SOCIAL AND GENDER NORMS TIP SHEETS

Changing Norms to Address Gender-based Violence and Harmful Practices

Tip Sheet 4: Female Genital Mutilation

UNFPA

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UNFPA's Asia Pacific Regional Office has developed a series of Social and Gender Norms Tip Sheets. These resources are designed to support UNFPA country offices and partners in the region to implement social and gender norm change programmes to address gender-based violence and harmful practices, including child marriage and female genital mutilation. The Tip Sheets are designed to complement UNFPA's forthcoming global **Toolkit on Transforming Gender and Social Norms.**

Not all harmful practices are social norms or gender norms, and norm change is not always necessary to shift harmful behaviours and practices. Increased access to opportunities, services and infrastructure, and legislative and policy reforms can also help shift harmful behaviours. Even where a harmful practice is not itself a norm, powerful indirect social and gender norms may influence the practice. ***Norm diagnosis***[1] *can help to determine whether a harmful practice is a norm in the specific setting where the behaviour takes place. Norm change interventions should be complemented by other interventions as part of a comprehensive, multisectoral approach to address harmful practices across the socioecological model.*

What's included here:

Figures and tables:

1 See Tip Sheet #2: **Norm Diagnosis**.

Table 1: Definitions[2]

Attitudes	What I think. My personal opinions.
Behaviour	What I do. Individual or collective actions and practices.
Personal normative beliefs	What I think I should do, and what I think others should do as well. • **Prudential**[3] **normative beliefs**: What I think is in my own and others' best interests. • **Non-prudential normative beliefs**: What I think is the right thing to do, based on ethical or moral convictions and values.
Social norms	**Patterns of behaviour** that are motivated by a desire to conform to the shared social expectations of a community or group. The **"rules of action"** shared by communities or groups that define what is considered normal and acceptable behaviour. Social norms include **beliefs** about what most other people do (what is common) and approve of (what is expected): • **Descriptive norm:** What I think most others do. What is considered typical or common. Sometimes called empirical expectations. • **Injunctive norm:** What I think most others approve of and expect me to do/what I should do according to other people. What is considered appropriate and "normal." Sometimes called normative expectations.
Direct norm	When a practice is itself a social and/or gender norm and directly determines people's behaviour. Social expectations are one of the main reasons people practice the behaviour. I conform to the practice because I think most others do (descriptive norm) and they expect me to as well (injunctive norm).[4]
Indirect norm	Norms[5] that help keep a practice in place as part of a wider system of social expectations. These include closely related norms–such as proximal norms, which strongly influence behaviour and create a favourable environment for it, and deeply rooted "meta-norms" that contribute to and uphold gender inequality.
Gender norms	Social norms defining **acceptable and appropriate actions** for women and men as well as girls and boys in a given group or society.
Reference group	The specific community or group of people whose opinions, expectations and behaviours influence an individual's attitudes and actions around a particular practice. Reference groups can differ for specific norms. Reference groups may also be virtual and online communities.
Sanctions/ benefits	**Outcome expectations**: a person's beliefs or expectations about how others will respond if they comply with or resist the norm. These anticipated reactions help enforce compliance to the norm. They include: • **Sanctions/consequences** of non-compliance with the norm. Social pressure or other forms of punishment. A negative outcome expectation. • **Benefits and rewards** for complying with the norm. Social approval or other rewards. A positive outcome expectation. **Power dynamics**: those with the power to impose sanctions have greater (relative) power.
Positive deviance	When individuals in a community act in ways that significantly differ from prevailing social norms but achieve more positive outcomes, despite the risk of sanctions for challenging social expectations.

2 Definitions are drawn from the UNFPA's forthcoming global Toolkit on Transforming Gender and Social Norms, as well as other sources cited in this Tip Sheet.

3 In this context, "prudential" refers to beliefs concerned with protecting the wellbeing of oneself, others or the wider community.

4 This is known as "conditional preference," where people choose to act based on what they think most others in their reference group do and expect of them.[xiii] The concept is important for norm diagnosis as it helps distinguish socially motivated behaviours from those driven by other factors, such as moral convictions or material realities. Conditional preference can be measured in both quantitative and qualitative studies through hypothetical scenarios or vignettes (see Tip Sheet #6: **Measurement**).

5 Throughout the Tip Sheets, "norms" is used as shorthand for social and gender norms, per the definitions in this table.

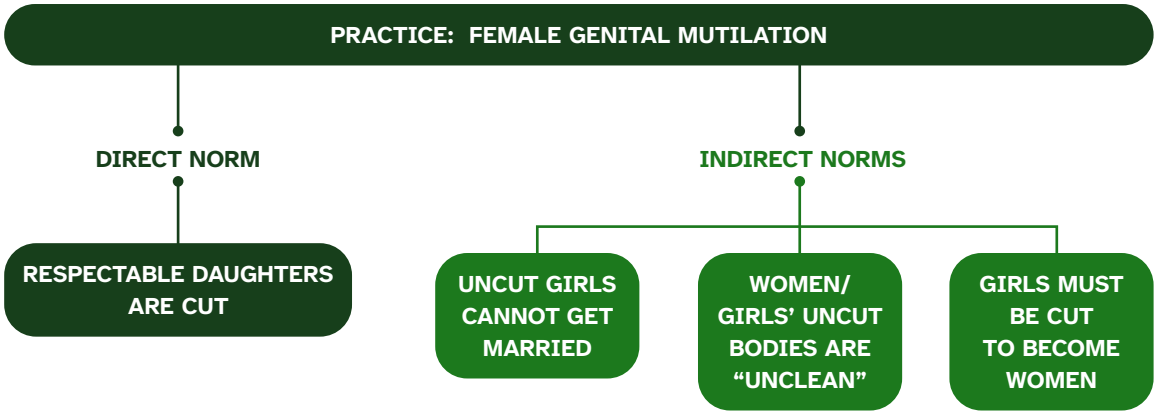
Is it a norm?

Female genital mutilation (FGM) is often **a norm**, including in high-prevalence settings and among ethnic or religious communities and population groups where it is widely practiced.[iii,iv] In high-prevalence settings, FGM can be considered a **direct norm**: the practice coincides with the presence of both a descriptive norm *(I think most girls in my community undergo FGM)* and an injunctive norm *(I think most others expect me to arrange for my daughter to undergo FGM)*. Additionally, there are **benefits** and **sanctions** associated with FGM. *For example, women who have undergone FGM may be considered "pure," or parents of girls who have not undergone FGM may be ostracised.* Even where individual attitudes deviate from the norm, and people do not find FGM acceptable, they may still practice FGM if there are significant benefits or strong sanctions for non-compliance. FGM is often practiced by communities as a way of maintaining social and cultural identity and may also be seen as a religious requirement. FGM may be adopted in settings where it did not previously exist; *for example, migration and displacement can lead to transmission and diffusion of the norm/practice.* Indirect harmful social and gender norms about women's sexuality and about women and girls' bodies also influence FGM, as shown in Figure 1. **Formative research** can help determine whether FGM is a norm, and how influential norms are relative to other drivers of FGM in the specific settings and among specific groups where the practice occurs.[6]

Table 2: Norm Diagnosis Examples

	Descriptive norm	Injunctive norm	Sanctions	Conditional preference
FGM likely **IS** a social norm when...	Most people believe that most other people in their community get their daughters cut	Most people believe that most others in their community expect them to get their daughters cut, too	Most people believe they will face negative consequences if they do not get their daughters cut	Based on these social expectations, most people choose to get their daughters cut
FGM is **NOT** likely a norm when...	Most people believe that most other people in their community do **not** get their daughters cut	Most people believe that most others in their community do **not** expect FGM	Most people do **not** face serious consequences if they choose not to get their daughters cut	Parents make decisions about FGM based on personal preferences, morals or values rather than conformity

Figure 1: Direct and Indirect Norms. Adapted from: Cislaghi and Heise 2018.



6 See Tip Sheet #2: **Norm Diagnosis** for further guidance on assessing whether practices are social and gender norms.

Because FGM is often a **direct norm** (the norm and the practice coincide), dedicated norm change interventions **can be effective** in helping to change the practice. There is good evidence that norm change interventions are effective in shifting the FGM norm and reducing prevalence (see the section below, "What does the evidence say?").[i,v] A gender-transformative approach is essential. Norm change approaches to end FGM should address gendered power dynamics between men and women, including the vested interests that maintain the practice and disadvantage women and girls. Norm change efforts should be integrated with other interventions across the socioecological framework, such as:

- Legislative reform
- Engagement with religious leaders
- Capacity building of health and medical practitioners
- Investment to keep girls in school and provide comprehensive sexuality education (CSE) and life skills education
- Access to gender-based violence and child protection services
- Support for women and girls who have undergone the practice

There are a range of available tools and resources to support FGM norm change programming, but one caveat is that they do not always adopt a gender-transformative approach. In the past, some FGM interventions tended to focus on changing the direct norms that require girls to undergo the practice, using social norm change approaches based on behaviour change and diffusion of innovation theories. Gender-transformative approaches take a broader view of norm change, addressing the underpinning gender norms about women's sexuality and bodily autonomy to better achieve long-term results. While social norms approaches can help change the direct FGM norm and thereby reduce prevalence, interventions also need to address root causes, including indirect harmful gender norms that sustain the practice.[i,ii] For more on the difference between social and gender norm theories and approaches, see Tip Sheet #1 Theory and Practice.

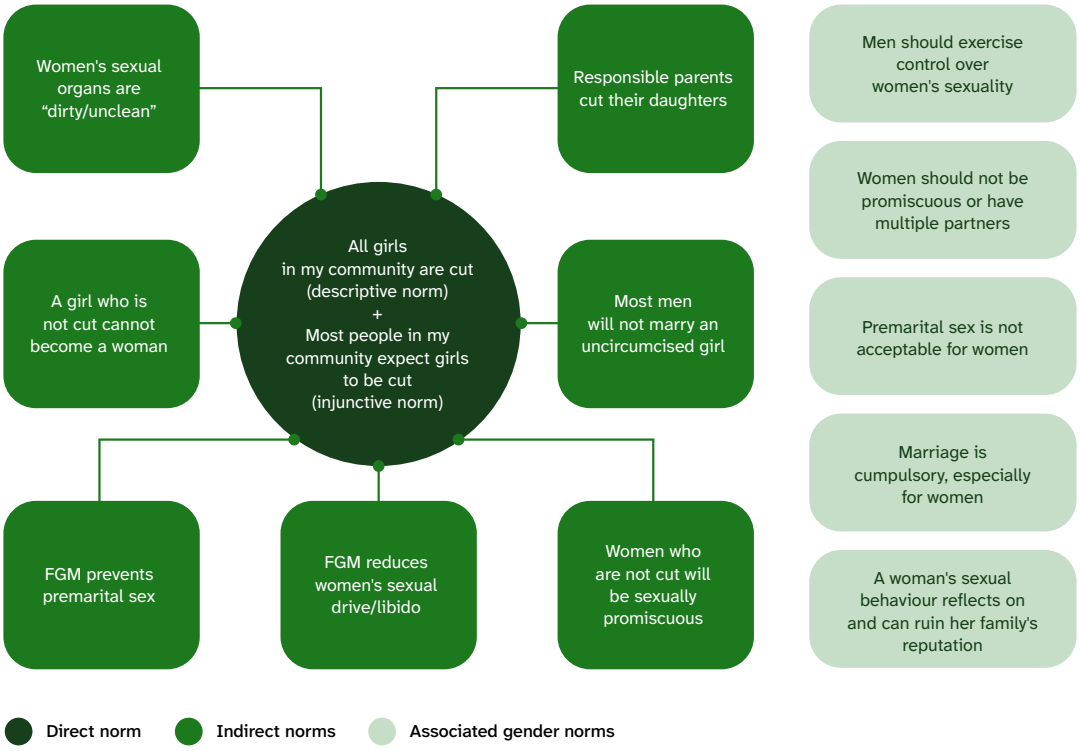
The UNFPA-UNICEF **Joint Programme on the Elimination of Female Genital Mutilation** is now in its fourth phase (2022-2030). The evaluation of Phases I and II (2008-2017) identified the need to shift from a focus on social norms to gender norms, including norms around control over adolescent sexuality.[ii] In Phases III and IV, the Programme has increasingly focused on changing gender norms that enable or promote the practice of FGM. This has included an increased focus on promoting adolescent girls' voice, agency and leadership, and engaging with women-led organizations and feminist-led movements. The programme also emphasises engaging families, communities, men and boys alongside strengthening service systems to increase women and girls' access to preventative and protection services, which are important elements of a gender-transformative approach.

Which norms are we trying to change?

Norms that support FGM include **direct norms**: most people think others in their community expect girls to undergo FGM (it is acceptable or desirable) and believe that most (or all) girls in their community undergo the practice (it is common or typical). Examples of indirect or proximal norms that support FGM include: responsible parents will ensure their daughters undergo FGM; men will not marry an uncircumcised girl; a girl who has not undergone FGM is unmarriageable; women's sexual organs are dirty or unclean; and FGM prevents premarital sex and promiscuity and reduces women's sexual drive/libido.

Broader social and gender "meta-norms" regarding men's control over women's sexuality, the importance of women's chastity before and fidelity during marriage, and that marriage is required particularly for women (compulsory marriage) also drive the practice (Figure 2). Many of these social and gender norms also support child marriage and gender-based violence. Material drivers include the lack of access to resources, education and economic opportunities that make marriage necessary for women and girls' survival.

Figure 2: Gendered Norms and Beliefs Contributing to FGM



Where FGM is practiced on babies and infants, and where the practice is increasingly medicalized, it is essential to address norms held by parents and extended family members, as well as health and medical practitioners. Before undertaking any social or gender norm interventions, it is important to understand which norms are especially salient (powerful), how strong they are, and what sanctions apply for non-compliance. Because norms vary between settings and communities, formative research can help determine which norms are most influential and important to change.

What does the evidence say?

A 2025 evidence review conducted by UNICEF and UNFPA has identified that interventions addressing FGM-related social and gender norms are effective.

Specifically, norm change interventions that **engage communities**–such as community dialogues/conversations and engagement with religious and cultural leaders–are particularly effective in shifting FGM-related social norms. **Health education, media, edutainment** and **social marketing campaigns** also help change social norms and attitudes towards abandonment of FGM and, in some cases, have contributed to reducing prevalence.

However, while raising awareness may contribute to changing individual beliefs and attitudes, this is not sufficient to change shared social norms and behaviour. Alternative income sources for traditional practitioners and alternative rites of passage are ineffective, because they do not shift the underlying norms that drive the practice.[i,v,vi] **Public declarations** of abandonment are considered promising when combined with other interventions, but some studies question the effectiveness of this approach, as it may not reach those whose beliefs are most entrenched or may drive the practice underground.

Legislative reform is promising in changing FGM-related norms, attitudes and behaviours when combined with other interventions, and with consideration of local contexts and settings. Laws on their own are not effective in changing the norm and can lead to harmful consequences, such as increased medicalization, cutting at younger ages, or cutting in secret. Legislative change is more effective when the FGM norm is already changing, to reinforce abandonment of the practice.[i,vi]

The **Saleema** programme in Sudan aimed to promote long-term abandonment of FGM and protect girls from the practice. The programme was designed to promote positive terminology to describe women and girls' natural (uncut) bodies, increase acceptance of uncut girls and shift normative beliefs about acceptability of remaining uncut. FGM was considered a direct social norm in the specific context; changing the norm was therefore a key step in changing the behaviour. The programme specifically aimed to change the descriptive norm: the belief that most other people cut their daughters. Challenging the perception that the practice is widespread will help shift the norm. The intervention included public pledges to abandon FGM, including not cutting newly born daughters, and community dialogues on FGM. An independent evaluation found that Saleema was effective in reducing pro-FGM social norms: there was a measurable reduction in norms supporting the practice. However, change in prevalence was not measured.[vii]

Norm change programming on FGM

1. Design

Formative research:
- Identify attitudes, descriptive/injunctive norms, sanctions, reference groups
- Power and gender analysis
- Qualitative methods

2. Implementation

- Community engagement
- Identify positive deviants/ champions
- Weaken/challenge sanctions
- Reinforce positive behaviour

3. Monitoring

- Continuous monitoring
- Track and respond to backlash
- Identify unintended consequences
- Adapt programming

4. Data and Measurement

- Measure impact of norm change interventions
- Dedicated surveys (baseline, endline)
- Use proxy measures as an indication of norm change

Table 3: Norm Change Programming Process

1. Design formative research Prepare for and conduct formative research.

a. Determine which **settings/communities** are a priority for programming to change FGM and related social and gender norms. *For example, this may include settings where prevalence of FGM remains high; where it is already declining and change can be accelerated; or where the practice is newly emerging or increasing due to migration or internal displacement, conflict or crisis.* Consideration should also be given to whether other supportive interventions are in place in target communities to complement and reinforce norm change programming. These might include, *for example, strengthened legislative and policy frameworks, capacity building of education and health service providers, existing community outreach by civil society organizations (CSOs) and faith-based organizations (FBOs), and availability of support services for survivors of the practice.*

b. Review **available data and research** on targeted settings/communities, where available, to identify prevalence and any changes in the practice, as well as prevailing attitudes and beliefs, to help guide formative research. While research and data on FGM is often limited at a national level, local and small-scale studies can help inform the design of norm change interventions. Community dialogues can be used to identify and support norm diagnosis when resources are limited or where extensive research and data are already available.

c. Conduct **formative research** in targeted settings/communities to confirm whether FGM is a **direct norm**, which **indirect norms** are most significant, and which norms should be prioritized in norm change interventions. Formative research can help identify which norms are most powerful, influential and "sticky" (hard to change), and which are already shifting and therefore may be easier to change. *For example, norms around control of women and girls' sexuality may be harder to change compared to norms around whether it is acceptable for adult women to remain uncut, which may already be beginning to shift.*

Positive, **protective norms**, *for example parents' desire to protect their children or the value placed on education, may also be salient (important) leverage points to build on.* Formative research can help reveal these.

Identifying the **reference groups** for the direct and indirect norms that support FGM–such as young people themselves, parents, religious and community leaders, and service providers–is another important aspect of formative research, as this helps determine who the intervention should engage. Reference groups are likely to differ for specific norms, and formative research can help clarify this.

Formative research should also explore the **sanctions** (consequences/penalties) for non-compliance, their strength and the consistency in which they are applied. *For example, communities may exclude parents of uncut girls.* This information is important to inform programme design (see further detail in the next step).

Qualitative methods are recommended for formative research, including use of vignettes.[ii, 7] For more on norm diagnosis, see Tip Sheet #2, as well as Module 4 of the UNFPA's forthcoming global **Toolkit on Transforming Gender and Social Norms.**

d. Undertake a dedicated **gender and power analysis** to inform intervention design, including to determine how gender inequalities, power dynamics and other forms of inequality and discrimination–such as disability, age, ethnicity, migrant/refugee status, caste and socio-economic status–intersect with FGM and the norms that support the practice. The analysis should also examine how gender roles and gender inequalities, as well as other forms of inequality, exclusion and discrimination, impact access to services, resources, opportunities and decision-making. It is also important to understand who has a vested interest in maintaining harmful/inequitable norms that support FGM (and why), and who has the power to impose sanctions for non-compliance with these norms. Understanding who has direct power or influence over the decision to undertake FGM is essential, including the roles of mothers, fathers and extended family members such as grandmothers. For more on gender and power analysis, see Module 5 of UNFPA's forthcoming global **Toolkit on Transforming Gender and Social Norms**.

2. Determine programme implementation strategies

Determine programming approach to norm change based on formative research.[8] First, locate where the norm occurs (e.g. community-level vs. society-wide) and the strength of the norm. For example:

a. If FGM and related **norms are specific to a particular setting/community**, community engagement approaches can be used. *For example, contexts where FGM is practiced by a specific ethnic or religious group or community.*

b. If norms are **widely held across population groups or society**, mass media/awareness raising can complement other interventions. *For example, contexts where prevalence data is available and shows that FGM is widely practiced across the population*. See point "j" below for more on mass media approaches.

c. In settings where most people's **individual attitudes align with FGM norms**, interventions can target individual attitudes alongside other norm change strategies by combining awareness-raising and community-based norm change approaches. *For example, where survey data shows that most people think it is acceptable and normal for their daughters to undergo FGM.*

7 Vignettes are hypothetical stories that place an invented character in a specific context. Guiding questions enable structured responses and explore perceptions of specific behaviours and how these would be viewed within the community or reference group of focus.

8 This is a high-level overview of norm-change programme considerations and possibilities, not a comprehensive or prescriptive guide.

d. However, where **individual attitudes diverge from the norm**, interventions can engage communities in norm questioning to highlight the gap between individual beliefs and social expectations. *For example, if most parents don't want their daughters to undergo FGM but believe it is expected by others in their community.*

e. If most people assume others are complying with the norm when in fact this isn't the case–called **"pluralistic ignorance"**–interventions can raise awareness that prevalence is lower than people think or is falling, bringing visibility to shifting prevalence. *For example, if people believe most girls in their community are undergoing the practice, when in fact this is not the case.*

f. Formative research may also show that some people don't follow the norm. If these **"positive deviants"** are willing to speak up against the practice, they can serve as examples and/or champions, inspiring and encouraging other people to do the same. See point "j" below for more on positive deviance.

g. If research identifies that **sanctions** are weak or inconsistently applied, this can also be a lever for awareness raising. *For example, if there is no stigma against marrying women who have not undergone FGM.* However, if sanctions remain strong/punitive, interventions can focus on weakening them. *This could involve reducing the exclusion of parents whose daughters have not undergone FGM or increasing acceptance among men of marrying women who have not undergone the practice.*

Then, select specific programming approaches based on the considerations above. For example:

h. **Community-led and community-based approaches** have proven effective in changing FGM norms. Sustained, intense interventions that engage communities over time (18 months to three years) are more effective than short-term or one-off initiatives. The timing required will depend on the readiness of the community.

i. Programming with communities should **engage all key actors in relevant reference groups**, including parents, young people, community and religious leaders and councils, civil society organizations, women's groups, local governments and service providers. In line with a "do no harm" approach, engagement and empowerment interventions should not focus only on those who are most impacted by the practice/ more vulnerable such as young girls and women, without also focusing on those with greater power, including parents and religious authorities. Addressing power imbalances and challenging gender norms is essential for sustainable, effective change, while engaging powerholders can also help prevent backlash.

j. **Edutainment and mass and social media awareness campaigns**, tailored to specific settings and contexts and tested with stakeholders and communities, can complement community-based interventions. However, raising awareness that a practice such as FGM is widespread can unintentionally reinforce the norm–*specifically the descriptive norm: the belief that most other people are doing it.* Public awareness messaging for the general community should highlight the positive stories of **people who are not practicing FGM**, the extent of positive deviance if it is significant or growing, and any evidence that abandonment is increasing. Where FGM is practiced by a specific ethnic or religious group, mass media should not be used, due to the risk of stigmatising these communities.

3. Monitoring

Throughout implementation, undertake continuous monitoring of social and gender norm change programming to track changes in FGM norms and prevalence of the practice. This can include monitoring shifts in:

- **Behaviour**, such as increasing medicalization of FGM;
- Individual **attitudes**, such as a change in the proportion of people in the community/setting who do not want their girls to undergo FGM; or less acceptance of norms around female sexual purity;
- **Indirect norms** that support FGM, such as beliefs that most other people in an individual's reference group think girls should undergo FGM to prevent pre-maritial sex; and
- **Sanctions**, such as reduced stigma against girls who do not undergo the practice.

Monitoring is also critical to track and respond to **resistance**, **backlash** and other potentially harmful **unintended consequences**, *for example by those with vested interests in maintaining the practice*. Norm change interventions, such as legislation or public pledging and declarations of abandonment, may inadvertently drive the practice underground *(practicing FGM in secret or taking daughters to other areas to undergo FGM, as examples)*. Norm change programming may also increase medicalization of the practice. Monitoring can support **adaptation and learning** to improve programme outcomes.

Monitoring can include tracking of activities and participation, as well as directly observing changes in communities *(for example, on a monthly basis)*. It can also involve key informant interviews and focus groups with participating communities. Additionally, monitoring may cover changes in local institutions and policies *(for example, on a quarterly or bi-annual basis)*, depending on the length and intensity of the programme.

4. Measurement

Unlike in other regions, data and evidence to measure **behaviour**, including prevalence of FGM, geographical concentration and socio-economic variations–usually collected through the DHS and/or MICS–are not available for most countries in Asia-Pacific, except Indonesia and the Maldives. The 2024 Indonesian national survey on violence against women includes questions on prevalence, knowledge and acceptability of FGM, and the reasons for practicing it. Prevalence stands at about 46 per cent. In an earlier 2021 survey, 68 per cent of respondents said FGM is a religious requirement, while 40 per cent cited "most local people do it" as a reason for the practice, indicating that FGM is likely to be a norm.[viii] Estimates are available for other countries, including Malaysia where 93 per cent of the female Muslim population is estimated to have undergone the practice and it remains widely supported, suggesting it is a widely held norm.[ix]

The World Values Survey[9] provides data for 13 Asia-Pacific countries on **attitudes** towards control of women's sexuality, including views on the acceptability of premarital sex, as well as broader attitudes on gender equality. Data on descriptive and injunctive norms and sanctions is not available so must instead be collected through dedicated studies.

9 World Values Survey data is available for the following countries: Bangladesh, China, India, Indonesia, Iran, Malaysia, Maldives, Mongolia, Myanmar, Pakistan, Philippines, Thailand and Viet Nam. Not all countries have data for all gender-attitude related questions.

Data on prevalence and attitudes can sometimes be used as a **proxy for norm change**. *For example, declining prevalence in conjunction with a decrease in supportive attitudes towards FGM can signal that norms are changing*. Advocacy to ensure availability of national prevalence data is essential to support effective behaviour and norm change programming. However, as this data is not available for most countries in the region, many FGM norm change programmes will need to conduct dedicated studies to demonstrate their impact.

Because FGM is usually a norm, most FGM interventions should include social and gender norm change components. To assess effectiveness, it is essential to measure their impact on both the prevalence of FGM (the behaviour) and the direct and indirect norms that sustain it. It is also important to measure the effects of other interventions designed to address FGM, to build as complete an understanding as possible of the different factors driving change.

While randomized controlled trials are considered the "gold standard" of impact evaluation research, often resources are not available to support these studies. Other approaches can be used such as mixed-methods studies. In Asia-Pacific, where there is limited research to-date on FGM outside Indonesia, formative/baseline and endline research is recommended to assess changes in behaviour and attitudes, as well as in descriptive and injunctive norms and sanctions. Longer programmes should also consider mid-term research to enable adjustments in programming, as needed. Sometimes FGM norms change but behaviours remain in place; and sometimes prevalence changes but the norms that support the practice remain strong, which means there is a risk of re-emergence, *for example if medicalized FGM becomes more widely available*. Measurement is important to understand how norm and behaviour change happens and to inform and adjust programming.

The Joint Programme on the Elimination of FGM has developed a comprehensive indicator guide on measurement of FGM prevalence and associated norms. The ACT Framework includes comprehensive guidance, tools and indicators to measure changes in knowledge, attitudes and norms that support FGM. Other, less intensive approaches are also available, though these are not specifically tailored to measuring FGM norms and norm change (see selected resources below). Choosing the right measurement approach depends in part on the scope of the norm change intervention: the more extensive the programme, the greater the investment needed to measure change. For long-term, significant investments in norm change, independent evaluation should also be undertaken.

Selected resources

Evidence base

Accelerating action towards FGM elimination: Lessons from evidence on effective interventions – **UNFPA and UNICEF** (2025)

Effectiveness of Interventions Designed to Prevent or Respond to Female Genital Mutilation: A Review of Evidence – **UNFPA, UNICEF, WHO and Population Council, Kenya** (2021)

FGM norm change programming

Manual on Social Norms and Change – **UNFPA and UNICEF** (2022)

Rethinking End FGM/C Work: A guide to designing effective social norms change programmes – **Plan International** (2022)

Technical Guidance: A Comprehensive Approach to Accelerating the Elimination of Female Genital Mutilation – **UNFPA and UNICEF** (2021)

Gender Transformative Approaches for the Elimination of Female Genital Mutilation – **UNICEF** (2020)

Measurement

Measuring Effectiveness of Female Genital Mutilation Elimination: A Compendium of Indicators – **UNFPA and UNICEF** (2020)

The ACT Framework Package: Measuring Social Norms Around Female Genital Mutilation – **UNICEF** (2020)

Resources for Measuring Social Norms: A Practical Guide for Program Implementers – **Social Norms Learning Collaborative** (2019)

References

i. Matanda D, Groce-Galis M, Gay J, Hardee K. *Effectiveness of Interventions Designed to Prevent or Respond to Female Genital Mutilation A Review of Evidence*. 2021.

ii. Chambel A, Cadondon K, Reichel L, Turrall S. *Joint Evaluation of the UNFPA-UNICEF Joint Programme on the Abandonment of Female Genital Mutilation: Accelerating Change Phase I and II (2008–2017) Volume 1*. 2019.

iii. Ben Cislaghi, Lori Heise. *Measuring Gender-Related Social Norms*. 2016.

iv. Ben Cislaghi, Karima Manji, Lori Heise. *Social Norms and Gender-Related Harmful Practices: Theory in Support of Better Practice*. 2018.

v. Siddiqi M, Subrahmanian R. *Accelerating Action towards FGM Elimination: Lessons from Evidence on Effective Interventions*. 2025.

vi. Matanda DJ, Van Eekert N, Croce-Galis M, Gay J, Middelburg MJ, Hardee K. What interventions are effective to prevent or respond to female genital mutilation? A review of existing evidence from 2008–2020. *PLOS Global Public Health*. 2023;3(5).

vii. Evans WD, Donahue C, Snider J, Bedri N, Elhussein TA, Elamin SA. The Saleema initiative in Sudan to abandon female genital mutilation: Outcomes and dose response effects. *PLoS One*. 2019;14(3).

viii. Ministry of Women Empowerment and Child Protection Republic of Indonesia. *Violence Against Women Survey - 2021. 2022*.

ix. Orchid Project, Asia Network to End FGM/C. *Country Profile: FGC in Malaysia*. 2024.

x. Cristina Bicchieri. *Norms in the Wild: How to Diagnose, Measure, and Change Social Norms*.; Oxford University Press.; 2017.