FEMALE GENITAL MUTILATION IN HUMANITARIAN SETTINGS IN THE ARAB REGION

Gaps and priorities for prevention and response programming

Synthesis report

2021

Acknowledgments

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Contents

Acronyms

AIDS	Acquired immunodeficiency syndrome
COVID-19	Coronavirus Disease 2019
DHS	Demographic and Health Surveys
FGD	Focus group discussion
FGM	Female Genital Mutilation
GBV	Gender-based violence
GBVIMS	Gender-based Violence Information Management System
HIV	Human immunodeficiency virus
IDP	Internally displaced person
MICS	Multiple Indicator Cluster Surveys
M&E	Monitoring and Evaluation
MISP	Minimum Initial Service Package
MSF	Médecins Sans Frontières
NAP	National Action Plan
NGO	Non-governmental organization
SGBV	Sexual and gender-based Violence
UN	United Nations
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund

Introduction

Female genital mutilation (FGM) is considered a human rights violation and is condemned in several international conventions and treaties.[1] The Arab region is home to 50 million cases of FGM, accounting for a quarter of global cases.[2] The urgency to end FGM is reflected in its inclusion as a target in the Sustainable Development Goals, as part of goal five to achieve gender equality and empower women and girls.[3] The root causes of FGM are complex and include a mix of deeply entrenched sociocultural, religious, economic, and political factors rooted in gender inequality and discrimination.[4] To accelerate the abandonment of FGM, UNFPA and UNICEF launched the Joint Programme on the Elimination of Female Genital Mutilation.[3] The programme harnesses the complementary expertise of the two agencies and is implemented in partnership with governments, civil society, social movements, religious leaders, and communities. Since its launch in 2008, more than 31 million people have publicly declared the abandonment of FGM, and prevalence rates among adolescent girls have declined in 10 countries.[5] In the Arab region, the Joint Programme is being implemented in Egypt, Djibouti, Somalia, Sudan, and Yemen.

While harmful practices, including FGM, are concerns across the humanitarian–development nexus, the focus in research and the programmatic response has so far been in more stable contexts. In the Arab region, there is lack of evidence on the impact of humanitarian crises, in particular the effects of conflict and forced displacement on rates and drivers of FGM.[6] Several of the countries in the Arab region with high rates of FGM are fragile,

1 These include the Universal Declaration of Human Rights, the Convention relating to the Status of Refugees, and the Convention on the Elimination of all Forms of Discrimination against Women, among many others.

2 United Nations Children's Fund (UNICEF), Female Genital Mutilation in the Middle East and North Africa: Facts and Figures, 2020, www.unicef.org/mena/media/7081/file/FGM English .pdf.pdf.

3 United Nations Population Fund (UNFPA), UNFPA–UNICEF Joint Programme on Female Genital Mutilation, November 2021, www.unfpa.org/unfpa-unicef-joint-programme-elimination-female-genital-mutilation-0.

4 World Health Organization, Eliminating female genital mutilation: an interagency statement UNAIDS, UNDP, UNECA, UNESCO, UNFPA, UNHCHR, UNHCR, UNICEF, UNIFEM, WHO (Geneva: World Health Organization, 2008).

5 Building Bridges to End FGM, Preventing and Responding to Female Genital Mutilation in Emergency and Humanitarian Contexts: Results from the Virtual International Stakeholder Dialogue, December 2020, https://copfgm.org/wp-content/uploads/2020/12/Report_Preventing-and-responding-to-FGM-in-Emergency-and-Humanitarian-Contexts_17.12.20.pdf.

6 Hazel R. Barrett, Nafisa Bedri and Nishan Krishnapalan, "The Female Genital Mutilation (FGM) – migration matrix: The case of the Arab League Region," Health Care for Women International, 42(2): 186–212, https://doi.org/10.1080/07399332.2020.1789642.

affected by crisis or host large internally displaced populations. The five Arab countries included in the Joint Programme are all classed as having humanitarian contexts, having been impacted by protracted conflict, natural disaster, or both, or having experienced an influx of refugee populations in recent years. Little is known about the scale of FGM in humanitarian settings in these contexts, especially how shifts in prevalence, social norms from the country of origin, and host community norms impact the incidence of FGM. As a result of this lack of data and evidence, FGM is often considered a "secondary" issue in these contexts and is overshadowed by other priorities, leaving women and girls at risk of FGM and a lack of supportive services for survivors.[6] All this means effective and evidence-based prevention and response interventions are all urgently needed to address this critical issue.

This report synthesizes learnings from a scoping review and participatory discussions with experts and practitioners from Egypt, Sudan, and Yemen working on FGM across the humanitarian–development nexus. The three study sites were selected because they are either crisis-affected or host sizable displaced populations, and they are also countries where FGM takes place. Focus group discussions and in-depth interviews were used to explore the approaches that should be prioritized in humanitarian programming to prevent and respond to FGM.

Review of existing evidence

The prevalence of FGM in humanitarian settings and how the practice is impacted by conflict, forced displacement and climate-related disasters remain largely unknown.[7] The few studies that have examined FGM in these settings indicate that the impact of humanitarian crises on FGM is multifaceted and context specific. There is evidence that harmful social norms may be acquired and transferred during migration flows.[8] In some instances, displacement can cause the erosion of social norms that drive FGM,[9] while in others, the incidence of FGM remains unchanged, although the type shifts from more harmfully perceived forms, such as pharaonic, to less radical forms, such as sunna.[10],[11] However, the evidence base remains too limited to understand the mechanisms by which humanitarian crises engender shifts in social norms and how these in turn impact practices around FGM.

The available literature documents a wide range of factors associated with FGM in humanitarian settings, including a continued sense of social belonging and identity, marriageability, social pressure, and the perception that the practice promotes cleanliness.[12,13,14,15] Other factors associated with FGM in humanitarian settings include protection from sexual violence;[16] patriarchy and the subjugation of women to gendered roles;[17] reduced opportunities or alternatives to

7 S. Elnakib and J. Metzler, "A scoping review of FGM in humanitarian settings: an overlooked phenomenon with lifelong consequences", under review, 2021.
8 H.R. Barrett, N. Bedri and N. Krishnapalan, "The Female Genital Mutilation (FGM) – migration matrix: The case of the Arab League Region," Health Care for Women International, 42(2), https://www.tandfonline.com/doi/abs/10.1080/07399332.2020.1789642.
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11 Z. Jinnah and L. Lowe, "Circumcising Circumcision: Renegotiating Beliefs and Practices among Somali Women in Johannesburg and Nairobi," Medical Anthropology, 34(4): 371–388, https://doi.org/10.1080/01459740.2015.1045140.
12 H. Im, L. Swan and L. Heaton, "Polyvictimization and mental health consequences of female genital mutilation/circumcision (FGM/C) among Somali refugees in Kenya," Women & Health, 60(6): 636–651, https://doi.org/10.1080/03630242.2019.1689543.
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14 R. Gately, "Sudan: A humanitarian response to a Silent genocide: An American nurse's perspective. Journal of Emergency Nursing," Journal of Emergency Nursing, 31(3): 325–332. Medline. https://doi.org/10.1016/j.jen.2005.01.008.
15 K. Plo, K. Asse, D. Seï and J. Yenan, "Female genital mutilation in infants and young girls: Report of sixty cases observed at the general hospital of Abobo (Abidjan, Cote d'Ivoire, West Africa)", International Journal of Pediatrics, 2014:837471, https://doi.org/10.1155/2014/837471.
16 Jinnah and Lowe.
17 Mitike and Deressa.

livelihoods;[18] aesthetics;[19] a lack of laws banning the practice;[20] and disruption of education of girls.[21]

The consequences of FGM in humanitarian settings mirror those in stable settings. However, they often occur against a backdrop of increased vulnerability, due to the gendered effects of humanitarian crises on women and girls. Consequences documented in the literature include infections, including of the reproductive and urinary tracts;[22] pain;[23] minimal to excessive bleeding, depending on the type of FGM;[24] difficulty urinating;[25] fistula;[26] disfigurement of the vaginal area;[27] infectious diseases, such as HIV;[28] and death.[29] In refugee camps in Sudan, girls who have been raped—some as young as 10—have experienced serious pregnancy-related complications due to their young age but also because they had undergone FGM, which further increased their already high risk of complications during childbirth.[30] Other consequences include lower self-reported physical health;[31] menstrual pain;[32] painful sexual intercourse;[33] low sex drive;[34] diminished sexual pleasure;[35] and a lack of pleasure or sensation during intercourse.[36] FGM has also been linked to several mental health and psychosocial consequences in humanitarian contexts.[37,38]

Early attempts to respond to FGM in humanitarian action are frequently described in the literature in relation to broader responses to the sexual and reproductive health needs of women using the Inter-Agency Field Manual on Reproductive Health in Refugee Situations.[39] The minimum initial service package for sexual and reproductive health continues to be a lifesaving set of services and activities that include guidance for service providers to support deinfibulation or referrals for services as needed for childbirth. Interventions documented in the literature include the strengthening of anti-FGM national laws and the establishment of a legal and policy framework for working with displaced populations;[40,41] education and the dissemination of information, including on sexual and reproductive health among girls, families and communities;[42] active civil engagement and political debate to support the transformation of social and cultural norms;[43] and enhancing sanitation solutions for survivors to promote cleaner and more efficient waste disposal and proper hygiene.[44] Other documented interventions include capacity-building for government actors, practitioners, and health-care workers to support service provision.[45] The use of participatory, localized, and bottom-up approaches and integrated services to support survivors or girls who are at risk are commonly referenced as key intervention approaches.[46,47,48]

18 Furuta and Mori.
19 Plo, Asse, Seï and Yenan.
20 Furuta and Mori.
21 Marianna Ryan, Alison Glennie, Louise Robertson and Ann-Marie Wilson, "The impact of emergency situations on female genital mutilation", 28 Too Many Briefing Paper, 2014, https://www.refworld.org/docid/54bcda474.html.
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25 O. Ivanova, M. Rai, W. Mlahagwa, J. Tumuhairwe, A. Bakuli, V.N. Nyakato and E. Kemigisha, "A cross-sectional mixed-methods study of sexual and reproductive health knowledge, experiences and access to services among refugee adolescent girls in the Nakivale refugee settlement, Uganda," Reproductive Health, 16(1): 35, https://doi.org/10.1186/s12978-019-0698-5.
26 M. Campbell and Z. Abu Shamm, "Sudan: Situational analysis of maternal health in Bara District, North Kordofan," World Health Statistics Quarterly, 48(1): 60–66, https://pubmed.ncbi.nlm.nih.gov/7571715/.
27 N. Khalife, "They took me and told me nothing": Female genital mutilation in Iraqi Kurdistan. Human Rights Watch, 2010.
28 Ibid.
29 Gately.
30 Ryan, Glennie, Robertson, and Wilson.
31 Im, Swan and Heaton.
32 Ivanova, et al.
33 Gately.
34 Khalife.
35 Gately.
36 Khalife.
37 Im, Swan and Heaton.
38 Khalife.
39 United Nations High Commissioner for Refugees (UNHCR); World Health Organization (WHO); United Nations Population Fund (UNFPA). Reproductive Health in Refugee Situations. An Inter-Agency Field Manual, 1999. https://www.refworld.org/docid/403b6ceb4.html
40 Ibid.
41 Mitike and Deressa.
42 Ryan, Glennie, Robertson and Wilson.
43 Khalife.
44 R. Nyoka, A.D. Foote, E. Woods, H. Lokey, C.E. O'Reilly, F. Magumba, P. Okello, E.D. Mintz, N. Marano and J.F. Morris, "Sanitation practices and perceptions in Kakuma refugee camp, Kenya: Comparing the status quo with a novel service-based approach," PLOS ONE, 12(7): e0180864, https://doi.org/10.1371/journal.pone.0180864.
45 Khalife.
46 Ryan, Glennie, Robertson and Wilson.
47 Furuta and Mori.
48 Khalife.

Study setting

FGM is widespread in a number of countries in the Arab region. In Yemen, 19 percent of women and girls aged 15–49 have been subjected to the practice, while in Djibouti and Somalia rates are substantially higher (94 percent and 98 percent, respectively). Similarly, in Egypt and Sudan, rates are high at 87 percent. In places where FGM is practiced in the region, it is considered a rite of passage and sometimes even as a prerequisite for marriage. As a result, it is a deeply entrenched social norm and an integral part of culture and identity. The following section provides a brief overview of FGM in the three locations of the study.

Sudan

On April 22, 2020, the Sudanese government amended the law criminalizing FGM in Sudan. Prior to that, only the most severe form of FGM (known as type III or pharaonic FGM, in which the external genitalia were entirely removed and the vaginal opening was stitched) was criminalized, while type I (known as the sunna form which entails partial or total removal of the clitoris) was permitted.[49]

Sudan has one of the highest rates of FGM in the world.[49] According to the most recent multiple indicator cluster surveys in 2014, 86.6 percent of women and girls 15–49 years of age and 31 percent of girls younger than 15 years of age had undergone FGM.[50] This estimate varies geographically, ranging from a low of 45.4 in Central Darfur to highs of 97.[49] for North Kordofan, 97.6 in North Darfur and 97.3 in East Darfur.[49,50]

Sudan hosts over 1 million refugees and asylum seekers, who reside in camps or are interspersed among host communities. Over 700,000 of these are South Sudanese refugees. There are also 2.5 million new and protracted internally displaced persons (IDPs) in the country. The four states with the highest concentration of IDPs are South Darfur (33 percent), North Darfur (21 percent), Central Darfur (16 percent) and West Darfur (14 percent). While 90 percent of IDPs had been displaced due to armed conflict, the humanitarian situation is exacerbated by natural disasters, including floods like the one in 2020, which affected around 900,000 people.[51,52] The most affected states were North Darfur and Khartoum. Little is known about the scale and drivers of FGM among IDPs in these states and how they have been affected by recent flooding, one of the worst episodes experienced by Sudan in the last century.

49 M. Lugiai, Y. Shalabi, V. Racalbuto, D. Pizzol and L. Smith, "Female Genital Mutilation in Sudan: is a new era starting?" Sexuality and Culture, 25: 1540–1545, https://doi.org/10.1007/s12119-021-09823-y.

50 Central Bureau of Statistics, United Nations Children's Fund. Sudan Multiple Indicator Cluster Survey 2014 [Internet]. 2014 [cited 2021 Dec 9]. Available from: https://mics.unicef.org/files?job=W1siZiIsIjIwMTYvMDUvMTgvMjEvNTkvNTEvODg3L1N1ZGFuXzIwMTRfTUlDU19FbmdsaXNoLnBkZiJdXQ&sha=32907fc39e6e2e6e.

51 United Nations Office for the Coordination of Humanitarian Affairs (OCHA), Sudan Humanitarian Needs Overview 2021, December 2020, https://reliefweb.int/report/sudan/sudan-humanitarian-needs-overview-2021-december-2020

52 United Nations High Commissioner for Refugees (UNHCR), Sudan Operations, cited December 9, 2021, https://reporting.unhcr.org/sudan.

Yemen

In Yemen, the ongoing war, which has been described as the world's worst humanitarian crisis, has caused massive internal displacement, with over 4 million IDPs due to armed conflict and violence.[53,54,55] Over a half of all IDPs live in rented accommodation, while 35 percent reside in informal settlements, public buildings, and tents.[55] Host communities have been impacted by relentless waves of new displacement and the conflict itself, meaning they face a range of vulnerabilities. While conflict constitutes the overwhelming cause of displacement in the country, natural disasters—specifically floods—have been responsible for recent waves of new displacements, although conflict remains the overwhelming cause of displacement in the country.[55] In addition to the IDP population, the country hosts 138,000 migrants and 178,000 refugees and asylum seekers (as of December 2020).[55] Around 90 percent of migrants are Ethiopian, while 81 percent of refugees and asylum seekers come from Somalia.[54]

According to the latest demographic and health survey in 2013, 19 percent of women 15–49 years of age had experienced some form of circumcision.[56] This percentage is smaller among younger cohorts, although there is significant variation across governorates, with estimates ranging from non-existent (0 percent) in the Al Baidha governorate to as high as 80 percent in Hadramout and 84.7 percent in Al Mhrah.[57] Female circumcision is performed at a very young age in Yemen, with the majority of circumcised women reporting that the procedure was conducted in their first week of life.

There is still no law banning FGM in Yemen. The only legal instrument in place is a 2001 ministerial decree prohibiting FGM in health facilities.[58] The country's Safe Motherhood Law was passed in March 2014, without a provision prohibiting FGM. In 2019, Yemen developed a national action plan, which provides a policy framework to implement United Nations Security Council Resolution 1325 on Women, Peace and Security over the period 2020–2023.[59] Goal three of the plan mentions FGM as a form of violence toward women and girls and the government emphasizes the need to strengthen the protection of women from all forms of violence. However, little has been done to enforce this goal and ensure its implementation at the government level.

The COVID-19 pandemic has also affected the implementation of the UNFPA–UNICEF Joint Programme, delaying the scaling-up of FGM prevention efforts by diverting attention and effort toward COVID-19. As such, 2020 and 2021 saw a two-year delay in the start of FGM prevention programmes as a result of COVID-19 restrictions, including social distancing requirements and restrictions on domestic travel, which limited the availability of technical staff to carry out planned teaching and training workshops.

53 Internal Displacement Monitoring Centre, Yemen, cited December 9, 2021, www.internal-displacement.org/countries/yemen.
54 UNHCR. Country - Yemen [Internet]. Operational Portal: Yemen. [cited 2021 Dec 9]. Available from: https://data2.unhcr.org/en/country/yem.
55 OCHA. Yemen Humanitarian Needs Overview 2021 [Internet]. ReliefWeb. 2021 [cited 2021 Dec 9]. Available from:, https://reliefweb.int/report/yemen/yemen-humanitarian-needs-overview-2021-february-2021-enar.
56 Republic of Yemen Ministry of Public Health and Population and Central Statistical Organization, Yemen National Health and Demographic Survey 2013, 2015, http://dhsprogram.com/pubs/pdf/FR296/FR296.pdf.
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58 G.A Al-Khulaidi, K. Nakamura, K. Seino and M. Kizuki, "Decline of Supportive Attitudes among Husbands toward Female Genital Mutilation and Its Association to Those Practices in Yemen," PLOS ONE, 8(12): e83140, https://doi.org/10.1371/journal.pone.0083140.
59 UN Women, Global Study on the Implementation of United Nations Security Council Resolution 1325, 2021, https://wps.unwomen.org/.

6

Egypt

As of December 2020, Egypt had 259,292 registered refugees and asylum seekers.[60] While the majority are Syrian refugees, 49 percent of this population are refugees from sub-Saharan Africa, Yemen, and Iraq. Almost 70,000 refugees come from Sudan and South Sudan. Egypt is also home to Ethiopian, Eritrean, Somali, and Yemeni refugees fleeing political instability in the Horn of Africa and Yemen. It is among the five countries with the most urban refugees in the world. Most refugees reside in the Greater Cairo area.

FGM is a deeply rooted practice in Egypt, with 87 percent of women and girls 15–49 years of age reporting having undergone FGM.[61] The rate is lower but nonetheless significant among younger age groups. For example, 70 percent of girls 15–19 years of age reported having undergone FGM in the country's latest health issues survey.[62] Urban governorates, where most refugees reside, tend to have lower FGM rates compared to rural areas. Rates are highest in rural areas (97 percent according to the latest demographic and health survey in 2014) and lowest in frontier governorates, where 69.5 percent women 15–49 years of age have undergone FGM.[63] Places where refugees reside, such as Cairo and Giza, have rates of 83.3 percent and 93.8 percent respectively. The median age of circumcision is reported to be 10.5 years, illustrating that the practice is tied to puberty.

60 UNHCR. Egypt: Global Focus, cited December 9, 2021, https://reporting.unhcr.org/egypt.
61 O. El-Gibaly, M. Aziz and S. Abou Hussein, "Health care providers' and mothers' perceptions about the medicalization of female genital mutilation or cutting in Egypt: a cross-sectional qualitative study," BMC Int Health Hum Rights, 19(1): 26, https://doi.org/10.1186/s12914-019-0202-x.
62 Egypt, Ministry of Health and Population, Egypt Health Issues Survey 2015, Cairo, 2015, http://dhsprogram.com/pubs/pdf/FR313/FR313.pdf.
63 Egypt, Ministry of Health and Population, Demographic and Health Survey 2014, Cairo, 2015, http://dhsprogram.com/pubs/pdf/FR302/FR302.pdf.

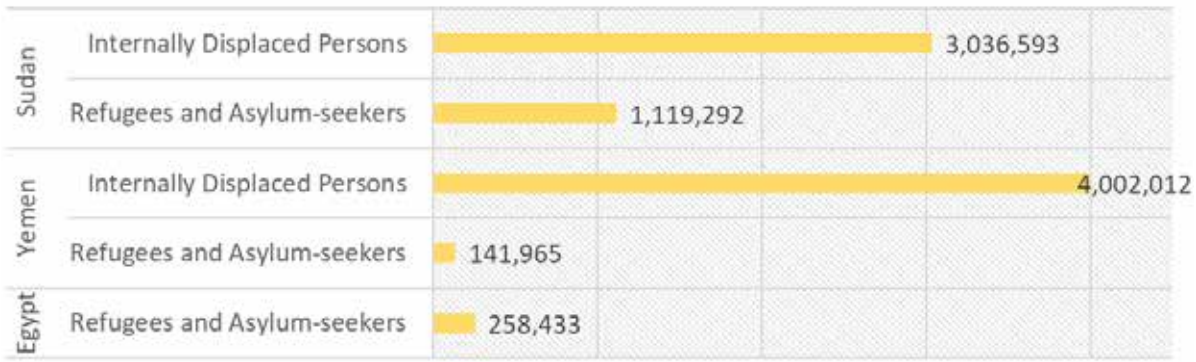
7

Methodology

Study design

A literature review was conducted from September to December 2021. Studies on FGM in humanitarian settings were extracted and analyzed, with findings synthesized in a separate publication.[64] A contextual analysis was completed, consisting of existing population-based data sources. A total of six focus group discussions were conducted virtually with practitioners and experts working on FGM in humanitarian contexts or across the humanitarian–development–peace nexus in three settings: Egypt, Sudan, and Yemen (figure 1).

Figure 1. Estimates of the numbers of refugees and IDPs



Retrieved from the UNHCR Refugee Data Finder at https://www.unhcr.org/refugee-statistics/

64 S. Elnakib and J. Metzler, "A scoping review of FGM in humanitarian settings: an overlooked phenomenon with lifelong consequences", under review, 2021.

8

Data collection

Data collection was guided by consensus, a method that facilitates agreement among experts on issues of practice.[65] The consensus methodology was chosen because it is a quick method for generating evidence in contexts where there is a lack of formal research studies on a given topic. The lack of empirical evidence about FGM response and prevention efforts in humanitarian contexts allowed participants to reflect on the topic, speak freely and think independently about key issues relevant to FGM in humanitarian response, as well as discuss and explore connections in their collective responses. It also allowed prioritization of issues through consolidation to establish areas of consensus.

Participants engaged in a series of steps: first, they were invited to participate and individual responses were elicited on each research question. Specifically, participants were asked about the approaches to FGM prevention and response that exist, how effective they believe they are, and the gaps in prevention and response (including measurement). Individual responses were captured using virtual sticky notes on the Jamboard platform.[66] Participants were then asked to discuss their responses in a group, leading to the categorization of responses based on shared understanding. They also discussed linkages between responses and broader categories and were asked to explain similarities and differences in individual responses.

Eligibility criteria

The eligibility requirement for primary data collection was participants who were professionals who met one of the following criteria:

1. Directly engaged in work on FGM through implementing, monitoring, or evaluating prevention, protection, or care services for girls at risk and survivors of FGM.
2. Worked on gender-based violence (GBV), sexual and reproductive health, or child protection, and can speak on the issue of FGM in humanitarian settings.
3. Having cross sectoral responsibilities that included FGM prevention or response (i.e. a person in the education sector whose role is to address GBV concerns).

65 S.M. Campbell and J.A. Cantrill, "Consensus methods in prescribing researcher," Journal of Clinical Pharmacy and Therapeutics, 26: 5-14, https://doi.org/10.1111/j.1365-2710.2001.00331.x.

66 www.google.com/jamboard.

Table 1. Focus group discussions in Egypt, Sudan, and Yemen

Country	Focus group discussion	Number of participants
Egypt	1	3
	2	6
Sudan	3	5
	4	3
Yemen	5	13
	6	10

Participants were national or international actors. They came from different professional backgrounds, worked for governmental entities, national or international NGOs, United Nations agencies, or civil society organizations in policy, programme, or advocacy roles. All participants had to be currently working with or have previously worked with refugees or IDPs.

Data analysis

The focus group discussions (FGDs) were recorded and transcribed and those conducted in Arabic were translated. The Jamboard files were also translated into English. Thematic analysis was then conducted. First, a codebook was developed using deductive codes that reflected the objectives of the research. This was coupled with an inductive approach, which expanded the set of initial codes based on themes that emerged from the data. The codebook was then tested against the data and discussed with the team, leading to additional iterations. Data from the participatory exercises were also compiled for each country and analyzed for similarities and differences.

Results

The following sections describe results in five research areas:

Prevention strategies for FGM in humanitarian settings

Response strategies for FGM in humanitarian settings

Gaps in current response and prevention strategies

Measurement issues relating to FGM in humanitarian settings

Barriers and facilitators to FGM response and prevention in humanitarian settings

The findings are specific to programmes and interventions that included a focus on refugees, asylum seekers, or IDPs.

Prevention strategies for FGM in humanitarian settings

Participatory discussions revealed that there were very few structured long-term interventions focusing on FGM prevention being implemented in Yemen and Sudan as part of humanitarian responses. In Egypt, there was a wider range of interventions, although they appeared to be one-off and ad hoc in nature.

> *"We will meet some beneficiaries or talk on WhatsApp maybe once or twice. Then we both get busy and there is no follow-up… If there was a dedicated system for follow-ups, it would be a lot better and our interventions would be more systematic and more able to help women." (Practitioner, Egypt)*

> *"I wish we were working on comprehensive protection and response programmes for women who have undergone FGM in Egypt, no matter whether the woman is Egyptian or not. Both refugees and Egyptian women have the right to receive medical services and to have a programme that supports them as survivors of GBV or FGM. The idea of a link between women and girls who were exposed to FGM and between the safe units can be made effective, but unfortunately this link is missed. I know there are attempts by people to deal with each other for referral, but not for FGM. I hope stakeholders meet and put a programme together and engage the women, NGOs, human rights NGOs, and clerics." (Practitioner, Egypt)*

Across the three settings, the most frequently mentioned interventions were social and behavioral change interventions (most commonly awareness-raising activities targeting community members). These activities frequently targeted older community members, such as mothers and grandmothers, because of the assumption that FGM is perpetuated by older women in the community. Asked whether this assumption was based on any empirical data, participants said no, but cited widely held beliefs that the practice is driven by older women in the family rather than by men. In Yemen, participants noted that grandmothers commonly conduct the procedure themselves, making them important targets for social and behavioral change interventions.

> *"Recently, we ran sessions for Sudanese grandmothers over fifty years of age. We found that they were the drivers of the practice of FGM or had an impact on FGM, so we invited them to individual conversation sessions. As for the sequence of such sessions, we first talked about their needs and suffering in Egypt, and how this reflects on some types of violence that can be practiced on us, and, then, what violence I am practicing. We introduced it in a series so that we can see the extent of their influence on grandchildren who suffer FGM." (Practitioner, Egypt)*

In Yemen and Sudan, activities that engaged religious leaders were also prioritized, because the practice was said to be deeply rooted in Islam. In both settings, participants denounced the absence of a strong religious fatwa, or decree, against FGM which they contrasted with the situation in Egypt. Activities targeting religious and community leaders were cited across all three settings. Most of these activities were taking place in specific locations prior to the arrival of displaced communities, meaning the extent to which they were part of humanitarian responses is not entirely clear. They seem to be asso-

ciated with development efforts that predated displacement but continued to be provided as part of humanitarian response activities and programmes in areas affected by the influx of displaced populations.

> *"In Yemen, there are a number of religious movements: Sunnah, consisting mostly of the Sunnah, but differences within it, which are the Shafi'is, the Hanbalis, and so on. Regarding circumcision, we are not able to unite the religious ranks, because if we come together and obtain a fatwa for a specific trend, the rest of the currents do not necessarily recognize it as a fatwa, and this is one of the difficulties. We have reached the conclusion that FGM is ultimately led by religious leaders. As such, we began to build camp plans in Yemen on this basis, if we are supposed to target religious leaders, such as Al-Azhar, and so on. All of this happened to us in Yemen because basically there is no reference for fatwa." (Practitioner, Yemen)*

In Egypt, many of the activities cited were part of humanitarian response efforts that have been taking place for years, due to the protracted nature of refugees in the country. Egypt hosts several nationalities of refugees, some of whom have been in the country for nearly a decade. Participants in one FGD noted that the training manual their organization used to guide community dialogs and awareness-raising activities was not tailored to different nationalities of refugees. Instead, a single Arabic training manual was used for Arabic-speaking refugees from sub-Saharan Africa, and refugees from Iraq, Syria, and Yemen. This was despite the recognition that the drivers of FGM differed based on nationality and that decision-makers were not always the same. While practitioners noted this as a weakness in their activities, they stated that they lacked the data and evidence needed to inform tailored interventions. Similarly, in Yemen, participants noted that none of the FGM prevention activities were targeted at refugees from sub-Saharan Africa, even though the practice flourished in these communities, particularly Somali communities living in the country. Instead, FGM activities focused on Yemenis.

> *"The displaced are…the African groups displaced from the neighboring African countries. Indeed, there are almost no interventions. There are programmes that target Yemeni IDPs who came from different governorates due to the current political situation. As such, this approach is mostly for those IDPs (Al-Yemeni–Yemeni) (Yemeni–Somali) or Yemeni, for example, from Ethiopia or from any Abyssinian African country who cannot be directly reached by these programmes." (Practitioner, Yemen)*

Table 2 lists prevention activities conducted in the three settings. These activities did not always focus exclusively on FGM and instead were part of broader programmatic approaches. For example, interactive theater was used as a tool to address several issues related to GBV, including domestic violence, sexual harassment, and other topics. As such, FGM messages were one of a number of messages delivered as part of several of these interventions. FGM prevention messaging was also integrated into cash and voucher assistance, alongside other psychosocial approaches, including programming to target life skills, sports, and providing psychological advice to girls.

Table 2. Prevention and response interventions across settings

Intervention	Egypt	Yemen	Sudan
Dialogue with mothers, mothers-in-law, and grandmothers	✓	✓	✓
Interactive theater, psychodrama, and art	✓	✓	✓
Capacity building/ awareness raising activities targeting religious leaders	✓	✓	✓
Capacity building / awareness raising activities targeting law enforcement	✓		✓
Capacity building / awareness raising activities targeting health workers (midwives, physicians, nurses)	✓	✓	✓
Community outreach	✓[67]		
Community dialogue sessions	✓	✓	✓
Help line	✓		
Empowerment activities	✓		
Engaging men and boys	✓[68]		
Social media and traditional media campaigns		✓	
School-based awareness activities and school clubs		✓	✓
Policies banning health workers from conducting FGM	✓	✓	✓
Awareness-raising about laws on FGM	✓		✓

67 Participants mentioned a door-to-door outreach campaign that took place in the country as an example
68 For example, participants mentioned sports activities that aim to achieve social goals as a way to engage men and boys

> *"The idea of using interactive theater and how we can use the theater to deliver messages to families in our communities about the effects of FGM. We try to persuade families through interactive theater." (Practitioner, Egypt)*

> *"[The programme] for women who are subjected to violence. They provide them with apartments or places and pay the rent. They were giving them subsidies through the supermarket, in the form of coupons, which they spend monthly. But this is not related to FGM, it relates to violence in general." (Practitioner, Egypt)*

> *"One of the most important interventions that we have and that we are working on is the issue of education and awareness. There are many methods within it. Part of the lectures can deal with the level of societies, and the interactive theater, the mobile cinema. We use lots of tools and methods for raising awareness." (Practitioner, Sudan)*

In Sudan and Egypt, practitioners noted that many of the displacement contexts in the two settings were protracted. For example, in Sudan, some communities had been displaced since 2003, meaning these interventions were more commonly applied in these contexts. At the onset of an emergency, however, these interventions were not always feasible, which meant they were sometimes implemented at a later stage.

Response strategies for FGM in humanitarian settings

Specific response strategies for FGM were rarely highlighted in discussions across the three settings. Most often, participants in the three settings reported that the FGM response was included into the wider response to sexual violence and GBV, specifically as part of routine case management in safe spaces for women and girls, youth centers, and youth clinics. When asked about how case management specifically addressed the needs of FGM survivors, participants in Yemen and Sudan noted that FGM cases were seldom identified through case management, since the fact that the practice is often shrouded in silence makes the identification of survivors challenging. As such, in theory, GBV case management addressed the needs of FGM survivors by offering a continuum of services, including medical, legal, housing, and psychosocial. In practice, however, very little is being done to actively screen women for FGM or to address their different needs.

> *"As long as the suffering continues in silence, the husband suffers in silence and may exert pressure on her or take certain actions against her. But unfortunately, the support does not come until late." (Practitioner, Yemen)*

In Egypt, practitioners stated that identification of survivors was more common through case management in the context of safe spaces for women and girls. The safe spaces were said to provide a package of specialized services to survivors, both in-house and through referrals. For example, psychosocial counseling and other psychosocial activities (such as psychodrama, art therapy, and interactive theater) were implemented through safe spaces. Women requiring medical attention or medical rehabilitation were referred to organizations providing medical services, such as Médecins Sans Frontières. The interagency sub-working group on sexual violence and GBV has developed

a referral pathway to guide organizations working with survivors on where women and girls can receive services. Organizations were using the referral pathway to direct survivors to services they were not offering themselves.

> *"Case management will deal with all GBV cases. If a woman suffers from rape and comes to us, we will handle the legal part of the case if she wants. For girls exposed to early marriage, we will handle the referral part. This means there is legal and psychological support and there is support in all areas for all the women who suffer GBV, including FGM." (Practitioner, Egypt)*

> *"All survivors of violence are transferred and reported through the networks or through the police. They come to the hospital and are transferred to this facility, to the codification area. At this facility, women receive the services described. In respect of young people, there is health support and psychological support, even for women that need advanced psychological support, since they can then be transferred to the trauma center..." (Practitioner, Sudan)*

In Sudan and Yemen, participants noted that they were not aware of any medical or legal services being provided to survivors of FGM. In Yemen, participants said there was no law to protect survivors, meaning no legal action can be taken against perpetrators of FGM and thus legal services were sought by survivors. In Sudan, despite the practice being outlawed, none of the participants were aware of legal action being sought by survivors from displaced communities. The most common service available in the two settings was said to be psychosocial support, which again was provided to survivors of sexual violence and GBV generally and not specifically to FGM survivors. For example, there are no support groups targeting FGM survivors in either of the two settings, and while one-on-one counseling for FGM survivors was available in theory, the lack of identification of FGM cases precluded its delivery.

Gaps in current response and prevention strategies

Participants noted several gaps in the way in which FGM is addressed in prevention and response programming in each of the three settings. The gaps noted included a lack of comprehensive services for survivors; lack of sustained programming to promote lasting impacts for girls; poor coordination; low prioritization of FGM as a lifesaving issue in humanitarian action; and programme innovation.

The lack of key supports central to comprehensively addressing the needs of survivors was apparent throughout discussions. In Sudan, participants said there were no medical interventions being provided to survivors of FGM and, while FGM reporting was weak, some women may have suffered from hemorrhage, urinary tract infections, and other medical issues that required attention. To date, none of the programmes discussed were set up to help women with these kinds of medical needs. In Egypt, practitioners noted there was insufficient engagement of men and boys in existing programming and that most activities exclusively targeted girls and women. Participants also noted that the absence of economic empowerment and other livelihood activities targeting women refugees was a major gap, due to the need to strengthen the bargaining power of women in households and their overall worth in society. Instead, most prevention activities

focused on social and behavior change, which was not enough to cause the transformative change needed to eliminate FGM.

"'I have a limited source of income, and sometimes they send me money from there, so I am forced to obey them [in reference to undergoing FGM]'. This means that when a woman does not have economic empowerment, she will face more pressure to obey these decisions or from the community. The community sometimes indirectly puts pressure on her and provides her with assistance. However, if she is able to be different, it will be easier for her to say no." (Practitioner, Egypt)

"In places where women do not work and do not have separate financial liability, it becomes difficult to make decisions at home." (Practitioner, Egypt)

Concerns around the sustainability of interventions and their intensity were consistently cited in all three settings, with participants highlighting the one-off nature of their activities. This was exacerbated by the uncertainty of the funding they received to support GBV and FGM activities. Issues around the frequency and intensity of interventions were brought up in Sudan, with participants stating that the frequency of awareness-raising interventions was insufficient to trigger concrete behavior change. In Yemen, the main gaps identified centered around the fact that the FGM programme was fragmented: each organization had its own one-off activities, without coordination with other actors. The lack of coordination among organizations working among displaced populations was cited in Sudan but was also a common concern in all three settings. This resulted in the duplication of work, and participants noted that many participants were receiving the same intervention with different organizations.

There was agreement among participants in FGDs from Sudan and Yemen that FGM and other GBV activities were not major priorities because there were other more pressing needs, such as food, shelter, and health in areas beset by conflict and insecurity. This lack of prioritization, which many participants said was warranted, exacerbated what they described as an already fragmented FGM response framework.

"Even if there is funding, it will go to other, more important programmes." (Practitioner, Yemen)

The need for credibility and appropriate messaging was discussed as central to the innovation required to meet the needs of women, girls, and communities. In Egypt, participants stated that activities centered around telling refugee women about the dangers of FGM, which a lot of women were already aware of. Participants used examples of risk around hemorrhage and loss of sensation during sexual intercourse to illustrate how dangers of FGM were often exaggerated, and many women were left unconvinced because the reported consequences did not match experiences in their communities.

"One issue that we confront is that a lot of women are already cut and do not feel or experience any harm from FGM, so when we lecture about the harm of FGM and say it causes such and such, they think 'well, that didn't happen to me, so you are probably lying'. This is why exaggeration in awareness sessions is a problem.

While hemorrhage is a possibility, not all girls will experience hemorrhage." (Practitioner, Egypt)

"There are many women who have been circumcised and have not experienced any complications. This is what confuses public opinion." (Practitioner, Yemen)

"We need to diversify the ways in which we can talk about the issue. We don't limit it to one thing but we do say that if your daughter is circumcised, this is what will happen. No, this is not the problem. We just say things based on what we have observed. But the topic goes much deeper." (Practitioner, Egypt)

Measurement issues relating to FGM in humanitarian settings

Across the three settings, participants noted that they were "working in the dark" due to the absence of data, meaning they had little information on which to base services and contextualize interventions. Participants highlighted three major issues related to measurement:

- lack of quantitative data on the scale of FGM in displaced communities
- lack of qualitative data on the drivers of FGM in displaced communities, as well as on the dynamics of FGM, including who makes decisions around FGM, who conducts the procedure, and where the procedure is done
- absence of robust monitoring and evaluation (M&E) systems, including tools and guidelines, to help track the impact of work

In Sudan, participants noted that they lacked the expertise, know how, and needed resources to assess the impact of their work, such as data-collection tools and a general M&E framework tailored to the realities of humanitarian responses. Participants emphasized the difficulties of measuring FGM as a phenomenon and in measuring shifts in social norms over time, specifically in crisis contexts. They expressed a need for standardized, validated tools and instruments, which they said were lacking. They also noted that in some places, FGM is known to be an issue through anecdotal evidence or outdated data. Whether FGM is actually taking place or how it is impacted by displacement pressures remains largely unknown, meaning there is no sense of urgency or strong justification to conduct FGM interventions. Participants stated that the only source of quantitative data in the country is the multiple indicator cluster survey from 2014, which is outdated and does not reflect recent displacement waves. According to participants, the demographic and health survey 2019 did not materialize and the 2022 survey has been delayed. This prevents access to critical data. However, the "Voices from Sudan" was cited as a helpful and more up-to-date resource that provided qualitative information on GBV in the country. Other measurement-related hurdles mentioned in Sudan included the mobility of many communities, which precluded long-term follow-up and sustained interventions; the complex security situation, which prevented staff from reaching certain areas; and the lack of funding for M&E activities.

"Possibly the most important gaps cited by the people who are generally involved in this issue include the subject of information or data. We find that there is a very big problem in obtaining specific information and data about societies, for example, about the practice lineage, about abandonment, or other things." (Practitioner, Sudan)

In Yemen, participants echoed many of the same issues, noting that the absence of baseline estimates means it is not possible to draw conclusions about the effectiveness of prevention activities or trends in FGM practices in displaced communities, specifically on whether FGM is increasing due to internal migration (as indicated by emerging anecdotal evidence). In both FGDs, participants stated that data in the south of the country were being collected by international NGOs and other humanitarian actors. However, because there was no robust central data repository that collated the data from the different organizations working with IDPs, data were fragmented and went unused. Moreover, data collected were on GBV in general and did not distinguish FGM from other types of GBV. In Yemen, it was revealed that a GBV information management system is not in place, meaning GBV service providers do not collect and report data during the implementation of case management response activities. It was also noted that if M&E funds are made available, it is hard to prioritize M&E and data collection in a state of war and thus there is a perception that M&E is not a priority.

"When an exodus of this kind occurs, people retain their traditions and work to spread them in the new places they have moved to. The opposite of your question occurred. There are several IDPs in Hadramout who are from the northern region. They do not circumcise and there is a possibility that they adopted FGM from the host society, whose members practice female circumcision, and this practice spread among them in this way." (Practitioner, Yemen)

"The latest statistic indicates the arrival of many displaced people from Ma'rib during the past month I expect there some governorates have seen a significant increase in female circumcision while others have not." (Practitioner, Yemen)

Issues specific to Egypt included social desirability bias and fears of legal ramifications, which participants said prevented refugee women from giving truthful answers about their attitudes toward FGM and whether they were practicing it, due to laws that criminalize FGM in the host country. Additional issues included challenges on attribution, with participants expressing concern that humanitarian organizations targeted the same beneficiaries, which made attributing behavioral change to a specific intervention challenging, as well as problems around follow-ups for participants. Follow-up issues were specifically cited in relation to sub-Saharan African refugees, due to the occasionally transient nature of their stay in Egypt, often considered a transit country prior to resettlement.

"We need to know how many refugee women have undergone FGM in the past years. Then we have to divide them into age groups. After that, we will measure the number and percentage of programmes directed to confront FGM for these same groups, so that we can know how much effort was made compared to the actual result achieved on the ground." (Practitioner, Egypt)

Barriers and facilitators for FGM response and prevention

Participants noted several enablers and barriers for the implementation of both FGM prevention and response programming in each of the three settings. Barriers

included a lack of reporting mechanisms for perpetrators and medical providers; lack of awareness or absence of anti-FGM laws; limited number and therefore capacity of child protection committees and networks for response efforts; the influence of elders on decision-making; social identity and connectedness; language barriers restricting access to services; programme reach limited by outreach strategies; and a lack of funding. Enablers included media and social media as outreach tools; diverse pools of service providers; and innovative outreach strategies.

"There is also no mechanism to report such practices. There is no way to report health personnel. This has created a big problem." (Practitioner, Yemen)

A major barrier that was identified by participants in Sudan was the lack of mechanisms to report perpetrators of FGM. While there was a hotline established, participants said it is not active. There is also a widespread lack of awareness of laws around FGM and weakness in the enforcement of Criminal Law Article 141, which was passed last year. Community-based child protection committees and networks were cited as an asset for FGM response efforts but there was concern that there were not enough committees in areas with IDPs and that the committees were generally few in number.

In Yemen, the absence of a law against FGM in the country was a major barrier. Participants stated that there was a major lack of political support for the issue. FGM is not regarded as a priority by the government and there is a reluctance, specifically by the Sana'a government, to recognize it as an issue that should be part of humanitarian response. There was also no way to report health workers who conduct FGM, although participants noted that there were policies in health facilities that prevented midwives and other health personnel from conducting the procedure. Participants also lamented the absence of a mechanism for the initial reporting of FGM cases. Support for FGM from elderly people who wield a lot of influence was also cited as a barrier.

"In 2007, the Ministry of Health issued a decision banning the practice of female circumcision in hospitals. Before 2007, circumcision was normally allowed in hospitals" (Practitioner, Yemen)

In Egypt, participants stated that a major barrier to FGM prevention activities among sub-Saharan African refugees was the degree to which FGM served as an identity marker. This makes the phenomenon deeply entrenched and difficult to eliminate.

"The community, in particular, Sudanese and Africans, are trying to preserve their identity. To this end, they preserve the acts they used to carry out in their country, including FGM. This is merely a psychological issue. I can understand that it is very difficult, as they maintain their identity through practices." (Practitioner, Egypt)

One participant also noted that there is significant tribal diversity among beneficiaries from several African countries, which hampered practitioners' ability to communicate tailored messages to them. Additionally, many of these tribes do not speak Arabic. This makes it hard to reach them with targeted messages in their own language, unless effort is made to recruit and train community outreach

workers from these same communities, which takes time and effort. A disconnect between religious decrees against FGM and the individually held views of religious leaders in communities where FGM was practiced was noted. Many of these religious leaders used mosques to encourage members of the community to practice FGM. Lastly, participants noted that schools were great platforms for reaching girls and that school clubs have the potential to act as avenues for delivering FGM prevention and response. However, while there were some school clubs established, these were few in number and were not set up in areas that are hard to access and with a high concentration of displaced communities. Similarly, there were several concerns that activities were not reaching the most vulnerable and marginalized groups.

Enablers were less frequently discussed across the groups. In Egypt, media and social media were cited as highly influential tools but were said to be underused in humanitarian response activities. Using a wide range of providers was one way of navigating the language barriers that were frequently cited as impeding implementation and of ensuring appropriate communication and messaging. The use of alternative times and outreach strategies were also cited as enablers to implementing programmes, particularly those that engage men and boys.

"We need something clear that targets people with reasonable messaging based on studies, such as videos and documentaries; things that serve as visual aids and teach people about FGM and the harm it causes without scaring them." (Practitioner, Egypt)

"...the range of people that we use to raise awareness also helps greatly. In Eritrea we have more than one language in use. For example, I am fluent in a particular language and I have female health leaders in the team from various tribes, a number of whom are from tribes other than my own. They are fluent in other languages, some including Sudanese. The different dialects help greatly in communication. Sometimes it is more difficult. For me a large percentage do not primarily converse in Arabic. This in itself is a way of communicating awareness about circumcision to females in African societies." (Practitioner, Egypt)

"Another challenge is that most of the people who attend these meetings are women, not men, so the idea of reaching men or getting them to think about attending, is very hard. Of course, I understand this and the reason is that men work and will not take time off to come to us. Then we try other activities at other times so that they can come. However, this is still a challenge and in my opinion is still a barrier to eliminating FGM." (Practitioner, Egypt)

Recommendations

Study findings highlighted barriers to and enablers of FGM programming in humanitarian settings and provided a snapshot of the challenges confronting practitioners working to address FGM in different stages of crises. By synthesizing learnings from the three countries, we propose concrete recommendations on what is needed to drive action towards preventing FGM and responding to the needs of survivors in the context of humanitarian crises. The following section outlines key recommendations and considerations for future research, policy, and programming that are based on the study results.

Research

This study has shed light on specific aspects of FGM that require further study.

Integrate core FGM indicators into existing platforms and, where appropriate, conduct primary research to establish incidence and monitor trends. Several groups raised the need for more systematic documentation of FGM, either for use in policy engagement or in programme design and M&E. Vital to this pursuit is the development of standardized indicators for measurement of the incidence of FGM and integration of these indicators into population-based efforts so they are routinely used to monitor trends and detect spikes that may be associated with displacement pressures and migration flows. This would enable practitioners to ensure that appropriate case management and comprehensive services are available to survivors. It would also ensure that FGM services and funding mechanisms for prevention and response activities are prioritized in contexts where prevalence is known to be high.

Undertake or support additional research on what works to prevent or respond to FGM. Across groups, there was consensus on a need to understand the impact of existing prevention and response programming. More work should be done to assess the effectiveness of interventions

and to provide a suite of tools and guidance to support practitioners in the programming M&E.

Examine the drivers and consequences of FGM in different humanitarian contexts. More research is needed on the drivers and consequences of FGM in different humanitarian contexts. Examining the myriad persistent, new or crisis-related drivers would provide further practitioners with further support to directly address these drivers using more tailored programming approaches. Examining the consequences of FGM, particularly a more comprehensive exploration across the life course of girls and women and on different areas of life, should be prioritized. Such research would inform awareness-raising with credible messaging on the drivers and consequences of FGM and would ultimately support communities in eliminating the practice.

Explore the different roles of FGM influencers to inform programmatic approaches and modalities. More evidence is needed on the role of the different influencers and decision-makers in the prevention or promotion of FGM. A more in-depth exploration is needed on how social norms perpetuating FGM in the country of origin and in the destination country interact and impact the prevention or propagation of the practice. This would enable shifts in social norms to be monitored to ensure that the acquisition and transfer of harmful social norms associated with displacement and migratory flows do not take place. It would also enable possible entry points for social norms change in humanitarian settings that promote positive social identify markers for women and girls to be identified. Leveraging innovative methods through social media or dramatization, as noted by participants, can help accelerate efforts to eliminate FGM, including in emergency situations.

Policy

Prioritize funding for FGM programming and research. Across groups, participants indicated that FGM is not prioritized in humanitarian settings, due to a lack of funding and political will to advance prevention and response initiatives. Further efforts should be made to examine the extent to which this is the case across different types of humanitarian contexts – from acute situations to more protracted emergencies. More funding should be directed to FGM prevention and response programming in humanitarian settings, ensuring that appropriate funding for M&E is included in this.

Engage communities in developing comprehensive social change goals. Several groups mentioned the need for advocacy efforts targeted at legislative and healthcare reform. This includes strengthening policies around the medicalization of FGM and more detailed guidance for healthcare providers as part of the Minimum Initial Service Package (MISP) and transitions to comprehensive sexual and reproductive health care. However, this should be taken up with a comprehensive and community-grounded approach to ensure attempts to reform the system do not drive the practice of FGM underground. To ensure progress, it is important to explore change mechanisms and how the implementation of laws is more effective in different humanitarian contexts, and to learn more about how these laws resonate, are perceived, and are understood and known by the communities.

Programming

Ensure that GBV and FGM programming is integrated into all aspects of a humanitarian response while also developing tailored interventions for contextualized FGM prevention and response. FGM is a complex phenomenon that requires mul-

tisectoral action to not only support survivors, but also work to mitigate risks for girls. Humanitarian actors must ensure that GBV and explicitly FGM programming is mainstreamed into other sectors such as health, education, and cash, but this does not preclude the need for specific interventions that focus on FGM and that address the needs of survivors. More work to provide guidance and tools to support practitioners in these mainstream and sector-specific efforts is warranted.

Scale up comprehensive efforts that respond to the needs of FGM survivors throughout the humanitarian programme cycle. The study confirms the need for a stronger and distinct focus on FGM in service delivery. Prevention efforts, specifically gender-transformative programmes that empower women, are priorities in humanitarian emergencies but they should be coupled with specific activities that address the needs of survivors through provision of a continuum of services that includes medical, legal, and psychosocial support among others. Current efforts appear to focus more on prevention activities that are piecemeal and ad hoc rather than on responding to the needs of FGM survivors and empowering women.

Strengthen existing M&E frameworks in programming to be more inclusive of FGM indicators. The study confirms the need for a stronger and distinct focus on FGM in programme M&E. The introduction and roll-out of a GBV information management system (GBVIMS) or other incident-monitoring system that allows providers to collect, store, and analyze data on GBV and FGM is a helpful addition to a practitioner's toolkit. Using gender-transformative M&E frameworks in existing programming would enable a standardized set of core FGM and gender equality indicators to be measured. Attention should be paid to innovations that support remote monitoring options during the COVID-19 pandemic.

Ensure coordination among humanitarian and development actors to reduce duplication and fill programming gaps. Protracted displacement was common in the study sites, highlighting the need to strengthen links between humanitarian and development actors working on FGM activities. Collaboration and coordination between humanitarian and development actors providing GBV services in the same context will help amplify the impacts of interventions on the long run and extend the focus from immediate emergency responses to more sustainable, locally owned solutions.

Use the economic empowerment of women and girls, through livelihoods and cash interventions, as a tool to enhance protection. Programmes that guarantee women and girls' economic empowerment will increase their value in society and their bargaining power in the household, and have the potential to transform social norms that perpetuate FGM. They also promise to address links between FGM, marriageability and economic pressures that drive decisions to carry out FGM. There is robust evidence that indicates that economically empowering women provides some protection against FGM, which was underscored by the study findings.

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