Preventing and Responding to Female Genital Mutilation in Emergency and Humanitarian Contexts

Results from the Virtual International Stakeholder Dialogue

December 2020

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1. Introduction

DECADE OF ACTION

The urgency of addressing Female Genital Mutilation everywhere now

After decades of mobilisation and struggles, no country has yet fully achieved gender equality. This is deeply rooted in the fundamental structures of our societies and is exacerbated in times of crisis. It is indeed widely acknowledged that women and girls are disproportionately affected by emergencies and that all forms of gender-based violence (GBV) are exacerbated within these contexts. We cannot keep tolerating this!

Female Genital Mutilation (FGM) is internationally recognised as a violation of human rights, a form of GBV and a manifestation of gender inequality. As such, its elimination is included as a specific target within the Sustainable Development Goal 5, dedicated to Gender Equality.

Upon entering the Decade of Action to deliver the Sustainable Development Goals by 2030, if we truly want to leave no one behind and realise target 5.3, we cannot lose sight of the millions of women and girls living in humanitarian contexts and at risk of FGM or suffering its life-long consequences.

According to UNICEF data, more than 200 million women and girls today are survivors of FGM[1], based on 31 countries with nationally representative data on FGM[2], although there is evidence that FGM is present in over 90 counties worlwide[3]. Further research by UNFPA shows that, if the current upwards trajector is maintained, a further 68 million girls will face FGM between 2015 and 2030[4]. These new figures project that the 2015 estimates of 3.9 million girls cut annually, will rise to 4.6 million by 2030, unless massively scaled-up efforts are urgently taken to prevent this from happening. Such increase is due to the estimated population growth in communities that practice FGM. Moreover, the current global COVID-19 pandemic is impacting efforts to end FGM[5] and an estimated

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1 UNICEF (2016), Female Genital Mutilation/Cutting: A Global Concern

2 UNICEF figures (2020)

3 End FGM European Network, Equality Now and US End FGM/C Network (2020), FGM/C: A Call for a Global Response - Global Report (2020). The report shines a spotlight on the presence of FGM in 92 countries, which means at least 60 further countries where the practice of FGM has been documented compared to the official UN estimates, either through indirect estimates, small-scale studies, or anecdotal evidence and media reports. The report emphasises that the currently available already worrying numbers are a woeful under-representation of the phenomenon, since they do not take into account numerous countries where nationwide data on FGM prevalence is not available.

4 See UNFPA (2018) press release and infographic.

5 Technical note on COVID-19 Disrupting SDG 5.3: Eliminating Female Genital Mutilation (2020), UNFPA-UNICEF Joint Programme on FGM.

two million additional cases, caused by disruption of interventions in this crisis period, will need to be averted[6].

Within this context, and in line with the recent UN Human Rights Council resolution[7], the international community must urgently **scale up efforts and resources and ensure effective work collaboratively towards both the abandonment of FGM and the provision of adequate services for women and girls affected by FGM in different contexts, including emergency and humanitarian ones.** In particular, ensuring a more holistic and coordinated approach to the humanitarian-development nexus has shown to be of crucial importance.

FGM, "like many other harmful practices, is exacerbated in humanitarian situations, armed conflicts, pandemics and other crises, and that new forms, such as medicalization and cross-border practice, are emerging." States must ensure "a **more holistic and coordinated approach to the humanitarian-development nexus** by integrating the prevention and response to Female Genital Mutilation into humanitarian preparedness and response, including in the continuum of essential services for gender-based violence."

UN Human Rights Council, Resolution on Female Genital Mutilation (14 July 2020)[8]

[6] UNFPA (2020), Impact of the COVID-19 Pandemic on Family Planning and Ending Gender-based Violence, Female Genital Mutilation and Child Marriage.
[7] Human Rights Council 44th session resolution on Elimination of Femal Genital Mutilation adopted on 14 July 2020.
[8] Human Rights Council 44th session resolution on Elimination of Femal Genital Mutilation adopted on 14 July 2020.

FACTS

Female Genital Mutilation in humanitarian and fragile contexts – a neglected issue

The 15 countries with the highest FGM prevalence rate include 9 countries suffering from humanitarian crises and/or defined as "fragile countries"[9,10,11].

Half of the countries with nationally representative data on FGM prevalence rates worldwide are countries currently defined as fragile contexts[12] or have been hit in recent years by severe emergencies[13], whether they are man-made, natural disasters and other hazards, or a combination of the above. However, **FGM is not a priority for donors and policymakers, including those responsible for programming and humanitarian workers involved in fragile contexts**[14].

[9] Fragility is defined as the combination of exposure to risk and insufficient coping capacity of the state, system and/or communities to manage, absorb or mitigate those risks. Fragility can lead to negative outcomes including violence, the breakdown of institutions, displacement, humanitarian crises or other emergencies (OECD, States of Fragility report, 2016:22).
[10] World Bank, FY21 List of Fragile and Conflict-affected Situations.
[11] In order of overall FGM prevalence: Somalia (98%), Mali (89%), Sudan (87%), Eritrea (83%), Burkina Faso (76%), The Gambia (76%), Guinea Bissau (45%), Liberia (44%), Chad (38%, with an ethnic group prevalence of 92%).
[12] In addition to the ones above mentioned, and in order of overall FGM prevalence: Central African Republic (24%, with an ethnic group prevalence of 53%), Nigeria (20%, with an ethnic group prevalence of 55%), Yemen (19%), Iraq (8%, with zones above 50%), Niger (2%), Cameroon (1%, with an ethnic group prevalence of 13%).
[13] For instance, Indonesia (49% FGM prevalence) was hit in 2018 by a quake and tsunami, a natural disaster that devastated the country.
[14] End FGM European Network (2018), FGM in a Humanitarian Context Briefing.

Conflicts, natural disasters and related poverty fuel precarious situations, which can lead to population displacements, dramatically increasing the vulnerability of women and girls who are disproportionately affected by such crises. This can include additional exposure to exacerbated forms of GBV, among which is FGM. Emergency contexts generate additional challenges for organisations to provide long-term care to FGM survivors and implement sustainable prevention activities in the affected areas. This is largely due to the lack of opportunities to establish multi-year planning and budgeting, given the fragile contexts.

Moreover, in 2020, on top of the ongoing humanitarian crises, most countries in the world faced an emergency situation due to the outbreak of the COVID-19 pandemic. In response to this, governments imposed measures for the general population such as social distancing, limited movements, curfews, schools closures – which, on the one hand, helped contain the spread of the virus, but on the other, placed girls and women at a higher risk of being subjected to GBV overall, and FGM in particular[15]. The global nature of the 2020 crisis has tragically demonstrated that any country can rapidly fall into a state of emergency, including those not typically used to experiencing such situations. The pandemic has also laid bare the unpreparedness of anti-FGM actors and stakeholders unaccustomed to working in crises, which has severely undermined interventions. Preparedness and adaptability to volatile contexts, will be key in avoiding total future disruption of societies. Actors working on FGM will especially need to be prepared to shift from development to emergency actions quickly, in order not to jeopardise progress made towards the eradication of the harmful practice.

Despite all this, **FGM is still considered a secondary issue in situations of emergency,** since working on its abandonment and supporting survivors entails a **long-term process** of awareness-raising, behavioural change, prevention and care, which **does not fit in the rapid response strategy shaping the work in emergency settings**. For this reason, in efforts to build the resilience of vulnerable populations and ensure a more sustainable support in fragile contexts, humanitarian and development actors have come together, in recent years, to break silos and connect humanitarian aid with more medium- and long-term development action.

[15] UN Women (2020), COVID-19 and ending violence against women and girls.

The Virtual International Stakeholder Dialogue

Between October and November 2020, 76 experts[16] from 44 organisations[17] in 31 countries and 5 world regions[18] gathered online to participate in multiple virtual stakeholder dialogue sessions in the run up to the FGM Donors Working Group meeting on 16-17 November 2020. The online discussions focused on *"Preventing and Responding to Female Genital Mutilation in Emergency and Humanitarian Contexts"* with the explicit aim of providing a concrete set of recommendations for donors and key actors in the field.

The dialogue was organised by AIDOS, GAMS Belgium and the End FGM European Network in the framework of the UNFPA-UNICEF Joint Program on FGM supported project "Building Bridges between Africa and Europe to tackle FGM" and builds on the work of the **Community of practice on FGM (CoP FGM)**,[19] which provides virtual spaces for collective discussion, ideas and information-sharing on Female Genital Mutilation, whilst applying a Building Bridges perspective (focusing on Africa and Europe). The outcomes of the dialogue will be taken forward in the future work of the CoP FGM and will plant the seeds for further discussions.

[16] Grassroots activists, national or international NGOs, UN agencies, researchers and academics.
[17] See the Acknowledgements for the full list.
[18] Africa, Europe, Middle East, Asia and the Pacific, North America.
19 The Community of practice on Female Genital Mutilations (CoP FGM).

FACTS

A strong case for investment in a severely under-resourced area

Current efforts to end Female Genital Mutilation are widely acknowledged as severely under-resourced. A recent study from UNFPA estimates the amount needed between 2020 and 2030 to end FGM in 31 priority countries, is $2.4 billion[20]. In reality, the same study estimates that the amount for development assistance that has been allocated for this period of time to end FGM in those countries stands at only $275 million[21]. Therefore, ending Female Genital Mutilation by 2030 in 31 priority countries **still requires investments at a total of $2.1 billion**. As such, **only 11% of the funds needed to eliminate Female Genital Mutilation by 2030 in 31 countries are currently available.**

In addition, this UNFPA study, focusing on the achievement of the SDGs on prevention of Female Genital Mutilation, does not calculate necessary funding required for providing care and support for survivors. On this note, WHO has recently developed an economic cost calculator tool[22], to explore the financial burden on the health systems of 27 countries, for treating Female Genital Mutilation health complications. Currently, this has been calculated at a total of $1.4 billion per year, essentially requiring **at least $140 billion by 2030**,

[20] UNFPA (2020), Costing the three transformative results.
[21] UNFPA (2020), Costing the three transformative results.
[22] WHO (2020), FGM cost calculator tool.

without considering population growth. Incorporating population growth, that number is expected to increase by 50% over 30 years if prevalence rates remain the same. On the other hand, according to the WHO, if Female Genital Mutilation was abandoned, that number would decrease by 60%.

Moreover, these calculations on the lack of funding urgently needed to prevent Female Genital Mutilation and provide care for survivors are incomplete, as they should include the remaining 60 countries presenting growing evidence of FGM, but are unaccounted for in official UN data[23].

It is awfully evident that **current financial efforts within the development assistance are not sufficient to tackle the issue of Female Genital Mutilation and protect survivors of this harmful practice.**

If we look at the humanitarian response, the situation does not improve much, on the contrary. Gender-based violence (GBV) remains a hugely underfunded area in comparison to other sectors, with funding not matching the scale of the problem. In 2016, 2017 and 2018, **GBV funding accounted for merely 0.12% of all humanitarian assistance – representing only one third of funding requests for GBV**[24]. Within this extremely limited percentage, the majority of funding focuses on preventing and responding to sexual violence during emergencies, mostly neglecting FGM.

Urgent scaling up of funding targeted to anti-FGM programmes is needed, through both increasing development funding and the involvement of other donors and stakeholders, who traditionally do not invest in tackling FGM, particularly within the humanitarian assistance.

[23] End FGM European Network, Equality Now and US End FGM/C Network (2020), FGM/C: A Call for a Global Response - Global Report (2020).
[24] International Rescue Committee (2019), Where is the money? How the humanitarian system is failing in its commitments to end violence against women and girls, p. 10.

2. Executive Summary

Two out of three of the top 15 countries with the highest Female Genital Mutilation (FGM) prevalence rate are suffering from humanitarian crises and/or defined as "fragile countries". Nevertheless, **this harmful practice is not a priority** for donors and policymakers, including those responsible for programming and humanitarian workers involved in fragile contexts. Upon entering the Decade of Action to deliver the Sustainable Development Goals by 2030, **if we truly want to leave no one behind and realise target 5.3, we cannot lose sight of the millions of women and girls living in humanitarian contexts and at risk of FGM or suffering its life-long consequences.**

The COVID-19 pandemic has tragically demonstrated that any country can rapidly fall into a state of emergency, including those not typically used to experiencing humanitarian crises, whether they are ongoing man-made, natural disasters and other hazards or a combination of both. This pandemic has also laid bare the unpreparedness of actors and stakeholders unaccustomed to working in crises, which has severely undermined interventions and will potentially lead to a further 2 million girls at risk of FGM by 2030, on top of the previously estimated 68 million due to population growth. On the other hand, humanitarian actors, who come into action during emergencies, and are therefore familiar with such contexts, along with governments and donors who fund them, do not consider FGM as a key issue to tackle during crises, alongside other forms of gender-based violence (GBV) or through the provision of sexual and reproductive health (SRH) services. It is widely acknowledged that women and girls are disproportionately affected by emergencies and that all forms of gender-based violence, including FGM, are usually exacerbated within these contexts.

In a world that is increasingly more prone to experience protracted crises, it appears evident that the issue of how to best work to prevent Female Genital Mutilation and provide care for survivors within humanitarian and emergency settings is a dramatically urgent one to address.

The Virtual International Stakeholder Dialogue, which gathered 76 experts from 31 countries in 5 world regions, had the explicit objective of responding with solutions to this key question. The dialogue took place in the run up to the annual FGM Donors Working Group meeting, in order to bring forward this crucial issue to governments and donors, given the **severe underfunding of the sector**. As revealed in 2020, only 11% of the funds needed to eliminate FGM by 2030 in 31 countries are currently available within development

assistance. Furthermore, FGM is barely considered within the 0,12% of humanitarian funds directed to combatting GBV in emergencies.

The present report is the outcome of a broad expert consultation with multiple stakeholders from grassroots organisations, national and international non-governmental organisations (NGOs), United Nations (UN) agencies, as well as researchers and academics, who work, or attempt to work, on FGM within diverse humanitarian settings.

The **impact of humanitarian and emergency situations on the harmful practice of Female Genital Mutilation**, in relation to the heightened risk of women and girls being subjected to it, and lack of support for survivors, has been poorly researched thus far. After identifying the main factors for increased risk of FGM due to insecurity of crisis situations, disruption of the education system and dynamics related to population displacement, the report also analyses the lack of adequate support services during emergencies, as well as the heightened risk of FGM survivors suffering the negative consequences of other forms of GBV.

The report then presents the **main challenges fragile contexts pose towards work preventing Female Genital Mutilation and supporting survivors.** Here, prolonged instability undermining long-term planning and lack of awareness around the importance of working on FGM in humanitarian settings is particularly concerned, which results in this issue being neglected within humanitarian programming and funding. Humanitarian staff not being trained on FGM, the fundamental disconnection from local actors and structures, as well as major obstacles in data collection, were some other key challenges identified when tackling FGM in fragile contexts.

Finally, a **set of recommendations** have been put forward, targeting development and humanitarian actors, as well as governments and donors, to ensure FGM is no longer neglected, but recognised as a key issue to address in emergencies. These recommendations include ways to integrate FGM in humanitarian programming, adequate training for professionals, in addition to preventing FGM and providing care for survivors. Other critical areas identified include ensuring women, girls and community leadership and ownership, essentially through connecting with existing local structures and stakeholders, ensuring coordination among actors, establishing solid monitoring & evaluation and data collection systems, to truly bridge the gap between development and humanitarian work.

The final section of the report also includes a **list of good practices** with concrete examples from the field on how to implement these recommendations. This has been extracted from experts who participated in the dialogue as well as existing literature on the subject.

3. Key Recommendations

Three overarching priorities came out of the Virtual International Stakeholder Dialogue:

1) Preventing **Female Genital Mutilation** and providing care for survivors must be **urgently prioritised** within humanitarian and emergency settings;
2) **Funds** for such programmes must be **substantially scaled up** through both increasing development funding and the involvement of other donors and stakeholders within the humanitarian assistance;
3) The **development-humanitarian nexus** must be achieved through implementing **gender-transformative and sustainable programmes in emergencies** with the key involvement of women, girls and communities.

Furthermore, specific recommendations were provided around 10 key priorities:

1. Integrate Female Genital Mutilation in humanitarian programming

Recognise that FGM is among the forms of Gender-Based Violence (GBV) that increase during emergencies and need to be addressed with a multi-sectorial approach across all humanitarian clusters and throughout the humanitarian cycle. Scale up long-term and flexible investments on combating FGM and providing support for survivors in emergencies.

2. Prevent Female Genital Mutilation in humanitarian contexts

Prioritise and invest in gender-transformative programmes ensuring long-term sustainable behavioural change, as well as programmes guaranteeing women and girls' economic empowerment and education in fragile contexts. This should also include tackling poverty and economic hardships for all sectors of the population, in order to mitigate the risk of undergoing FGM. Use innovative means such as media campaigns and online tools, to amplify the voices of women and girls, as well as community leaders and champions.

3. Provide adequate care for Female Genital Mutilation survivors in humanitarian contexts

Ensure that FGM-related services are not de-prioritised within the service provision in the humanitarian response. Define a Package of care for FGM survivors including knowledge about FGM in Objectives 2, 4 and 6 of the Minimum Initial Service Package both in the lifesaving acute phase (particularly concerning de-infibulation during delivery) and in the restoration of comprehensive SRH and GBV services in the long-term.

4. Train humanitarian organisations and professionals on Female Genital Mutilation

Include FGM within systematic specialised training and capacity building for organisations on GBV and SRH, and provide it at different organisational levels. Ensure financial and human resources are made available for such training. Adopt clear organisational policies on Zero Tolerance against FGM, as well as practical protocols around it, and invest in their implementation.

5. Ensure women, girls and community-leadership in interventions to create resilience

Ensure interventions are community-based and community-owned, to increase resilience and empower field-based decision-making and initiatives, that are informed by women and girls' self-defined needs. Enable or strengthen safe spaces, community dialogues and support groups, as well as surveillance protection and referral community mechanisms. Support and fund the work of communities and community-led organisations during emergencies.

6. Connect with and support existing structures and stakeholders

Work in close collaboration with local actors, including women and girls-led organisations, and community health workers. Build the capacity of existing stakeholders, structures and services and work in close cooperation with local and national institutions, including Ministries. Create online platforms to map already existing and available services for FGM survivors. Governments and donors should facilitate and invest in such connections to ensure sustainability.

7. Ensure effective coordination among actors working on Female Genital Mutilation in humanitarian contexts

Conduct a stakeholder analysis to map all actors working on FGM in the field. Based on this, create an in-country multi-stakeholder coordination platform to share information, data and strategise interventions on FGM through periodic meetings and a continuous and open communication, including with the creation of a shared database centralising all data and information available on FGM in that context.

8. Monitoring & Evaluation (M&E) and accountability

Ensure integration of prevention and response to FGM, in projects' quality monitoring indicators and for M&E mechanisms to include a minimum number of indicators on FGM, for both acute and long-term phase of the crisis applicable to host and displaced populations. Donors should extend the reproductive health and GBV set of indicators, beyond immediate assistance to sexual violence survivors and life-saving interventions around deliveries.

9. Data collection

Invest in training and empowering community members to collect data at local level in emergency contexts and through adapted, new and innovative technology and tools, both online and offline, through mobile phone and remote surveys. Ensure that stakeholders who collect data within the humanitarian sector, do so on all forms of GBV, including FGM, to inform evidence-based targeted interventions. Governments should ensure relevant national information always includes disaggregated data on FGM.

10. Bridge the gap between development and humanitarian sectors

Invest in the establishment of multi-sectoral partnerships through both vertical and horizontal coordination between humanitarian and development actors, that encourage them to work more closely. Invest in the drafting of Transition Strategies and Preparedness Plans for development actors to be able to adapt to sudden emergencies and in Long-term Sustainability Plans for humanitarian actors, for more focus on impact in the long-term, resilience and local ownership.

4. Current State of Play

Impact of emergencies on FGM and organisations working on the practice

There is a general **lack of data and research around the impact of humanitarian and emergency situations on FGM**, which is a challenge. The current state of play has therefore been drawn, complementing the limited literature available on the subject with concrete experiences and challenges from the field. These were shared by experts during the International Virtual Stakeholders Dialogue. Key elements regarding the impact of humanitarian crises on FGM are outlined, particularly on the perpetration of the practice, access to services for FGM survivors and obstacles that development and humanitarian actors face when addressing this issue in crisis situations.

i. FACTORS[25]

Heightened risk of FGM and distruption of services for survivors

a. The insecurity of crisis situations reinforces some traditional harmful practices and other forms of GBV

In emergency contexts, the **general breakdown in law and order and in protective societal norms increases population vulnerability**, notably for women and girls. Social connections and networks are disrupted, economic hardship increases due to limited job opportunities and consequent loss of livelihood within crisis situations. Moreover, in conflict zones, men may be involved in fighting and therefore forced to leave their families behind, contributing to family separation. The lack of protection and stability resulting from fragile contexts often contributes to **enhanced violence against women and girls**. The rate of child early and forced marriage tends to increase in the wake of natural disasters, which may result in FGM

[25] This Section is based on the End FGM European Network (2018) FGM in a Humanitarian Context Briefing, complemented with existing literature and concrete examples shared with experts during the Virtual International Stakeholder Dialogue.

occuring at an earlier age, if social norms promote this for girls' marriageability[26]. In such tumultuous circumstances, parents or caregivers may be driven to subject their daughters to FGM, in order to increase their chances of marriage, so that they would be "protected" and provided for in wedlock[27]. Families may also see the bride price of adolescent girls as an economic relief for the family. Sometimes, this can take place to save the family "honour", particularly if a girl was a victim of rape during armed conflict.

challenge

CAMEROON: In Cameroon in September 2012, an internal Plan assessment and programme design report found that floods placed an economic strain on families. As a consequence, they were willing to marry their daughters off at an earlier age. One father from the community said, "If men come for our daughters, we would give"[28].

challenge

HORN OF AFRICA: During the 2011 drought in the Horn of Africa, the Office of United States Foreign Disaster reported that, over time, families married off daughters aged as young as nine years old, in order to pay their dowries in kind, before their livestock died[29].

challenge

YEMEN: During the conflict in Yemen, families were afraid that their daughters would be victims of human trafficking or enslaved, and therefore resorted to FGM and child marriage so that they could be safe and "protected" within a marriage[30].

In further case studies from Nigeria, girls and women are forced into prostitution, as the only means of income for families, and in preparation for this, are subjected to FGM[31].

On the other hand, **traditional cutters** may also experience instability and hardships during crisis situations, which can fuel their motivation to continue and even increase the practice for income generation.

challenge

SOMALIA: In Somalia during COVID-19, cutters have been taking initiative and going from house to house with the proposal to perform FGM at a discounted price to families, to overcome loss of income from other activities[32].

[26] Coalition for Adolescent Girls (2012), Missing the Emergency: Shifting the Paradigm for Relief to Adolescent Girls, p.5.
[27] Save the Children, Physical Violence and Other Harmful Practices in Humanitarian Situations, p.3.
[28] DFID (2013), Violence against Women and Girls in Humanitarian Emergencies - CHASE Briefing Paper, p. 4.
[29] DFID (2013), Violence against Women and Girls in Humanitarian Emergencies - CHASE Briefing Paper, p. 4.
[30] Independent Yemeni journalist and human rights activist during the online dialogue.
[31] 28 Too Many (2014), The impact of emergency situations on Female Genital Mutilation – Briefing Paper, p. 4.
[32] Ifrah Ahmed (founder of the Ifrah Foundation and Regional Programme Director of the Global Media Campaign in Somalia/Ethiopia) during online dialogue.

challenge

NIGERIA: Anecdotal reports from Nigeria suggest that former cutters may be returning to providing FGC services as a way of making money whilst more formal economic roles and opportunities are limited[33].

b. Distruption of education and protection systems in emergencies puts more girls at risk

Being enrolled in the education system is another form of prevention and protection for girls against FGM. Apart from the level of education being in some contexts linked with the abandonment of the harmful practice, in general the so-called 'cutting seasons' take advantage of prolonged periods of school closures, such as (in normal times) school holidays, in order for ceremonies to take place and to provide the necessary time for wounds from the cut to heal. It goes without saying that the abrupt disruption of the school system and the prolonged absence of girls from classrooms during humanitarian crises pose major challenges to FGM prevention, as it creates a big "window of opportunity" for cutters to perform the practice. School closures may give rise to earlier cutting seasons in some contexts.

[33] Orchid Project (2020), Impacts of COVID-19 on female genital cutting, p. 8.

challenge

KENYA: Almost 2,800 girls from the Kuria community in south-western Kenya have undergone FGM since late September, at the end of a COVID-related seven-month long school closure[34].

challenge

NIGERIA: In Abuja, Nigeria, local organisations have reported an increase in the number of girls being cut across South-West Nigeria as a result of school closures, whilst prevention and protection efforts are unavailable due to social distancing and travel restrictions[35].

Moreover, during emergencies, the disruption of protection systems extends to safe houses, refuges and shelters for girls at risk of FGM, without adequate alternatives being provided.

challenge

KENYA: In Kuria, Kenya, due to the closure of safe houses, Msichana Empowerment Kuria (a grassroots organisation working to end FGM) have been forced to rescue girls at risk of undergoing FGM, by providing improvised shelters in their office or in activists' homes. They have been in urgent need of the most basic items, such as mattresses for girls to be able to spend the night in the unequipped premises, or menstrual helath kits[36].

[34] Natalie Robi Tingo (Founder and Director of Msichana Empowerment Kuria) during the online dialogue.
[35] Orchid Project (2020), Impacts of COVID-19 on female genital cutting, p. 8.
[36] Natalie Robi Tingo (Founder and Director of Msichana Empowerment Kuria) during the online dialogue.

c. Population displacement changes dynamics around FGM

In a context of population movement, whether forced displacement in crisis situations or resettlement within the asylum system, some families opt to let their daughters undergo FGM by a 'trusted cutter' **before undertaking the journey,** regardless of the age of the girls. This is done either because it is perceived as a form of protection for them, particularly from sexual violence[37], regarding their honour, or because FGM is criminalised in their future country of resettlement. In some situations, FGM may be carried out on girls earlier than the the norm (in some cases families decide to let newborns undergo the practice), while in other circumstances, FGM could take place at a later stage in life, and even performed on adult women.

challenge

KENYA: During an exercise involving the resettlement of Somali Bantu refugees to the United States [...], many took to circumcising their daughters, some as young as one and a half, in the camps, once they were informed that this is a criminal offense in the country of resettlement[38].

On the other hand, through population displacement the practice of **FGM becomes known not only to the affected communities, but also to the populations they come in contact with.** Due to emergencies, there are examples where non-practicing communities have relocated to regions where FGM is common, and have also adopted the practice. Social pressures, the need to integrate into a new home community and to ensure their daughters are accepted as future brides play a key role in this phenomenon[39].

challenge

MALI: Plan International discovered in their work in Mali that the daughters of displaced families from the North (where FGM is not traditionally practiced), but who are living amongst host communities in the South (where FGM is common), were being ostracised due to not being circumcised. This, in turn, led to families from the North feeling pressure to perform FGM on their daughters[40].

challenge

EGYPT: Reports are now emerging of young Syrian refugee girls in Egypt having their genitals mutilated - a widespread practice among Egyptians - by Syrian parents. [...] "Syrian refugees started adapting the culture, [and] they started accepting things we are trying to abandon," Aleksandar Bodiroza, who heads the United Nations Population Fund, told reporters in Cairo. Zaid M. Yaish, who also works at the UN fund, said poverty and desire to marry off daughters are among the likely factors that contribute to the abuse[41].

[37] FGM Type III (infibulation) is particularly considered as a form of protection for girls from rape.

[38] Munala (Fall 2003), Combating FGM in Kenya's Refugee Camps.

[39] Save the Children (2016), Physical Violence and Other Harmful Practices in Humanitarian Situations, p.3.

[40] DFID (2013), Violence against Women and Girls in Humanitarian Emergencies - CHASE Briefing Paper, p.5.

[41] EU Observer (25 Sept. 2017), Syrians find troubled homes in Egypt by Nikolaj Nielsen.

Often the opposite is said to be true. As **displaced populations bring their traditions with them, they often modify the known geography of where to find the practice.** After population movement, FGM might be found in regions where it originally did not exist, and unknown to untrained actors on the phenomenon working there, including within the asylum system. Moreover, the phenomenon of so-called "cross-border FGM" is highly affected by the lack of coordination and decision making between States around this issue in emergency settings.

d. Shifting of community priorities in emergency situations

As more pressing issues and immediate needs kick in during crises (e.g. access to food, water, loss of income and threat to security), **short-term, urgent priorities and survival are what matter the most**, and the abandonment of FGM is not perceived as important. If practicing FGM on a daughter is regarded as an approach to improve the family situation during a period of instability, the short, medium and long term harm associated with FGM as a form of GBV may be considered proportional with the immediate perceived benefits, or at least de-prioritised[42].

e. Being a FGM survivor enhances negative consequences of other forms of GBV

Incidences of rape dramatically increase in crisis situations, where it is the most widespread form of GBV, and even used as a weapon of war during armed conflicts. **Rape can be particularly dangerous if a girl has been subjected to FGM**, because she will most likely suffer greater complications, injuries and health problems.

challenge

SUDAN: In refugee camps in Sudan, girls as young as ten were found pregnant as a result of rape, having undergone FGM as young children, almost dying in childbirth. There are obviously specific physical and psychological complications associated with pregnancy and childbirth in young girls, particularly for those who have undergone FGM. With occurrences of rape increasing during crisis situations, including the rape of young girls, there will be a corresponding increase in young mothers and childbirth complications associated with FGM[43].

[42] Participants in the Virtual International Stakeholder Dialogue stressed the need to find ways to discuss FGM with communities while at the same time addressing their key priorities

[43] 28 Too Many (2014), The impact of emergency situations on Female Genital Mutilation – Briefing Paper, p. 4.

f. Fragile contexts suffer lack of adequate support services

Limited resources and poor sanitary conditions increase the probability of infections, and specialised treatment for complications may be geographically (due to the disruption of infrastructures) and financially (due to loss of livelihood) hard to access for women and girls affected by FGM living in humanitarian settings. Furthermore, crises and emergencies make it more difficult for those existing services operating to continue their work fully functional.

challenge

MAURITANIA/SENEGAL: In many countries, including Mauritania and Senegal, the initial response to the COVID-19 pandemic has been strictly sanitary, led by the Ministry of Health and solely focused on tackling the pandemic-related health consequences. GBV was only integrated in the response at a second stage[44].

challenge

KENYA: In Kenya, there have been a number of emergency situations such as locusts invasion, drought, and some areas are experiencing flooding by rising lake waters such as Lake Baringo and Lake Bogoria, displacing populations, impacting livelihoods, and subsequently submerging hospitals and health centres. This makes it extremely hard for FGM survivors to receive adequate care[45].

challenge

SUDAN: Sudan has been declared an emergency zone for three months after floods affected all states of the country. Floods killed and displaced dozens of people from their homes and villages, destroying the infrastructure of main roads and public and private facilities, including schools, health institutions, markets and livelihoods. This, exacerbated by the preexisting weak health system and limited capacity for effective response due to COVID-19 pandemic, has resulted in many women and girls not having access to SRHR services. Moreover, displacement often brings women and girls to shelters with shared spaces where tensions and violence are intensified (both rape cases and unsafe sex).

Moreover, health professionals, including psychologists, are not necessarily trained on FGM in emergency contexts and are present in insufficient numbers. Psychosocial services and long-term support are lacking due to healthcare being redirected towards immediate and urgent needs within emergencies. As a consequence, there is a **lack of integrated and holistic care**, including mental health, since this is not recognised as life-saving.

[44] Expert during the online dialogue.
[45] Expert from Amref Health Africa during the online dialogue.

challenge

KENYA: As an example of stretched services, when *28 Too Many* visited the Dadaab refugee camp on the Kenya – Somali border in 2011, there were 3 trained psychologists to provide support to over 250,000 Somali refugees amongst whom there is a very high prevalence of FGM"[46].

challenge

ETHIOPIA: Prof. Claude Emile Tourné published an article in the "Les Dossiers de l'Obstétrique" journal and highlighted that the Afar region, a zone severely hit by internal political conflicts in the North-East of Ethiopia, suffered from high rates of maternal mortality. This was largely due to the lack of resources (including limited access to hospitals) and trained staff. For example, there were two gyneacologists on the territory of the Afar Regional State, one in Doubte Hospital and the other in a health centre without a border town, inaccessible to the Afars. In one week, he recorded that nine women with Type III FGM died, as a result of fatal childbirth complications which doctors were not able to treat[47].

ii. CHALLENGES

FGM prevention work and provision of care for survivors in humanitarian settings

a. Crises and prolonged crisis situations undermine work towards FGM abadonment

Preventing FGM is more complex in a humanitarian context, and progress is harder to track when operating in an emergency context, with institutional and social disruption, poverty and food scarcity, and where populations are often internally displaced or on the move towards safer settings, including in other countries[48]. Crises reinforce the general challenges faced by stakeholders working in the field of FGM prevention, including reduction or lack of funding which are redirected to more pressing emergency issues, as well as the overall de-prioritisation of FGM by national governments and local authorities. Moreover, difficulties in communicating and reaching out to communities and direct contact with people in humanitarian crises to establish the state of needs is one of the major problems and affects the possibility of FGM prevention work. Communication with actors in the field also becomes slower and more complicated if people are on the move or in dangerous areas. Difficulties in accessing

[46] 28 Too Many (2014), The impact of emergency situations on Female Genital Mutilation – Briefing Paper, p. 4.
[47] Expert during the online dialogue.

[48] This exacerbates the phenomenon of "cross-border FGM" connected to population movements and resulting from many different factors, including (in stable contexts) knowledge of less strict (or non-existing) laws in neighboring countries around FGM.

the internet in rural and remote communities also pose problems concerning reachability and activity implementation.

Moreover, prolonged crisis situations undermine the possibility of establishing multi-year planning and budgeting, since the immediate needs of the population are the utmost priority and structures are very often not in place. This results in **extremely slow progress for the abandonment of FGM in fragile countries suffering from protracted crisis situations**. For instance, Somalia has the record for the highest FGM prevalence in the world since 1993 and unfortunately the practice has not substantially decreased since then, if compared to the pace of FGM abandonment in more stable countries[49].

b. Development actors are not equipped to work in emergency contexts and humanitarian actors do not work on the long-term

At the onset of a crisis in an otherwise stable country, **stakeholders working on development and cooperation towards the abandonment of FGM, often do not have the means or capacity to work in such fragile contexts**, which requires alternative planning, response and implementation of interventions. This has been highlighted by the disruption of interventions to prevent FGM, caused worldwide by the COVID-19 pandemic, which, as previously mentioned, will potentially cause a further two million cases of FGM[50]. On the other hand, **humanitarian actors**, who enter into play towards the start of an emergency, **often deal mostly with the mitigation of immediate and short-term consequences of the crisis**, and mainly fail to look at the long-term services needed or at the possible transformative impact of their actions in a sustainable way. There is a **lack of cooperation** between the development and the humanitarian sectors, which causes the disruption of interventions focused on preventing and responding to FGM.

challenge

In a crisis situation, the focus of GBV interventions shifts from being gender-transformative to being gender-responsive. We need to explore ways of keeping both approaches in humanitarian settings[51].

challenge

BURKINA FASO: In Burkina Faso, an organisation working on FGM prevention has noticed a resurgence of all types of gender-based violence during the pandemic. They continued with awareness-raising through door-to-door visits during the COVID-19 pandemic, taking necessary caution. However, because of heavy rainfall this year the preventive work was disrupted[52].

[49] 28 Too Many (2014), The impact of emergency situations on Female Genital Mutilation – Briefing Paper.

[50] UNFPA-UNICEF Joint Programme on FGM (2020), COVID-19 Disrupting SDG 5.3: Eliminating Female Genital Mutilation.

[51] Expert from UNFPA during the online dialogue

[52] Expert during the online dialogue.

c. Lack of humanitarian actors, governments and donors' awareness around the crucial importance of preventing FGM and providing care for survivors in humanitarian settings

There is a general **lack of recognition**, by humanitarian actors, governments and donors, **of FGM as one of the forms of GBV which is exacerbated in emergency contexts**, because of the failure to link it to the *continuum* of violence against women and girls. Regarding FGM as only a centuries-long traditional harmful practice, deeply rooted in culture and gender social norms, fails to capture the peculiarity of a humanitarian context and its influence in exacerbating this practice. Loss of livelihood, increased poverty rates, forced displacement and overall generalised insecurity are all factors that can push families to resort to FGM, to a wider extent than during stable periods. This is generally not perceived by humanitarian actors, governments and donors.

Furthermore, humanitarian actors and donors do not always consider their impact in the long term, but mainly carry out and invest in emergency and time-bound actions, with the main goal of addressing the contingency situation and ensuring immediate mitigation of threatening elements.

challenge

INDONESIA: FGM is unfortunately generally not regarded as a serious problem by government because they think is not a harmful practice. Even less in crisis settings (such as during COVID-19, conflict situations, or natural disasters), FGM is not prioritised by the government. This results in a reluctance at governmental level to recognise the exacerbation of FGM in emergency situations and to properly address it within the overall crisis response. The Indonesian government rather focuses on more immediate issues such as access to clean water, housing, food, education, and health[53].

Moreover, there is a generalised **lack of acknowledgement and connection between the physical and mental health consequences of FGM and other SRH complications**, making it more difficult to see the relevance of interventions that can integrate FGM within SRH service provision in emergency contexts, beyond the Minimum Initial Service Package (MISP) for reproductive health and within a more comprehensive SRH planning. Furthermore, the general focus on emergency life-saving interventions results in SRH indicators of outcome that fail to include holistic care, but to a greater degree at reducing maternal mortality and sexually transmitted diseases.

Finally, as mentioned, **donors who provide funding on FGM are mainly development and cooperation actors** and therefore the

[53] Expert from Kalyanamitra, Indonesia, during online dialogue.

impact wanted and **indicators** imposed to beneficiaries **might not be adapted to the disruption typical of emergency contexts.** On the other hand, as shown, **humanitarian donors do not consider responding to FGM as a priority and something to invest in within crises**, and advocating for its inclusion in an already underfunded sector of humanitarian aid is extremely challenging. According to the International Rescue Committee, in recent years only 0.12% of global humanitarian funding went to essential GBV services[54]. Moreover, during the COVID-19 pandemic, donors have shifted attention to focus mainly on pandemic-related programming, causing an even bigger reduction of funding towards work on the elimination of FGM and the support for survivors.

challenge

YEMEN: has been one of the worst humanitarian crises in the world for the last ten years. Although child marriage and FGM are a social norm in the country, human rights and women's rights specifically are considered a secondary priority by governments and donors, directing all resources to the crisis response. Since there are no recent data on FGM (last dating 2013), women's rights organisations have had to reorient their activities to the humanitarian sector, as their thematic areas are not funded[55].

[54] IRC (2019) 'Where is the money? How the humanitarian system is failing in its commitments to end violence against women and girls'.

[55] Saoussen Ben Cheikh, Internews, during the online dialogue.

d. Preventing and responding to FGM is not part of the humanitarian aid cycle preparedness and response planning and interventions concerning GBV, health promotion and sexual and reproductive health (SRH)

Long-term processes of behavioural change and awareness raising, as well as long-term provision of care, are not perceived as a competence of humanitarian actors, who mainly focus on responding to the immediate needs of the population hit by the crisis through a rapid and time-bound response.

For these reasons, in the humanitarian context, the work on GBV done within the Protection Cluster is mainly focused on preventing and responding to sexual violence (which dramatically increases in emergency settings, along with other forms of GBV). The Inter-Agency Standing Committee Guidelines on integrating GBV interventions in Humanitarian Action (which is the main source of guidance for humanitarian actors on this field) does not officially consider FGM as occurring in the acute phase of the crisis, but advises to take it into consideration in the more stabilised phases and during rehabilitation and recovery[56]. It has been noted also that the overall Child Protection response in humanitarian settings rarely focuses on physical violence and other harmful practices[57].

[56] Inter-Agency Standing Committee (2015) Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action: Reducing risk, promoting resilience and aiding recovery, p.1.

[57] Save the Children, Physical Violence and Other Harmful Practices in Humanitarian Situations, p.5.

Young people and particularly adolescent girls continue to be a neglected group in humanitarian settings, and when sexual and reproductive health (SRH) interventions do target them, FGM is not considered a priority[58]. Such interventions mainly seek to prevent and respond to potentially life-threatening phenomena, such as sexually transmissible diseases, teenage pregnancy or maternal and child morbidity and mortality, and FGM is therefore "not seen" as an issue[59]. The only times FGM might be recognised are cases of Type III, due to its complications during labour and childbirth and its severe physical consequences. FGM is also not addressed within health promotion, which focuses more on maternal health related priorities, HIV and domestic violence.

As a consequence, humanitarian professionals are not aware nor trained on FGM and therefore mostly unable to work in a sensitive, non-stigmatising and respectful way when they encounter survivors.

[58] Jennings et Al. (2019), A forgotten group during humanitarian crises: a systematic review of sexual and reproductive health interventions for young people including adolescents in humanitarian settings, Conflict and Health volume 13, Article number: 57.

[59] Expert from Médecins Sans Frontières during the online dialogue.

e. The humanitarian programming within the Health Cluster is not designed to recognise and detect FGM survivors

Healthcare services in humanitarian settings are focused on "**essential services**" only, including saving lives and treating severe health complications. SRH services are mainly centred on delivery and quality obstetric care, to lower the rates of maternal and newborn mortality and address immediate emergency obstetrical/delivery complications that may occur. The focus is fundamentally on the management of the immediate health conditions of the patients rather than taking a step back and looking at the bigger picture, including what might have caused them, such as FGM. In summary, the humanitarian programming within the Health Cluster is not designed to recognise and detect FGM survivors. It is considered an issue that is too complex to tackle in emergencies and too long-term, therefore deprioritised from the immediate interventions.

challenge

Given this emergency focus, staff from Médecins Sans Frontières are mainly able to identify FGM Type III, which results in severe complications during labour and delivery (such as in missions in Somalia and Sudan), while Type I and II mostly go undetected as they generally do not result in physical complications during childbirth (for instance in Sierra Leone or Yemen)[60].

[60] Expert from Médecins Sans Frontières during the online dialogue.

Moreover, during global pandemics such as COVID-19, there has been a **massive diversion of medical services and resources** towards direct COVID-19 response, at the expense of GBV and SRH services. Valid concerns are unfortunately greatly neglected, such as FGM increasing women and girls' vulnerability and placing them at heightened risk of suffering from numerous health issues. In general, during pandemics, hospitals and health centres may be over-run, undermining the care available for survivors of FGM who may also face urgent health problems.

challenge

SENEGAL: In Casamance, in Senegal, during the COVID-19 pandemic an infibulated girl had an infection and could not receive urgent care because hospitals were saturated[61].

f. Lack of FGM training for humanitarian staff and violations of the medical principle of "do-no-harm"

In the **absence of specific training on FGM**, health professionals in humanitarian contexts may be unable to provide the best possible care to survivors of FGM approaching health facilities to deliver. There is also a general lack of understanding of the connections between FGM and other health complications which brings about the **medical invisibilisation of the phenomenon**. This is a crucial issue for national healthcare staff working within humanitarian health facilities[62]. In the absence of adequate training and awareness raising on FGM, local staff may be caught between their medical profession and the gender social norms pertaining to their culture, and fail to associate the practice of FGM with serious physical complications during labour and delivery, and possibly even continue perpetrate the practice within healthcare facilities.

For instance, in cases of survivors with FGM Type III, the lack of healthcare professionals' awareness around FGM can lead to doctors re-infibulating women after childbirth, upon their request, thus going against the **medical ethical principle of do-no-harm**. Evidently, this is linked to the lack of awareness around the issue of FGM, as a harmful practice deeply rooted in gender inequality, and of the social and community pressures surrounding it. It is also connected to the absence of engagement with families, local communities and society in the medium and long-term, and lastly the possibility of healthcare staff belonging to affected communities and so raised within the same gender social norms.

[61] Fatou Diatta Alias Sister Fa, artist, anti-FGM activist and End FGM European Network Ambassador, during the online dialogue.

[62] Example brought by an expert from Médecins Sans Frontières to the online dialogue.

challenge

Even in the presence of a Zero Tolerance policy, an internal survey from Médecins Sans Frontières identified that in two out of three projects where women with Type III FGM are presenting complications during delivery, the majority of them leave the facilities re-infibulated after giving birth[63].

A major problem for anti-FGM organisations working in certain contexts includes, contrary to international law, a number of countries yet to adopt legislation criminalising the practice. This lack of legal framework can provide an enabling environment for communities to continue practicing FGM and resist engagement with organisations and activists tackling the issue.

challenge

Countries such as Indonesia, Liberia, Mali, Sierra Leone and Somalia are yet to adopt legislation against Female Genital Mutilation. In practice, this may present challenges for actors working in these countries to apply Zero-Tolerance policies and protocols if their efforts are not supported by local law. Communities could also use lack of anti-FGM legislation to justify and continue the harmful practice. In countries where the medicalisation of FGM is not illegal, healthcare workers may continue to carry out FGM, regardless of the emergency context[64].

[63] Expert from Médecins Sans Frontières during the online dialogue.
[64] Expert during the online dialogue.

g. Humanitarian disconnection with local stakeholders in the long-term

Humanitarian response is planned and delivered as a **time-bound and temporary intervention**, therefore it often fails to connect with local actors, stakeholders and communities to ensure sustainability and ownership by the local population. The arrival of humanitarian actors on the onset of a crisis, and the departure once the emergency is over, results in general detachment of the humanitarian sector from the local structures and population. In some of the most fragile contexts, humanitarian work can be done from a distance through "remote management", which clearly widens this gap.

challenge

SOMALIA: Médecins Sans Frontières manages its Somali mission from Kenya, with very few visits due to the security situation (including kidnapping of staff). In this condition, it is really difficult to supervise the job of the midwives in the delivery room and to ensure the implementation of the organisational policy of non-reinfibulation[65].

As such, local ownership of interventions as well as their sustainability beyond the crisis period are undermined. This is particularly true for prevention of FGM, which in the humanitarian context is almost completely overlooked. In terms of providing care for FGM survivors, this implies that only the most

[65] Expert from Médecins Sans Frontières during the online dialogue.

immediate and urgent needs are managed, while the rest are neglected. As a result, professionals treating FGM survivors may not be aware of the gender social norm underlying the phenomenon and thus insensitive towards them, due to not understanding the social pressure and dynamics surrounding the practice. Moreover, short-term assignments and high staff turnover do not guarantee continuity of approaches or a strong connection with the local population. Finally, this results in a lack of stakeholder analysis which could help with mapping key figures to ensure ownership and sustainability.

h. Data collection around FGM in humanitarian settings

Governmental health information systems do not include FGM within their indicators in humanitarian settings, which results in very **little data collected around the phenomenon**. Moreover, institutional, societal and service disruption during emergencies, in conjunction with population displacement, maintains adequate data collection as extremely challenging in humanitarian contexts, including the tracking of FGM survivors and ensuring a proper follow-up. This is all the more true when talking about GBV, due to the fact that during crisis there is a lack of reporting mechanisms (hotlines and helplines), particularly concerning FGM. Beyond the existing objective difficulties, as previously mentioned, within all forms of GBV, FGM is hugely de-prioritised during emergencies, and this is also reflected in data collection, which humanitarian actors do not undertake systematically on this issue. For instance, the **GBV working group in the Protection cluster only collects data on sexual violence**[66]. Furthermore, even when data is collected, it is usually inaccessible to donors, governments and humanitarian actors, and cannot therefore inform a proper needs assessment analysis, to shape tailored interventions and monitor impact.

[66] Inter-Agency Standing Committee (2015) Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action: Reducing risk, promoting resilience and aiding recovery.

5. Recommendations

The Virtual International Stakeholders Dialogue produced key recommendations, which provide a **comprehensive overview of what is concretely needed from different stakeholders to address FGM within humanitarian settings** and ensure we do not lose sight of the millions of women and girls living in fragile contexts. Some of the recommendations are backed with a series of existing good practices, which should be further explored, scaled up and invested in.

Three overarching priorities came out of the online dialogue:

1) Preventing Female Genital Mutilation and providing care for survivors must be **urgently prioritised** within humanitarian and emergencies settings.
2) **Funds** for such programmes **must be substantially scaled up** through both increasing development funding and the involvement of other donors and stakeholders within the humanitarian assistance.
3) The development-humanitarian nexus must be achieved through implementing **gender-transformative and sustainable** programmes in emergencies through the key involvement of women, girls and communities.

Furthermore, specific recommendations were provided around 10 key priorities:

1. Integrate Female Genital Mutilation in humanitarian programming

a. To humanitarian actors:

- Recognise that **all forms of GBV, including FGM, should be considered and addressed in emergencies**, not only conflict-related SGBV (particularly directed to the Inter-Agency Working Group on Reproductive Health in Crises – Sub-Working Group on GBV) and to the Call to Action on Protection from Gender-Based Violence in Emergencies[67];
- **Expand the programming of mainstream SGBV** projects, to integrate FGM prevention and response projects alongside specific and tailored indicators and objectives around FGM;

[67] This is a multi-stakeholder initiative supported by governments, international organisations and NGOs to transform the way GBV is addressed in humanitarian action.

- **Integrate FGM risk mitigation and response across all humanitarian clusters** including Health, WASH, Education, Protection (both GBV and Child Protection areas of responsibility), and Food Security[68] and in all humanitarian cycle phases (Preparedness, Needs Assessment, Strategic Response Planning, Response Implementation & Monitoring, Resource Mobilisation, Resilience);
- **Establish a multi-sectorial and coordinated prevention and response intervention around FGM, which is also linked to structures within the government** (Strategic Response Planning): the immediate response to and prevention of FGM in humanitarian settings should be led by the clusters of Protection and Health. This can be achieved through case management and referrals (Protection), and the provision of primary healthcare (Health) with referral pathway mechanisms for more specific healthcare, mental health and psychosocial support for survivors. These paths should be implemented alongside strengthening community-based GBV protection and support mechanisms;
- **Create Task Forces** to develop a grid of methodology-based research and data jointly collected in order to develop contextualised responses;
- **Systematically include FGM in all IASC[69] and other humanitarian actors'[70] guidelines on GBV and SRH in humanitarian response**, including its causes, consequences and concrete information on interventions to prevent FGM and provide adequate care for survivors.

b. To donors and governments:

- Recognise Female Genital Mutilation as a humanitarian issue and **scale up long-term and flexible investments on combating FGM and providing support for survivors in emergencies;**
- Support pilot projects and implement specific calls for proposals on integrating FGM prevention and response in humanitarian programming on SGBV and SRH, including by enabling women and girl-led as well as (small) community-led organisations to apply for such funding;
- Include strict Monitoring & Evaluation instruments, to allow for ongoing assessment around FGM prevention and response programming;

[68] Mentioned also in UNFPA-UNICEF Joint Programme on FGM Technical note on COVID-19 Disrupting SDG 5.3: Eliminating Female Genital Mutilation (2020).
[69] For instance, the Inter-Agency Standing Committee (2020), Identifying & Mitigating Gender-based Violence Risks within the COVID-19 Response, does not mention FGM.
[70] For instance, the International Planned Parenthood Federation (IPPF) Sexual and Gender Based Violence in Humanitarian action - Prevention and response to SGBV in humanitarian settings, does not mention FGM.

- Ensure government commitment and leadership in the response to end FGM, including within humanitarian crises, by ensuring responsibility around the issue at institutional level and its integration in relevant emergency interventions.

Good practice from the field

The IPPF SPRINT (Sexual and reproductive health in crisis and post-crisis situations) Initiative provides access to essential life-saving sexual and reproductive health services, in crisis and post-crisis situations. The initiative seeks to ensure SRH is integrated into the humanitarian agenda, by addressing the gaps in the implementation of the MISP, building the capacity of humanitarian workers to deliver such services and increasing access to SRHR information and services in humanitarian settings. It would be important to apply the same method to also integrate FGM into the humanitarian agenda.

Good practice from the field

ETHIOPIA: CARE Ethiopia has integrated FGM into its comprehensive GBV humanitarian and emergency response, through annual preparedness plans[71].

Good practice from the field

KENYA: Amref Health Africa in Kenya has integrated FGM into its broader development programs, to ensure FGM is addressed in all possible areas. In Kenya, Amref has implemented ARP-WASH projects and also integrated FGM into Reproductive Maternal Neonatal and Child Adolescent Health (RMNCAH) and SRH programs while taking into consideration community needs and priorities[72].

Good practice from the field

In 2020, Orchid Project joined the Global Resilience Fund initiative, which is a partnership between social justice funders committed to resourcing girls' and young women's activism through the COVID-19 crisis, by providing flexible emergency funding to girls and women-led grassroots organisations to limit the impact that the pandemic might have on them[73]

[71] Expert from CARE Ethiopia during the online dialogue.
[72] Expert from Amref Health Africa during the online dialogue
[73] Expert from Orchid Project during the online dialogue.

2. Prevent Female Genital Mutilation in humanitarian contexts

a. To humanitarian and development actors:

- **Implement gender-transformative programmes** for both host and displaced populations, to ensure long-term sustainable behavioural change surrounding harmful practices, including FGM, through tackling the root causes of gender inequality underpinning them;
- Design programmes guaranteeing **women and girls' economic empowerment and education in fragile contexts** and **tackling poverty and economic hardships for all sectors of the population** (both host and displaced), including families and cutters, to mitigate the risk of women and girls undergoing FGM because of loss of livelihood in emergencies. Within the humanitarian cluster system, make sure this is integrated specifically within the WASH, Education and Food Security Clusters in the humanitarian system;
- Ensure FGM is addressed during **health promotion** activities and while distributing dignity-kits[74] to women and girls in emergency contexts.

b. To development actors:

- Continue FGM prevention programmes in humanitarian settings, and **monitor behavioural change** throughout this time, whilst taking advantage of the opportunity that emergencies might bring in terms of potential changes in social structure and power dynamics[75];
- **Work with both host and displaced community champions**, leaders (both religious and traditional) and influencers, by amplifying their voices through **online campaigning and media channels** (social media, tv programmes, soap operas, radio) and empower young people to be agents of change;
- Use Social and Behavioural Change Communications tools or Communication for Development to overcome difficulties in reaching out to communities and train journalists and activists to integrate the issue of FGM into coverage of GBV.

[74] Dignity kits contain hygiene, sanitary and other items explicitly tailored towards the needs of women and girls of reproductive age.

[75] For instance, Eritrea went through 30 years of war and prolonged conflict. That is when the first project of FGM started. The women participated in the armed struggle, left their traditional domestic role, took the arms and fought side by side with the men. Female fighters would go and stay in different villages during the fight and before going to the next battle they would gather and talk among them about FGM.

c. To governments and donors:

Consider FGM prevention as an ongoing priority within emergency situations. Prioritise and invest in actions towards this goal that are sustainable, gender-transformative, and have a long term focus. Use emergency context as a hook for sustainable abandonment of FGM, for instance during pandemics. Learn lessons from Ebola and the "temporary FGM bans" which had no sustainable impact[76], and ensure that every sensitisation intervention around FGM during the pandemic includes both a short-term goal and messaging (avoiding the spreading of the infection) and a long-term sustainability (looking at the root causes and working on deeply unequal gender structures).

Good practice from the field

SOMALIA/SUDAN: Piloted in Somalia and Sudan, UNICEF developed the 'Communities Care: Transforming Lives and Preventing Violence programme', in response to the need to increase access to quality care and support services for sexual violence survivors. It also aims to develop and test effective strategies to prevent VAWG in conflict-affected settings. Through a community-based model (via 'facilitated dialogue'), the programme presents an opportunity for positive change in social norms that can contribute to gender equality and decrease gender-based violence (GBV) and discrimination.

Good practice from the field

The Global Media Campaign (GMC) trains religious leaders, activists and journalists, on how to use media to end FGM and supports them to broadcast to their own communities directly, in their own language, using their own words and amplify messages to end FGM. GMC carried out a survey which revealed more than 1 in 4 people who heard religious leaders denounce FGM, said that they would stop cutting their children. Similarly, as asylum seekers in refugee camps often gather in common areas to listen to their national radio stations, this presents a key opportunity to broadcast messages against FGM in humanitarian settings, right before broadcastings when more people are listening, by buying airtime[77].

[76] Due to a temporary ban on FGM put by the government to contain the spreading of Ebola in Sierra Leone, during the crisis FGM was interrupted. However, it resumed right after the end of the epidemic, without any impact on its long term abandonment. See also UNICEF (2020), Technical Note on COVID-19 and harmful practices.
[77] Maggie O'Kane, Executive Director of the Global Media Campaign to end FGM, during the online dialogue.

Good practice from the field

BURKINA FASO: In regions of Burkina Faso where armed groups are in command, it is sometimes very difficult to address FGM because the groups do not allow discussions on these types of issues (FGM, child marriage). Community-based organisations find creative ways to work around this by inviting them to group discussions on themes such as "peace and social cohesion".[78]

Good practice from the field

MALI: During the COVID-19 pandemic, a Malian community-based organisation developed posters combining messaging on Covid-19 prevention with FGM awareness-raising[79].

Good practice from the field

IRAQ: Supported by WADI (Association for Crisis Assistance and Development Cooperation), the independent community Iraqi Kurdish radio, Radio Denge NWE, broadcasts daily for 11 hours on the radio FM 88.6 MHz in Halabja governorate, Sharazoor, Hawraman and Arbat. The morning programs are broadcasted in Kurmanji dialect and in Arabic, and deal with hot topics on local society, focusing especially on refugees and internally displaced people, but also other health, social or cultural issues. The programme includes daily coverage of youth and women's issues, as well as daily awareness on FGM, women's rights, and more.

Good practice from the field

BELGIUM: During the COVID-19 pandemic GAMS Belgium, provided information about the pandemic to the migrant communities they work with, in African languages spoken by the communities. The organisation provided assistance, support and translation services to FGM survivors using online communication tools. Not only did this strengthen COVID-19 prevention and enhance well-being of vulnerable migrant communities, but it also ensured that the relationship with communities was maintained and that previous FGM prevention work was not lost when face-to-face activities had to be discontinued[80].

[78] Brigitte YAMEOGO, Mwangaza Action Program Officer, during the online dialogue.
[79] CoP FGM (2020), Tools and resources developed and shared by the members.
[80] Expert from GAMS Belgium during the online dialogue.

Good practice from the field

SPAIN: Within their humanitarian operations, Médicos del Mundo (MdM) incorporates comprehensive preventive interventions which guarantee coordination between the different areas that play a key role in the early detection of risk situations. MdM FGM projects are usually performed with agents of change or mediators, such as activist against FGM from the specific areas or women's associations with the same cultural/ethnical background as the communities. Their prevention activities include educational interventions with women and men, workshops with women and adolescents' groups, etc[81].

Good practice from the field

REPUBLIC OF GUINEA: During the COVID-19 pandemic the association ASD, in the framework of a project coordinated by AIDOS, and supported by the UNFPA-UNICEF Joint Programme on FGM, mainstreamed messages to promote the abandonment of FGM into consumables distributed to the population such as hand sanitisers. Consumables were distributed in the occasion of a series of sensitisations activities on FGM where participants were informed on COVID-19 prevention measures and sensitised on possible linkages between COVID-19 and FGM. Particular attention was given to girls who stayed at home from school due to the pandemic and at risk to being subject to FGM. 80% of the targeted population declared that they hadn't received any other prevention material or information about COVID-19 before[82].

3. Provide adequate care for Female Genital Mutilation survivors in humanitarian contexts

a. To humanitarian and development actors:

- Increase remote access to mental health, psychosocial, and legal support for survivors;
- Systematically **integrate community health workers and interpreters in the healthcare system**. Structures and service delivery for survivors should also be supported, in order to ensure cultural appropriateness, to enable proper referral systems, delivery of clear information and gathering of consent.

[81] Expert from Médicos del Mundo during the online dialogue.
[82] Expert from AIDOS during the online dialogue.

b. To humanitarian actors:

- **Ensure that FGM-related services**, within GBV and SRH areas of intervention, **are not de-prioritised and neglected within service provision in the humanitarian response**, to leave room for more urgent life-saving services;
- **Define a Package of care for FGM survivors in humanitarian contexts** throughout women and girls' lives, which is not limited to only delivery or the serious physical complication caused by FGM. This package should:
  - Address FGM as one of the forms of GBV which increases during emergencies, when training professionals around the MISP (Minimum Initial Service Package) for sexual and reproductive health;
  - Include knowledge about FGM and other forms of GBV within the second objective of the MISP ("Preventing sexual violence and respond to the needs of survivors"), as well as knowledge and concrete guidelines on de-infibulation in Objective 4 of the MISP ("Preventing excess maternal and newborn morbidity and mortality"), since this can be lifesaving during complicated deliveries (particularly in contexts where Type III FGM is practiced);
  - Integrating FGM into the restoration of comprehensive SRH and GBV services following the acute phase of the crisis within Objective 6 of the MISP ("Plan for comprehensive SRH services, integrated into primary health care as soon as possible. Work with the health sector/cluster partners to address the six health system building blocks"), including ensuring long-term psychosexual support.

c. To governments and donors:

- **Scale up investments and increase political prioritisation to ensure FGM is not de-prioritised within the provision of GBV and SRH services in emergency contexts;**
- Make sure the health system, including through the support of the Ministry of Health, continues to provide adequate and comprehensive support for survivors of FGM, in the short- medium- and long-term.

Good practice from the field

SIERRA LEONE: Case studies[83] have indicated that community health workers (CHWs) have proven to be effective in countries, such as Sierra Leone during the Ebola outbreak. CHWs can support in ensuring sufficient response by developing and applying emergency preparedness plans at the community level as well as improving its crisis response. As members of the community, this allows for greater levels of trust among community members and ensures resilience. Alongside many more reasons, CHWs are in better positions to use local networks to obtain information and engage influential community members as well as to strengthen the health system and referral to services in emergency contexts.

Good practice from the field

SUDAN: During the flooding, the Sudan Family Planning Association (SFPA) was part of the humanitarian response coordination mechanism body at federal level and member of emergency committee at states level. Their work focused on ensuring the displaced population's had access to basic and life-saving health services, through supporting health facilities with providing medical supplies, mobile clinics and mobile team for hard-to-reach areas; Community services through community based distribution and community mobilisers; Sanitation and hygiene promotion, Water sanitation (chlorination); Awareness raising through Information Education and Communication materials, TV and Radio shows, home visits, as well as community dialogues on HIV and Sexually Transmitted Illnesses, GBV including FGM, Family Planning, WASH etc[84].

4. Train humanitarian organisations and professionals on Female Genital Mutilation

a. To humanitarian actors:

- Ensure **systematic specialised training and capacity building for organisations and professionals on FGM as part of GBV and SRH training**, and particularly encourage the use of the following existing tools, among others:

[83] See for instance UNICEF, Save the Children, International Rescue Committee (2020), Policy Brief - Community Health Workers in Humanitarian Settings.
[84] Expert from International Planned Parenthood Federation - Arab World Region, during the online dialogue.

- *Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings*, 2018[85]:
- Inter-Agency Standing Committee (2015), *Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action - Reducing risk, promoting resilience and aiding recovery;*
- *User Guide and Pocket Guide on How to support a survivor of gender-based violence when there is no GBV actor in your area*[86];
- *The Women Protection and Empowerment Podcast*[87], specifically focus on supporting GBV risk mitigation and case management in humanitarian settings;

- Ensure professionals and organisations can access remote training and Virtual Capacity Development tools;
- Ensure FGM training is provided at different organisational levels, including management, adapting its content to the specific roles, so that not only the SRH staff are aware;
- **Adopt clear organisational policies on Zero Tolerance against FGM,** including non-reinfibulation, along with practical protocols on how to provide appropriate care for FGM survivors in emergencies and disseminate them adequately among the staff (particularly new staff being deployed to the field location), including by raising awareness on the need for implementation.

b. To governments and donors:

- Support and invest financial and human resources in training humanitarian staff on FGM.

Good practice from the field

ITALY: AIDOS trains professionals working in the reception system for refugees and asylum seekers to prevent and respond to different forms of gender-based violence, including FGM. The training focuses on understanding the root causes of FGM and adopting a cultural sensitive approach to address the issue. At the beginning of the trainings, the majority of professionals affirm that they don't think the women they work with are affected by FGM, while the opposite is true[88].

[85] Chapter 10 of the Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings (IAFM) is dedicated to GBV, and specifically addresses the impacts of FGM on SRH, including on mental health. Concrete recommendations on SRH response, maternal and newborn health, deinfibulation and contraception are provided for health professionals.
[86] The GBV Guidelines, User Guide and Pocket Guide on How to support a survivor of gender-based violence when there is no GBV actor in your area.
[87] The Women's Protection and Empowerment Podcast, mentioned in the UNFPA-UNICEF (2020) COVID-19 Disrupting SDG 5.3: Eliminating female genital mutilation.
[88] Expert from AIDOS during the online dialogue.

Good practice from the field

SUDAN: Since 1999, MSF have strongly opposed the practice of any form of FGM. In 2006 MSF declared a Zero-Tolerance Policy in Tagadom hospital (Port-Sudan) on re-infibulation and has started a reproductive health project with a specific focus on FGM since 2007. In Tagadom Hospital, health promotion to communities also started to spread more awareness on the practices and complications of FGM. Sensitisation on FGM complications is done inside and outside Tagadom hospital and well accepted by the population, particularly female. In September 2019, zero-tolerance for FGM, including non-reinfibulation, was incorporated into MSF Policy for Reproductive Health and Sexual Violence Care. The Policy states among other obligations, that "teams should spend time explaining the rationale for MSF's position of not re-infibulating to health staff and the local population"[89].

5. Ensure women, girls and community-leadership in interventions to create resilience

a. To humanitarian and development actors:

- **Ensure that interventions are community-based and community-owned** (with the participation from both displaced population and host communities) to increase community resilience and empower field-based decision-making and interventions. Ensure to work with and listen to people affected by the crisis, local NGOs, national and local authorities;
- Ensure approaches are informed by **girls' and women's self-defined needs** and include them in decision-making and programming;
- Include in projects: **safe spaces** (after checking if such structures already exist) for women and girls (aiming at protection, support, building resilience), **community dialogues, support groups** for survivors of FGM (which could be facilitated by a trained professional), as well as referral systems to responsible agencies, combined with training of local actors;
- Improve prevention of FGM and case management through ensuring access to vulnerable girls and women, especially in hard-to-reach areas, by **strengthening or establishing**

[89] However, in Tagadom hospital as of 2010, 1 out of 5 staff (17%) was not aware of the Zero Tolerance policy, an increasing percentage compared to three years before (when the FGM project started), where virtually no one (1,8%) was unaware of the policy.

community surveillance, protection and referral mechanisms, based on the model of the 'rescue brigades'[90] or through social media platforms as well as through strengthening communities' connection with existing national hotlines.

b. To governments and donors:

- **Support and fund the work of communities and community-led organisations during emergencies**, and fully integrate this into broader programming to ensure meaningful community engagement;
- Facilitate and support informal spaces at community level and utilise such existing spaces, and regularly consult with them to gather information and inform needs analysis in emergencies;
- Enable communities to keep shelters for girls at risk and for survivors open, and provide sustainable and adequate funding for their rescue activities;
- Facilitate and support exchange of knowledge and good practices between stakeholders working at community level, by supporting networks and funding projects run by coalitions of organisations.

Good practice from the field

TANZANIA: In Tanzania, TUSEME (in Kiswahili means Let's Speak Out') is an approach implemented by the Forum for African Women Educationists (FAWE) with the support of UNICEF, and is an empowerment programme which uses theatre-for-development techniques to address concerns that hinder the social and academic development of girls. Through TUSEME, girls are empowered to speak out on problems, find solutions and take appropriate action to address the identified problems. Since 2004, more than 600 secondary school teachers and about 17,600 secondary school students have been trained on the TUSEME approach (FAWE, 2015)[91].

[90] The rescue brigade model has proven effective in humanitarian crises and consists of women's rights/anti-female genital mutilation activists and youth service providers responding to cases of GBV and female genital mutilation through formal or informal referral mechanisms and providing referrals for survivors" (UNFPA-UNICEF 2020, COVID-19 Disrupting SDG 5.3: Eliminating female genital mutilation, p.4)

[91] Expert from Plan International during the online dialogue.

Good practice from the field

The Plan International project, called Girls Out Loud, uses social media platforms to give girls a safe space to openly discuss issues relevant to them. The insights gained from these discussions are used to find solutions to the problems they face and support them to become leaders on these issues, in their communities and beyond. The project is now live in 16 countries, among which Benin, Burkina Faso, Guinea Bissau, Guinea Conakry, Senegal, Sierra Leone and the UK[92].

Good practice from the field

SYRIA: In Damascus, Syria, UNHCR have adopted a protection response that follows a community-based approach and aims to reduce vulnerabilities and protection risks, through community centres. Such centres are a safe public space where women, girls, men and boys of diverse backgrounds can meet for social and recreational activities and attain integrated protection services including Sexual and Gender-Based Violence (SGBV) prevention and response activities, child protection interventions, and more, to address specific needs. The community centres also reach out to populations of concern and carry out awareness-raising activities[93].

Good practice from the field

KENYA: In Kenya, women in the community were used to talking about their problems in self-help groups where they would initially meet. They gained more socially from these organisations, talking about their issues with peers[94].

Good practice from the field

KENYA: In 2017, a group of Kenyan teenagers called "The Restorers" have created an App called i-Cut to help girls affected by Female Genital Mutilation to get legal and medical assistance. Girls who are forced to undergo the procedure can also alert local authorities by pressing a panic button on the App, or can seek shelter by pressing the Rescue Centers' button.

[92] Expert during the online dialogue.
[93] UNHCR (2016) Community Centres.
[94] Phyll (Academic at Erasmus University) during the online dialogue.

6. Connect with and support existing structures and stakeholders

a. To development and humanitarian actors:

- **Work in close collaboration with local actors** — particularly women and girl-led organisations and professional organisations — to support joint decisions by communities to abandon the practice in the long-term[95];
- **Work systematically with community health workers** to bridge the information and accessibility gap between services and community members, and act within a solid referral system to provide sustainable and comprehensive care for survivors;
- **Create online platforms to map existing and available services for FGM survivors** and ensure the information is shared and accessible to communities through referral mechanisms, including with the help of community health workers;
- **Build the capacity of existing stakeholders, structures and services and work in close cooperation with local and national institutions**, including the Ministry of Health, to ensure sustainability of interventions in the long-term.

b. To governments:

- **Facilitate cooperation and connections between humanitarian and development actors and existing structures and stakeholders**, including Ministries at governmental level, to ensure follow-up for short term humanitarian response;
- Ensure that community health workers are officially recognised within local referral systems to ensure a comprehensive care for survivors, integrate them officially within the health system, and support and reward them through adequate investments[96].

c. To donors:

- **Fund projects that go beyond the immediate emergency** and aim at building resilience and sustainability in the long-term through linking humanitarian and development actors with local existing structures and stakeholders;

[95] Inter-Agency Standing Committee (2015), Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action - Reducing risk, promoting resilience and aiding recovery, p. 153.
[96] See also WHO (2018), Guideline on Health Policy and System Support to optimize community health workers programmes

Good practice from the field

Amref Health Africa has over the past years engaged with community health workers (CHWs) both nationally and regionally. They have supported efforts to have them recognised within the Ministry of Health. CHWs serve as crucial community front line workers who support in disease prevention measures and become the link between survivors and health services by identifying and making referrals to health facilities especially so during humanitarian emergencies[97].

Good practice from the field

Within their humanitarian operations, Médicos del Mundo (MdM) strives to ensure the sustainability of their quality service provision in the long term. Therefore, MdM staff works very closely with existing infrastructures and services, and care activities often include capacity building, in order to not duplicate services and instead build the capacity for the national public health systems and staff for sustainable change and quality care[98].

7. Ensure effective coordination among actors working on Female Genital Mutilation in humanitarian contexts

a. To governments, development and humanitarian actors:

- **Conduct a stakeholder analysis to map all actors working on FGM in the field**, with their respective roles and responsibilities, to have a speedy referral system in place;
- Create an **in-country multi-stakeholder coordination platform** or informal cooperation mechanism to share information, data and strategise interventions on FGM, through periodic meetings and a continuous and open communication (similar to the humanitarian Cluster meetings on sexual violence), which is focused on establishing a long-term and impactful multi-stakeholder response to FGM;
- Set up and invest in a **shared database centralising all data and information available on FGM in that context** (including guidelines, trainings, organisations working on the issue, as well as information about survivors, while ensuring the security of data protection and confidentiality), so that knowledge is stored and accessible regardless of high turn-over of humanitarian staff.

[97] Expert from Amref Health Africa during the online dialogue.
[98] Expert from Médicos del Mundo during the online dialogue.

b. To donors:

- Invest in the establishment of coordination platforms for all actors working on FGM in the field, and in databases for in-country cooperation and information-sharing on the subject.

Good practice from the field

KENYA: The Anti-FGM Board carried out a stakeholder analysis, by mapping all organisations working on FGM in the various counties of the country, which helped to create a platform for referrals and collaborations for individuals and organisations requiring to work in those areas[99].

Good practice from the field

SPAIN: A database exists for those working on asylum to collectively input and share information. This ensures knowledge and access to information is maintained, regardless of staff turnover[100].

8. Monitoring & Evaluation (M&E) and accountability

a. To humanitarian actors:

- **Ensure integration of prevention and response to FGM in projects' quality monitoring indicators**, in line with the Core Humanitarian Standards on Quality and Accountability for organisations across emergency preparedness[101]. Some of these quality standards include that communities and people affected by crises:
  - receive appropriate and relevant assistance based on their needs from competent and well-managed staff and volunteers;
  - are not affected negatively by humanitarian response;
  - know their rights and entitlements;
  - have access to information and;
  - participate in decisions that affect them;
- **Ensure M&E mechanisms include a minimum number of indicators on FGM** for both the acute phase of the crisis (particularly around severe complications during labour

99 Expert from Amref Health Africa during the online dialogue.
100 Expert from Comisión Española de Ayuda al Refugiado during the online dialogue.
101 CHS Alliance, Group URD and the Sphere Project (2014), Core Humanitarian Standard on Quality and Accountability.

and delivery) and the following medium to long-term phase regarding increased comprehensive support for survivors, so the use of the "Package of care for FGM survivors" as well as progress towards the abandonment of FGM are monitored;

- Apply the Social Norms and Beliefs about GBV Scale in different humanitarian settings, to measure change over time on harmful social norms and personal beliefs associated with violence against women and girls, among community members in low resource and complex humanitarian settings[102];
- **Ensure M&E indicators capture both host and displaced population** and find systems to track changes in behaviour around FGM, including during (cross-border) population movements, to see potential linkages with host communities' attitudes.

b. To donors and governments:

- **Extend the Reproductive health and GBV set of indicators** for projects funded **beyond immediate assistance** to sexual violence survivors or number of life-saving interventions around deliveries. Integrate specific indicators around results on other forms of GBV and SRH interventions, such as FGM prevention and care for survivors in the short, medium and long-term."

9. Data collection

a. To development and humanitarian actors:

- **Train and empower community members to collect data at local level in emergency contexts and through adapted technology and tools** (which should be made more accessible by technology and communication companies), in order to continue gathering information and data, regardless of any societal and institutional disruption. Communities are the best placed to gather local data and carry out continuous consultations, including to identify community needs within the needs assessment phase;
- **Prioritise new technologies, online and offline tools in emergencies** to ensure accurate data collection and surveying, such as using mobile phones with or without internet;

[102] See Perrin et Al. (2019), Social norms and beliefs about gender-based violence scale: a measure for use with gender based violence prevention programs in low-resource and humanitarian settings, p. 10.

- Conduct rapid assessment using remote surveys, phone calls or third-party monitoring, to ensure contact with affected populations is maintained;
- Share and make accessible existing FGM prevalence surveys, studies and research to stakeholders working in humanitarian contexts. This should be further encouraged, in collaboration between communities and academics/research institutes.

b. To humanitarian actors:

- Ensure that the overall humanitarian response is evidence-based and built on available data. Ensure that stakeholders who collect data within the humanitarian sector (particularly the GBV and Child Protection Area of Responsibility within the Protection Cluster) **do so on all forms of GBV including FGM**, to inform targeted interventions (and also collect data to monitor the effectiveness of interventions). To this aim, ensure they:
    - are aware and use national population surveys and databases (such as MIGS and DHS), which collect information on FGM prevalence, in some high prevalence countries;
    - integrate specific questions on FGM within the standard population profiling surveys carried out (e.g. in refugee and IDP camps), specifically for girls and women below the age of 45 years.

c. To governments:

- Ensure data gathered through health, GBV or any other relevant national information management system **systematically includes FGM, is disaggregated by age**[103] and is made available to humanitarian and development actors;
- Make available national population and healthcare surveys, in addition to existing data on FGM to humanitarian and development actors.

d. To donors:

- **Fund research in humanitarian settings, particularly community-led research and data collection**, to ensure programmes and interventions are tailored to the needs of the affected populations, particularly concerning all forms of GBV, including FGM.

[103] See also UNFPA-UNICEF 2020, COVID-19 Disrupting SDG 5.3: Eliminating female genital mutilation.

Good practice from the field

Since 2015, Orchid Project has been supporting different community-based organisations (CBOs) in strengthening the use of research findings in their work to end FGM[104].

Good practice from the field

The UNICEF digital tool U-Report, a free messaging tool that empowers young people around the world to engage with and speak out on issues that matter to them, has managed to reach 1 million Nigerians. The tool works to collect and analyse data in real-time, by gathering opinions, information and evidence, to amplify community voices. This data can be mapped at local level to form national data and used to informing advocacy and development[105].

Good practice from the field

TANZANIA: Crowd2Map Tanzania is an entirely volunteer crowdsourced mapping project putting rural Tanzania on the map. Since 2015, trained volunteers have been adding schools, hospitals, roads, buildings and villages to OpenStreetMap with the help of volunteers worldwide and on the ground in Tanzania, to work with authorities to prevent FGM and provide support to survivors[106].

Good practice from the field

60 Decibels is an impact measurement company, that helps organisations around the world leverage mobile technology to impact measurement. 60 Decibels has a network of 150+ trained Lean Data researchers in 30+ countries who speak directly to customers to understand their lived experience. They combine voice, SMS, and other technologies to collect data remotely using mobile technology with survey tools[107].

104 Expert from Orchid Project during the dialogue.
105 Expert during the online dialogue.
106 Expert during the online dialogue.
107 Expert during the online dialogue.

Good practice from the field

SUDAN: The Afar community use "Dagu" which is a sophisticated indigenous system that keeps accurate, sourced information flowing among the Afar people across vast distances with remarkable speed. In recent years, dagu, along with another traditional structure—formal community dialogues, or "meblo"—have helped disseminate new knowledge about FGM/C and build consensus towards abandoning the practice[108]. Similar practices exist in several countries where FGM is prevalent; therefore, collaborating with communities has the potential to provide useful information.

10. Bridge the gap between development and humanitarian sectors

a. To humanitarian and development actors:

- **Establish multi-sectoral partnerships, through both vertical and horizontal coordination between humanitarian and development actors** working on the same field, including all humanitarian and development fields addressing GBV in the same context, to ensure and maximise impact in the short- medium- and long-term.

b. To devolopment actors:

- Draft **Transition Strategies and Preparedness Plans** to increase readiness for the sudden onset of a crisis (such as for instance during COVID-19, which also affected typically non-fragile contexts), to avoid disruptions of interventions and ensure continued work on ending FGM and supporting survivors in humanitarian & emergency contexts, including risk analysis and strategic and methodological adaptations.

c. To humanitarian actors:

- Draft **Long-term Sustainability Plans** that extend the focus from only immediate and emergency response, and include concrete indicators addressing the long-term impact of humanitarian response around FGM. Ensure local ownership and build community resilience.

[108] UNICEF, UNFPA (2017), 17 WAYS TO END FGM/C: LESSONS FROM THE FIELD, p. 22.

d. To government and donors:

- **Go beyond the traditional silos of either development or humanitarian funding, and invest and support coordinated projects** (including pilot projects) connecting humanitarian and development sectors, to ensure the humanitarian-development nexus becomes a reality;
- Fund projects in humanitarian settings that have a sustainable long-term goal and potential impact, as well as development projects with preparedness plans to adapt to emergency situations.

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