



PHOTO: USAID/MICL DUFF, 2018

HARMFUL TRADITIONAL PRACTICES IN URBAN SETTINGS

A REVIEW OF THE EVIDENCE ON PREVALENCE AND EFFECTIVE INTERVENTIONS

Harmful traditional practices (HTPs) reduce women and girls' ability to participate in economic, political, or social life. A form of gender-based violence, HTPs are practices, sustained by tradition in a variety of societies, that are harmful and destructive for the well-being of women and girls subjected to them and negatively impact development progress of their communities, countries, and regions. Although significant work has been done to understand the prevalence of and factors that perpetuate HTPs, related policies and interventions have often focused on rural communities. However, the available evidence suggests a more nuanced picture is necessary to understand the drivers of HTP in urban areas and the most effective interventions to address them.

To address this gap, this paper reviews the available evidence on HTP prevalence and effective interventions in urban areas, focusing on the following three HTPs where research is of sufficient depth for such a review:

- child, early, and forced marriages (CEFM)
- female genital mutilation/cutting (FGM/C) - the partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons
- female infanticide and feticide - the deliberate killing of an infant or the abortion of a fetus because they are female

This overview is intended to help donors, governments, non-governmental organizations, and researchers better understand the role of location, and particularly urban settings, on these three HTPs and to, in turn, inform policy, programming, and research agendas. The paper provides context, scope, and definitions; summarizes the available evidence on prevalence and effective solutions broadly and in urban areas; and calls attention to knowledge gaps that may merit further research and discussion. The review concludes that, despite evidence that some HTPs are prevalent in urban areas, there is limited rigorous evidence (i.e., evidence that meets specific methodological standards like peer review and the presence of a strong comparison group) on effective strategies and interventions to address them. Consequently, especially given rapid urbanization in many developing countries, there is an urgent need for greater attention by donors

and their international, national, and local partners to understand and address HTPs in urban areas.

HISTORICAL CONTEXT AND SCOPE

Traditional practices that harm women and girls have long been a concern of international development practitioners and human rights advocates. In 1993, the United Nations (UN) Declaration on the Elimination of Violence Against Women made an explicit link between HTPs and gender-based violence.¹ A UN General Assembly resolution on traditional or customary practices affecting the well-being of women and girls (1998) called upon all states to ratify or accede to the Convention on the Elimination of All Forms Discrimination against Women (CEDAW), and to adopt national measures to prohibit traditional practices that discriminate against women.² A resolution the following year (1999) emphasized “the need for technical and financial assistance to developing countries working to achieve the elimination of traditional or customary practices affecting the health of women and girls.”³

A 2003 resolution of the UN Commission on Human Rights⁴ affirmed that HTPs were forms of gender-based violence and outlined the following forms of traditional practices harmful to women: female genital mutilation, early and forced marriages, female infanticide, dowry-related violence and deaths, acid attacks, and violence related to commercial sexual and economic exploitation. Some⁵ have also included practices such as breast flattening, cosmetic mutilation, ‘honor’ crimes, corrective rape, ritual sexual slavery, virginity testing, practices related to initiation or menstruation, some widowhood rituals, and accusations of witchcraft levied at older women as constituting types of HTPs.

It’s important to observe that the terminology used to describe these practices can be contentious with some experts arguing that language linking such practices with culture or tradition can undermine efforts to address them.⁶ While this evidence paper adopts the commonly used “harmful traditional practices” term, it recognizes

that addressing these practices in ways that respect culture and tradition in order to engage communities is critical, as noted in the supporting literature.⁷

PREVALENCE OF SELECT HARMFUL TRADITIONAL PRACTICES

Several studies have estimated the global prevalence of specific HTPs and compared prevalence across countries and regions and trends over time. Although the prevalence rates of some HTPs are declining globally (even as some absolute numbers are increasing due to population growth), this decrease masks variations within and among countries and differences in rates of decline. In general, the data is limited by likely underreporting, particularly in countries where certain

¹ United Nations, 1993

² United Nations, 1998

³ United Nations, 1999

⁴ United Nations Office of the High Commissioner of Human Rights, 2003

⁵ See for example “Harmful traditional practices affecting women and girls,” ActionAid UK, Gender and Development Network, Womankind, International Planned Parenthood Federation, and Orchid Project, accessed May 2, 2019, https://www.ippf.org/sites/default/files/harmful_traditional_practices.pdf

⁶ Le Roux, Bartelink, and Palm, 2017

⁷ Mirchandani 2016

practices have been banned by law or custom.⁸ The prevalence of HTPs differs markedly not only between different regions and countries but also within countries, across ethnic groups, religious affiliations, social status and income groups, and, most relevant for this brief, geographies (urban versus rural). Although HTPs are often approached as primarily a rural concern, the evidence suggests a more nuanced picture.

Child, Early, and Forced Marriage (CEFM)

Globally, UNICEF estimates that 12 million girls are married in childhood (age <18) every year.⁹ Using data from Demographic and Health Surveys (DHS), Wodon et. al. 2017 estimated the prevalence of child marriage in 25 countries that account for the majority of child marriages globally (with 18 in Africa, 5 in South and Southeastern Asia, and 2 in Latin America). In that subset of countries, 47 percent of women (aged 18-49) had been married before the age of 18, and 17 percent had been married before the age of 15. Although data suggests women born more recently were less likely to be married by the age of 18 (37 percent of those aged 18-22 vs. 55 percent of those aged 41-49), the rate of child marriage remains high and that broad decline masks pockets of persistence. In Niger, for example, younger women (aged 18-22) were about as likely as older women (aged 41-49) to have been married by age 18 and, in Mali, younger women were even more likely.¹⁰

Evidence suggests that child marriage is generally much more common in rural areas. One study from 2014 observes that the “difference is especially striking in some countries in West and Central Africa and in Latin American and the Caribbean, where the prevalence of child marriage in rural areas is about twice the level found in urban areas.” A 2013 study from Ethiopia found that women in urban areas marry at older ages than rural women (19.3 years old vs. 16.6 years on average, respectively)¹¹ and Wodon, et. al. observe, “girls from poorer socio-economic backgrounds as well as girls from rural areas or lagging regions tend to be much more likely to marry early and/or have their first child before reaching 18 than girls from urban or more privileged backgrounds.”¹²

However, the generally higher prevalence of CEFM in rural areas should not obscure the fact that the practice remains high among the urban population of many countries: the share of urban women aged 20 to 49 years who were married or in union before age 18 exceeded 20 percent in approximately 50 countries and exceeded 40 percent in 14 countries.¹³

Female Genital Mutilation/Cutting (FGM/C)

Drawing from sources of nationally representative data (e.g., DHS and Multiple Cluster Surveys), UNICEF estimates that at least 200 million girls and women alive in 2016, from 30 countries, had undergone FGM/C.¹⁴ Although this is an increase in absolute numbers from a 2013 UNICEF estimate of 125 million, the overall trend is of declining prevalence. In 1985, half of all girls aged 15 to 19 in those 30 countries had undergone FGM/C while in 2017 that number has declined to

⁸ See, for example Shreeves and Prpic 2016, p. 4; Boyden, Pankhurst, and Tafere, p. 13; Sachdev 2018.

⁹ United Nations Children’s Fund (UNICEF), 2019

¹⁰ Wodon et al., 2017

¹¹ Boyden, Pankhurst, and Tafere, 2013

¹² Wodon et al., 2017

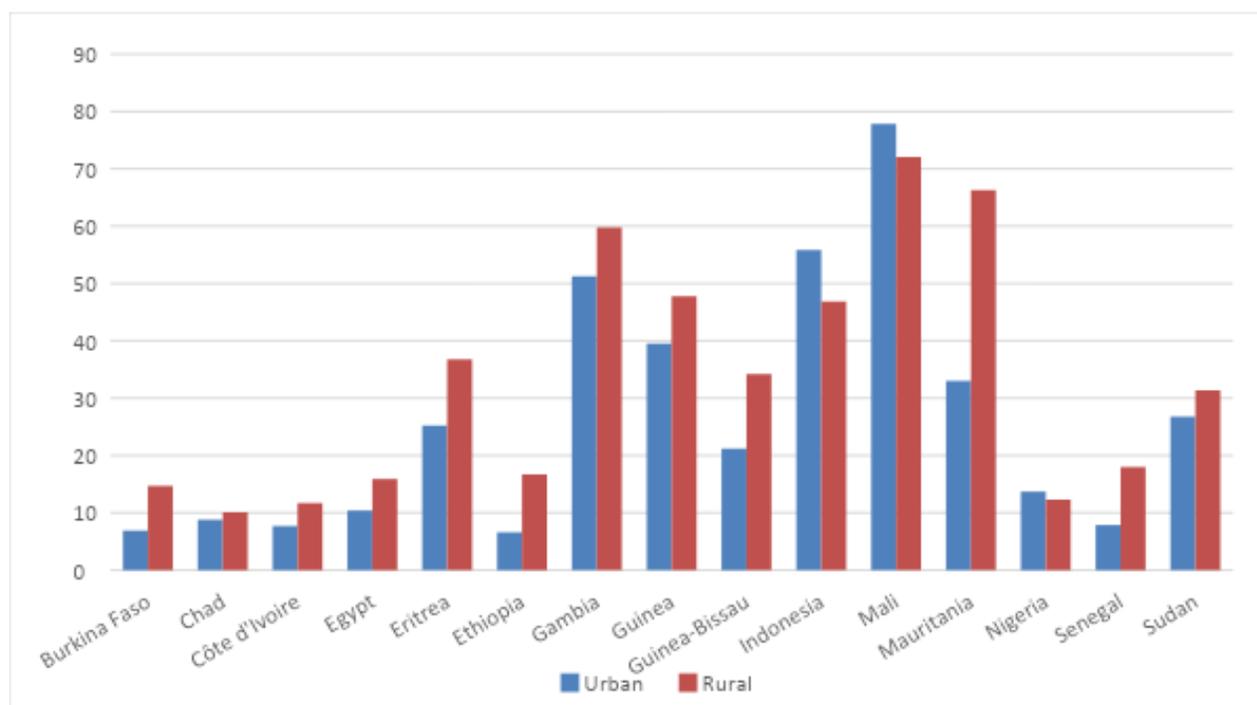
¹³ UNICEF, 2014b

¹⁴ United Nations Children’s Fund (UNICEF), 2016

just over a third.¹⁵ A study from 2017, also using DHS data, looked at the prevalence of FGM/C in 22 African and Middle Eastern countries over three decades and found that, while this practice is generally becoming less common over time, more than half of women in seven of the countries still experience it based on latest available data.¹⁶

In 15 countries where FGM/C is particularly prevalent (>10 percent), data compiled by UNICEF suggests that the practice is typically more common in rural settings. However, urban and rural prevalence was similar in some countries (e.g., Chad) while in three countries (Indonesia, Mali, and Nigeria), the practice was actually more common in urban settings (Figure 1). Additionally, even in countries which have higher prevalence rural areas, this does not suggest the HTP isn't a concern in urban ones; a 2013 study in Ethiopia estimated prevalence of FGM/C in that country to be 15 percent for women in urban areas compared with 24 percent in rural areas.¹⁷

Figure 1: Prevalence of FGM/C in 15 Countries by Urban/Rural



Source: UNICEF 2018

One study concluded that while place of residence is related to FGM/C prevalence, the relationship does not consistently favor urban or rural settings. In fact, in locations with a high prevalence of FGM/C, it appears to take place equally in both settings. The study concludes that the lack of a clear, consistent relationship between urbanization and prevalence in specific countries shows that a multitude of factors in a given location are important in affecting who

¹⁵ United Nations Children's Fund (UNICEF), 2018

¹⁶ Koski and Heymann, 2017

¹⁷ Boyden, Pankhurst, and Tafere, 2013

experiences FGM/C (e.g., ethnic composition, religion, education, etc.).¹⁸ Individual country analyses of DHS data demonstrate that wide in-country variation does exist. Studies from Burkina Faso¹⁹ and Ethiopia²⁰, for example, confirm that FGM/C is significantly more common in rural areas in those countries.

Female infanticide and feticide

Measuring or estimating female infanticide and feticide is extremely difficult due to likely underreporting and the lack of reliable data.²¹ Instead, many researchers and advocates focus on sex ratio at birth (SRB), which can be seen as a proxy for feticide. A natural SRB is approximately 1.05 male births to 1.00 female births. However, one study of data from 202 countries estimated global SRB in 2017 at 1.07 with the highest ratio in eastern Asia ranging as high as 1.14 in China.²² In addition to China, the study identified 11 other countries or regions with strong statistical evidence of SRB imbalance from 1970 to 2017: Albania; Armenia; Azerbaijan; Georgia; Hong Kong; India; Republic of Korea; Montenegro; Taiwan; Tunisia; and Vietnam. Over this period, this resulted in an estimate of nearly 12 million “missing women” in China and 10.6 million in India, alone.²³

Evidence on female infanticide and feticide suggest a mixed picture and strong conclusions are undermined by incomplete data. Two older studies (from 2009 and 2011) suggest that rural women in India are more likely to prefer sons than urban women but these studies are relatively small in scope, the difference between rural and urban preferences observed by one study was not significant, and the studies do not link preference with specific actions or outcomes (e.g., sex-selective abortion).^{24 25} Data from UNICEF show that in China, sex ratio at birth is more pronounced in rural areas than urban ones (Figure 2).

¹⁸ Hearst and Molnar, 2013

¹⁹ Karmaker et al. 2011

²⁰ Boyden, Pankhurst, and Tafere, 2013

²¹ Scrimshaw, 2008

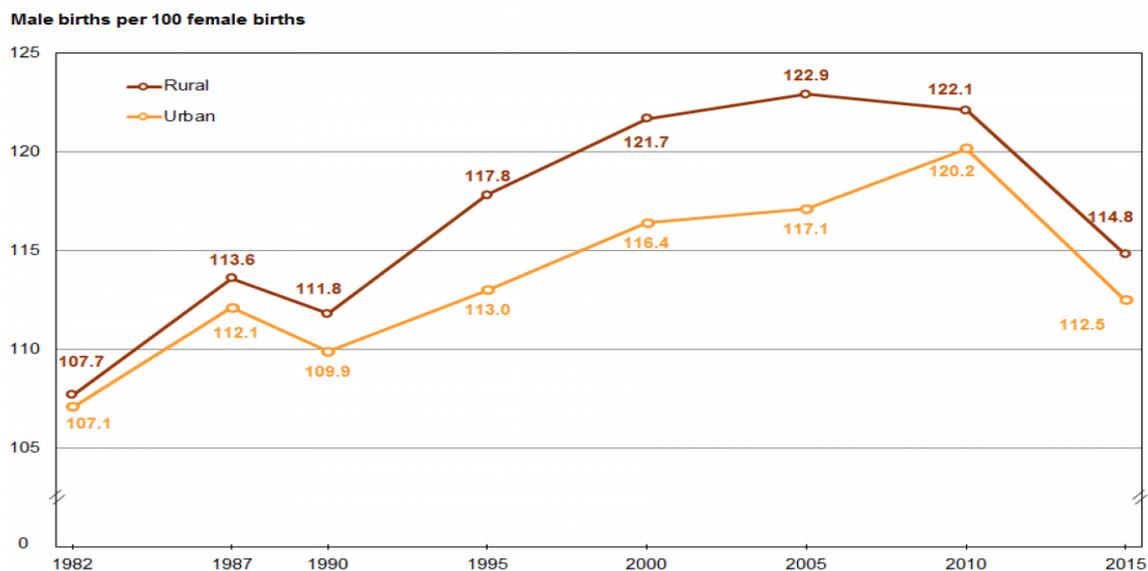
²² Chao et al, 2019

²³ Chao et al, 2019

²⁴ Chavada and Bhagyaxmi, 2009; Lei and Pals, 2011

²⁵ Gadi, Kumar, and Goyal, 2018

Figure 2: Male births per 100 female births in China



Source: NWCCW, NBS, UNICEF 2018, 20

NEGATIVE IMPACTS

Harmful traditional practices have severe and direct consequences on women and girls. Negative impacts have been observed on the health and well-being of women and girls (e.g., immediate and long-term physical and psychological harm²⁶, increased vulnerability to HIV infection²⁷, poor performance in school²⁸, etc.). These practices present significant barriers to their empowerment and access to opportunities.²⁹ Certain practices are especially costly for women and girls, including the severe health consequences and complications of FGM/C³⁰ (including death and disability³¹), the link between CEFM and adolescent pregnancy and the negative impact of those pregnancies on mothers and children.³²

A few studies have attempted to estimate the economic costs of these practices, particularly of CEFM. A broad review concluded that “the economic impacts and cost of child marriage are likely to be very high for the girls who marry early, their children, their families, their communities, and society at large.”³³ Ending child marriage yields economic benefits primarily by delaying childbirth and decreasing overall birth rates, thereby stabilizing population growth and increasing per capita GDP. One study estimated that if child marriage had ended in 2015, by 2030 the annual global benefit would be worth \$566 billion with \$98 billion in benefits accruing from reduced under-five mortality and stunting.³⁴ The report’s authors estimate that failing to end child marriage will cost

²⁶ United Nations Office of the High Commissioner for Human Rights (OHCHR), 2011

²⁷ Page, 2018

²⁸ United Nations Children’s Fund (UNICEF), 2014a

²⁹ Banda and Atansah, 2016

³⁰ Klein et al., 2018

³¹ United Nations Office of the High Commissioner for Human Rights (OHCHR), 2011

³² United Nations Population Fund (UNFPA), 2013

³³ Parsons et al., 2015

³⁴ Wodon, Savadogo, and Kes, 2017

the countries where it is prevalent “billions of dollars.” This review has found no rigorous studies estimating the economic impact of female infanticide/feticide or FGM/C.

UNDERSTANDING RURAL-URBAN DIFFERENCES

Some forms of HTPs may be less prevalent in urban settings than rural ones in the same country (although, as the evidence shows, this is often not the case), due to unique urban factors and the impact of rural to urban migration.

Singh and Samara (1996) show that urbanization is one of three factors which contribute most significantly to women’s age at first marriage – the others being participation in the labor force and acquisition of formal education (correlates with urbanization). The authors suggest that urbanization could empower women to delay marriage timing by exposing them to “modern values” favoring marriage postponement while providing geographic distance from community-based forms of social control and offering greater opportunities for nonmarital sexual relationships.³⁵

Shell-Duncan et. al (2016) suggest that urban settings may be more culturally diverse, providing opportunities to engage with individuals who do not practice FGM/C and weakening ties with home communities, making it easier and less punitive to deviate from longstanding harmful practices.³⁶

Some have explored the links between migration and culture change, suggesting that migration (broadly) provides an opportunity for “competing ideas about the way society is or should be organized [to] flourish.”³⁷

Sociologist Alice Evans (2018) considers whether cities can serve as “catalysts of gendered social change” based on ethnographic research from Zambia. Evans argues that people living in dense, heterogenous areas are more likely to see women perform socially valued roles, eroding strict gender ideologies and divisions of labor. Urban areas also provide greater access to services and supports that women can use to prevent or address gender-based violence.³⁸

While some forms of HTPs may be less prevalent in urban settings, this environment carries its own heightened risks that threaten the wellbeing and health of women and girls. For instance, crowded and unsafe living conditions could expose children to sex at an early age or increase their risk of rape, substance use, and human trafficking.³⁹ In addition, some urban characteristics (e.g., more fragmented social ties, the pressures of urban living, and reliance on public transport) can increase the risk of exposure to gender-based violence.⁴⁰

³⁵ Singh and Samara, 1996

³⁶ Shell-Duncan, Naik, and Feldman-Jacobs, 2016

³⁷ Curran and Saguy, 2001

³⁸ Evans, 2018

³⁹ Boyden, Pankhurst, and Tafere, 2013

⁴⁰ McIlwaine 2013

EVIDENCE ON EFFECTIVE HTP INTERVENTIONS AND URBAN SETTINGS

The success of interventions to address HTPs will vary given differences in infrastructure, institutions and institutional capacities, demographics, and norms in urban and rural settings. There is some evidence on effective interventions on reducing CEFM, limited evidence on interventions to change perceptions and attitudes on FGM/C, and practically no rigorous evidence on effective interventions to reduce female infanticide/feticide. There is extremely limited evidence on drivers and effective interventions in urban settings in particular which, given the high prevalence of several HTPs in the urban areas of some countries, suggests an urgent need for more research.

Broadly, interventions that address HTPs can be grouped in the following six categories⁴¹:

1. **Economic resource interventions** provide financial incentives to address the economic drivers of harmful practices, for example, resources to cover school fees or defray other costs related to schooling; provide conditional and unconditional cash transfers; or offer access to cash grants to start businesses.
2. **Human resource interventions** build women and girls' skills and capacities, such as educational or vocational skills, to improve their independence.
3. **Social resource interventions** help women and girls develop a range of connections outside of the family, for example female adult mentors, role models, advocates, and peer supports.
4. **Voice and agency opportunity** interventions improve women and girls' confidence and empowerment, including by teaching assertiveness, communication, and negotiation.
5. **Community engagement interventions** target changing social norms and focus on participatory activities to mobilize community residents and engage them in shared problem solving.
6. **Community infrastructure interventions** enhance educational and health service supports for women and girls.

This section summarizes overall evidence on the effect of interventions for each HTP before considering what evidence exists related to urban contexts and what implications this might yield for funders, policymakers, and advocates.

Child, Early, and Forced Marriage (CEFM)

Several systematic reviews of child marriage interventions have been undertaken^{42,43} covering eleven different evaluations across eight countries (Table 1) in Africa, Latin America, and South Asia. The reviews did not focus explicitly on urban interventions but do provide evidence on effective interventions more generally.

The popularity and moderate success of *economic resource* interventions to address child marriage may be due to their ability to address a key driver of early marriage: household costs.

⁴¹ Yount, Krause, and Miedema, 2017

⁴² Kalamar, Lee-Rife, and Hindin, 2016

⁴³ Lee-Rife et al., 2012

Early marriage is a clear way to lower a household's cost burden. Once a daughter is married, parents are no longer economically responsible. Marriage may also mean a dowry payment for the family in certain parts of the world. Economic transfers such as cash transfers may limit those burdens. The evidence from these studies shows that the availability of economic transfers in the forms of school fees or simple cash transfers can lower the proportion of girls getting married at a young age – although the length of marriage delay may vary. There is some evidence that investments in *voice and agency*, specifically life-skills, can also be effective in delaying child marriage. The theory of change is that life-skills allow young women to develop confidence enabling them to voice opposition to HTPs.

Although child marriage persists in both urban and rural settings, there is relatively little rigorous research on drivers of and interventions to address child marriage in urban contexts.⁴⁴ A 2018 review of evidence found just two evaluations set in solely urban settings.⁴⁵ A high-quality 2009 natural experiment measured a range of outcomes for adolescents and families in poverty participating in the Government of Mexico's Oportunidades incentives program, an economic resource intervention using conditional cash transfers, and found that the program led to delays in marriage, onset of premarital sex, and age at first and second birth.⁴⁶ More recently but less rigorously, a 2015 quasi-experimental study of an empowerment and advocacy intervention in urban slums in Bangladesh found improvements in confidence and awareness among the girls (aged 10-19) who participated.⁴⁷

Other studies have looked at interventions with participants in both rural and urban areas but do not provide results by setting. Nonetheless, there is reason to expect that urban settings influence the effectiveness of certain CEFM interventions. For example, models for educating youth and engaging them in community discussions on advocacy and child rights – for instance “child clubs” supported by Save the Children – that require time commitments may be easier for urban children to participate in due to their shorter commutes to school.⁴⁸ On the other hand, a 2017 qualitative study of child marriage practices among Syrian conflict-affected populations in Lebanon found that concerns about girls' honor – specifically the high value placed on girls' virginity and limiting non-marital sexual activity and pregnancy – was a stronger cause of child marriage among families living in urban areas than for families living in refugee camps.⁴⁹ Further, despite lower prevalence of child marriage in urban areas (in most places), rural to urban migration does not always reduce the risk of early or forced marriage and for some families, may increase it in the short term. One study from India found that migrant families often arrange marriages for their daughters before leaving their villages as this is one of the few accessible ways for families to provide security for their daughters.⁵⁰

⁴⁴ Freccero and Whiting, 2018, p. 5

⁴⁵ Freccero and Whiting, 2018, p. 15

⁴⁶ Gulemetova-Swan, 2009

⁴⁷ Freccero and Whiting, 2018, p. 71

⁴⁸ Freccero and Whiting, 2018, p.36

⁴⁹ Mourtada, Schlecht, and DeJong, 2017

⁵⁰ Nirantar Trust, 2015

Female Genital Mutilation/Cutting (FGM/C)

Existing efforts to document and evaluate FGM/C interventions (regardless of urban or rural setting) have been limited. A Campbell Collaborative systematic review from 2012 only found eight studies of intervention effectiveness that met sufficient standards of rigor (it also reviewed a further 27 context studies).⁵¹ The studies came from seven different African countries (Burkina Faso, Egypt, Ethiopia, Somalia/Kenya, Mali, Nigeria, and Senegal). The review concluded that evidence on FGM/C interventions points to limited effectiveness and weak overall evidence quality, making it difficult to draw conclusions on “what works.” The study did suggest that educational interventions that emphasize the negative consequences of FGM/C or correct inaccurate knowledge may be able to trigger changes in beliefs and attitudes, but the review found limited effects on the actual practice of FGM/C. A more recent RCT using four variants of a video highlighting different views on cutting, found that dramatizing the issue can shift attitudes about uncut girls, with a stronger effect measured when individuals watched the movies alone (as opposed to individuals watching the community screenings).⁵²

Most FGM/C interventions focus on leveraging social resources, many from the local community, in the form of training, education, or advocacy. The underlying theory of change is that people lack knowledge about the negative consequences of FGM/C and behavior will change once this knowledge is shared through peer networks. Until recently, a common understanding has been that interventions should target the community level. Norms around FGM/C were viewed as a coordination problem, where communities coordinate to hold the view, in this case, that FGM/C is necessary to ensure the marriageability of girls. To shift norms, the thinking was that interventions must shift the entire community’s (an “all or nothing” approach to behavior change).⁵³ However, recent research shows that there is significant local variation in households on attitudes around FGM⁵⁴ suggesting that interventions should focus on both the individual and community level.

The limited overall evidence makes it even more difficult to conclude what interventions are most or least effective in urban settings as few studies look specifically at this variable or make their raw data available for further analysis. The evidence that does exist mirrors the overall finding of the Campbell Collaborative systematic review: educational programs can change attitudes and beliefs but don’t necessarily affect prevalence. One comparison study of an educational intervention for female students at an urban university in Egypt, for example, found that the program was effective at increasing knowledge on FGM/C and other sexual and reproductive health topics.⁵⁵ The study did not measure impact of the intervention on behavior.

Nevertheless, it’s reasonable to expect that urban context should inform intervention selection and design. A systematic review from 2018 suggests that geographic context (urban vs. rural) is an important factor when designing health education and awareness campaigns.⁵⁶ Rural settings face some unique challenges: females in rural settings seem more likely to support the continuation of FGM/C⁵⁷, health education interventions in rural areas may require more intense

⁵¹ Berg and Denison, 2012

⁵² Powell 2017

⁵³ Powell 2017

⁵⁴ Bellemare, Novak, and Steinmetz, 2015

⁵⁵ Mounir, Mahdy, and Fatohy, 2003.

⁵⁶ Waigwa, et al. 2018.

⁵⁷ Alo and Gbadebo, 2011.

planning and implementation⁵⁸, and the inherent isolation in rural areas may make awareness efforts more difficult.⁵⁹

Conversely, urban areas may present an opportunity for achieving swift reductions in FGM/C rates given the relatively individualized nature of decision-making, access to greater services, and exposure to different ethnic groups and perspectives. Beyond measures aimed at reducing new cases of FGM/C, urban areas may also be ideal places to offer support for women and girls who have suffered from FGM/C and associated negative consequences, especially given high rates of rural to urban migration in many developing countries (including a number with high rural prevalence rates). Yet urban stakeholders are often not involved in the development of FGM/C interventions⁶⁰ and less support for continuing the practice among urban women does not, as noted above, always translate into lower prevalence rates. Instead, the practice is often medicalized and performed by health care providers in urban areas.⁶¹ Further, some evidence has shown that pressure to conform and beliefs around the moral virtue and aesthetic “benefits” of FGM/C span the urban – rural divide⁶², and a 2018 study in Sudan suggests that rural to urban migration may actually exacerbate FGM/C prevalence due to social pressure to adopt the practice in order to integrate into new communities.⁶³ Taken as a whole, this evidence suggests the need to consider urban context when designing interventions and to target barriers that prevent higher awareness from enabling reductions in prevalence.

Female infanticide and feticide

This review found no rigorous evidence of effective programming to address female infanticide or feticide. Existing efforts typically fall into three categories: criminalizing abortion and infanticide through legislation to limit the use of technology for sex-selection purposes; legal and policy measures to address inequalities between boys and girls (e.g., equitable inheritance, pension programs for families with girls only, etc.); and campaigns to raise awareness and change mindsets.⁶⁴ Despite the existence of a number of programs and policies to address this issue, it is unclear what approaches have demonstrated effectiveness, either in isolation or in combination.

Similar to other HTPs, urbanization itself and the access to opportunities, services, alternative ideas, and relative stability that it is thought to offer, is believed to contribute to re-balancing sex ratios (i.e., declines in female infanticide and feticide). However, this relationship is not always present and linear. The strongest evidence on the persistence of female infanticide and feticide challenges in urban areas comes from India. A study of sex birth ratios from Tamil Nadu in the 1990s suggest urban areas there had greater imbalances than neighboring rural ones⁶⁵ and a 2015 study in Bihar finds that female feticide continues to increase despite rising levels of autonomy and education among women.⁶⁶ The growth across India of private clinics providing access to female feticide, starting in the 1970s, may have contributed to higher imbalances in many urban areas.⁶⁷ At a minimum, this suggests urban areas merit the attention of policies and

⁵⁸ Alo and Gbadebo, 2011.

⁵⁹ Ruiz, Martinez, and Del Mar Pastor Bravo, 2016

⁶⁰ World Health Organization, 2011a.

⁶¹ World Health Organization, 2011a.

⁶² Shell-Duncan, et. al, 2018, p. 9.

⁶³ Bedri et al., 2018.

⁶⁴ World Health Organization, 2011b

⁶⁵ Srinivasan and Bedi, 2011.

⁶⁶ Kumari, 2015.

⁶⁷ Grewal and Kishore, 2004.

interventions designed to address female infanticide and feticide, and points to the insufficiency of strategies that rely solely on urbanization itself as well as increasing income, literacy, and autonomy.

Table 1: Impact Summary of high-quality early marriage interventions

Country	Program	Intervention	Evaluation (age)	Proportion Married (Decrease Expected)	Age Married (Increase Expected)
Colombia	PACES	School voucher program	13 - 17		
Mexico	Oportunidades	Conditional Cash Transfers	14 - 21		
Zimbabwe	School Subsidies for HIV Education	Subsidy	17		
India	Improving the Reproductive Health of Married and Unmarried Youth in India	Life skills curriculum	11 - 17		
Ethiopia	Berhane Helwan	School support; life-skills curriculum	10 - 19	 	
Malawi (a)	ZOMBA CashTran	Conditional Cash Transfers	14 - 23		
Malawi (b)	Cash Transfer Program: Conditional and Unconditional	Conditional/ Unconditional Cash Transfers	13 - 22		
India	Development Initiative on Supporting Healthy Adolescents (DISHA)	School support; life-skills curriculum	14 - 18		
Bangladesh	UNICEF Adolescent Girls' Adventure	Life skills curriculum	15 - 25		
Kenya	Subsidy + HIV Education Program	School uniforms; teacher training	20.5		
Kenya	Kenya Cash Transfer for Orphans and Vulnerable Children	Unconditional cash transfers	12 - 24		

Source: Authors' modification of Yount, Krause, and Miedema 2017.

-  P < 0.001
-  P < 0.01
-  P < 0.05
-  Not statistically significant

EVIDENCE GAPS AND RECOMMENDATIONS FOR USAID PROGRAMMING AND POLICY

USAID has supported several interventions aimed at addressing the three HTPs reviewed in this brief, particularly FGM/C and CEFM (Appendix 1). This portfolio of projects, primarily in Africa, emphasizes the role of community engagement and education in changing norms and decreasing HTP prevalence. Rather than conducting an evaluation of the USAID portfolio, we looked at the available evidence on interventions more generally and extracted lessons which are relevant to USAID's programming and the broader field.

This review of evidence has revealed several knowledge gaps in the field. For example:

- There is relatively limited rigorous evidence on the effectiveness of FGM/C interventions and practically no evidence on the effectiveness of infanticide/feticide interventions. Difficulties in measuring impact complicate intervention evaluations for both. The measurement challenges have also made it difficult to estimate the prevalence of HTPs, and FGM/C in particular, with precision.
- Few studies of prevalence focus on differences between rural and urban populations, much less explore potential reasons for differences, should they exist. Similarly, most interventions are not explicitly designed for application to either urban or rural settings, and most evaluations do not detail how outcomes differ across geography even though such data may be available from intervention records, making it difficult to draw insights that are especially relevant for urban settings.
- The role of migration in changing HTP-related norms merits further research. While there is some evidence that international migration changes norms held both by immigrants as well as by those they maintain ties with in the home country⁶⁸ and that the norms held by international immigrants related to HTPs change, there is insufficient evidence that this changes HTP norms in the home country.⁶⁹ Further, it is unclear in this research review to what extent these processes play out with internal migration (especially rural to urban migration), what specific causal role urbanization itself plays on changing norms around HTPs, and the relative rate of this factor compared with other variables. There is also insufficient evidence on norms and the prevalence of HTPs within sub-populations (e.g., households and communities that have long lived in urban areas vs. new arrivals).
- Although there is evidence that urban areas correlate with support for gender equality⁷⁰, there is relatively little established understanding in the wider field on the precise mechanisms and channels through which norms and values change. For instance, the role of individual agency is unclear. There also isn't enough evidence, particularly from rigorous evaluations, on the impact of specific variables in contributing to continued persistence of HTPs (e.g., the role of men in determining outcomes).

⁶⁸ Beine and Sekkat, 2013; Tuccio, Wahba, and Hamdouch, 2016

⁶⁹ Johnsdotter and Essen, 2016

⁷⁰ Evans, 2018

If a more accurate picture of HTP prevalence, drivers, and effective programming options is to be made, these gaps should be filled by targeted research. A review of the evidence lends itself to several recommendations for policy and programming, including ways to address evidence gaps and build on the evidence that does exist:

While evidence of the role of urbanization in affecting prevalence and the effectiveness of individual interventions is limited, existing evidence suggests that HTPs are not only a challenge in rural communities. Many HTPs are prevalent in urban environments and some HTPs in certain countries may be more prevalent in urban areas. Interventions designed primarily or exclusively for rural communities are insufficient to address the complex challenges posed by HTPs - **policies and programming on HTPs should target urban environments, as well.**

- Many interventions have been grounded in the belief that community-level approaches (i.e., decreasing HTP prevalence requires changing the norms of the entire community) work best. This view has been challenged by emerging evidence showing that attitudes and beliefs vary at the household level, suggesting interventions aimed at individuals or households may be effective. It's reasonable to adopt **an approach to programming and policies that targets both communities and individual households.**
- By removing a key driver of many HTPs (financial pressure), **economic incentive interventions can be effective, particularly for stemming CEFM.** However, effectiveness can vary by age-group, type of incentive, and context, as marriage markets can be extremely localized.⁷¹ Effectiveness might also be constrained when economic incentives are not paired with messaging on the value of girls designed to change social norms.⁷² While there is some evidence that *voice and agency* interventions empower women and girls to voice opposition to a practice, it is not always clear that this leads to decreased prevalence and other evidence suggests the role of individual agency in changing norms around HTPs is still unclear.⁷³
- Given the evidence gaps described, stakeholders should consider **investing in rigorous evidence building for all HTP interventions** it supports. The appropriate research design (e.g., RCT, pre/post, etc.) will differ by project but deepening the evidence base is fundamental. This is particularly important to build the evidence base on what works in specific settings and contexts (e.g., urban). Such a study could compare the impact of the same program on urban and rural populations and with a comparison group in each.

As this evidence review shows, several HTPs remain far too prevalent in far too many places, affecting millions of women and girls. These practices often persist in urban environments despite a tendency to consider HTPs as primarily rural concerns. Although there are a number of important gaps in the field's knowledge related to prevalence, effective interventions, and the role of various factors (including urbanization itself), there is growing evidence on the types of interventions that are effective and the approaches and factors that development partners, such as USAID, should take into consideration in order to design effective programming and policies to eliminate HTPs.

⁷¹ See Erulkar, Medhin, and Weissman 2017.

⁷² Ibid

⁷³ See, for example, Cislighi et. al. 2019, which shows how increased agency in some settings can actually sustain the practice of early marriage.

APPENDIX 1: USAID PROGRAMMING ON SELECT HARMFUL TRADITIONAL PRACTICES

A scan of USAID's existing programming to address the three HTPs covered by this evidence brief surfaced 11 projects.⁷⁴

HTP Type	Project name	Geography	Intervention Type	Actions	Relevant targeted outcomes
FGM/C	Tostan ⁷⁵	West Africa (rural)	Participatory Education Program	Integrative education of democracy, problem solving, basic math, literacy, health (including FGM/C)	Community commitment to ending practice of FGM/C
FGM/C	Creating Attitudes Favorable to Elimination of the Practice of FGM/C ⁷⁶	Egypt (urban)	Community Engagement/ Education	Information distribution, education, public awareness campaigns. Training of health care providers, community leaders, volunteers for advocacy and mental health.	Coherent national strategy on issue and improved messaging.
FGM/C	Unnamed (project with US Special Envoy for Sudan and S. Sudan) ⁷⁷	Sudan (West Nile State)	Community Engagement/ Education	Community leaders (and men, women, and children) organizing to support collective statements against FGM/C. Community leaders are educated and use existing social structures to engage with community on these topics and "build community ownership."	Create community consensus that discourages and phases out practice of FGM/C.
FGM/C	Kenya Centre Of Excellence for FGM/C ⁷⁸	Kenya (N/A)	Research/ Community Engagement	Creating a "pan-African" center of learning and research around health issues of traditional practices. Will train and educate leaders/students about harms of FGM/C.	Create community consensus that discourages and phases out practice of FGM/C.

⁷⁴ This table is not necessarily inclusive of all current and recent USAID programs targeting these three HTPs. Other programs may exist, including ones which indirectly touch on these HTPs

⁷⁵ "The U.S. Government Working Together for the Abandonment of Female Genital Mutilation/Cutting," US Agency for International Development, accessed May 1, 2019, <https://www.usaid.gov/news-information/fact-sheets/jan-2014-us-government-working-together-abandonment-female-genital-mutilation>

⁷⁶ Ibid

⁷⁷ Ibid

⁷⁸ Ibid

FGM/C	The Grandmother's Project ⁷⁹	Senegal (primarily rural)	Family planning program	Open discussions about FGM (specifically involving grandmothers and elderly women)	Reach consensus on best alternative solution to FGM/C
CEFM	Healthy Unions Project ⁸⁰	Ethiopia (unclear)	Community engagement/school-level intervention	Established 78 community committees trained to assist girls who married early and had birthing complications (providing/identifying medical care). Provided paralegal training for 650 community volunteers. School interventions taught school aged girls of basic finance and created platform to speak out and organize against HTP. Helped to engage in income generation activities.	Abandonment of FGM/C practice through awareness/community advocacy and legal avenues.
CEFM	The Time to Learn Project ⁸¹	Zambia (rural and urban)	Education	Strengthen education support (assist Ministry of Ed.) Supports scholarships for OVCs (orphans and vulnerable children) who would otherwise be married off -- have high risk of contracting HIV	Increase school adherence and teach girls to care for themselves and postpone marriage
CEFM	Safe Age of Marriage Project ⁸²	Yemen (rural)	Education	Mobile clinics and community-based awareness sessions to raise age of marriage.	End child marriage and set dowry caps. Change attitudes towards women and marriage.
CEFM	Women's Legal Rights Initiative in Benin ⁸³	Benin (rural and urban)	Public Awareness Campaign	Campaign reaching over 100,000 to educate about women's legal rights and family code (passed in 2014 addressing early marriage and rights/responsibilities of men and women). Distribution of booklets, brochures, film screenings,	Increased awareness on women's legal rights and new family code

⁷⁹ Ibid

⁸⁰ "Fact Sheet: USAID's Vision for Action on Child Marriage," US Agency for International Development, accessed May 1, 2019, <https://www.usaid.gov/documents/2155/fact-sheet-child-marriage-vision>

⁸¹ Ibid

⁸² Ibid

⁸³ Ibid

				community meetings, and TV/radio broadcasts.	
CEFM	Reproductive Health for Married Adolescent Couples Project (RHMACP) ⁸⁴	Nepal (unclear)	Education/Community Engagement	Married adolescent peer educators. Training to health care providers on how to inform young couples. Rallies held against child marriage and dowry system.	Increase in attitudes of parenting as a shared responsibility. Increase in hospital visits throughout pregnancy and early parenting. Increased age of marriage for females in 2 districts from 14 to 16 years old.
Female Infanticide (GBV largely)	Gender Roles, Equality, and Transformation (GREAT) Project ⁸⁵	Northern Uganda (rural)	Education/Community Engagement/Health Provision Training	Radio serial drama, toolkit with tailored discussion guides, activity cards, games that allow adolescents (married/un-married) to challenge gender norms and understand sexual health. Training for Village health workers on reproductive health services	Reduction in GBV and increased gender equality and respect for women and girls.

⁸⁴ Ibid

⁸⁵ “Preventing and Responding to Gender-Based Violence,” US Agency for International Development, accessed May 1, 2019, <https://www.usaid.gov/gbv>

REFERENCES

- Alo, O.A. and B. Gbadebo. 2011. "Intergenerational attitude changes regarding female genital cutting in Nigeria." *Journal of Womens Health*, 20: 11. Retrieved from <https://www.ncbi.nlm.nih.gov/pubmed/21919739/>
- Banda, Joyce and Priscilla Atansah. 2016. "An Agenda for Harmful Cultural Practices and Girls' Empowerment." Washington, DC: Center for Global Development. Retrieved from <https://www.cgdev.org/publication/agenda-harmful-cultural-practices-and-girls-empowerment>
- Bedri, Nafisa, Huda Sherfi, Ghada Rodwan, Sara Elhadi, and Wafa Elamin. 2018. "Medicalization of female genital mutilation/cutting in Sudan: Shifts in types and providers." *Evidence to end FGM/C: Research to help girls and women thrive*. New York: Population Council. Retrieved from https://www.popcouncil.org/uploads/pdfs/2018RH_FGMC-MedicalisationSudan.pdf
- Beine, Michel and Khalid Sekkat. 2013. "Skilled migration and the transfer of institutional norms." *IZA Journal of Migration*, 2(9). Retrieved from <https://izajodm.springeropen.com/articles/10.1186/2193-9039-2-9>
- Bellemare, Marc F., Lindsey Novak, and Tara L. Steinmetz. 2015. "All in the family: Explaining the persistence of female genital cutting in West Africa." *Journal of Development Economics*, 116: 252-265. Retrieved from <https://www.sciencedirect.com/science/article/pii/S0304387815000620>
- Berg, Rigmor C. and Eva Denison. 2012. "Interventions to reduce the prevalence of female genital mutilation/cutting in African countries." *Campbell Systematic Reviews*, 8:1. Retrieved from <https://onlinelibrary.wiley.com/doi/10.4073/csr.2012.9>
- Boyden, Jo, Alula Pankhurst, and Yisak Tafere. 2013. *Harmful Traditional Practices and Child Protection: Contested Understandings and Practices of Female Child Marriage and Circumcision in Ethiopia*. Oxford, UK: Young Lives. Retrieved from https://www.younglives.org.uk/sites/www.younglives.org.uk/files/YL-WP93_Boyden.pdf
- Chao, Fengqing, Patrick Gerland, Alex R. Cook, and Leontine Alkema. 2019. "Systematic assessment of the sex ratio at birth for all countries and estimation of national imbalances and regional reference levels." *Proceedings of the National Academy of Sciences of the United States of America*, 116 (9): 9303-9311. Retrieved from <https://www.pnas.org/content/116/19/9303>
- Chavada, Mallika and A. Bhagyalaxmi. 2009. "Effect of socio-cultural factors on the preference for the sex of children by women in Ahmedabad district." *Health and Population: Perspectives and Issues*, 32(4): 184-189. Retrieved from <http://medind.nic.in/hab/t09/i4/habt09i4p184.pdf>
- Cislaghi, Beniamino, Leah Kenny, Hamse Koshin, and Munshi Sulaiman. 2019. "Adolescent-led marriage in Somaliland and Puntland: A surprising interaction of agency and social norms." *Journal of Adolescence*, 72 (2019): 101-111. Retrieved from <https://www.sciencedirect.com/science/article/pii/S0140197119300405?via%3Dihub>
- Curran, Sara R. and Abigail C. Saguy. 2001. "Migration and Cultural Change: A role for gender and social networks?" *Journal of International Women's Studies*, 2(3): 54-77. Retrieved from <https://vc.bridgew.edu/cgi/viewcontent.cgi?referer=https://scholar.google.com/&httpsredir=1&article=1619&context=jiws>
- Erukhar Annabel, Girmay Medhin, and Eva Weissman. 2017. "The Impact and Cost of Child Marriage Prevention in Three African Settings," Addis Ababa; New York: Population Council. Retrieved from https://www.popcouncil.org/uploads/pdfs/2017PGY_ChildMarriageAfrica_report.pdf
- Evans, Alice. 2018. "Cities as Catalysts of Gendered Social Change? Reflections from Zambia." *Annals of the American Association of Geographers*, 108(4): 1096-1114. Retrieved from <https://www.tandfonline.com/eprint/ujY8EACcdXKpkI5GktCY/full>
- Freccero, Julie and Audrey Whiting. 2018. "Toward an End to Child Marriage." Berkley, CA: Human Rights Center at the University of California, Berkley, School of Law. Retrieved from: <https://www.law.berkeley.edu/wp-content/uploads/2018/08/Toward-an-End-to-Child-Marriage-Report-FINAL.pdf>

- Gadi, Nabeel Ahmed, Randhir Kumar, and Anmol Goyal. 2018. "Factors influencing gender preference among women of Ambala, Haryana: a cross-sectional study." *International Journal Of Community Medicine and Public Health*, 5. Retrieved from https://www.researchgate.net/publication/327856156_Factors_influencing_gender_preference_among_women_of_Ambala_Haryana_a_cross-sectional_study
- Grewal, Indu and Jugal Kishore. 2004. "Female foeticide in India." *Humanist Outlook*, 11: 2 (pp. 61-65). Retrieved from https://www.researchgate.net/publication/257821034_Female_Foeticide_in_India
- Gulemetova-Swan, Michaela. 2009. "Evaluating the impact of conditional cash transfer programs on adolescent decisions about marriage and fertility: the case of Oportunidades." PhD diss., University of Pennsylvania. <https://search.proquest.com/docview/304980107>
- Hearst, Adelaide A. and Alexandra M. Molnar. 2013. "Female Genital Cutting: An Evidence-Based Approach to Clinical Management for the Primary Care Physician." *Mayo Clinic Proceedings*, 88 (6): 618-629. Retrieved from [https://www.mayoclinicproceedings.org/article/S0025-6196\(13\)00264-4/pdf](https://www.mayoclinicproceedings.org/article/S0025-6196(13)00264-4/pdf)
- Johnsdotter, Sara and Birgitta Essen. 2016. "Cultural change after migration: Circumcision of girls in Western migrant communities." *Best Practice and Research Clinical Obstetrics and Gynaecology*, 32: 15-25. Retrieved from <https://www.sciencedirect.com/science/article/pii/S1521693415001959>
- Kalamar, Amanda M., Susan Lee-Rife, and Michelle J. Hindin. 2016. "Interventions to Prevent Child Marriage Among Young People in Low- and Middle-Income Countries: A Systematic Review of the Published and Gray Literature." *Journal of Adolescent Health*, 59(3): 16-21. Retrieved from [https://www.jahonline.org/article/S1054-139X\(16\)30161-6/fulltext](https://www.jahonline.org/article/S1054-139X(16)30161-6/fulltext)
- Karmaker, Bue, Ngianga-Bakwin Kandala, Donna Chung, and Aileen Clarke. 2011. "Factors associated with female genital mutilation in Burkina Faso and its policy implications." *International Journal for Equity in Health*, 10(20). Retrieved from <https://equityhealth.biomedcentral.com/track/pdf/10.1186/1475-9276-10-20>
- Klein, Elliot, Elizabeth Helzner, Michelle Shayowitz, Stephan Kohlhoff, and Tamar A. Smith-Norowitz. 2018. "Female Genital Mutilation: Health Consequences and Complications—A Short Literature Review." *Obstetrics and Gynecology International*, 2018. Retrieved from <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6079349/>
- Koski, Alissa and Jody Heymann. 2017. "Thirty-year trends in the prevalence and severity of female genital mutilation: a comparison of 22 countries." *British Medical Journal Global Health* 2(4). Retrieved from <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5717946/>
- Kumari, Dweepika. 2015. "Autonomy of educated urban women and their attitude towards female foeticide in India." *Human Geographies – Journal of Studies and Research in Human Geography*, 9: 1. Retrieved from <https://pdfs.semanticscholar.org/1060/c01460ae0a2c6a38721d7feb74d7edc3aac8.pdf>
- Le Roux, Elisabet, Brenda E. Bartelink, and Selina Palm. 2017. "What is the harm in 'harmful traditional practices'?" Retrieved from <https://jilifc.com/wp/wp-content/uploads/2017/11/What-is-the-harm-in-%E2%80%98harmful-traditional-practices%E2%80%99-final-draft.pdf>
- Lee-Rife, Susan, Anju Malhotra, Ann Warner, and Allison McGonagle Gliniski. 2012. "What Works to Prevent Child Marriage: A review of the evidence." *Studies in Family Planning*, 43(4): 287-303. Retrieved from <https://onlinelibrary.wiley.com/doi/abs/10.1111/j.1728-4465.2012.00327.x>
- Lei, Lei and Heili Pals. 2011. "Son Preference in China: Why is it stronger in rural areas?" *Population Review*, 50(2). Retrieved from https://www.researchgate.net/publication/236745068_Son_Preference_in_China_Why_is_it_Stronger_in_Rural_Areas
- McIlwaine, Cathy. 2013. "Urbanization and gender-based violence: exploring the paradoxes in the global South." *Environment and Urbanization*, 25(1): 65-79. Retrieved from <https://journals.sagepub.com/doi/pdf/10.1177/0956247813477359>

- Mirchandani, Rajesh. 2016. "How to Tackle FGM and Early Marriage—and Still Respect Culture: Podcast with President Joyce Banda and Kakenya Ntaiya." Washington, DC: Center for Global Development." Retrieved from <https://www.cgdev.org/blog/how-tackle-fgm-and-early-marriage-and-still-respect-culture-podcast>
- Mounir, G.M., N.H. Mahdy, and I.M. Fatohy. 2003. "Impact of health education program about reproductive health on knowledge and attitude of female Alexandria University students." *Journal of the Egypt Public Health Association*, 78(5-6):433-66. Retrieved from <https://www.ncbi.nlm.nih.gov/pubmed/17219905/>
- Mourtada, Rima, Jennifer Schlect, and Jocelyn DeJong. 2017. "A qualitative study exploring child marriage practices among Syrian conflict-affected populations in Lebanon." *Conflict and Health*, 11 (Suppl 1): 27. Retrieved from <https://www.girlsnotbrides.org/resource-centre/qualitative-study-exploring-child-marriage-practices-among-syrian-conflict-affected-populations-lebanon/>
- National Working Committee on Children and Women (NWCCW), National Bureau of Statistics (NBS), and United Nations Children's Fund (UNICEF). 2018. *An Atlas of Social Indicators*. Retrieved from <https://www.unicef.cn/sites/unicef.org.china/files/2019-04/Atlas%202018%20final%20ENG.pdf>
- Nirantar Trust. 2015. "Early and Child Marriage in India – A Landscape Analysis." New Delhi, India: Nirantar Trust; and New York, NY: American Jewish World Service. Retrieved from https://ajws.org/wp-content/uploads/2015/05/EarlyChildMarriageinIndia_LandscapeAnalysis_FULL.pdf
- Page, Samantha. 2018. "'Harmful traditional practices' and AIDS." *Development, Sexual Cultural Practices and HIV/AIDS in Africa*, 61-106. Retrieved from https://link.springer.com/chapter/10.1007/978-3-030-04119-9_4#citeas
- Parsons, Jennifer, Jeffrey Edmeades, Aslihan Kes, Suzanne Petroni, Maggie Sexton and Quentin Wodon. 2015. "Economic Impacts of Child Marriage: A Review of the Literature." *The Review of Faith & International Affairs*, 13(3), 12-22. Retrieved from <https://doi.org/10.1080/15570274.2015.1075757>
- Powell, Kendall. 2017. "A nagging persistence." *Nature Human Behavior*, 1. Retrieved from <https://www.nature.com/articles/s41562-016-0026?draft=collection#references>
- Ruiz, Ismael Jimenez, Pilar Almansa Martinez, and Maria Del Mar Pastor Bravo. 2016. "Key points for abolishing Female Genital Mutilation from the perspective of the men involved." *Midwifery*, 34: 30-35. Retrieved from <https://www.ncbi.nlm.nih.gov/pubmed/26971445/>
- Sachdev, Chhavi. "UNICEF's Good News About Child Marriage Isn't As Good As It Sounds." *National Public Radio*, March 14, 2018. Accessed March 13, 2020. Retrieved from <https://www.npr.org/sections/goatsandsoda/2018/03/14/593155781/unicefs-good-news-about-child-marriage-isnt-quite-as-good-as-it-sounds>
- Scrimshaw, Susan C.M. 2008. "Infanticide in Human Populations: Societal and Individual Concerns." In *Infanticide: comparative and evolutionary perspectives*. (ed. Glenn Hausfater and Sarah Blaffer Hardy). Retrieved from <http://www.nlb.gov.sg/biblio/13692449>
- Shell-Duncan, Bettina, Reshma Naik, and Charlotte Feldman-Jacobs. 2016. *A State-of-the-Art Synthesis on Female Genital Mutilation/Cutting: What do we know now?* New York City: Population Council. Retrieved from https://www.popcouncil.org/uploads/pdfs/SOTA_Synthesis_2016_FINAL.pdf
- Shell-Duncan, Bettina, Amadou Moreau, Katherine Wander, and Sarah Smith. 2018. "The role of older women in contesting norms associated with female genital mutilation/cutting in Senegambia: A factorial focus group analysis." *PLoS ONE*, 13 (7). Retrieved from <https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0199217>
- Shreeves, Rosamund and Martina Prpic. 2016. "'Harmful practices' as a form of violence against women and girls." Brussels, Belgium: European Parliamentary Research Service. Retrieved from [https://www.europarl.europa.eu/RegData/etudes/BRIE/2016/593556/EPRS_BRI\(2016\)593556_EN.pdf](https://www.europarl.europa.eu/RegData/etudes/BRIE/2016/593556/EPRS_BRI(2016)593556_EN.pdf)

- Singh, Susheela and Renee Samara. 1996. "Early Marriage among Women in Developing Countries." *International Family Planning Perspectives*, 22(4): 148–158. Retrieved from http://www.whatkidscando.org/featurestories/2008/04_immigrant_students/pdf/Early%20Marriage%20Among%20Women%20in%20Dvp'g%20Coutries%20.pdf
- Srinivasan, Sharada and Arjun S. Bedi. 2011. "Ensuring daughter survival in Tamil Nadu, India." *Oxford Development Studies*, 39: 3. Retrieved from <https://www.tandfonline.com/doi/abs/10.1080/13600818.2011.594500>
- Tuccio, Michele, Jackline Wahba, and Bachir Hamdouch. 2016. "International Migration: Driver of political and social change?" *IZA Discussion Paper No. 9794*. Retrieved from https://papers.ssrn.com/sol3/papers.cfm?abstract_id=2750277
- United Nations. 1993. "Declaration of the Elimination of Violence against Women." United Nations General Assembly Resolution, A/RES/48/104. New York City: United Nations. Retrieved from <https://www.un.org/documents/ga/res/48/a48r104.htm>
- United Nations. 1998. "Traditional or customary practices affecting the health of women and girls." United Nations General Assembly Resolution, A/RES/52/99. New York City: United Nations. Retrieved from <https://digitallibrary.un.org/record/251600>
- United Nations. 1999. "Traditional or customary practices affecting the health of women and girls." United Nations General Assembly Resolution, A/RES/53/117. New York City: United Nations. Retrieved from <https://digitallibrary.un.org/record/265762>
- United Nations Children's Fund (UNICEF). 2014a. *Hidden in Plain Sight: A Statistical Analysis of Violence against Children—Summary*. New York City: UNICEF. Retrieved from https://www.unicef.org/publications/index_74865.html
- United Nations Children's Fund (UNICEF). 2014b. *Ending Child Marriage: Progress and prospects*. New York City: UNICEF. Retrieved from https://www.unicef.org/media/files/Child_Marriage_Report_7_17_LR..pdf
- United Nations Children's Fund (UNICEF). 2016. "Female Genital Mutilation/Cutting: A Global Concern." New York City: UNICEF. Retrieved from [https://www.unicef.org/media/files/FGMC_2016_brochure_final_UNICEF_SPREAD\(1\).pdf](https://www.unicef.org/media/files/FGMC_2016_brochure_final_UNICEF_SPREAD(1).pdf)
- United Nations Children's Fund (UNICEF), 2018. "Percentage of girls who have undergone FGM (as reported by their mothers, by place of residence and household wealth quintile)." New York City: UNICEF. Retrieved from <https://data.unicef.org/topic/child-protection/female-genital-mutilation/>
- United Nations Children's Fund (UNICEF). 2019. "Child Marriage." New York City: UNICEF. Retrieved from <https://data.unicef.org/topic/child-protection/child-marriage/>
- United Nations Office of the High Commissioner of Human Rights. 2003. "Elimination of violence against women." Commission on Human Rights Resolution, 2003/45. New York City: United Nations. Retrieved from http://ap.ohchr.org/documents/E/CHR/resolutions/E-CN_4-RES-2003-45.doc
- United Nations Office of the High Commissioner for Human Rights (OHCHR). 2011. "Harmful Practices, Especially Forced Marriage and Female Genital Mutilation." Geneva: OHCHR. Retrieved from https://www.ohchr.org/Documents/Issues/Women/WRGS/SexualHealth/INFO_Harm_Pract_WEB.pdf
- United Nations Population Fund (UNFPA). 2013. "Motherhood in Childhood: Facing the challenge of adolescent pregnancy." New York City: UNFPA. Retrieved from <https://www.unfpa.org/sites/default/files/pub-pdf/EN-SWOP2013-final.pdf>
- Vogt, Sonja, Nadia Ahmed Mohammed Zaid, Hilal El Fadil Ahmed, and Charles Efferson. 2016. "Changing cultural attitudes towards female genital cutting." *Nature*, 538: 506-509. Retrieved from <https://www.nature.com/articles/nature20100>

- Waigwa, Susan, Lucy Doos, Caroline Bradbury-Jones, and Julie Taylor. 2018. "Effectiveness of health education as an intervention designed to prevent female genital mutilation cutting (FGMC): a systematic review." *Reproductive Health*, 15: 72. Retrieved from <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5897952/>
- Wodon, Quentin, Chata Male, Ada Nayihouba, Adenike Onagoruwa, Aboudrahyme Savadogo, Ali Yedan, Jeff Edmeades, Aslihan Kes, Neetu John, Lydia Murithi, Mara Steinhaus, and Suzanne Petroni. 2017. *Economic Impacts of Child Marriage: Global Synthesis Report*. Washington, DC: The World Bank and International Center for Research on Women. Retrieved from <http://documents.worldbank.org/curated/en/530891498511398503/pdf/116829-WP-P151842-PUBLIC-EICM-Global-Conference-Edition-June-27.pdf>
- Wodon, Quentin, Aboudrahyme Savadogo, and Aslihan Kes. 2017. *Economic Impacts of Child Marriage: Work Earnings, and Household Welfare*. Washington, DC: The World Bank and International Center for Research on Women. Retrieved from <http://documents.worldbank.org/curated/en/312761498512784050/pdf/116835-BRI-P151842-PUBLIC-EICM-Brief-WorkEarningsHousehold-PrintReady.pdf>
- World Health Organization. 2011a. *Female genital mutilation programmes to date: what works and what doesn't*. Policy brief. Retrieved from https://apps.who.int/iris/bitstream/handle/10665/75195/WHO_RHR_11.36_eng.pdf?sequence=1
- World Health Organization. 2011b. *Preventing gender-biased sex selection: An interagency statement OHCHR, UNFPA, UNICEF, UN Women and WHO*. Geneva, Switzerland: World Health Organization. Retrieved from <https://www.ohchr.org/Documents/Issues/Women/GenderAndEquality/PreventingGenderBiasedSexSelection.pdf>
- Yount, Kathryn M., Kathleen H. Krause, and Stephanie S. Miedema. 2017. "Preventing gender-based violence victimization in adolescent girls in lower-income countries: Systematic review of reviews." *Social Science and Medicine*, 192: 1-13. Retrieved from <https://www.ncbi.nlm.nih.gov/pubmed/28941786>

This document was produced by Matthew Eldridge and Reehana Raza, Urban Institute, for review by the United States Agency for International Development (USAID). It was prepared under USAID's Communications, Evidence, and Learning (CEL) Project (contract GS00F061GA 7200AA18M00006), implemented by a consortium led by the Training Resources Group.