would speak to the erroneous association of Islam and FGM. The concerted efforts to engage religious leaders seems to have derived from preintervention research to understand the context of the practice, which revealing a strong link between FGM and Islam among Somalis and Ethiopians.

In the Ethiopian context, where the intervention succeeded in mobilizing religious leaders, it triggered improvement in knowledge of the harmful consequences of FGM, a belief that the practice compromises the human rights of females, and intentions not to perform FGM in the future. However, the study does not measure effects or impact beyond the individual respondents’ knowledge of and attitude towards FGM, so it is hard to assess whether the intervention affected actual FGM practice.

In the Kenyan context of Somali refugees, the intervention failed to generate significant change. At least two factors help explain this. First, there was a mixed engagement with religious leaders: “In Ethiopia, the project worked extensively with religious leaders. This was planned in Kenya, but never was realized during the intervention period” (Chege et al. 2004, 9). Another factor emphasized by Berg and Denison was that “the programme was implemented by the National Council of Churches of Kenya and it is possible that efforts by a Christian group to end a practice which is closely linked with Islam antagonised the target



community” (Berg and Denison 2013b, 327). The authors themselves points out other methodological weaknesses, such as population movements into and out of the intervention and comparison areas and different approaches to human rights education in Kenya and Ethiopia (Chege et al. 2004).

Nonetheless, this is the only intervention study included in this review that explicitly acknowledges religion as a driver of FGM by specifically targeting religious leaders with messages to delink the association between Islam and FGM. While we cannot conclude based on one study only, Berg and Denison indicate that this might be a promising approach:

[W]here there is a strong link between FGM and religion, programme planners must attract religious leaders’ support and commitment. It is possible that campaigns with greater focus on religious interpretation of the custom’s undesirability will be more effective than one that stresses health complications or violation of human rights. (Berg and Denison 2013b, 333).

However, qualitative research in and among other CARE’s intervention sites in Afar, Ethiopia, suggest that the inclusion of religious leaders as advocates of FGM abandonment might not have been so successful as it seems on the surface. In the international NGO workshops and educational sessions, religious leaders’ public message to abandon the practice was not internalized and was only displayed “to satisfy the ears’ (*gurramaaf*) of the government and the NGOs” (Østebø and Østebø 2014, 96).

**A key female Muslim informant in Østebø and Østebø’s qualitative study on religious leaders’ role in abandonment in Ethiopia illustrates this point through the following quote:**

I went to Afar in order to discuss the issue of FGM with religious leaders. When I arrived I was told that I came at a good time as there would be a meeting with the religious leaders from the whole district the following day. The meeting was arranged as a result of CARE’s involvement. I went there. I sat there. All kinds of issues were raised. Then the mufti denounced FGM. It was almost like a decree. He said: “You will be punished for 2-3 years if you practice FGM.” Two days later I had my meeting with the district’s religious leaders, traditional leaders, and women. I thought the meeting a couple of days ago had been great, and that it now would make things easy for me. But when I raised the issue with reference to the previous meeting the denouncing of FGM, all of them were laughing at me, saying: “Do you really believe that we support this? Out of 60 traditional leaders there was only one of us who supported it.” So they pretended that they agreed. And CARE and the media were happy (Quoted in Østebø and Østebø 2014, 96).

## 7.4. Communication interventions

Two studies evaluate mass media communications tools—one in Nigeria (Babalola et al. 2006) and the other in Sudan (Vogt et al. 2016). In Nigeria, the Health Communication Partnership, in collaboration with the National Association of Women Journalists (NAWOJ) and Women Action Research Organization (WARO), designed a multitiered and multimedia program called *Ndukaku* (the Igbo word

for “health is better than wealth”). It was implemented in three local government areas in Enugu State (Uzo-Uwani, Isi-Uzo, and Enugu South), which is a Nigerian state with about 37% prevalence of FGM in communities with little or no education.

The intervention aimed to change knowledge, attitude, and behavioral intentions and included a mass media component and a community capacity and mobilization component (the latter comparable to the Tostan approach discussed earlier). NAWOJ designed and implemented state-level activities that used mass media (e.g. regular newspaper columns, radio call-in shows, and public forums) to stimulate and publicize dialogue around FGM. WARO “assist[ed] community core groups to examine their knowledge, attitudes and practices surrounding women’s reproductive health and then provid[ed] the groups with guidance and support as they developed action plans to improve women’s health situation” (Babalola et al. 2006, 1595).

Babalola et al. rely on a baseline survey conducted in July/August 2003 and a follow-up survey implemented in September 2004 to evaluate the effect of the intervention. Both surveys were based on an intervention–comparison group design and took place in Enugu (intervention) and Ebonyi (comparison) States. The study shows a large reduction in intention to perform FGM on daughters and concludes that program exposure through both mass media and community activities affected change more than exposure through either means alone (ibid., 1601). The authors also note that in April 2005, the Enugu State House of Assembly passed into law a bill, sponsored by NAWOJ that seeks to abolish FGM and attributes this to the intervention (ibid.).

Babalola et al. (ibid., 1600) point out a “dosage” effect that is also found in Vogt et al.’s (2016) study from Gezira, Sudan. That study explores the effect of “edutainment,” a communication strategy that works through entertainment media with the aim of promoting a better context for behavioral change than the delivery of information alone. The intervention is based around the creation of four soap opera films that have a plot revolving around members of a rural family in Sudan that express different prevalent perspectives on FGM familiar to the local community. The films do not associate negative characters with arguments in favor of FGM, but rather “dramatize how difficult a decision about cutting can be for parents who want the best for their daughters in a society where cutting is common, but attitudes and practices vary” (Vogt et al. 2016, 506).

The Sudan study examines the effect of these different messages on attitudes about FGM (Vogt et al. 2016). The theory of change suggests that FGM is subject to constant negotiation within the culture and that arguments for abandonment are already present within local communities. Exposing local rationales against cutting changes attitudes among supporters of FGM. The authors themselves describe the films as “experiments on cultural change that exploited the existence of conflicting attitudes within cutting communities” (ibid., 506). Considering that backlash against outside interventions to abandon FGM is

commonplace in Sudan (see Gruenbaum 2001; Tønnessen and al-Nagar forthcoming), this approach seems finetuned to the local context.

The three opera films of approximately 90 minutes each have small variations to the plot and how the dispute regarding FGM is settled. The first film focuses on different individual level values (like hygiene, religious observation, or purity), the second film focuses on community level values (marriageability), the third film combines the two, and a fourth control film includes the main plot, but does not mention FGM at all. The variation in film content allowed the researchers to examine whether certain arguments related to abandonment of FGM were more compelling in changing attitudes toward the practice. The films were shown to people in two randomized and controlled experiments to ensure that the effect of the film was captured in their effect estimates (Vogt et al. 2016; 506). The researchers collected baseline data on attitudes towards cut and uncut girls before the intervention. The measured results indicate that attitudes towards uncut girls improved significantly and especially among older women with daughters. However, participants who entered the experiment with the most negative attitudes toward uncut girls did not change their attitude. The results show that all the three films produced robust and significant changes in attitudes, but also that the combined film “produced attitudinal change that lasted longer” (ibid., 507).

This study suggests that messages to abandon FGM should be locally grounded and when arguments are combined, they are more effective in changing attitudes toward uncut girls. However, it is important to note that only attitudes are measured in this study; the study does not address the effect of the intervention on actual behavior in terms of cutting. If messaging regarding FGM were integrated into local TV broadcasts and other popular entertainment (for which there is a consistent demand), this could be a way of sensitizing communities to cutting in a way that could have a broader reach than for, example, documentaries or other types of interventions that mainly attracts those already interested in the topic (ibid.). For example, recent studies show that commercial TV can improve the status of women in Brazil (e.g., La Ferrera, Chong, and Duryea 2012).

## 7.5. Social norms interventions

Only one study evaluates the effect of a social norm intervention that is considered quite unique, namely the Saleema campaign, which was initiated in Sudan in 2008 (Evans et al. 2019). The broad objective of Saleema is to change the way people talk about FGM. The negative religious term *ghalfa* has traditionally been used to describe uncut girls and is associated with being unhygienic, impure, and hypersexual. By introducing the positive term *saleema*—which means “whole, healthy in body and mind, unharmed, intact, pristine, untouched, and in a God-given condition”—the campaign not only addresses drivers of FGM but aims to change social norms underpinning it in a Sudanese context. It can be described as a social marketing campaign to reframe the public discourse around uncut girls and to create acceptance for being “saleema.” Various communication tools were used in the campaign, including posters, stickers, children’s puzzles, a multimedia campaign kit (including a song), an animated television spot, four linked radio spots,

a comic book, and Saleema design tobies (the Sudanese traditional dress) and shawls to be distributed during public campaigns. The theory of change builds on social norm theory:

The Saleema initiative, and in turn research to evaluate its effects on FGM social norms and behavior in Sudan, is based on a theoretical model of social norms and the potential to change those norms through creating an alternative narrative and identity for abandonment of the practice. (Evans et al. 2019, 3)

The Saleema campaign was implemented across Sudan's 18 states, through multiple stages, all organized around large-scale community dialogues, including public pledges of abandonment.

The study design is quasi experimental, since levels of Saleema exposure (dosage) naturally varied by geographical location (across the 18 states) and over time in Sudan. Data from a nationally representative sample was collected prior and after a planned increase in the media delivery of Saleema (in terms of both reach and frequency) to create a "heavy up" effect. This increase in campaign dose acts as a quasi-experimental control. The aim of the study was to determine whether there was a dose-response relationship between higher exposure to Saleema and disagreement with normative beliefs about FGM. Respondents were asked questions related to beliefs around Saleema, exposure to advertising, message receptivity, and FGM intentions and social norms. The authors created per capita indicators of community, government, and media event participation to reflect the scale of activity by state population. The study presents a slight reduction in pro-FGM norms in the study period and finds that this decline is positively associated with higher "dosage" of the Saleema campaign.

This is the only intervention study that evaluates an attempt to change social norms underpinning FGM and as such is noteworthy. The initiative is unique and adapted to the Sudanese context and cannot be directly adapted to other contexts, but negative terms are used for uncut girls in other places, so the idea of changing the language of discourse may be worth pursuing. According to the authors, the intervention "represents a promising strategy for abandonment of FGM in Sudan" (Evans et al. 2019). Although the study reports positive results and the campaign is clearly based on preintervention mapping and research about drivers of FGM, its design does not allow us to learn which groups of people are more likely to be positively affected by the campaign or whether Saleema's culturally sensitive approach was able to reach the strongest supporters of FGM. As in the case of most other intervention studies of effects, it only measures secondary outcomes and does not measure behavioral change.

## 8. Discussion and take away points

The body of research on the effects of FGM abandonment interventions reflects neither the full range of interventions types nor necessarily the quality of contemporary interventions. These studies on effects of interventions are considered weak (Berg and Denison 2012; Esho, Karumbi, and Njue 2017). Some reasons for this have already been mentioned and include the following:

- With the exception of the studies evaluating effect of the Tostan village empowerment interventions in Burkina Faso (Diop et al. 2004) and Senegal (Ouobo et al. 2004), which collect data on prevalence, all the other studies only measure secondary outcomes such as increased knowledge of harmful effects, attitudinal changes towards FGM, and intentions regarding FGM. The collective evidence from these 10 studies on whether these interventions has had effect on abandonment of FGM (that is, caused behavioral changes) is therefore considered poor.
- While two of the studies identify effects of the interventions on FGM prevalence, neither of them collects biological data. Knowing that there are discrepancies in self-reported answers on FGM versus behavioral change, this is a weakness. However, biological data is difficult to collect and is often only possible and ethical when an intervention occurs in a medical facility.
- Overall, the studies provide little information about the interventions, both with regards to the content and the quality (Shell-Duncan, Moore, and Njue 2017). Even if some of these studies do showcase a positive effect on prevalence, knowledge, or attitudes, it is nonetheless difficult to draw more general lessons from the studies, especially since so few interventions have been examined and they were carried out in very different contexts.
- The nature or design of multifaceted community interventions does not allow us to evaluate the effect of different components. Although the Tostan village empowerment interventions offer complex education modules on FGM, including both health and human rights, the effect of the different components is not measured. One notable exception here is the “edutainment” study from Sudan, which actually measures the effect of different locally grounded anti-FGM messages and finds that a combined message is the most effective (Vogt et al. 2016).
- Although we only selected studies with treatment and control groups, many of the studies report variation between the groups at the baseline (Berg and Denison 2012). For example, in the study by Ouroba et al. (2004), a majority of the participants in the intervention group were Muslims, while the majority of participants in the control group were Catholic (ibid., 37). Assuming that Muslims and Catholics may have different trends in FGM over time, this study provides incorrect estimates of the effects. In the Tostan studies, there may be a selection bias, since villages that demonstrated a readiness for change were more likely to receive the intervention (Ouroba et al. 2004; Diop et al. 2004; Easton, Miles, and Monkman 2002). This is methodologically problematic because treatment and control groups must be similar in terms of the characteristics that determine the program effects. Key differences between the groups at baseline will likely affect whether individuals are inclined to change FGM practice and make the results less reliable, since the measured effect of the intervention may stem from these between-group variations instead of the intervention.

- Several studies report that the intervention was contaminated, which again means that the measured effect may be less reliable. For example, in the advocacy intervention in Kenya and Ethiopia, the authors report that “[t]he study design was contaminated in both Kenyan and Ethiopian sites, due to population movements into and out of the intervention and comparison areas” (Chege et al. 2004, 7). If such movement leads FGM messages in the intervention areas to also be communicated to people in the comparison areas, the measured effect may be zero (since both groups are then exposed to the program).
- Finally, some of the studies may be biased because stakeholders of anti-FGM organizations are part of the intervention’s implementation and analysis. For example, Molly Melching, the founder of the Tostan programme features as a coauthor of two of the reports, both the one on Burkina Faso (Diop et al. 2004) and the one on Senegal (Ouoba et al. 2004).

Although the methodology in most of these studies can be described as weak (Berg and Denison 2012; Esho, Karumbi, and Njue 2017), there are nonetheless important takeaways.

## 8.1. Context matters

The importance of local embeddedness—operating in the language of the intervention community or wrapping the intervention into existing social structures—cannot be overstated. Nonetheless, there is no magic bullet or “one size fits all” approach. Rather, preintervention mapping that connects the intervention to local drivers of FGM is essential. This entails examining what types of FGM are practiced in the community and what harmful effects of the practice are perceived by local communities (including medical personnel and others), so that the intervention can be tailored to the local context. This mapping should also include understanding local FGM decision makers and gatekeepers. For example, in a context where men are seen the main decision makers regarding FGM, an intervention solely targeting women is less likely to accelerate abandonment.

Interventions that are not locally adapted may lead to backlash (Shell-Duncan and Herlund 2000; Gruenbaum 2001). Some of the studies report that the intervention was seen as contrary to culture and religion. For example, after the intervention in Senegal there was an increase in the percentage of men who believed FGM was religiously sanctioned (Diop et al. 2004).

Taking the local context into consideration is also important during implementation of an intervention, for example, in the selection of implementing partners and facilitators. Facilitators who publicized their opposition to FGM in Kenya received threats (Chege et al. 2004). The fact that the intervention in Kenya was implemented among Muslim Somali refugees by the National Council of Churches of Kenya (a primarily Christian organization) may have been an important contributor to backlash (Berg and Denison 2013b, 328). The larger literature emphasizes partnering with local communities in implementing

interventions, since ethnic and religious differences between a facilitator and FGM practicing communities can negatively influence the effectiveness of interventions (see, e.g., Waigwa et al. 2018).

Finally, local laws prohibiting FGM are important contextual factors that should be considered in evaluating the strength and weaknesses of self-reported answers from participants in interventions. Participants who are asked direct questions about their opposition towards FGM are more likely to give reliable answers in countries where FGM is legal, since they would not fear prosecution if they state that they believe in the practice (see Easton, Miles, and Monkman 2002). On the other hand, questions about whether mothers have cut their daughters may not be reliably answered in a country where FGM is illegal, such as Burkina Faso, since participants may fear prosecution if they answer the question truthfully (Ouoba et al. 2004).

## 8.2. A flawed measurement of change?

Although some of the studies on interventions suggest that their effect is based on complex theories of change, the actual effects of the inventions are measured based on rather simplistic evaluations of (a) increased knowledge (e.g., asking the question whether respondents can list more than two harmful effects of FGM) or (b) changed attitudes towards FGM (as expressed individually or in a public setting). Only two studies examined the prevalence of daughters actually being cut. Even the studies that could be considered to take a more complex approach (such as the Tostan studies from Burkina Faso and Senegal), do not measure the potentially different effects of different components of the FGM educational modules; thus, it is impossible to know whether the focus on health or on human rights, or the combination of the two, works best. Furthermore, the studies only collected data on knowledge of harmful effects related to the health component; no data was collected regarding participants' knowledge of human rights or whether they considered FGM as a violation of girls' and women's rights.

The interventions studied in this review seem to consider increased knowledge as a steppingstone to changes in attitudes and behavior. Knowledge is thereby seen as a first stage of change, although at least one study explicitly acknowledges that increased knowledge is alone insufficient to spark behavioral change (Mahgoub et al. 2019). This conclusion is supported by literature in related fields of study (such as sexual and reproductive health) that concludes that educational programs are as effective on their own as they are in combination with efforts to address broader norms (See for example Sandøy et al. 2016). Following from this, programs with an intention of abandonment of FGM should address attitudinal change towards not only the practice of FGM, but also the social norms that underpin the practice (including taboo topics such as control of women's sexuality and virginity). They also need to include indicators to scientifically measure these changes.

From the studies included in this review, only two studies from Sudan seem to measure changes in drivers of FGM, including the question of whether FGM makes a female more chaste and hygienic (Mounir, Mahdy, and Fatohy 2003; Vogt et al. 2016). Three studies measure respondents' perceptions of FGM as

an Islamic practice (Babalola et al. 2006; Mounir, Mahdy, and Fatohy 2003; Diop et al. 2004, only with regard to male participants). If changes in social, cultural and religious norms driving FGM are measured (even as secondary outcomes), this will allow us to learn whether postintervention changes in attitudes towards FGM are taking place in isolation or in tandem with larger societal changes in attitudes towards girl's and women's rights and roles within the community. Furthermore, in contexts where FGM is criminalized, one would expect that respondents would present the politically correct answer for whether they practice FGM (due to fear of prosecution). However, they may be more willing to truthfully answer questions regarding the norms driving the practice, such as beliefs about the need to control girls' sexuality to prevent promiscuous behavior. Even if FGM is actually declining, if the social norms are still strong, communities are likely to find new and potentially harmful ways of controlling girls' and women's sexuality (such as preventing their education or marrying them off at an early age).

Based on the studies included in this review, we cannot say that increased knowledge about FGM (whether from the perspective of health, human rights, or social and religious norms) has a positive, measurable effect on prevalence of the practice. What we know from the general literature is that individuals do not make autonomous decisions about FGM. Therefore, one individual's increased knowledge is in itself insufficient to produce real behavioral change because an individual must also consider the preferences of their household and the larger community in which they live. In other words, even if a respondent reports increased knowledge of FGM or even an intention to leave their daughters uncut (as in some of the studies reviewed here), this may not say much about future behavior, since the actual decision is not taken by the individual respondent alone (Cloward 2015).

Thus far, there has been no attempt to measure change beyond the individual level, except by asking respondents to speculate about whether they think their spouse (dis)approves of FGM and whether they are willing to discuss (or have discussed) FGM with others. More qualitative research about changes in public discourse on FGM could be a good way to trace such changes (for example, through content analysis of FGM debates in different media outlets over time, discourse analysis of Islamic sermons over time, or ethnographic fieldwork in a village before, during, and after interventions).

### 8.3. Combined messages

Limited ability to assess the effect of interventions makes it difficult to determine what is actually working or to evaluate the transferability of interventions to other contexts. However, the communication intervention studies (in Sudan and Nigeria) and the social norm intervention (in Sudan) suggest that a higher exposure to a message in multiple outlets, including combined anti-FGM messages, may be the most effective. In the case of Nigeria, exposure to consistent health messages from a variety of sources (in this case, media and community-level activities) was more effective than exposure to only one component of the intervention (Babalola et al. 2006, 1602). The study evaluating the impact of the Saleema campaign in Sudan also suggests that a dosage effect (that is, exposure to more intervention events) creates more positive attitudes towards uncut girls (Evans et al. 2019). The "edutainment" intervention suggests that in



order to abandon FGM, anti-FGM messages should be locally grounded and that arguments are more effective in changing attitudes when they are combined (Vogt et al. 2016). Although there is no universal approach to changing “sticky” social norms such as FGM, these three studies seem to suggest that there is a need for multi-dimensional interventions.

#### 8.4. Readiness to change?

Several studies point to individuals’ and communities’ readiness to change as an important take away point. Indeed, some of the Tostan studies point to how some of the villages were asking for the intervention and through that showcased their willingness to abandon the practice (Berg and Denison 2013b, 39). Some studies take as the point of departure that there is an active debate about abandoning FGM already underway in the local communities. For example, in the “edutainment” study, heterogenous local points of argument were incorporated as part of the intervention to “tap into” local attitudes. There is an expectation (perhaps rightfully so) that interventions tend to first appeal to those who are already questioning or have abandoned the practice and see interventions as a way to get social acceptance for their choices (Mohamud, Radeny, and Ringheim 2006). This is a common pattern in social change that helps those that are already converted to translate their conviction into action and gives others who are ambivalent a push towards change (Johansen et al. 2013; Shell-Duncan et al. 2013).

The fact that FGM prevalence has declined fastest (in relative terms) in countries with lower initial prevalence, and more slowly in countries with higher initial prevalence (Batyra et al. 2020) implies that the next phase of interventions—reaching the starkest supporters of FGM—may require a different approach. In contexts with the highest prevalence and strongest supporters of FGM, “external” interventions (though international NGOs or UN) are often seen as an attack on traditional and religious values, so it is important that such interventions are seen as coming from within the community.

## References

- 28 Too Many. 2020. "Terminology and FGM." London: 28 Too Many.  
<https://www.28toomany.org/thematic/terminology-and-fgm/>.
- . (no date)"Ethiopia" London: <https://www.28toomany.org/country/ethiopia/>
- Abatshun , A.D., J. Sundby, and A.A. Gele. 2016. "Attitude toward Female Genital Mutilation among Somali and Harari People, Eastern Ethiopia." *International Journal of Women's Health* 8: 557–569.
- Aberese Ako, M., and P. Akweongo. 2009. "The Limited Effectiveness of Legislation against Female Genital Mutilation and the Role of Community Beliefs in Upper East Region, Ghana." *Reproductive Health Matters* 17, no. 34: 47–54.
- Ahlberg, B.M., I. Krantz, G. Lindmark, and M. Warsame. 2004. "'It's Only a Tradition': Making Sense of Eradication Interventions and the Persistence of Female 'Circumcision' within a Swedish Context." *Critical Social Policy* 24, no. 1: 50–78.
- Alcaraz, M.R., J. Siles González, and C. Solano Ruiz. 2013. "Attitudes Towards Female Genital Mutilation: An Integrative Review." *International Nursing Review* 61, no. 1: 25–34.
- Alkhalailah, D., S.R. Hayford, A.H. Norris, and M.F. Gallo. 2018. "Prevalence and Attitudes on Female Genital Mutilation/Cutting in Egypt since Criminalisation in 2008." *Culture, Health and Sexuality* 20, no. 2: 173–182.
- Babalola, S., A. Brasington, A. Agbasimalo, A. Helland, E. Nwanguma and N. Onah. 2006. "Impact of a Communication Programme on Female Genital Cutting in Eastern Nigeria." *Tropical Medicine and International Health* 11, no. 10: 1594–1603.
- Balfour, J., J. Abdulcadir, L. Say, and M.J. Hindin. 2016. "Interventions for Healthcare Providers to Improve Treatment and Prevention of Female Genital Mutilation: A Systematic Review." *BMC Health Services Research* 16, no. 409.  
<https://bmchealthservres.biomedcentral.com/track/pdf/10.1186/s12913-016-1674-1>.
- Banks, E, O. Meirik, T. Farley, O. Akande, H. Bathija, and M. Ali. 2006. "Female Genital Mutilation and Obstetric Outcome: WHO Collaborative Prospective Study in Six African Countries." *The Lancet* 367, no. 9525:1835–1841.
- Batyra, E., B. Wilson, E. Coast, and V. Cetorelli. 2020. "Female genital Mutilation/Cutting across Africa: Dynamics of Change and Socio-economic variation." *Stockholm Research Reports in Demography* no. 2020:25.  
[http://eprints.lse.ac.uk/105269/1/Coast\\_female\\_genital\\_mutilation\\_cutting\\_across\\_africa\\_publication.pdf](http://eprints.lse.ac.uk/105269/1/Coast_female_genital_mutilation_cutting_across_africa_publication.pdf).
- Bedri, N., H. Sherfi, G. Rudwan, S. Elhadi, C. Kabiru, and W. Amin. 2019. "Shifts in FGM/C Practice in Sudan: Communities' Perspectives and Drivers." *BMC Women's Health* 19, no. 168. <https://bmcwomenshealth.biomedcentral.com/track/pdf/10.1186/s12905-019-0863-6>
- Behrendt, A., and S. Moritz. 2005. "Posttraumatic Stress Disorder and Memory Problems after Female Genital Mutilation." *American Journal of Psychiatry* 162, no. 5: 1000–1002.

- Berg, R.C., V. Underland, J. Odgaard-Jensen, A. Fretheim and G.E. Vist. 2014. "Effects of Female Genital Cutting on Physical Health Outcomes: A Systematic Review and Meta-analysis." *BMJ Journal* 4, no. 11: 1–12. <https://bmjopen.bmj.com/content/bmjopen/4/11/e006316.full.pdf>.
- Berg, R.C., and E.M. Denison. 2012. "Does Female Genital Mutilation/Cutting (FGM/C) Affect Women's Sexual Functioning? A Systematic Review of the Sexual Consequences of FGM/C." *Sexuality Research and Social Policy* 9: 41–56.
- . 2013a. "A Tradition in Transition: Factors Perpetuating and Hindering the Continuance of Female Genital Mutilation/Cutting (FGM/C) Summarized in a Systematic Review." *Health Care for Women International* 34, no. 10: 837–859.
- . 2013b. "A Realist Synthesis of Controlled Studies to Determine the Effectiveness of Interventions to Prevent Genital Cutting of Girls." *Paediatrics and International Child Health* 33, no. 4: 322–333.
- Bergom Lunde, I., and M. Sagbakken. 2014. "Female Genital Cutting in Hargeisa, Somaliland: Is There a Move towards Less Severe Forms?" *Reproductive Health Matters* 22, no. 43: 169–177.
- Berggren, V., S. Musa Ahmed, Y. Hernlund, E. Johansson, B. Habbani, and A.K. Edberg. 2006. "Being Victims or Beneficiaries? Perspectives on Female Genital Cutting and Reinfibulation in Sudan." *African Journal of Reproductive Health* 10, no. 2: 24–36.
- Camilotti, G. 2016. "Interventions to Stop Female Genital Cutting and the Evolution of the Custom: Evidence on Age at Cutting in Senegal" *Journal of African Economies* 25, no. 1:133–158.
- Chege, J., I. Askew, S. Igras, and J. Mutesh-Strachan. 2004. "Testing for the Effectiveness of Integrating Community-based Approaches for Encouraging Abandonment of Female Genital Cutting into CARE's Reproductive Health Programs in Ethiopia and Kenya." *FRONTIERS Final Report*. Washington: Population Council.  
[https://knowledgecommons.popcouncil.org/departments\\_sbsr-rh/1/](https://knowledgecommons.popcouncil.org/departments_sbsr-rh/1/).
- Gillespie, D. and M. Melching. 2010. "The Transformative Power of Democracy and Human Rights in Nonformal Education: The Case of Tostan" *Adult Education Quarterly* 60, no. 5: 477–498
- Cloward, K. 2015. "False Commitments: Local Misrepresentation and the International Norms Against Female Genital Mutilation and Early Marriage." *International Organization* 68, no. 3: 495–526.
- Crisman, B., S. Dykstra, C. Kenny and M. O'Donnell. 2016. "The Impact of Legislation on the Hazard of Female Genital Mutilation/Cutting: Regression Discontinuity Evidence from Burkina Faso." Center for Global Development, working paper 432 (July).  
<https://www.cgdev.org/sites/default/files/impact-legislation-hazard-female-genital-mutilationcutting-regression-discontinuity.pdf>.
- Diop, N.J., and I. Askew 2009. "The Effectiveness of a Community-based Education Program on Abandoning Female Genital Mutilation/Cutting in Senegal." *Studies in Family Planning* 40, no. 4: 307–318.

- Diop, N.J., M.M. Faye, A. Moreau, J. Cabral, H. Benga, F. Cisse, B. Mane, I. Baumgarten, and M. Melching. 2004. "The TOSTAN Program: Evaluation of a Community Based Education Program in Senegal." FRONTIERS Final Report. Washington: Population Council. [https://knowledgecommons.popcouncil.org/departments\\_sbsr-rh/31/](https://knowledgecommons.popcouncil.org/departments_sbsr-rh/31/).
- Diop, N.J., A. Moreau, and H. Benga. 2008. "Evaluation of the Long-term Impact of the TOSTAN Programme on the Abandonment of FGM/C and Early Marriage: Results from a Qualitative Study in Senegal." FRONTIERS Final Report. Washington: Population Council. [https://knowledgecommons.popcouncil.org/departments\\_sbsr-rh/138/](https://knowledgecommons.popcouncil.org/departments_sbsr-rh/138/).
- Diop, N.J., F. Traore, H. Diallo, O. Traore, A.H. Toure, Y. Diallo, M. Sangare, F.T. Keita, and A. Toure. 2007. "Study of the Effectiveness of Training Malian Social and Health Agents in Female Genital Cutting Issues and in Educating Their Clients." Final Report. Bamako: Population Council. [https://knowledgecommons.popcouncil.org/departments\\_sbsr-rh/83/](https://knowledgecommons.popcouncil.org/departments_sbsr-rh/83/).
- Dotimi, D.A. 2016. "Lived Experiences of Women from the Odi community in Nigeria of Female Genital Mutilation." PhD diss., Walden University, Minneapolis, MN. <https://scholarworks.waldenu.edu/dissertations/2282/>.
- Doucet, M.-H., C. Pallitto, and D. Groleau. 2017. "Understanding the Motivations of Healthcare Providers in Performing Female Genital Mutilation: An Integrative Review of the Literature." *Reproductive Health* 14, no. 46. <https://link.springer.com/article/10.1186/s12978-017-0306-5>.
- Easton, P., R. Miles, and K. Monkman. 2002. "Final report on the evaluation of the Tostan/IEP village empowerment program pilot project in the republic of Mali." Tallahassee: Florida State University.
- Elamin, W., and A.J. Mason-Jones. 2020. "Female Genital Mutilation/Cutting: A Systematic Review and Meta-Ethnography Exploring Women's Views of Why It Exists and Persists." *International Journal of Sexual Health* 32, no. 1: 1–21.
- El-Damanhoury, I. 2013. "The Jewish and Christian View on Female Genital Mutilation." *African Journal of Urology* 19, no. 3: 127–129.
- Elmusharaf, S., N. Elhadi, and L. Almroth. 2006. "Reliability of Self Reported Form of Female Genital Mutilation and WHO Classification: Cross Sectional Study." *BMJ* 333, no. 7559: 124. <https://www.bmj.com/content/bmj/333/7559/124.full.pdf>.
- Engelsma, B., G. Mackie, and B. Merrell. 2020. "Unprogrammed Abandonment of Female Genital Mutilation/Cutting." *World Development* 129, no. 104845: 1–9.
- Esho, T., J. Karumbi, and C. Njue. 2017. "Rapid Evidence Assessment: Quality of Studies Assessing Interventions to Support FGM/C Abandonment." New York: Population Council. [https://www.popcouncil.org/uploads/pdfs/2017RH\\_RapidEvidenceAssessmentFGMC.pdf](https://www.popcouncil.org/uploads/pdfs/2017RH_RapidEvidenceAssessmentFGMC.pdf).
- Evans, W.D., C. Donahue, J. Snider, N. Bedri, T.A. Elhussein, and S.A. Elamin. 2019. "The Saleema Initiative in Sudan to Abandon Female Genital Mutilation: Outcomes and Dose Response Effects." *PLoS ONE* 14, no. 3: e0213380.
- Fahmy, A., M.T. El-Mouelhy, and A.R. Ragab. 2010. "Female Genital Mutilation/Cutting and Issues of Sexuality in Egypt." *Reproductive Health Matters* 18, no. 36: 181–190.

- Gruenbaum, E. 2001. *The Female Circumcision Controversy: An Anthropological Perspective*. Philadelphia: University of Pennsylvania Press.
- Hashi, K., and L. Sharafi. 2007. "A Holistic Approach to the Abandonment of Female Genital Mutilation/Cutting." New York: UNFPA. <https://www.unfpa.org/publications/holistic-approach-abandonment-female-genital-mutilationcutting>.
- Hassanin, I.M.A., and O.M. Shaaban. 2013. "Impact of the Complete Ban on Female Genital Cutting on the Attitude of Educated Women from Upper Egypt toward the Practice." *International Journal of Gynecology and Obstetrics* 120, no. 3: 275–278.
- Hayford, S.R., and J. Trinitapoli. 2011. "Religious Differences in Female Genital Cutting: A Case Study from Burkina Faso." *Journal for the Scientific Study of Religion* 50, no. 2: 252–271.
- Hernlund, Y. 2000. "Cutting Without Ritual and Ritual Without Cutting: Female 'Circumcision' and the Re-ritualization of Initiation in the Gambia." In *Female "Circumcision" in Africa: Culture, Controversy and Change*, edited by B. Shell-Duncan and Y. Hernlund, 235–252. Boulder, CO: Lynne Rienner.
- Hernlund, Y., and B. Shell-Duncan (eds). 2007a. "Contingency, Context, and Change: Negotiating Female Genital Cutting in The Gambia and Senegal." *Africa Today* 53, no. 4: 43–57.
- (eds). 2007b. *Transcultural Bodies: Female Genital Cutting in Global Context*. New Brunswick, NJ: Rutgers University Press.
- Hosken, F.P. 1979. *The Hosken Report: Genital and Sexual Mutilation of Females*. Lexington, MA.
- Hurn, A., and C. Pinder. 2018. "The Law And FGM: An Overview Of 28 African Countries." *28 Too Many*. [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%20law%20and%20fgm%20v1%20(september%202018).pdf).
- Izette, S., and N. Toubia. 2000. "Female Circumcision/Female Genital Mutilation." In *Women and Health*, edited by M.B. Goldman and M.C. Hatch, 404–420 San Diego: Academic Press.
- Jackson, E.F., P. Akweongo, E. Sakeah, A. Hodgson, R. Asuru, and J.F. Phillips. 2003. "Inconsistent Reporting of Female Genital Cutting Status in Northern Ghana: Explanatory Factors and Analytical Consequences." *Studies in Family Planning* 34, no. 3: 200–210.
- Johansen, R.E.B., Nafissatou J. Diop, G. Laverack, and E. Leye. 2013. "What Works and What Does Not: A Discussion of Popular Approaches for the Abandonment of Female Genital Mutilation." *Obstetrics and Gynecology International*. <https://www.hindawi.com/journals/ogi/2013/348248/>.
- Johansen, R.E.B. 2017. "Virility, Pleasure and Female Genital Mutilation/Cutting. A Qualitative Study of Perceptions and Experiences of Medicalized Defibulation among Somali and Sudanese Migrants in Norway." *Reproductive Health* 14, no. 1: 25. <https://www.springermedizin.de/virility-pleasure-and-female-genital-mutilation-cutting-a-qualit/12058954>.
- Johnsdotter S, Moussa K, Carlbom A, Aregai R, Essén B (2009): "Never my daughters'. A qualitative study regarding attitude change towards female genital cutting among Ethiopian and Eritrean families in Sweden". *Health Care for Women International* 30:114-133.

- Kandala, N.-B., M.C. Ezejimofor, O.A. Uthman, and P. Komba. 2018. "Secular Trends in the Prevalence of Female Genital Mutilation/Cutting among Girls: A Systematic Analysis" *BMJ Global Health* 3, no. 5. <https://gh.bmj.com/content/bmjgh/3/5/e000549.full.pdf>.
- Kahan, D.M. 2000. "Gentle Nudges vs. Hard Shoves: Solving the Sticky Norms Problem." *University of Chicago Law Review* 67, no. 3: 607–645.
- Kimani, S., and B. Shell-Duncan. 2018. "Medicalized Female Genital Mutilation/Cutting: Contentious Practices and Persistent Debates." *Current Sexual Health Reports* 10, no. 1: 25–34. <https://www.springermedizin.de/medicalized-female-genital-mutilation-cutting-contentious-practi/15480960>.
- Kizilhan, J.I. 2011. "Impact of Psychological Disorders after Female Genital Mutilation among Kurdish Girls in Northern Iraq." *European Journal of Psychiatry* 25, no. 2: 92–100.
- Klouman E., R. Manongi, K.-I. Klepp. 2005. "Self-reported and Observed Female Genital Cutting in Rural Tanzania: Associated Demographic Factors, HIV and Sexually Transmitted Infections." *Tropical Medicine and International Health* 10, no. 1:105–115.
- Koski, A., and J. Heymann. 2017. "Thirty-year Trends in the Prevalence and Severity of Female Genital Mutilation: A Comparison of 22 Countries." *BMJ Global Health* 2, no. 4. <https://gh.bmj.com/content/bmjgh/2/4/bmjgh-2017-000467.full.pdf>.
- Knipscheer, J., E. Vloeberghs, A. van der Kwaak, and M. van den Muijsenbergh. 2015. "Mental Health Problems Associated with Female Genital Mutilation." *BJPsych Bulletin* 39, no. 6: 273–277.
- La Ferrara, E., A. Chong, and S. Duryea. 2012. "Soap Operas and Fertility: Evidence from Brazil." *American Economic Journal: Applied Economics* 4, no. 4: 1–31.
- Leye, E., N. Van Eekert, S. Shamu, T. Esho, H. Barrett, and ANSER. 2019. "Debating Medicalization of Female Genital Mutilation/Cutting (FGM/C): Learning from (Policy) Experiences across Countries." *Reproductive Health* 16: 158. <https://reproductive-health-journal.biomedcentral.com/track/pdf/10.1186/s12978-019-0817-3>.
- Mackie, G. 1996. "Ending Footbinding and Infibulation: A Convention Account." *American Sociological Review* 61, no. 6: 999–1017.
- . 2000. "Female Genital Cutting: The Beginning of the End." In *Female "Circumcision" in Africa: Culture, Controversy, and Change*, edited by Bettina Shell-Duncan and Ylva Hernlund, 253–281. Boulder, CO: Lynne Rienner Publishers.
- . (2009). *Social Dynamics of Abandonment of Harmful Practices: A New Look at the Theory*. UNICEF Innocenti Research Centre, Innocenti Working Papers.
- Mahgoub, E., M. Nimir, S. Abdalla, and D.A. Elhuda. 2019. "Effects of School-based Health Education on Attitudes of Female Students towards Female Genital Mutilation in Sudan." *Eastern Mediterranean Health Journal* 25, no. 6: 406–412. [https://applications.emro.who.int/emhj/v25/06/EMHJ\\_2019\\_25\\_06\\_406\\_412.pdf](https://applications.emro.who.int/emhj/v25/06/EMHJ_2019_25_06_406_412.pdf).
- Modrek, S., and M. Sieverding. 2016. "Mother, Daughter, Doctor: Medical Professionals and Mothers' Decision Making about Female Genital Cutting in Egypt." *International Perspectives on Sexual and Reproductive Health* 42, no. 2: 81–92.

- Mohamud, A., S. Radeny, and K. Ringheim. 2006. "Community-based Efforts to End Female Genital Mutilation in Kenya: Raising Awareness and Organising Alternative Rites of Passage." In *Female Circumcision: Multicultural Perspectives*, edited by Rogaia Mustafa Abusharaf, 75–103. Philadelphia: University of Pennsylvania Press.
- Monkman, K., R. Miles, and P. Easton. 2007. "The Transformatory Potential of a Village Empowerment Program: The Tostan Replication in Mali." *Women's Studies International Forum* 30, no. 6: 451–464.
- Mounir, G.M., N.H. Mahdy, and I.M. Fatohy. 2003. "Impact of Health Education Program about Reproductive Health on Knowledge and Attitude of Female Alexandria University Students." *Journal of the Egyptian Public Health Association* 78, no. 5/6: 433–466.
- Muthumbi, J., J. Svanemyr, E. Scolaro, M. Temmerman, and L. Say. 2015. "Female Genital Mutilation: A Literature Review of the Current Status of Legislation and Policies in 27 African Countries and Yemen." *African Journal of Reproductive Health* 19, no. 3.
- Obiora, O.L., J.E. Maree, and N. Nkosi-Mafutha. 2020. "Female Genital Mutilation in Africa: Scoping the Landscape of Evidence." *International Journal of Africa Nursing Sciences* 12, no. 200189.
- Ogunsiji, O., L. Wilkes, and H.N. Chok. 2018. "'You Take the Private Part of Her Body, . . . You Are Taking a Part of Her Life': Voices of Circumcised African Migrant Women on Female Genital Circumcision (FGC) in Australia." *Health Care for Women International* 39, no. 8: 1–13.
- OHCHR (Office of the UN High Commissioner for Human Rights), UNAIDS (Joint UN Programme on HIV/AIDS), UNDP (UN Development Programme), UNECA (UN Economic Commission for Africa), UNESCO (UN Educational, Scientific and Cultural Organization), UNFPA (UN Population Fund), UNHCR (UN High Commissioner for Refugees), UNICEF (UN Children's Fund), UNIFEM (UN Development Fund for Women), and WHO (World Health Organization). 2008. *Eliminating Female Genital Mutilation: An Interagency Statement*. Geneva: WHO.  
<https://www.who.int/reproductivehealth/publications/fgm/9789241596442/en/>.
- Ouoba D., Z. Congo, N.J. Diop, M. Melching, B. Banza, G. Guiella, and I. Baumgarten. 2004. "Experience from a Community-based Education Program in Burkina Faso: The Tostan Program." *FRONTIERS Final Report*. Washington: Population Council.  
[https://knowledgecommons.popcouncil.org/departments\\_sbsr-rh/30/](https://knowledgecommons.popcouncil.org/departments_sbsr-rh/30/).
- Philips, S. K. 2016. "Heroes or victims: The Lived Experiences of Women on Female Genital Mutilation/Cutting in Northwestern Nigeria." PhD diss., Walden University, Minneapolis, MN. <https://scholarworks.waldenu.edu/dissertations/2998/>.
- Raafat, Y. 2017. "Sugar-coating Female Genital Mutilation in United Nations Documents in English and Arabic: A Diachronic Study of Lexical Variation." Masters thesis, University of Witwatersrand, Johannesburg.  
[https://www.28toomany.org/static/media/uploads/Thematic%20Research%20and%20Resource%20Terminology/yasmin\\_rafat\\_suger-coating\\_fgm\\_in\\_the\\_un.pdf](https://www.28toomany.org/static/media/uploads/Thematic%20Research%20and%20Resource%20Terminology/yasmin_rafat_suger-coating_fgm_in_the_un.pdf).
- Rasheed SM, Abd-Ellah AH, Yousef FM. 2011. "Female genital mutilation in Upper Egypt in the new millennium". *Int J Gynaecol Obstet* 114, no.1:47–50

- Sandøy, I.F., M. Mudenda, J. Zulu, E. Munsaka, A. Blystad, M.C. Makasa, O. Mæstad, B. Tungodden, C. Jacobs, L. Kampata, K. Fylkesnes, J. Svanemyr, K.M. Moland, R. Banda, and P. Musonda. 2016. "Effectiveness of a Girls' Empowerment Programme on Early Childbearing, Marriage and School Dropout among Adolescent Girls in Rural Zambia: Study Protocol for a Cluster Randomized Trial." *Trials* 17, no. 588.  
<https://trialsjournal.biomedcentral.com/articles/10.1186/s13063-016-1682-9>.
- Shell-Duncan, B. 2008. "From Health to Human Rights: Female Genital Cutting and the Politics of Intervention." *American Anthropologist* 110, no. 2: 225-236.
- Shell-Duncan, B., and Y. Hernlund. 2000. "Female 'Circumcision' in Africa: Dimensions of the Practice and Debates." In *Female "Circumcision" in Africa: Culture, Controversy and Change*, edited by B. Shell-Duncan and Y. Hernlund, 1-40. Boulder, CO: Lynne Rienner.
- Shell-Duncan B, Z. Moore, and C. Njue. 2017. "Trends in Medicalization of Female Genital Mutilation/Cutting: What Do the Data Reveal?" New York: Population Council.  
[http://www.popcouncil.org/uploads/pdfs/2017RH\\_MedicalizationFGMC.pdf](http://www.popcouncil.org/uploads/pdfs/2017RH_MedicalizationFGMC.pdf).
- Shell-Duncan, B., K. Wander, Y. Hernlund, and A. Moreau. 2011. "Dynamics of Change in the Practice of Female Genital Cutting in Senegambia: Testing Predictions of Social Convention Theory." *Social Science and Medicine* 73, no. 8: 1275-1283.
- . 2013. "Legislating Change? Responses to Criminalizing Female Genital Cutting in Senegal." *Reproductive Health Law and Society Review* 1, no. 4: 803-835.
- Tønnessen, L., and S. al-Nagar. Forthcoming. "Women's Policy Reform in Sudan's Islamist State: The Case of Criminalizing Female Genital Mutilation/Cutting." *International Feminist Journal of Politics*.
1. Tønnessen, L, S. al-Nagar, and S. Bamkar. 2017. "[Weak law forbidding FGM in Sudan](https://www.opendemocracy.net/en/north-africa-west-asia/paper-tiger-law-forbidding-fgm-in-sudan/)" Open Democracy, March 17 <https://www.opendemocracy.net/en/north-africa-west-asia/paper-tiger-law-forbidding-fgm-in-sudan/>
- UN. 1995. *Beijing Declaration and Platform for Action*. New York: UN Women.  
[https://beijing20.unwomen.org/~media/headquarters/attachments/sections/csw/pfa\\_e\\_final\\_web.pdf](https://beijing20.unwomen.org/~media/headquarters/attachments/sections/csw/pfa_e_final_web.pdf).
- UNICEF. 2020a. "Female Genital Mutilation (FGM)." UNICEF Data.  
<https://data.unicef.org/topic/child-protection/female-genital-mutilation/>.
- . 2020b. "Female Genital Mutilation: A New Generation Calls for Ending an Old Practice." New York: UNICEF Data and Analytics Section. <https://data.unicef.org/resources/female-genital-mutilation-a-new-generation-calls-for-ending-an-old-practice/>.
- UNICEF and UNFPA. 2008. *UNFPA-UNICEF Joint Programme on Female Genital Mutilation/Cutting: Accelerating Change. Summary Report of Phase I, 2008-2013*. New York: UNFPA. <https://www.unfpa.org/sites/default/files/pub-pdf/Joint%20Programme%20on%20FGMC%20Summary%20Report.pdf>.
- Van Bavel, H., G. Coene, and E. Leye. 2017. "Changing Practices and Shifting Meanings of Female Genital Cutting among the Maasai of Arusha and Manyara Regions of Tanzania." *Culture, Health and Sexuality* 19, no. 12: 1344-1359.



- Varol, N., S. Turkmani, K. Black, J. Hall, and A. Dawson. 2015. "The Role of Men in Abandonment of Female Genital Mutilation: A Systematic Review." *BMC Public Health* 15, no. 1034. <https://bmcpublichealth.biomedcentral.com/articles/10.1186/s12889-015-2373-2>.
- Vinois, A., E.R. Mwenda, E. Calimoutou, F. Daverio, I.M. Drossos, I.M. Santagostino Recavarren, L.L. Bogado, M. Goldstein-Bolocan, P. Reddi, and W.J. Melis. 2018. *Compendium of International and National Legal Frameworks on Female Genital Mutilation*, 2nd ed.. Washington: World Bank Group. <http://documents.worldbank.org/curated/en/828661517490252879/Compendium-of-international-and-national-legal-frameworks-on-female-genital-mutilation>.
- Vogt, S., N.A.M. Zaid, H.F. Ahmed, E. Fehr, C. Efferson. 2016. "Changing Cultural Attitudes towards Female Genital Mutilation." *Nature* 538: 506–509.
- Waigwa, S., L. Doos, C. Bradbury-Jones, and J. Taylor. 2018. "Effectiveness of Health Education as an Intervention Designed to Prevent Female Genital Mutilation/Cutting (FGM/C): A Systematic Review." *Reproductive health* 15, no. 62: 1–14.
- WHO, UNICEF, and UNFPA. 1997. *Female Genital Mutilation: A Joint WHO/UNICEF/UNFPA Statement*. Geneva: WHO. <https://apps.who.int/iris/handle/10665/41903>.
- Yoder, P.S., and S. Khan. 2008. "Numbers of Women Circumcised in Africa: The Production of a Total." *DHS Working Papers* no. 39. Calverton, MD: Macro International. <https://dhsprogram.com/pubs/pdf/WP39/WP39.pdf>.
- Yirga, W.S, N.A Kassa, M.W. Gebremichael, and A.R. Aro. 2012. "Female Genital Mutilation: Prevalence, Perceptions and Effect on Women's Health in Kersa District of Ethiopia." *International Journal of Women's Health* 4 :45–54.
- Østebø, M., and T. Østebø 2014. "Are Religious Leaders a Magic Bullet for Social/Societal Change?: A Critical Look at Anti-FGM Interventions in Ethiopia." *Africa Today* 60, no. 3: 82–101.

We have conducted a review of studies looking at the effect of interventions to abandon female genital mutilation/cutting (FGM) in Africa. Although there has been an overall decline in the prevalence FGM, we know surprisingly little about what has caused this decline, to what extent interventions to abandon FGM in Africa have contributed to this positive development, and which types of interventions work the best.

In this review, we have only included studies looking at the effect of interventions to abandon FGM in Africa. The scope of studies is thereby limited to those with an approach designed to evaluate effect using a controlled before and after methodological design. We found only 10 studies from Sudan, Egypt, Mali, Burkina Faso, Senegal, Nigeria, Kenya, and Ethiopia that met our inclusion criteria.

**Chr. Michelsen Institute (CMI)** is an independent, non-profit research institution and a major international centre in policy-oriented and applied development research. Focus is on development and human rights issues and on international conditions that affect such issues. The geographical focus is Sub-Saharan Africa, Southern and Central Asia, the Middle East and Latin America.

CMI combines applied and theoretical research. CMI research intends to assist policy formulation, improve the basis for decision-making and promote public debate on international development issues.

#### Find us here



#### Contact us

Phone: 47 93 80 00

Phone: +47 55 70 55 65 (from abroad)

cmi@cmi.no

www.cmi.no

P.O. Box 6033,

N-5892 Bergen, Norway

Jekteviksbakken 31, Bergen

**CMI** CHR.  
MICHELSEN  
INSTITUTE