



THE ACT FRAMEWORK PACKAGE:  
**MEASURING SOCIAL NORMS AROUND  
FEMALE GENITAL MUTILATION**

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December 2020





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The ACT Framework and all associated data collection instruments and implementation templates are the product of four years of work involving numerous contributors.

The development and validation of the ACT Framework was initiated by and developed under the oversight of the UNFPA–UNICEF Joint Programme on the Elimination of Female Genital Mutilation: Accelerating Change. The work was led by Dornsife School of Public Health, Drexel University, in Philadelphia, Pennsylvania, under the supervision of Suruchi Sood, involving Carmen Cronin, Kelli Kostizak, Maho Okamura, Corrinne Shefner-Rogers, Sarah Stevens and Sereen Thaddeus, in close collaboration with UNICEF’s Communication for Development (C4D) and Child Protection Sections of the Programme Division and UNFPA’s Gender and Human Rights Branch. Global leadership was provided by Nankali Maksud (Senior Advisor of Child Protection, UNICEF Headquarters) and Nafissatou Diop (Chief of Gender and Human Rights Branch, UNFPA Headquarters), with support from Rafael Obregon (Chief of C4D, UNICEF HQ), and technical leadership and coordination assured by Charlotte Lapsanski (C4D Specialist, UNICEF HQ) and Mar Jubero (Child Protection Specialist, UNICEF HQ). Data analysis was undertaken by Farren Rodrigues and Nicole Mertz (Dornsife School of Public Health, Drexel University), with support from Thierno Diouf (Monitoring and Evaluation Specialist, UNFPA HQ). Technical support to steer, develop and drive feedback was given by Mona Aika, Harriet Akullu, Thierno Diouf, Berhanu Legesse, Alessia Radice and Massimiliano Sani.

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Authors: Suruchi Sood, Sarah Stevens, Kelli Kostizak and Maho Okumura

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# LIST OF ABBREVIATIONS

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<b>CAPI</b>	Computer-assisted personal interviewing
<b>FGD</b>	Focus group discussion
<b>FGM</b>	Female genital mutilation
<b>IDI</b>	In-depth interview
<b>IO</b>	Implementing organization
<b>IRB</b>	Institutional review board
<b>LRP</b>	Local research partner
<b>M&amp;E</b>	Monitoring and evaluation
<b>SEM</b>	Social-ecological model
<b>TOR</b>	Terms of reference
<b>UNICEF</b>	United Nations Children's Fund
<b>UNFPA</b>	United Nations Population Fund

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# FOREWORD

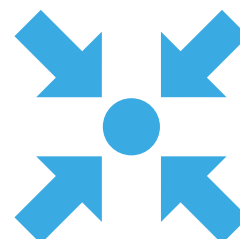
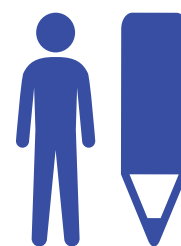
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The Beijing Declaration and the 2030 Agenda for Sustainable Development call for a transformative global agenda that prioritizes the human rights of girls and women including the elimination of female genital mutilation (FGM). Despite an overall decline in prevalence over the last three decades, FGM affects at least 200 million women and girls currently alive, with a further 4 million girls at risk of undergoing the practice annually. Moreover, it is estimated that the COVID-19 pandemic will result in an additional 2 million cases of FGM that may have otherwise been averted. Bringing together change makers of all ages and gender, Gender Equality offers the world an extraordinary opportunity to bolster its efforts to deliver on the promises made in 1995 and build back better from COVID-19, with an intentional focus on the elimination of all forms of violence against women, including FGM.

At the heart of this race towards the realisation of Sustainable Development Goal 5 (SDG 5): Achieve gender equality and empower all women and girls, stands the UNFPA–UNICEF Joint Programme on the Elimination of Female Genital Mutilation: Accelerating Change. As the largest global effort focused on the elimination of FGM, the Joint Programme is actively contributing to the advancement of women’s rights and the attainment of gender equality. Through rights-based and culturally sensitive strategies, the Joint Programme has increasingly recognized and addressed the pivotal role that long-standing and deep-rooted social norms play in upholding and ending FGM. Despite progress in understanding the contextual drivers of FGM and harmful practices, programmes have been challenged by limited availability of tested approaches, indicators and tools for measuring social norms change.

In response to this gap, the Joint Programme is proud to introduce the ACT Framework, a macro-level monitoring and evaluation tool, containing a rich compendium of indicators and tools that can be adapted to different contexts and needs, in order to track social norms change around FGM, assess overall impact and inform necessary programme adaptations. The ACT Framework considers important dimensions of social norms change, such as descriptive and injunctive norms, outcome expectancies, social networks and gender and power dynamics. In addition, it allows users to track and link individual and social changes either directly or indirectly to programmatic approaches. The ACT Framework is designed to be adaptable, while still providing standardization in the measurement of social norms. Although developed primarily for FGM, it has the potential to be adapted to social norms measurement of other harmful practices such as child marriage or violence against children.

The ACT Framework was developed through a partnership with Drexel University, in Philadelphia, Pennsylvania, under the leadership of UNICEF and UNFPA, with input from global experts from a wide range of disciplines, including child protection, social and behaviour change, gender, sociology, anthropology and more. While designed to strengthen the Joint Programme, we are confident that programme planners and implementers beyond UNICEF and UNFPA will find that the ACT Framework yields valuable insights into the deep-rooted drivers of FGM, empowering them to design, track and strengthen evidence-based interventions that accelerate our collective momentum towards the 2030 vision, where girls and women have a voice, choice and control of their own lives, and live free of the threat of FGM.



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# HOW TO USE THIS DOCUMENT

This document contains a macro-level monitoring and evaluation (M&E) framework, referred to as the ACT Framework, that can be used to measure changes in social norms related to female genital mutilation (FGM). In addition to presenting the relevant indicators, this document provides guidance on the adoption, adaptation and implementation of the ACT Framework.

The intended audience includes UNICEF and UNFPA staff members involved in implementing the UNFPA–UNICEF Joint Programme on the Elimination of FGM: Accelerating Change. However, the ACT Framework is accessible to the broad community of social and behaviour change practitioners and researchers, who are interested in addressing social norms related to FGM and other harmful practices, such as child marriage, gender-based violence and violence against children.



**Figure 1: ACT framework package core documents**

<b>ACT Framework (this document)</b>	<ul style="list-style-type: none"> <li>· Explains the framework</li> <li>· Describes the indicators included in the framework</li> <li>· Provides guidelines for implementation of the framework</li> </ul>
<b>ACT Instruments</b>	<ul style="list-style-type: none"> <li>· Contains the quantitative and qualitative data-collection tools: Structured Interview at Household Level, Focus Group Discussion Guide, and In-Depth Interview Guide</li> <li>· Includes notes on preparing the tools for use, pretesting questions and training data collectors</li> </ul>
<b>ACT Implementation Templates</b>	<ul style="list-style-type: none"> <li>· Offers adaptable templates that give additional support to researchers for implementing the framework</li> <li>· Specifically meant to accompany Section 3 of the ACT Framework ('Implementing the ACT Framework')</li> </ul>

The **ACT Framework Package** includes three core documents: the **ACT Framework** (this document), the **ACT Instruments** and the **ACT Implementation Templates**. *Figure 1* outlines what is included in each of these documents.<sup>1</sup>

In addition to the three core documents, the ACT Framework Package contains supplementary materials that can be accessed for reference. These provide further contextual information and explanation. These supplementary materials include:

- 1. Social Norms Desk Review:** Outlines the results of a 2016 literature review of existing information on social norms and measurement of FGM, which was used to design the core documents of the ACT Framework Package.
- 2. ACT Global Validation Process Report:** Details the steps taken to develop and validate the ACT Framework and the ACT Instruments (measurement tools).
- 3. Summary of the ACT Framework:** Presents a four-page overview of ACT Framework, published in February 2020. It was published before the ACT Framework (this document) was finalized so it may contain some discrepancies with the final ACT Framework.

<sup>1</sup> All the documents in the ACT Framework Package are available online



Figure 2: Intended purpose of ACT

**ACT is designed for...**

- Monitoring and evaluating existing programmes
- Quantifying shifts in social norms
- Explaining that gender is related to social norms
- Demonstrating how norms are connected to social networks and social support
- Supplementing formative research
- Examining attribution and contribution of social norms change programming

**ACT is not designed for...**

- Identifying if an issue is a social norm
- Replacing formative research
- Providing in-depth analysis of gender dynamics in a society or culture
- Performing a comprehensive social network analysis

**Before delving into the ACT Framework, it is important to understand what it can help assess and what is beyond its scope** (see Figure 2). The ACT Framework<sup>2</sup>

is a social norms M&E framework, designed to measure changes in FGM-related social norms. Because social norms are interrelated with many theoretical constructs, additional factors are included for measurement in the framework, such as social networks and gender. ACT captures information on these constructs to the extent that they inform the understanding of FGM-related social norms; however, ACT does not replace in-depth studies of all the important concepts. For example, despite exploring gender as it relates to FGM, ACT cannot replace a study designed specifically to examine gender attitudes and norms. Additionally, ACT is not designed to identify whether or not social norms are among the drivers of the traditional practice being studied. Social norms diagnostic tools already exist,<sup>3</sup> and it is assumed that such situation analysis has already been conducted and that norms are already known to be an important driver of the issue. While the participatory qualitative measures in ACT may supplement formative research, ACT specifically focuses on monitoring and evaluating the effectiveness of programmes aimed at changing FGM-related social norms.

It is recommended that you (the implementing organization, or IO) read this document in its entirety before beginning the process of implementing the ACT Framework. Figure 3 outlines the major sections of this document and the information that is contained in each.

**ACT Framework implementation requires the following steps:**

1. Familiarize yourself with the background of the ACT Framework and the conceptual model (see Section 2).
2. Compare the ACT conceptual model with your programme theory of change (if you have one) and note points of alignment. If you do not have a theory of change, the ACT conceptual model can be a foundation to develop one.
3. Establish how you will use the ACT Framework: as a stand-alone M&E framework or by integrating select indicators of ACT into an existing M&E framework.

<sup>2</sup> Also referred to simply as 'ACT' – the two terms can be used interchangeably.

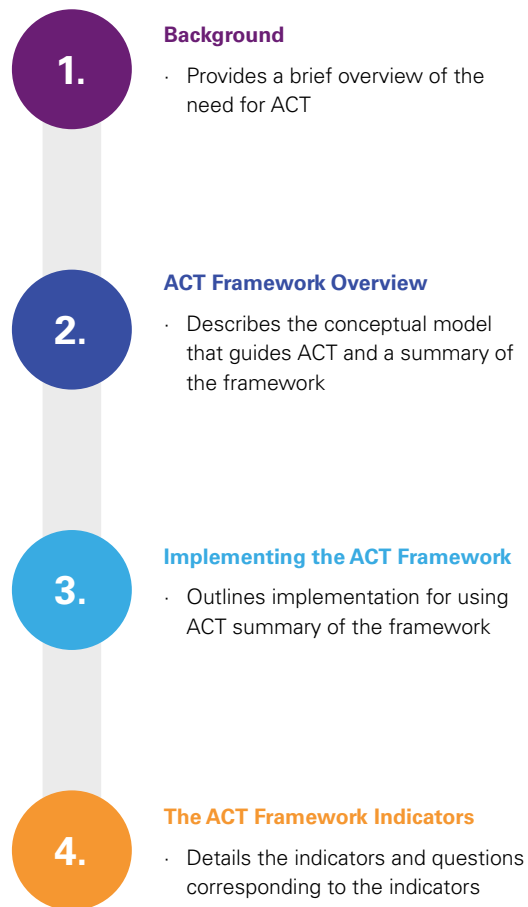
<sup>3</sup> For examples, see: (1) [Everybody Wants to Belong](#) and (2) [The Social Norms Exploration Tool](#)

4. Select indicators. To implement the ACT Framework as a whole, include all indicators (see Section 4). If resources are limited or if a pre-existing M&E framework already covers many ACT constructs, choose only relevant indicators.
5. Follow the nine steps to implement the ACT Framework (see Section 3).

Additional materials needed to support implementation of the ACT Framework can be found online in the **ACT Framework Package**. These include:

- **The ACT Instruments:** Three data collection instruments – the structured interview questionnaire, focus group discussion (FGD) guide and in-depth interview (IDI) guide.
- **The ACT Implementation Templates:** The document contains templates and samples related to ACT implementation, such as terms of reference (TOR), protocols, sampling calculations and FGD materials.

**Figure 3: Sections of ACT framework report**



# SECTION 1

## BACKGROUND



### 1.1 IMPETUS FOR THE ACT FRAMEWORK

Female genital mutilation (FGM) is a harmful traditional practice affecting over 200 million girls and women worldwide.<sup>4</sup> The World Health Organization (WHO) defines FGM as “all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons.”<sup>5</sup> The practice confers no health benefits to those who undergo it, but it is associated with numerous negative health outcomes – both physical and mental. These negative health outcomes can be both short and long term and include issues such as haemorrhage, sepsis, urinary track infections, increased risk of sexually transmitted infections such as HIV, chronic pain, pain with intercourse, increased risk of childbirth complications, obstetric fistula and psychological problems.<sup>6</sup> As such, FGM violates the human rights of girls and women. Yet despite decades of programming aimed at ending the practice, girls around the world continue to be subjected to FGM. In 2018, UNICEF and UNFPA estimated that another 68 million girls will undergo FGM by the year 2030 based on the current rate of FGM and projected population growth.<sup>7</sup>

In 2008, the UNFPA–UNICEF Joint Programme on the Elimination of Female Genital Mutilation: Accelerating Change (hereafter referred to as ‘the Joint Programme’) was formed to accelerate the abandonment of FGM, with the goal of eliminating the practice within one generation.<sup>8</sup> As the largest intervention targeting FGM to date, the Joint Programme provides financial and technical support to 17 countries<sup>9</sup> where FGM is prevalent. A key approach of the Joint Programme is to use human rights-based and culturally sensitive approaches to implement social and behaviour change communication (SBCC) initiatives aimed at changing the social norms that perpetuate FGM. Under the leadership of national actors and in partnership with civil society, religious leaders, community influentials and other key stakeholders, the Joint Programme has contributed to the advancement of FGM abandonment by families and communities. Since its inception, over 24 million individuals across 9,000 different communities have made public declarations of their intention to abandon FGM and 3.3 million girls and women

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<sup>4</sup> UNFPA–UNICEF Joint Programme to Eliminate FGM, [Ending Female Genital Mutilation: An investment in the future](#), UNICEF and UNFPA, 2018.

<sup>5</sup> World Health Organization, [Eliminating Female Genital Mutilation: An interagency statement: OHCHR, UNAIDS, UNDP, UNECA, UNESCO, UNFPA, UNHCR, UNICEF, UNIFEM, WHO, WHO](#), Geneva, 2008.

<sup>6</sup> World Health Organization, [‘Fact Sheet: Female genital mutilation’](#), Geneva, WHO, 2020, accessed 23 October 2020.

<sup>7</sup> UNFPA–UNICEF, *Ending Female Genital Mutilation*, 2018.

<sup>8</sup> UNFPA–UNICEF Joint Programme on Female Genital Mutilation, [Performance Analysis for Phase II](#), UNICEF and UNFPA, 2018, accessed 11 November 2020.

<sup>9</sup> The 17 countries are: Burkina Faso, Djibouti, Egypt, Eritrea, Ethiopia, the Gambia, Guinea, Guinea-Bissau, Kenya, Mali, Mauritania, Nigeria, Senegal, the Sudan, Somalia, Uganda and Yemen.

have benefited from FGM prevention and care services across the 17 Joint Programme countries.<sup>10</sup>

While monitoring and evaluation (M&E) has always been a focus of the Joint Programme, there has not been a commonly used and validated methodology for measuring social norms change that could be scaled up for use in all Joint Programme countries. The most robust measurements relied on data from the Demographic and Health Surveys (DHS) and the Multiple Indicator Cluster Surveys (MICS), which, while examining trends over time at the country level, do not report on the relationship between programme implementation and subsequent individual and social change. The Joint Programme recognized that a rigorous M&E framework was needed to link programmatic approaches to the changes observed in order to determine what works, what refinements are needed, what challenges persist, and the overall impact of the work. The ACT Framework, a macro-level M&E framework designed to be adaptable while still providing standardization around social norms measurement, was developed to meet this need.

<sup>10</sup> UNICEF, [Female Genital Mutilation/Cutting: A statistical overview and exploration of the dynamics of change](#). UNICEF, New York, N.Y., 2013, accessed 11 November 2020.

## 1.2 ACT DEVELOPMENT AND VALIDATION

Since its inception in October 2016, the draft versions of the ACT Framework and related tools have gone through many stages of development, review and validation, as illustrated in *Figure 4*. Framework development started with a desk review on the subject of social norms and FGM, which was followed by several meetings and consultations with experts in fields related to social norms, communications and FGM. From the desk review and the expert meetings, a conceptual model and framework, including indicators and potential means of verification, were drafted and revised. Instruments were then created to measure the indicators representing the ACT constructs.

The Joint Programme then selected Ethiopia and Guinea as validation sites for the ACT Framework and tools. These countries were selected in part due to their unique FGM contexts, the different languages spoken, and the fact that the Joint Programme already existed there. A local research partner (LRP) was hired in each country – Frontieri in Ethiopia and Sonfonia University in Guinea – to help

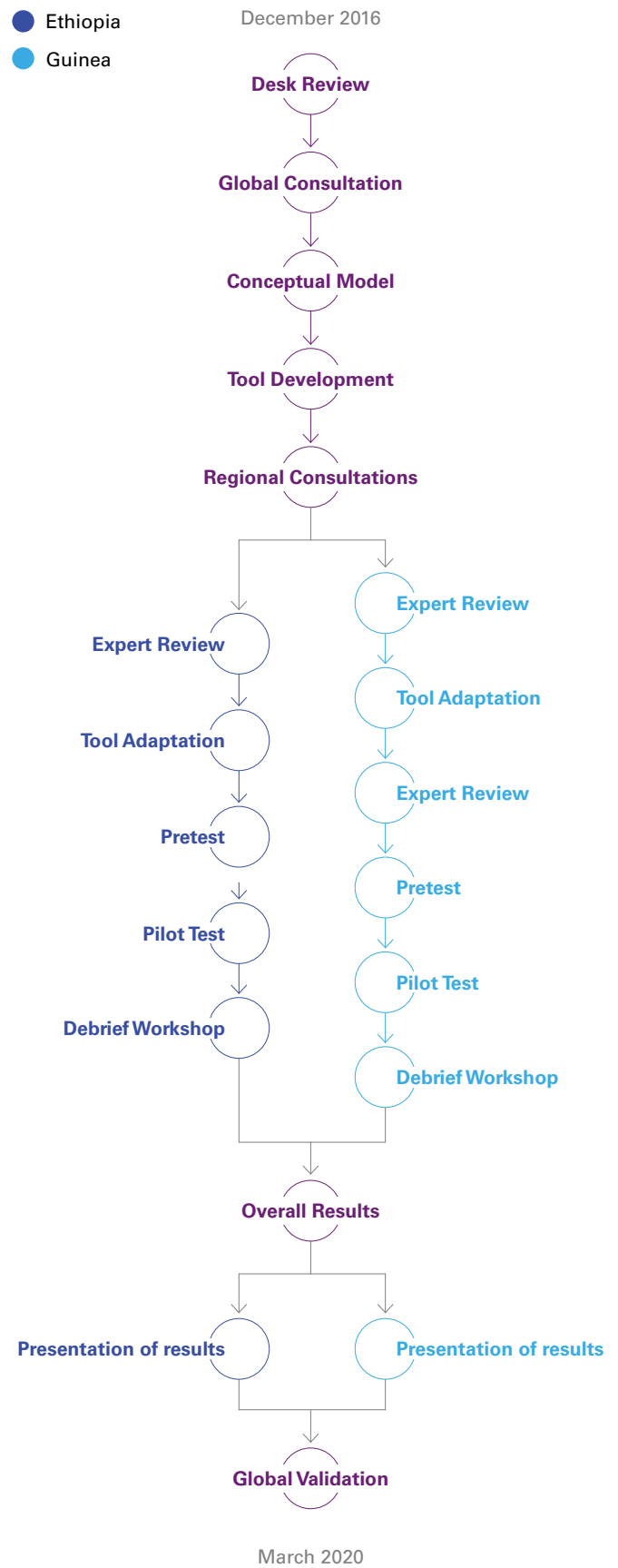
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facilitate the in-country validation process. Along with the LRP, experts in each country were consulted to review the instruments and assist with adapting them to the local context. The adapted instruments were pretested and pilot tested, a process which culminated in a validation debrief workshop in each country. Each validation debrief workshop brought together all those involved in field work and Joint Programme staff to reflect on the findings of the pilot and propose improvements to the instruments and overall framework. Results from the individual validations in Ethiopia and Guinea were combined to make changes to the global ACT Framework. The validated and revised ACT Framework and instruments were then presented at the global validation workshop on 23 April 2020 for expert review, including by some of the same experts from the 2016 global consultation. Final revisions were based on the suggestions received from the global expert review at this time. The final ACT Framework is presented in this document. For more information on the ACT development and validation, please see the ACT Global Validation Process Report (which can be found online with the rest of the ACT Framework Package).

Figure 4: Development and validation process of the ACT framework and tools



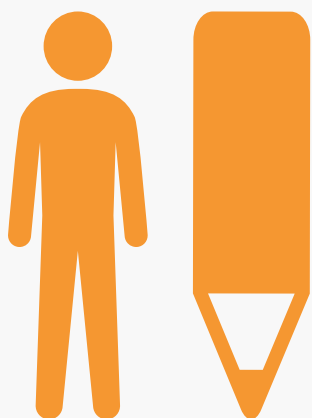


# SECTION 2

# ACT

# FRAMEWORK

# OVERVIEW



This section provides a brief overview of the conceptual framework behind the ACT Framework (also referred to as 'ACT'), as well as a summary of the ACT Framework itself. ACT is described in detail in *Section 4* of this document. Further information on the creation of the conceptual framework can be found in the Social Norms Desk Review.

## Box 1:

### Note on terminology relating to social norms

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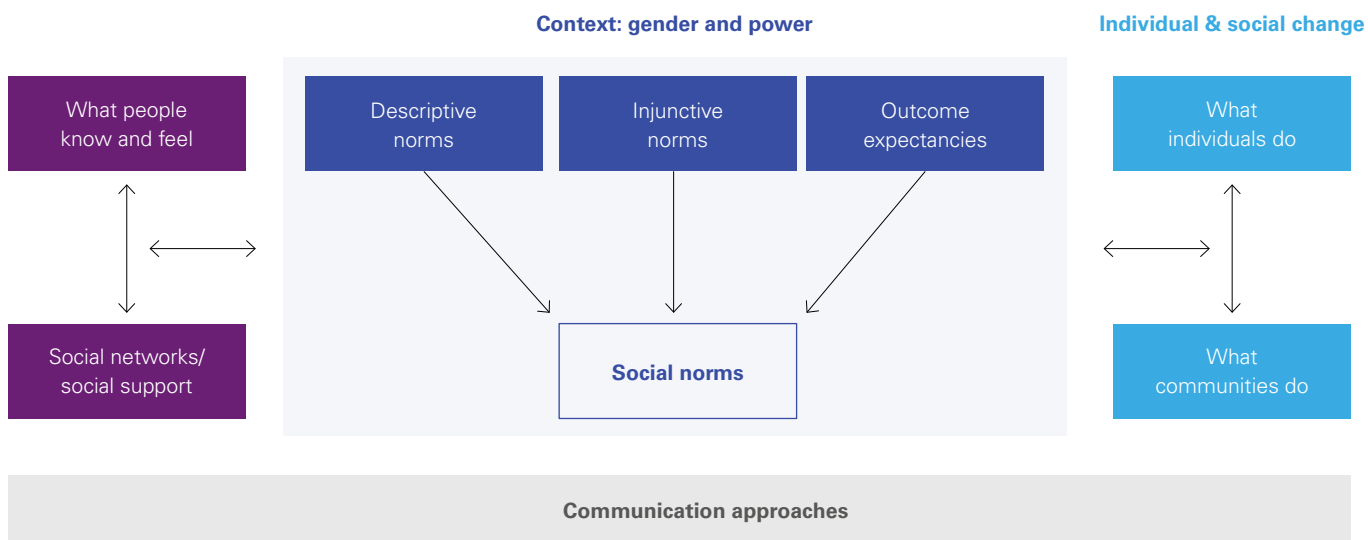
In the current literature around social norms, there is debate around the terminology associated with social norms components. The tension around terminology stems in part from the academic orientation of social scientists studying social norms. The Social Norms Desk Review attempts to sort through different perspectives of theorizing and research on social norms. The ACT Framework does not aim to resolve these deliberations over terminology. Instead, the ACT conceptual model describes the key constructs that interact with one another to uphold the social norms around FGM (see *Figure 5*). In the ACT Framework, social norms, which are at the heart of the model, are comprised of three normative constructs: descriptive norms (empirical expectations), injunctive norms (normative expectations) and outcome expectancies (positive and negative) (see *Figure 6*). ACT has chosen to use the terms 'descriptive norms' and 'empirical expectations' interchangeably, and the same applies to the use of 'injunctive norms' and 'normative expectations'. From an academic standpoint, the terms 'descriptive norms' and 'injunctive norms' refer to our beliefs about what other people do and what they expect us to do, respectively; thus, they do not necessarily influence behaviour. When descriptive and injunctive norms drive specific behaviours and practices, such as FGM, then one can say that social norms influence behaviours. That is to say, when beliefs about what others do and what they want or expect one to do cause individuals and communities to behave in certain ways – actually influence behaviour – then social norms are an influencing factor for that behaviour. Given that ACT is based on the presumption that social norms have already been identified as an influencing factor, the decision was made to think of normative terminology more broadly. This is reflected in the core ACT documents and related materials.

## 2.1 CONCEPTUAL FRAMEWORK SUMMARY

The conceptual model for the ACT Framework was developed in 2016, based on a thorough desk review of social norms measurement literature and a global initial consultation with experts in the field.

Figure 5 presents the conceptual model, and Figure 6 defines the social norms components used in ACT.

**Figure 5: Conceptual model of ACT**



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**Figure 6: Social norms components of ACT**

Descriptive norms/ Empirical expectations	Injunctive norms/ Normative expectations	Outcome expectancies -positive	Outcome expectancies -negative
<ul style="list-style-type: none"> <li>Beliefs about what people do</li> </ul>	<ul style="list-style-type: none"> <li>Beliefs about what others approve of/think people should do</li> </ul>	<ul style="list-style-type: none"> <li>Beliefs about the perceived benefits/rewards</li> </ul>	<ul style="list-style-type: none"> <li>Beliefs about the perceived punishments/sanctions</li> </ul>

The conceptual model of ACT (*see Figure 5*) is based on the theoretical premise that norms influence thoughts and behaviours, and thoughts and behaviours influence norms; if social norms change, then change in thoughts and behaviours may ensue, and vice versa. The conceptual model depicts social norms as the intermediary step between what people know and feel, their social networks and their social support on the left-hand side, and individual and social change on the right-hand side. The two-way arrows indicate the dynamic, bidirectional relationship between norms and these other elements of the model.

The conceptual model incorporates a social-ecological perspective by situating the individual-level factors of knowledge, attitudes and practices within the broader environmental context, as well as accounting for multiple levels of influence. For example, the social-ecological model (SEM) acknowledges that what individuals know and feel are affected by, and in turn affect, their social networks and the level of social support they receive and give. Likewise, individual and social change is a result of the dynamic relationship between what individuals do and what communities do.

These constructs all fall under the broader umbrella described in the conceptual model as 'Context: Gender and Power' (*see Figure 5*) to illustrate the influence that contextual factors have on each construct and the relationships between them. Gender and power are the contextual factors of interest here because of the particular effect they have on FGM.<sup>11</sup> The entire conceptual model is contained within a bracket titled 'Communication Approaches' to signify the influence that social and behaviour change interventions can have on all aspects within the model. Linking the communication approaches within a larger country-level FGM programme to individual and social change through ACT

allows your organization to measure the effectiveness and contribution of your communication efforts and provides key insights into the process of change. For more information on the constructs in the conceptual model and how they are related, please see the Social Norms Desk Review.

## 2.2: THE ACT FRAMEWORK SUMMARY

Using the acronym 'ACT' (*see Figure 7*), the framework measures the constructs identified in the conceptual model (*see Figure 5*). Both the 'A' and 'C' contain constructs critical to examining social norms change holistically, while the 'T' constructs emphasize the larger monitoring and evaluation (M&E) process within which ACT is housed.

**Figure 7: Constructs of ACT**

<b>A</b>	<ul style="list-style-type: none"> <li>Assess what people know, feel and do</li> <li>Ascertain normative factors</li> </ul>
<b>C</b>	<ul style="list-style-type: none"> <li>Consider the context, especially gender and power</li> <li>Collect information on social networks and support</li> </ul>
<b>T</b>	<ul style="list-style-type: none"> <li>Track individual and social change</li> <li>Triangulate all data and analysis</li> </ul>

<sup>11</sup> Berg, R.C., and Denison, E., 'Interventions to reduce the prevalence of female genital mutilation/cutting in African countries', *Campbell Systematic Reviews*, vol. 9. 2012, doi:10.4073/csr.2012.9.

CARE, WE-MEASR: A new tool for measuring women's empowerment in health programs technical update, CARE, 2013.

World Health Organization, [Understanding and Addressing Violence Against Women: Female genital mutilation](#), WHO, Geneva, 2012, accessed 11 November 2020.

**A:** Includes knowledge, attitude and behaviour indicators, and indicators to measure descriptive norms, injunctive norms, and outcome expectancies.

**C:** Includes indicators to examine the contextual factors of gender and power, and social networks and social support.

**T:** Includes broad indicators to examine access to, frequency and length of exposure to, and engagement with social and behaviour change platforms and interventions.

The set of indicators for the 'A' and 'C' constructs (see *Section 4*) are operationalized both quantitatively and qualitatively using questions in the structured interview questionnaire and activities in the focus group discussion (FGD) and in-depth interview (IDI) guides (located in the ACT Instruments). The 'Track individual and social change' section is critical to linking programmatic efforts to observed changes in the 'A' and 'C' constructs, and has sample indicators associated with quantitative questions in the structured interview tool. These indicators must be customized to fit specific objectives and expected results of individual programmatic efforts. Additionally, this section can examine the extent to which other projects and programmes (not part of the Joint Programme) may be helping or hindering efforts. The second 'T' section, 'Triangulate all data and analysis', does not contain indicators but instead emphasizes the importance of data triangulation and explains how ACT inherently facilitates triangulation



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# SECTION 3

## IMPLEMENTING THE ACT FRAMEWORK



This section outlines the nine steps required to implement the ACT Framework, from planning through to dissemination (see Figure 8).

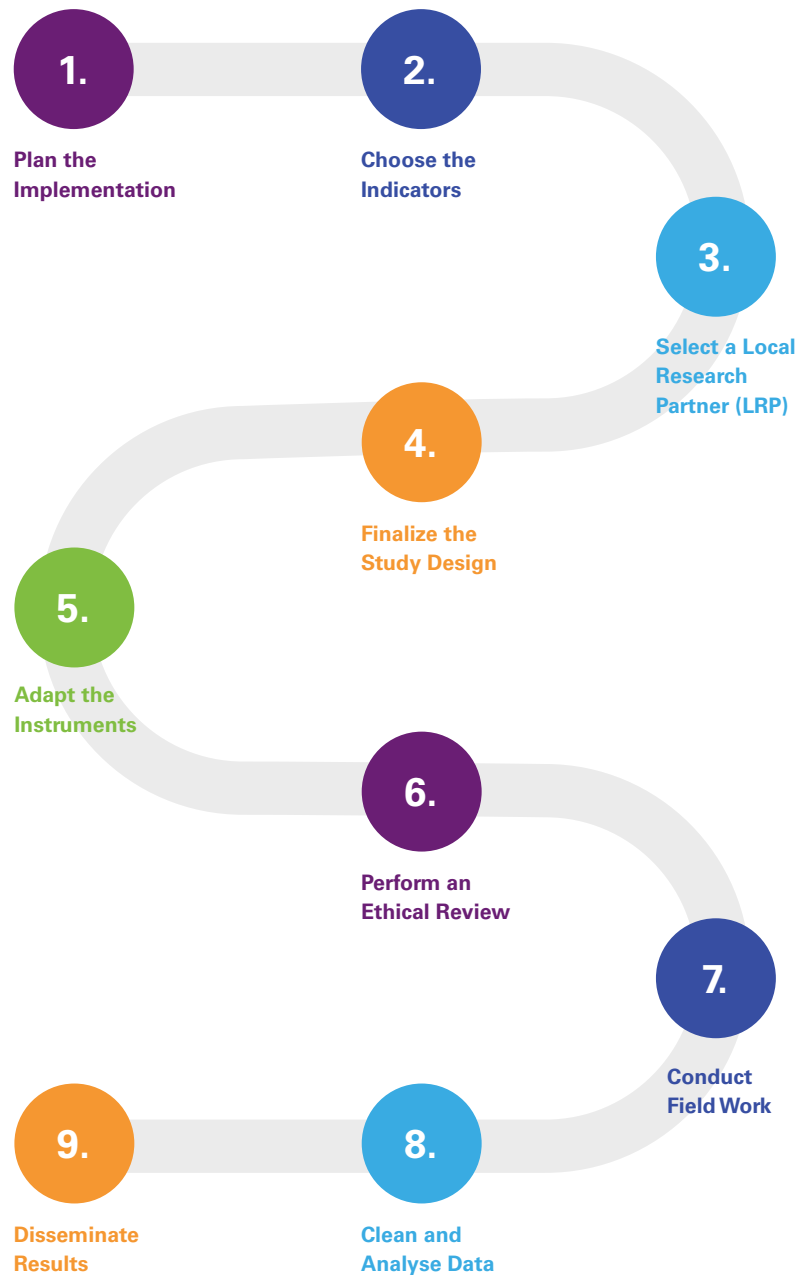
Implementation of ACT will depend on the scale at which you choose to utilize the Framework – in its entirety or only incorporating selected indicators into an existing monitoring and evaluation (M&E) system. There are two options:

**Stand-alone implementation:** This is the use of ACT as a distinct, stand-alone M&E framework, not integrated into an existing framework. While stand-alone implementation is considered ‘full’ implementation, it does not necessarily imply the inclusion of every single ACT indicator.

**Integrated implementation:** This refers to the approach of selecting specific ACT indicators and inserting them into a pre-existing M&E framework to make it more robust and to enable that framework to capture social norms change holistically.

Each step in this section presents separate guidance depending on which approach is taken.

Figure 8: ACT implementation steps



Note: Steps 4 (Finalize the study design), 5 (Adapt the instruments) and 7 (Conduct field work) include sub-steps, which are written up separately within the steps below.

ACT implementation (whether stand-alone or integrated) will require collaboration with a local research partner (LRP). Before this collaboration can be developed, you will need a working knowledge of the requirements and expectations of the tasks to successfully recruit and oversee the LRP. The subsections that follow offer guidance for the implementing organization’s (IO’s) role in each step in the process.

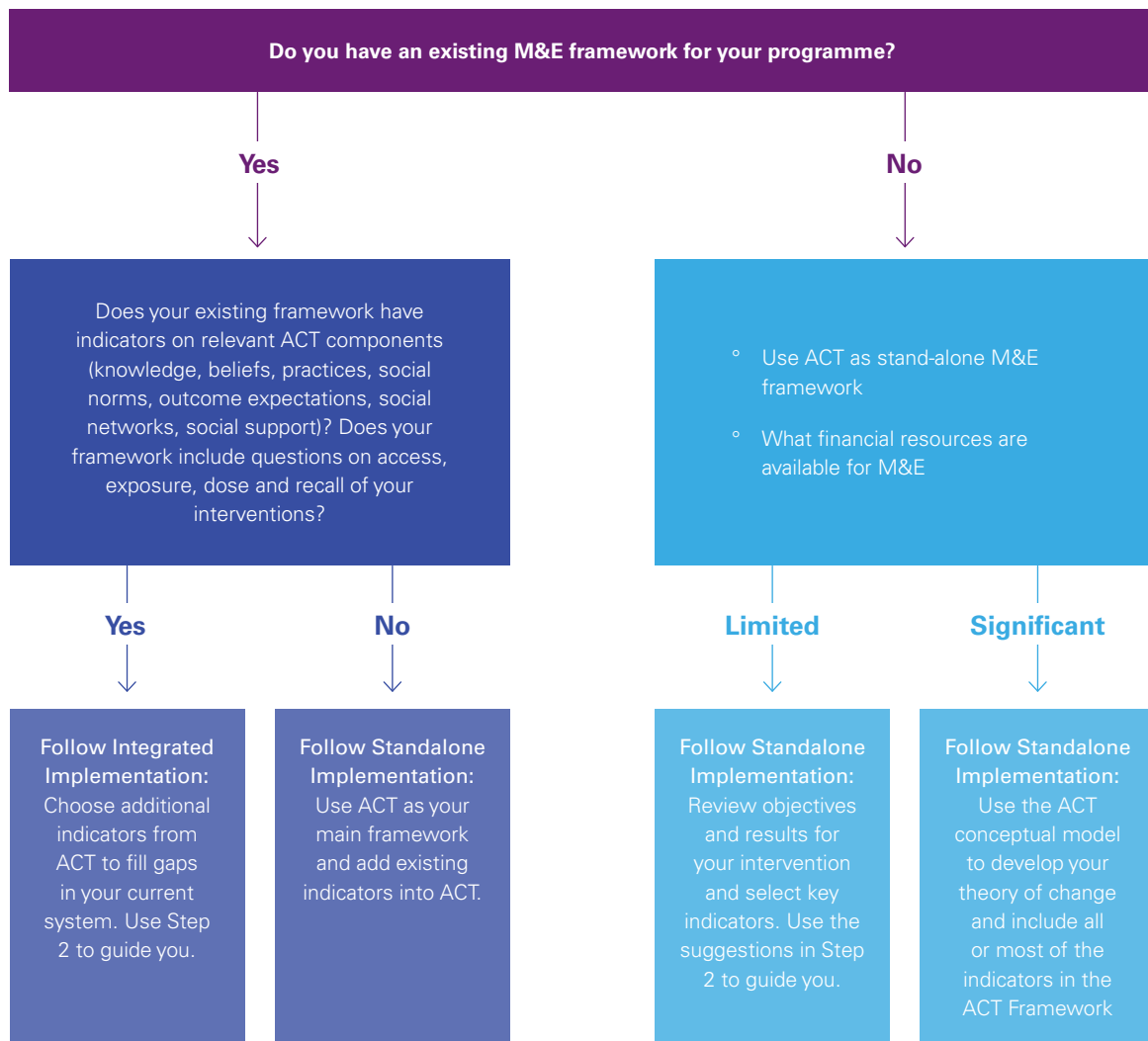
## STEP 1: PLAN THE IMPLEMENTATION

The first step is planning the work involved, from financial, technical and time perspectives. As the available resources vary greatly by context, this toolkit provides general recommendations for these components of workplanning.

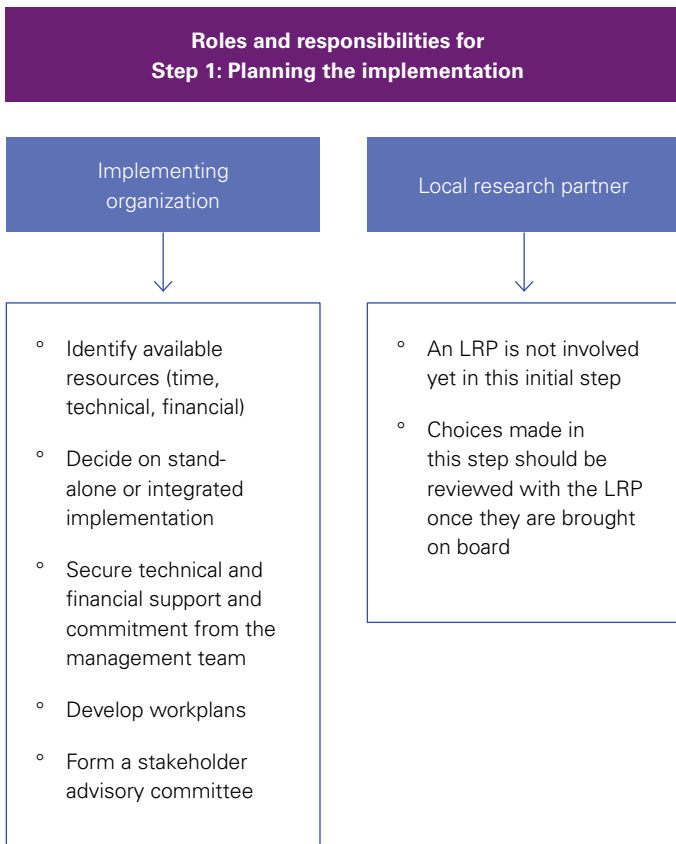
Select stand-alone or integrated implementation: One of the first decisions to make is whether you will undertake stand-alone or integrated implementation of the ACT Framework (see description on the previous page). Even if you employ ACT as a stand-alone framework (or ‘full’ implementation), resource requirements will vary greatly by the number of indicators selected for inclusion. The existence and quality of ongoing measurement activities, along with available financial resources, can help make this determination. *Figure 9* can help guide your decision about the type of implementation.



**Figure 9: Selecting type of ACT implementation**



**Select your research design:** Selection of your research design is critical to measuring effectiveness of communication approaches. You will need to select a research design that allows for either multiple data collection points over time or the inclusion of a comparison group. If you are planning for data collection over time – for example, through a baseline, midline and end-line evaluation – make sure there is adequate time between the phases. Typically, a one-year gap is recommended between data collection rounds, with ongoing monitoring in between. If you choose a comparison design, ensure that the comparison group is similar to your programme audience(s) on both demographic (residence, age, education) and psychographic (values, beliefs) characteristics.



**STEPS AND CONSIDERATIONS FOR STAND-ALONE IMPLEMENTATION**

**1. Consider the necessary staff capacities and ensure they are in place.**

- a. Assign at least one programme person with some M&E background to be responsible for implementation, dedicating a minimum of 50 per cent of their time to management of ACT implementation. This person should receive additional support from evaluation specialists.

- b. Obtain both technical and financial support and commitment from the management teams.

**2. Ensure the necessary budget is in place.**

- a. While it is impossible to provide accurate budget estimates relevant to each context, you can use the information on potential budget line items included in section 1.1 of the ACT Implementation Templates, as well as the sample terms of reference (TOR) for the LRP, in section 3.1 of the ACT Implementation Templates, to guide you.

**3. Create a timeline for the tasks in the workplan**

- a. You can use the information in section 1.2 of the ACT Implementation Templates, to create a detailed table of tasks for all partners, along with the estimated minimum time allowed for completion.

**4. Form an ACT Framework Stakeholder Advisory Committee.**

- a. Invite representatives from relevant government ministries, local civil society organizations (CSOs) and non-governmental organizations (NGOs) and others with relevant expertise to help decide on relevant indicators and approaches. This is essential to secure buy-in. Use the sample TORs in section 1.3 of the ACT Implementation Templates, which contain information on the composition, structure and responsibilities of this committee.

**Considerations for Planning the implementation under 'Integrated Implementation'**

- The steps for stand-alone implementation all apply to integrated implementation of ACT, with staff capacities and resources being the only difference.
  - You will still need the dedicated part-time involvement of a lead person who understands social and behaviour change research.
- Forming an ACT Framework Stakeholder Advisory Committee is also strongly recommended.

## STEP 2: CHOOSE THE INDICATORS

ACT indicators were designed to create a holistic picture of the pathway of change towards abandonment and eventual elimination of FGM through addressing the social norms upholding the practice. Multilevel social and behaviour change interventions will benefit from measurement of the entire framework. If this is not feasible, or you already have a set of indicators and instruments that you have been using, then select the indicators most relevant to your objectives and results to fill in the gaps in your existing measures.

Table 1 lists the ACT constructs (see Figure 7) used in the conceptual model guiding ACT (see Figure 5), along with the associated subconstructs for which ACT contains indicators. You should compare your programme objectives and results with the subconstructs below to enable you to select key indicators (in the tables in Section 4) to augment your work.



**Table 1: ACT constructs, subconstructs and numbers of associated indicators and questions**

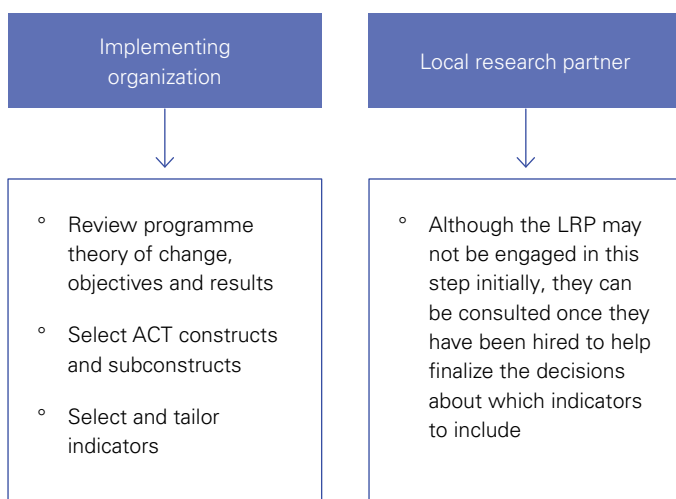
ACT construct	Subconstructs		Number of indicators	Number of quantitative questions
<b>Assess what people know</b>	Awareness of FGM		1	4
	Awareness of FGM as a harmful traditional practice		1	1
	Knowledge of types of FGM		1	1
	Knowledge of risks of FGM		1	3
	Knowledge of laws of FGM		4	4
<b>Assess what people feel</b>	Beliefs about FGM	As a function of gender, power and/or control	1	10
		As a function of identity	1	3
		As a function of religion	1	6
		As a function of health	1	8
		As a function of human rights	1	3
	Attitudes towards those that do not practise FGM (both girls and communities)		2	16



	Support for FGM abandonment	Personal support for FGM abandonment	1	1
		Beliefs about social network's support for FGM	1	7
	Sense of ownership in abandoning FGM		1	1
	Willingness to support those who abandon FGM		1	1
	Behavioural intent	Intention to practise FGM	1	1
		Willingness of men to marry women who have not undergone FGM	1	1
	Self-efficacy to abandon FGM		1	5
<b>Assess what people do</b>	Prevalence of FGM		2	6
	Behaviour shift towards abandoning FGM		1	2
	FGM decision-making		1	4
	Public support for those who abandon FGM		1	1
<b>Ascertain normative factors (social norms)</b>	Descriptive norms/ Empirical expectations	Perceived prevalence	1	3
		Perceived change in prevalence	1	2
	Injunctive norms/ Normative expectations	Perceptions of others' expectations	1	6
	Overall social norms	Composite score for strength of social norms	1	9
	Outcome expectancies	Existence of benefits and sanctions	2	2
		Willingness to apply benefits and sanctions to others	2	2
		Expectation of experiencing benefits and sanctions	2	2
<b>Consider the context, especially gender and power</b>	Female agency	Female mobility	1	5
		Financial control	1	2
	Female decision-making power		1	7
	Gender role beliefs	Violence against women	1	1
		Gender equality	1	8

<b>Collect information on social networks and support</b>	Discussion about FGM		3	3
	Spousal communication about FGM		3	3
	Social support	Instrumental support	1	2
		Informational support	1	2
<b>Track individual and social change (over time)</b>	Engagement in programme activities (e.g., community-based, interpersonal)		1 per type of activity	3 per type of activity
	Reach of programme messages		1	4 per type of platform
	Encouraging others to abandon FGM		1	3
	Self-reported outcome of interest		1 per type of activity	2 per type of activity

### Roles and responsibilities for Step 2: Choosing the indicators



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## STEPS AND CONSIDERATIONS FOR STAND-ALONE IMPLEMENTATION

### 1. Review your programme’s theory of change and key objectives, and list the short-, medium- and long-term results you will track.

### 2. Select the required constructs and subconstructs (Table 1).

- a. The ‘awareness of FGM’ subconstruct (associated with the ‘Assess what people know’ construct, and with one indicator) is required as the four questions associated with this subconstruct determine eligibility to complete the rest of the structured interview questionnaire.
- b. All programmes should select indicators from the following core constructs:
  - i. ‘Ascertain normative factors (social norms)’ – because they are the reason behind the creation of ACT – descriptive norms, injunctive norms and at least one set of outcome expectancies.
  - ii. ‘Collect information on social networks and support’ – since what others think, do and expect determines social norms.
  - iii. ‘Track individual and social change’ – in order to measure attribution and contribution of communication efforts.

### 3. Choose specific indicators under each of the selected constructs and subconstructs.

- a. Use the information in *Section 4* of this document to understand the indicators so you are better able to select those that correspond to the key objectives of your programme.
- b. Review the ACT Instruments to finalize your selection of indicators.

### 4. Tailor indicators to your programme.

- a. Choose denominators for your selected indicators.
  - i. If the programme needs indicators reported by certain characteristics (e.g., gender, region, respondent type), make sure you specify the population type and change the denominator for the indicator.
  - ii. Keep the choices around reporting disaggregated indicators in mind when making sampling decisions (*see Step 4 below*).
- b. Add time frames to relevant indicators.
  - i. Review the ACT Instruments to tailor all indicators that should reference a time frame.
  - ii. The tailored indicators will require associated changes in the structured interview questions (*see Step 5 on adapting the instruments*).

### 5. Develop indicators to use to ‘Track individual and social change’.

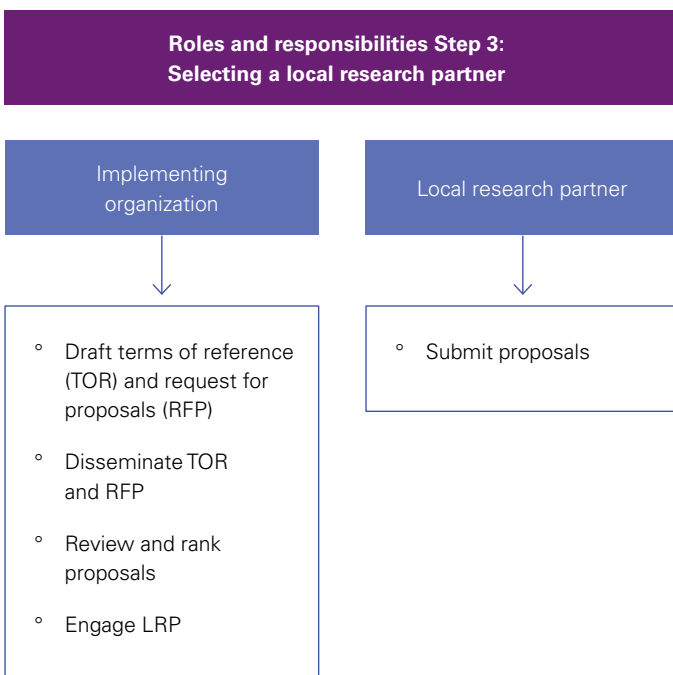
- a. Remember that the indicators in this section must be contextualized based on your specific communication efforts.
- b. Create indicators to measure programme-specific outcomes, as well as access, exposure, dose, recall and engagement with programme activities.

#### Considerations for Planning the implementation under ‘Integrated Implementation’

- Review what exists, including the quantity and quality of the data, and identify gaps in the current system. Use the programme theory of change, as well as objectives and results, as described in the stand-alone implementation instructions.
- Study the extent to which existing systems provide comprehensive information, specifically on social norms, social networks and tracking change.
- Select ACT indicators to fill gaps and improve existing measures.

## STEP 3: SELECT A LOCAL RESEARCH PARTNER (LRP)

The selection of an LRP is one of the most important tasks. The qualifications and suitability of the selected LRP will determine the success of the ACT implementation. The LRP might be a university, a research agency, a research consultant group, or a global partner with a regional or local presence and experience. The LRP can be engaged either through a contract or a partnership agreement (e.g., MOU), depending on the kind of institution and the implementing organization's (IO's) preference for mode of engagement. Regardless of the type of organization it is, *Box 2* lists some of the desired qualifications that an appropriate LRP should have.



### STEPS AND CONSIDERATIONS FOR STAND-ALONE IMPLEMENTATION

#### 1. Read *Section 3* of this document in its entirety.

- a. Drafting the terms of reference (TOR) requires explaining the scope of work. Final decisions for all implementation steps can be made once the LRP is hired, but you (the IO) must provide an outline of your expectations.
- b. **Draft a detailed TOR according to your standard office procedures. Involve your regional and global offices in reviewing the TOR. Be sure to stipulate:**
  - a. Specific objectives of the project
  - b. Expected tasks
  - c. Deliverables

#### Box 2: Desired local research partner qualifications

- Previous experience in the last three years in conducting studies related to FGM or other sensitive topics involving harmful practices
- Expertise in both quantitative and qualitative social and behavioural research, especially on attitudes and social norms
- Experience with qualitative, participatory research
- Proven ability to conduct training, guidance and supervision of field staff
- Experience in using computer-assisted personal interviewing (CAPI)
- Access to experienced data collectors
- Multilingual team to assist with translation of the instruments into local language(s)
- A team leader with a minimum of 10 years of experience in designing, planning, organizing and conducting participatory, quantitative and qualitative research and evaluation, including sample (household) surveys, preferably associated with children, parents/caregivers, communication for development (C4D), FGM and/or social norms
- To the extent possible, the management and field team should embody a range of perspectives (gender balance, cultural or ethnic background, etc.)
- Adequate data transfer and storage capabilities
- Experience of working with United Nations partners (preferred)

- d. Approximate timelines
- e. Minimum qualifications for the LRP team
- f. Evaluation criteria
- g. Note: An example TOR is provided in *section 3.1* of the ACT Implementation Templates.

**2. Release the TOR with a request for proposals (RFP) for bidding according to your standard procedures.**

**3. Review and rank proposals.**

- a. Ensure you have a diverse team to review the proposals.
- b. Table 2 lists some requirements you should consider in the proposal review process to select the LRP that best suits your needs.

**4. Engage an LRP following your organization’s standard procurement and/or partnership procedures.**

**Table 2: Considerations for Lrp proposal review**

<b>1. Background and introduction</b>
<ul style="list-style-type: none"> <li>◦ The team understands the situation and issue being studied.</li> <li>◦ The team demonstrates an understanding of the TOR contents and expected deliverables.</li> </ul>
<b>2. Team composition</b>
<ul style="list-style-type: none"> <li>◦ The team reflects a range of expertise and skills that cover all requirements of the TOR.</li> <li>◦ The ratio of management to staff is appropriate to ensure adequate supervision of junior-level staff.</li> <li>◦ They have designated a team leader who will be responsible and serve as a liaison with the implementing organization’s focal point or contract manager.</li> <li>◦ They describe the manner in which they will recruit field staff.</li> </ul>
<b>3. Technical resources</b>
<ul style="list-style-type: none"> <li>◦ They describe the devices (tablets/phones) to be used for data collection and indicate whether they already own them or will need to purchase them. If the devices need to be purchased, the cost has been included in the budget.</li> </ul>

<ul style="list-style-type: none"> <li>◦ They list the CAPI program that will be used for data collection. If it is a paid program, they have included the cost in their budget.</li> <li>◦ They have clearly outlined the steps for maintaining confidentiality during data storage.</li> <li>◦ They describe the quantitative and qualitative data analysis software they will use and include it in their budget, if applicable.</li> <li>◦ They have clearly demonstrated previous experience with quantitative research.</li> <li>◦ They have clearly demonstrated previous experience with participatory research.</li> </ul>
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<b>4. Logistics arrangements</b>
<ul style="list-style-type: none"> <li>◦ They have allocated resources for tool finalization – pre-testing, translating and back translation, as needed</li> <li>◦ They have included logistical considerations for training data collectors, e.g., venue, refreshments and per diem (see Step 7).</li> <li>◦ The details on the composition of the field team (data collectors, supervisors and study coordinators) match those outlined in Step 7.</li> <li>◦ They have outlined quality control mechanisms.</li> <li>◦ They have explained communication between the team leader and the field staff.</li> </ul>

<b>5. Ethical clearance</b>
<ul style="list-style-type: none"> <li>◦ They describe their process for obtaining ethical clearance and it matches the standards listed in Step 6.</li> <li>◦ They have access to an institutional review board (IRB) as part of their organization or have identified an external IRB to work with.</li> <li>◦ At least one month is included in their timeline for obtaining ethical approval.</li> </ul>

<b>6. Field work</b>
<ul style="list-style-type: none"> <li>◦ The minimum qualifications set for hiring data collectors and field supervisors meet those outlined in Step 7.</li> <li>◦ Field staff training is included in their timeline, sufficient to meet the needs described in Step 7.</li> <li>◦ The roles of the study coordinators and field staff are adequately described and meet those outlined in Step 7</li> </ul>

## 7. Data cleaning and analysis

- They have previous experience conducting the level of quantitative analysis required to interpret findings.
- They have previous experience with analysing qualitative data, including conducting thematic and content analysis.

## 8. Report writing

- They provide examples of previous research reports and presentations.
- They have included costs for an editor and graphic designer to finalize deliverables.
- They have a dissemination plan beyond the standard reports and presentation.

## Considerations for Selecting an LRP under 'Integrated implementation'

- If you have an existing partnership under a Long-Term Agreement (LTA) with an LRP, review their scope of work to see if any amendments need to be made. Consult *Table 2* for suggested capabilities. In particular:
  - Discuss their understanding of communication interventions and social norms.
  - Review their capacity to conduct both quantitative and qualitative participatory data collection and analysis.
  - Insist that the LRP hires technical assistance to support them with areas in which they do not have experience.
  - Ensure that the LRP has adequate field staff for data collection, experts to conduct data analysis, and writers/editors with graphics capability to prepare reports that are ready for dissemination.
- If you do not have an existing LRP, assess the extent to which ACT additions to your M&E system can be handled within your current capacity for research and reporting. You may need to partner with an LRP if ACT has significantly increased the scope of work beyond your capacity.

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## STEP 4: FINALIZE THE STUDY DESIGN

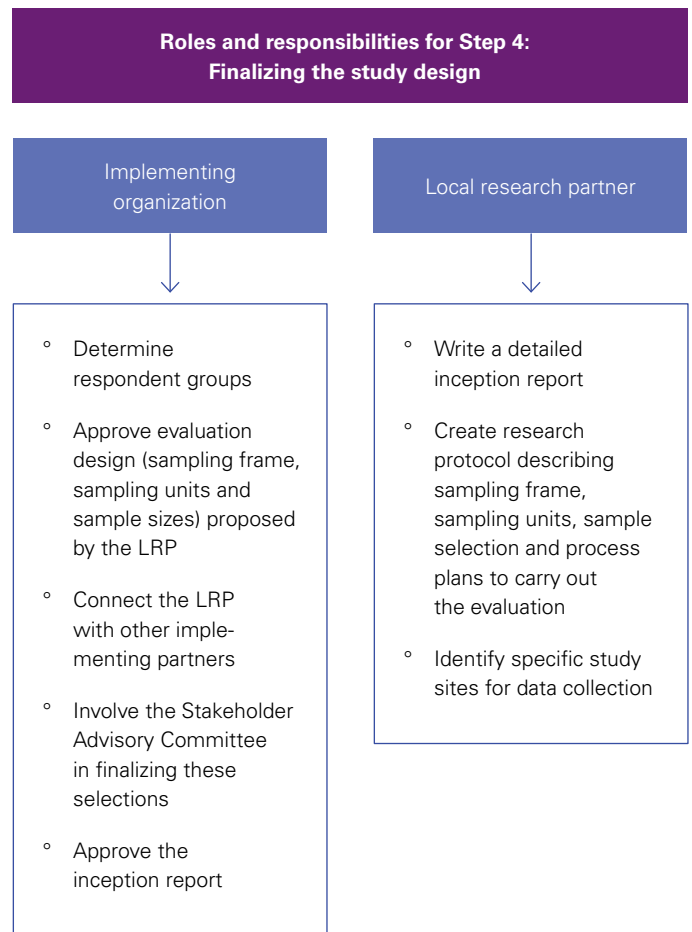
This section outlines the steps required to finalize the study design, including:

### 4A: Finalize the evaluation design

### 4B: Choose the respondent groups

### 4C: Identify study sites.

Once hired, the LRP's first task should be to prepare and submit an inception report and research protocol that outlines their choices for these three study design steps. After reviewing this report, the IO should have the final say on whether or not to approve the LRP's choices. An example research protocol is provided in *section 6.1* of the ACT Implementation Templates, to guide submission of the inception report by the LRP.



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## STEP 4A: FINALIZE THE EVALUATION DESIGN

Evaluation designs determine the strength of the evidence of change gathered from ACT implementation. *Table 3* lists some common types of study designs. When choosing the design, it is important to find the balance between academic rigor and practical constraints. The typical time difference between baseline and end-line is approximately one year, but it can be more or less depending on the scope, innovativeness and intensity of the implementation. When developing a case-comparison study, the comparison community should be as similar as possible to the case community in terms of demographic and psychographic characteristics.



**Table 3: Study design types**

Evaluation design	Intervention group	Programme baseline	Programme end-line
<b>Post-programme Only</b>	Case		X
	Comparison		
<b>Post-programme only, case-comparison</b>	Case		X
	Comparison		X
<b>Pre- and post-programme</b>	Case	X	X
	Comparison		
<b>Pre- and post-programme, case-comparison</b>	Case	X	X
	Comparison	X	X

### STEPS AND CONSIDERATIONS FOR STAND-ALONE IMPLEMENTATION

#### 1. Consider the programme timeline.

- Where are you in programme implementation? Is there enough time remaining that it is feasible to collect data at a minimum of two points in time?

#### 2. Consider programme coverage.

- Is it possible to find a similar community that hasn't received the intervention? If your programme is a full coverage programme (e.g., nationwide mass media campaign), this will clearly limit the scope for finding a "comparison" community.

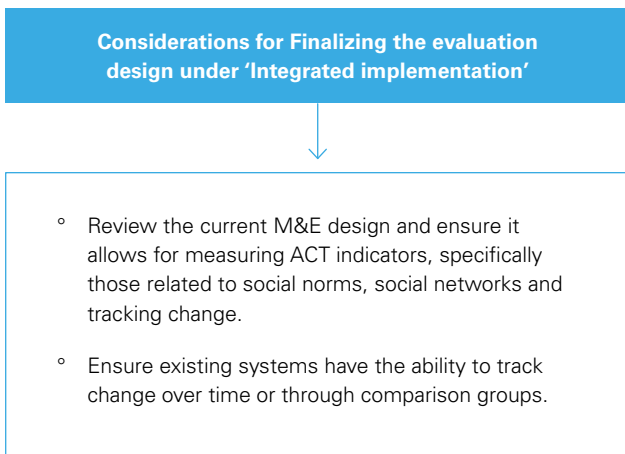
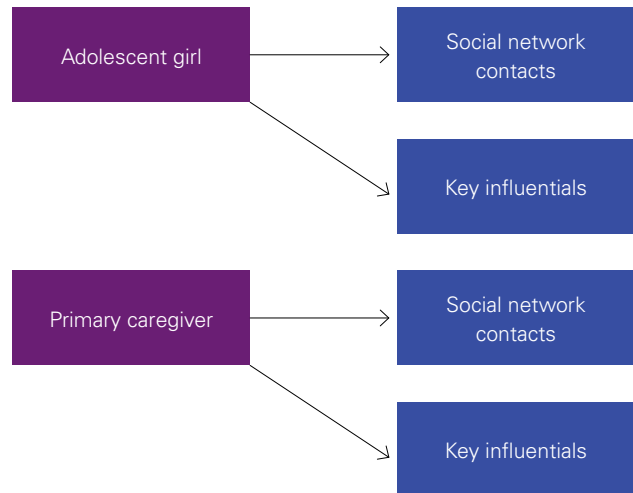
#### 3. Consider resources.

- How do the funds available compare to the cost of data collection? Pre- and post-intervention case-comparison designs offer strong evidence of effectiveness, but they are usually the most expensive. Section 1.2 (Sample budget and budget line items) and section 3.1 (Sample TORs for the LRP) of the ACT Implementation Templates are provided to guide you.

#### 4. Plan for a feedback loop.

- Determine how to periodically apply findings to programme implementation to improve effectiveness.



**Figure 10: ACT sampling strategy**

## STEP 4B: CHOOSE THE RESPONDENT GROUPS

Recommended sampling methods for ACT take into account the importance and influence of social networks in establishing, perpetuating and abandoning social norms. Adolescent girls aged 10–19 are the core starting point for ACT, as they are the group most likely to be affected by FGM and for whom behaviour change would have the greatest impact for generations to come. For stand-alone implementation of ACT, randomly selected adolescent girls and one of their primary caregivers are asked to identify additional respondents. A sample of the social network contacts of the adolescent girls, the social network contacts of the primary caregivers, and community influentials identified by the girls and their primary caregivers are included in the overall sample for data collection (see *Figure 10*).

It is possible that your programme focuses on primary audiences other than adolescent girls and women; in such cases, different respondent groups should be chosen. ACT was validated with adolescent girls aged 10–19, female and male caregivers aged 20–73, female and male social network contacts aged 10–89, and female and male community influentials aged 10–88.

The LRP should be responsible for calculating the final, exact sample sizes and providing a robust explanation of their decision-making process. To do this they have to obtain concrete information on the population of interest, from the IO and from members of the Stakeholder Advisory Committee.

## STEPS AND CONSIDERATIONS FOR STAND-ALONE IMPLEMENTATION

### 1. Select the respondents

- a. Identify the primary and secondary audiences of your programme.
- b. Assess the feasibility of conducting a full network study, considering available resources.
- c. To ensure the most robust results, include as many different respondent groups as possible as research participants.

### 2. Decide the level of disaggregation of data that will be needed.

- a. Standard variables to use as a basis for disaggregation include residence (rural/urban), age group, gender, ethnicity and religion.
- b. A good approach is to disaggregate your sample by characteristics that are relevant to FGM (including the examples given above).
- c. *Figure 11* provides additional considerations about each type of respondent group and disaggregation of these groups.
- d. Increasing levels of disaggregation requires exponential increases in sample sizes, so only choose the level of disaggregation that is necessary to draw conclusions.
- i. The LRP can help balance the desire for disaggregation with what is practical within contextual constraints.

### 3. Choose the sampling technique(s).

- a. The LRP should present you with their suggested sampling techniques and statistically calculate sample size requirements.
- b. For qualitative data, sample respondents from the same or similar locations from which you are collecting the quantitative data,
- c. Individual respondents should only participate in one type of data collection, either qualitative (FGD or IDI) or quantitative (structured interview).
- d. See *section 4.1: Calculating samples sizes*, in the ACT Implementation Templates for additional details on sample size considerations and calculations.
- i. Use a formal statistical method (differences method or power analysis) to compute quantitative sample sizes.
- ii. There is no rule of thumb for sample sizes for qualitative research.
- iii. The ideal is to have an iterative design that allows for data collection until saturation is attained.
- iv. However, this may not be practical in a field-based scenario. The minimum sample must include three activities (structured interviews, FGDs, IDIs) for each disaggregated participant type.

#### Considerations for Choosing respondent groups under 'Integrated implementation'

- FGM programmes that address different levels of the social-ecological model are likely to have discrete primary and secondary audiences.
- Ensure the current M&E system is designed to specifically represent the primary intended audiences for the social and behaviour change interventions. You may have to revise the sampling in your current system to appropriately calculate the denominators for your ACT indicators.

Figure 11: Special considerations for primary and secondary respondent groups<sup>12</sup>

Adolescent girls	Caregivers	Social network contacts	Community influentials
<ul style="list-style-type: none"> <li>◦ Using the WHO definition, adolescent girls are those aged 10–19.</li> <li>◦ It is recommended to disaggregate adolescent girls by age group: at least 10–14 and 15–19 (or even narrower groups).</li> </ul>	<ul style="list-style-type: none"> <li>◦ If you are specifically interested in the opinion of male caregivers, you will need to make them an intentional respondent group; they are unlikely to be identified when asking for the adolescent girl's primary caregiver.</li> </ul>	<ul style="list-style-type: none"> <li>◦ Disaggregate by the levels of social networks that are important to your programme: family (immediate vs. extended), friends/peers, community members</li> </ul>	<ul style="list-style-type: none"> <li>◦ If there is a specific type of influential person that your programme has targeted, you may want to oversample from that group to obtain disaggregated data specific to your primary audience of influentials, e.g., local government, religious leaders, health workers.</li> </ul>

<sup>12</sup>The WHO definition of adolescence can be found online [here](#)

## STEP 4C: IDENTIFY THE STUDY SITES

The study sites to include will depend on the evaluation design. Case-comparison designs require sites both exposed and unexposed to the intervention, while studies without a comparison group require only those exposed to the intervention.

### Considerations for Identifying study sites under 'Integrated implementation'

- Review existing systems to ensure study sites are covered or not covered by the social and behaviour change intervention as necessary to measure ACT indicators.

## STEPS AND CONSIDERATIONS FOR STAND-ALONE IMPLEMENTATION

### 1. Identify regions that are programmatically important.

### 2. Ask the LRP to suggest regions, and specific sites for data collection within those regions.

### 3. Introduce the LRP to your programme's implementing partners to facilitate any local approvals prior to data collection.

- a. Implementing partners can play a crucial role in accompanying the study supervisors and data collection team, to facilitate introductions in the study area.
- b. Do NOT provide implementing partners with detailed information on specific individuals who are to be included in the study; this can introduce bias.

### 4. Study site selection depends on the evaluation design.

- a. For a case-comparison design, the LRP must know the geographic boundaries of your intervention sites, so they can select an adequate comparison site without risk of contaminating the sample.
- b. For a pre- and post-intervention design, the LRP should be able to follow-up with the same individuals or select participants with very similar backgrounds to ensure the data are comparable over time.

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## STEP 5: ADAPT THE INSTRUMENTS

ACT includes a quantitative structured interview questionnaire, a qualitative FGD guide and a qualitative IDI guide to collect data to operationalize the indicators (these are provided in the ACT Instruments). These instruments need to be adapted for ACT implementation in the context of your programme and research objectives, through a series of sub-steps. This process begins once the relevant indicators have been chosen (see Step 2). The sub-steps described below are:

### 5A: Prepare the instruments in English

### 5B: Translate and back-translate the instruments

### 5C: Pretest and revise the instruments

### 5D: Transfer instruments to CAPI

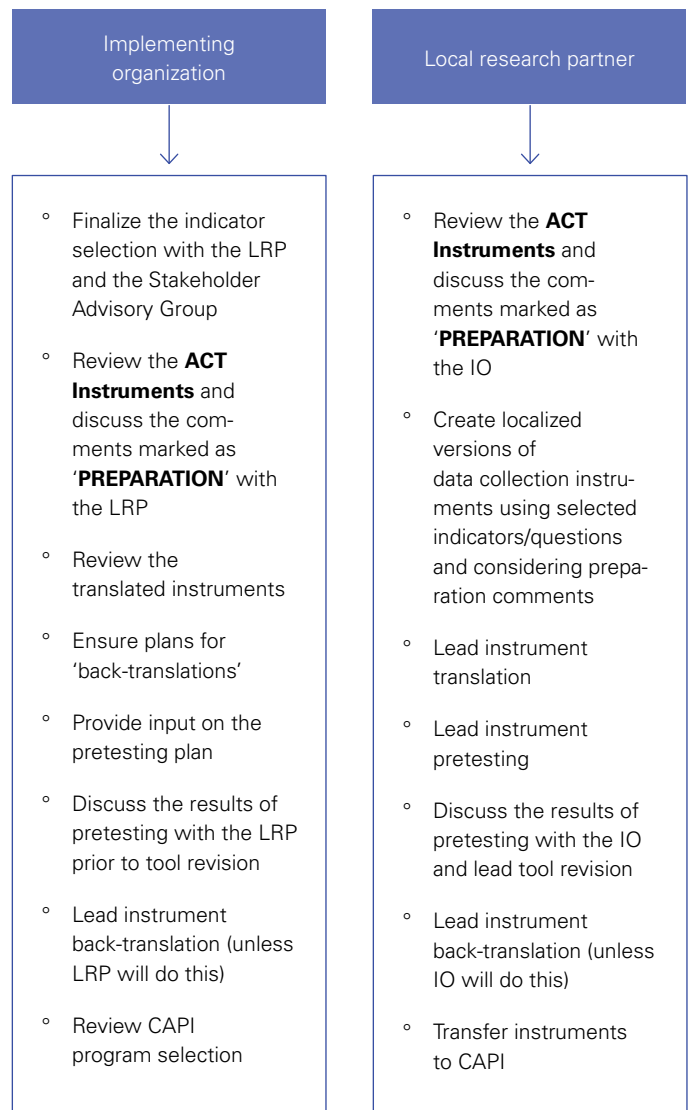
## STEP 5A: PREPARE THE INSTRUMENTS IN ENGLISH

The ACT indicator tables in *Section 4* of this document lists the quantitative (structured interview) questions associated with each indicator. These questions were validated and determined to be necessary and sufficient to adequately and accurately measure that indicator. Therefore, all questions associated with a specific selected indicator should be included in your final version of the quantitative questionnaire.

Given the sensitive nature of FGM, as well as the complexity of the ACT constructs, it is always recommended that you do not solely collect data with the quantitative questionnaire; qualitative activities should also be employed. The qualitative activities identified to be associated with the indicators you've chosen should be included (see *Table 25 in section 4.6*). You can find instructions for these activities in the FGD and IDI guides in the ACT Instruments.



### Roles and responsibilities for Step 5: Adapting the instruments



## STEPS AND CONSIDERATIONS FOR STAND-ALONE IMPLEMENTATION

**1. Select questions on the structured interview questionnaire.**

- Refer to *Table 1 in Step 2* to select sub-constructs and indicators.
- Refer to *Tables 11–24 in Section 4* to determine which specific questions are necessary to measure your chosen indicators.

**2. Select additional context questions.**

- Some questions in the structured interview are not directly associated with an indicator but provide additional context or a way to verify responses to indicator questions. These questions are marked as 'n/a' in the 'indicator' column in *Tables 11–24 in Section 4*.
- Use your discretion in deciding which of these questions are relevant to your indicators and programme needs.
- Delete those questions not associated with chosen indicators or otherwise relevant.

**3. Select qualitative activities from the FGD and IDI guides.**

- Refer to *Table 25 (section 4.6)* to see which activities are necessary to triangulate the data for your chosen indicators.
- Delete those activities from the FGD and IDI guides not associated with the chosen indicators.

**4. Collaborate with the LRP to follow instrument-specific preparation instructions.**

- Each of the three instruments has a section color box with a 'NOTE TO THE IMPLEMENTING ORGANIZATION' on the first page. Indeed, the structured interview has one of these boxes for each section and subsection of questions. These boxes include some preparation instructions for the tool, which you should review with the LRP.
  - For example, the first box in the structured interview questionnaire mentions "Throughout the interview instrument presented here, you will see blue highlighted, italicized blue text in capital letters [*LIKE THIS*]: This text indicates specific places where context-specific information needs to be inserted, so you will need to collaborate with the LRP to fill in these fields.
- The structured interview also contains a column labelled 'Preparation & training instructions'. Any text in this column marked 'PREPARATION': indicates

attention or action required to prepare the tool that is specific to that question.

- For the FGD and IDI guides, the activity-specific preparation instructions are contained in text boxes labelled 'PREPARATION & PRETESTING'.
- Use this information to ensure quality control during the instrument development process.

**5. Update structured interview questions to match indicators selected in Step 2.****6. Review response categories with the LRP.**

- Response options to many questions may be context specific and you should use your experience with the programme and knowledge of the situation to anticipate any additional responses that respondents may give.
- Additional response options may also be generated through pretesting.

**7. Adapt the indicators on 'Track individual and social change over time' (section 4.5), for the LRP.**

- Being most familiar with the objectives of your efforts, you should take the lead in ensuring that the questions in the 'Track behaviour and social change over time' section adequately reflect the content of your social and behaviour change interventions.

**Considerations for Preparing instruments in English under 'Integrated implementation'**

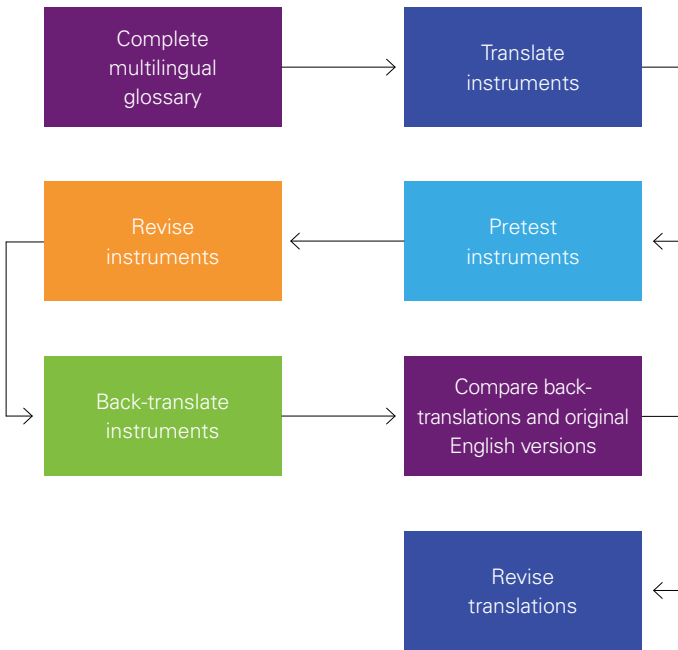
- As with stand-alone implementation, all questions or activities associated with a given indicator should be incorporated into your existing data collection indicators.

See the end of both the FGD and IDI guides in the ACT Instruments for a checklist of materials needed to conduct FGDs and IDIs and the activity templates that are used as part of each of the activities. Additionally, there is a 2x2 Tables Training Guide that can be used to adapt the 2x2 tables activity and to train facilitators.

## STEP 5B: TRANSLATE THE INSTRUMENTS

Translation is a critical step in ACT adoption and implementation; Figure 12 lists all the steps involved in creating accurate translations of the instruments. Site selection must be finalized prior to translation, so you are aware of the language(s) into which the tool should be translated.

**Figure 12: Steps in tool translation**



### STEPS AND CONSIDERATIONS FOR STAND-ALONE IMPLEMENTATION

#### 1. Finalize the multilingual glossary.

- The multilingual glossary is provided in section 5.1 of the ACT Implementation Templates.
- This glossary lists technical terms that may not be widely known or easily expressed in the local language.
- The glossary allows for the whole research team to describe complex, more technical concepts in a standardized manner.
- Assist the LRP to review the multi-lingual glossary and translate it using local terms to ensure it contains all relevant terms prior to translating the instruments.

#### 2. Translate instruments.

- Preliminary translation of the instruments should be done by the LRP prior to pretesting, as nuanced word choice may affect the meaning of the questions or the participant's ability to understand what is being asked.

#### 3. Back-translate the instruments.

- After pretesting and revision of the local language versions of the instruments, back-translation is the next crucial step in ensuring the quality of the instruments.
- Either the IO or the LRP may lead the back translation process. Back translations must not be done by the same person who did the initial translations
- Depending on timelines, back-translation may be done before or after pretesting

#### 4. Compare the back-translations with the original English versions.

- Comparison of back-translations and the original English versions may be done by you or the LRP but should be conducted by someone not involved in either forward or back translation.
- Use the comparison to identify errors in translation word choice and phrasing.

#### 5. Revise the translations.

- With improvements in translation software over time, it is becoming more and more feasible to use translation software to double check translations.

#### Considerations for Translating the instruments under 'Integrated implementation'

- Follow your standard translation procedures, noting the importance of rigor described in the steps for stand-alone implementation of ACT.
- The multilingual glossary will be useful even when integrating ACT into existing systems.

## STEP 5C: PRETEST AND REVISE THE INSTRUMENTS

Pretesting is the process of administering the adapted and translated research instruments to a small sample of intended respondents to assess the appropriateness of the instruments in the intended context. Revisions can be made to the instruments to improve them after pretesting (see *Figure 12*). Pretesting can:

- **Help determine the cultural relevance of questions**
- **Assess the suitability of vignettes and examples**
- **Help verify word choices and determine the quality of translation in the translated tools**
- **Ensure the amount of time to complete the questionnaire or activity doesn't create an undue burden on participants**
- **Identify relevant response categories for inclusion on closed-ended questions.**

These and other considerations relating to pretesting are presented in *Figure 13*.

Although the ACT instruments have been validated, pretesting them specifically in the context of your research area and respondent groups is critical, especially when the study will be implemented in a language other than English. The LRP will lead the pretesting and revision process, but the IO should expect to play an active role in this step.



**Figure 13: Key pretesting considerations**

Why?	Where?	When?	With whom? influentials
<ul style="list-style-type: none"> <li>◦ Determine cultural appropriateness of instruments</li> <li>◦ Assess cultural relevance of examples and vignettes</li> <li>◦ Determine the quality of the translation of instruments</li> </ul>	<ul style="list-style-type: none"> <li>◦ Intended study areas</li> </ul>	<ul style="list-style-type: none"> <li>◦ Before implementing the full study but after study design is decided and instruments have been adapted and translated.</li> </ul>	<ul style="list-style-type: none"> <li>◦ 3 structured interviews per respondent group</li> <li>◦ 1 FGD with every intended respondent group</li> <li>◦ 1 IDI with every intended respondent group</li> </ul>

## STEPS AND CONSIDERATIONS FOR STAND-ALONE IMPLEMENTATION

**1. Review pretesting considerations for each of the three instruments.**

- a. In the structured interview, in the 'Preparation & training instructions' column, there are comments labelled 'PRETESTING'. These comments indicate specific questions that require special attention during pretesting.
- b. The FGD and IDI guides contain text boxes labelled 'PREPARATION & PRETESTING' that contain pre-testing instructions for specific qualitative activities.

**2. Decide on the sample size for pretesting.**

- a. Pretest your quantitative tool with a minimum of three individuals from each (disaggregated) respondent group (e.g., three girls aged 10–14 and three aged 15–19, if that is how you plan to disaggregate the data in your results report).
- b. Given the participatory nature of the qualitative instruments in ACT, you should pretest the FGD and IDI with at least one group of people from each type of respondent group.
- c. Table 4 shows an example of what your pretest sample would look like if implementing ACT with all recommended respondent groups.
  - i. If conducting the study in more than one language, pretest with this number of respondents in each language.

**3. Arrange pretesting staff.**

- a. The LRP should be able to assign its key research personnel to conduct the pretesting.

- b. If the LRP wants to use recruited field staff to conduct the pretesting, they will first need to recruit and train these staff members.
- c. Make sure that the LRP has described their process and arrangements for pretesting in their research proposal.

**4. Pretest the instruments.**

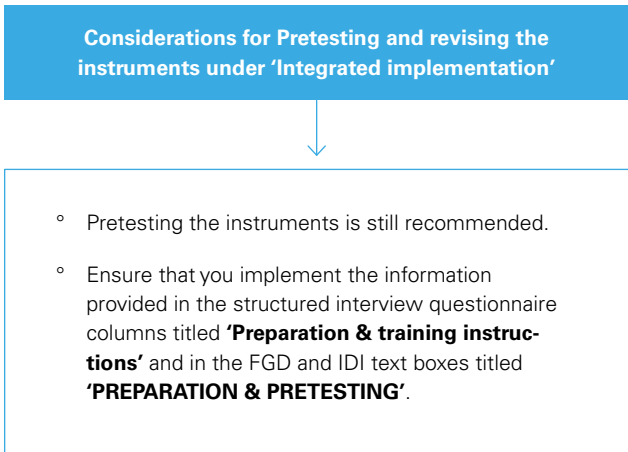
- a. Pretesting provides some information on the length of time it takes to administer a tool. Note that actual data collection takes considerably less time. A rule of thumb is that the final tool will take two thirds of the time taken during pretesting.
- b. Staff from the IO should observe the pretesting as a non-participant, to ensure that the LRP data collector:
  - i. Focuses on participant and interviewer/facilitator behaviours during pretesting.
  - ii. Utilizes the pretesting to finalize response categories, specifically for multiple choice questions.
  - iii. Reviews the words selected during initial translation.
  - iv. Reviews the terms in the multilingual glossary.

**5. Review the LRP's pretesting report explaining the revisions to the instruments resulting from the pretesting activity.****6. Approve the suggested revisions and ensure these are incorporated into the instruments by the LRP.**



**Table 4: Pretesting sample sizes**

Respondent type	Structured interviews	FGDs	IDIs
Adolescent girls 10–14 years old	3	1	1
Adolescent girls 15–19 years old	3	1	1
Female caregivers	3	1	1
Male caregivers	3	1	1
Social network contacts	3		
Community influentials	3		
<b>Total</b>	<b>18</b>	<b>4</b>	<b>4</b>



**Table 5: Benefits of CAPI**

<b>Automatic filtering and skip patterns</b>	<ul style="list-style-type: none"> <li>◦ Reduces data collector error</li> <li>◦ Allows data collector to fully concentrate on the conversation</li> </ul>
<b>Eliminates need for data entry at a later point</b>	<ul style="list-style-type: none"> <li>◦ Reduces data entry errors</li> <li>◦ Reduces additional costs for data entry</li> </ul>
<b>Allow respondents to directly answer some questions on the device</b>	<ul style="list-style-type: none"> <li>◦ Increases response rate to sensitive questions</li> </ul>
<b>Allows for daily transfer of study materials to a central database</b>	<ul style="list-style-type: none"> <li>◦ Increases security of confidential information</li> </ul>

### STEP 5D: TRANSFER INSTRUMENTS TO CAPI

Computer-assisted personal interviewing (CAPI) is an interviewing technique in which an in-person interviewer uses a computer (such as a laptop, tablet or smartphone) to administer a survey and capture the responses. Use of CAPI is not required, but it is strongly recommended. Table 5 lists some benefits of using CAPI.

#### STEPS AND CONSIDERATIONS FOR STAND-ALONE IMPLEMENTATION

##### 1. Review CAPI program selection.

- a. The LRP will likely have a preference for which CAPI program to use.
- b. You should let the LRP use the CAPI program they are most comfortable with.

- c. However, if you want to approve their selection, Table 6 below provides some questions that can guide your review of their CAPI program.
- i. For example, you may need to choose a platform that allows for offline data collection if not all your study areas have adequate Internet connectivity.
- ii. Or, if the survey will be administered in several languages, you should choose a program with a multilingual option.

#### Considerations for Transferring instruments to CAPI under 'Integrated implementation'

- If your system is currently using CAPI, integrate the ACT Instruments into this CAPI program.
- If your system is not currently using CAPI, consider switching, using the guiding questions above to help your selection.

**Table 6: Questions to ask about your CAPI program**

<b>1. Data capture</b>
<ul style="list-style-type: none"> <li>◦ Does the CAPI software capture all forms of data that you need, i.e., text, numbers, pictures, audio, etc.?</li> <li>◦ Does it have the language support that you need to conduct multilingual surveys or record multilingual answers?</li> <li>◦ Does it work with the hardware options you have available (computers, tablets, smartphones)?</li> </ul>
<b>2. Questionnaire navigation</b>
<ul style="list-style-type: none"> <li>◦ Is it easy to navigate through the questionnaire in the software?</li> <li>◦ Can the software perform the skips and loops that you need to have in your survey?</li> </ul>
<b>3. Data quality control</b>
<ul style="list-style-type: none"> <li>◦ Does the CAPI software provide ways of controlling the quality of data (i.e., values within certain range, values with a required character, values without a certain character, etc.)?</li> </ul>
<b>4. Data management</b>
<ul style="list-style-type: none"> <li>◦ Is the data output file from the CAPI software compatible with the statistical tool you will use to analyse datasets?</li> </ul>
<b>5. Case management</b>
<ul style="list-style-type: none"> <li>◦ How easy does the software make management of tasks for various people in the hierarchy (team leaders, data collectors, etc.) during a survey?</li> </ul>



## STEP 6: PERFORM AN ETHICAL REVIEW

Performing an ethical review is an essential and necessary step in any research study in which human subjects are asked about personal attitudes and behaviours. Ethical review requires approval from an institutional review board (IRB), which serves as an objective third-party ethical oversight committee for all research involving human subjects (also known as an ethical review board or research ethics board). This protects and manages risks to human participants involved in research, ensures adherence to the ethical values and principles underlying research, ensures that only ethical and scientifically valid research is implemented, and addresses concerns from the general public about the responsible conduct of research. By certifying that the benefits of the research outweigh potential risks to the

subjects, IRB approval is an integral part of research using a human rights-based approach.

IRB approval is often time intensive; therefore, it is important to prepare for it in the planning stage. While you will not be able to submit a request for ethical approval until the instruments are adapted, you should begin the process as soon as possible. This will make the process easier and quicker once the instruments are ready.

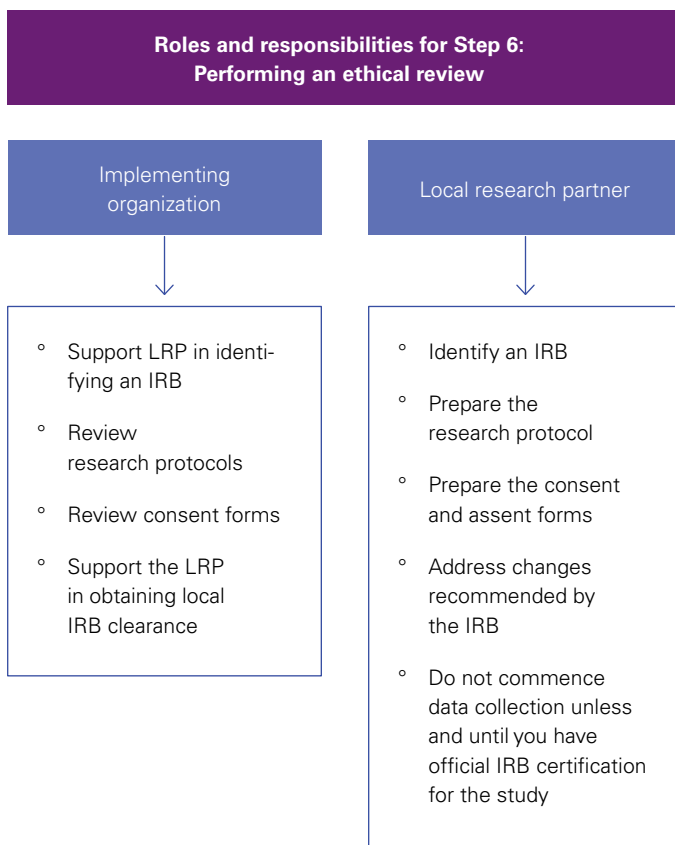
Figure 14 lists the key aspects of your research that will need to be reviewed by an ethics board. You should review the LRP’s research protocol to ensure they describe all their procedures to protect human subjects in detail.

Figure 14: Key IRB considerations

Research design (study population, sample size, timeline, etc.)	Research instruments	Risks and benefits to participants	Qualifications of the researchers
Proposed recruitment strategy	Safeguards for vulnerable populations	Community impact	Protocols to protect participants during and after research
Informed consent procedures	Mechanisms to maintain confidentiality and privacy of participants	Data storage and management	Results sharing



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- b. Given the sensitive nature of FGM-related questions, it is almost certain that the research will be classified as human subjects' research.
  - i. If the research is being conducted with key influentials in their official capacities and does not ask questions about their personal beliefs and behaviours, then ethical review may not be necessary.
  - ii. If adolescent girls under the age of 18 are included in your M&E plan, ethical review is especially important; children are considered a 'vulnerable population' requiring extra protections when involved in research.
- c. Ethical review is necessary for both quantitative and qualitative research methods.

### 3. Compile the research protocol.

- a. The LRP should lead this step, but it is recommended that the IO review the protocol before it is submitted to the IRB.
- b. A research protocol (IRB submission) template is provided in section 6.1 of the ACT Implementation Templates. This will need to be adapted to fit your local IRB requirements, but can serve as a starting point.

### 4. Develop consent and assent procedures.

- a. The LRP should lead this step, but it is recommended that the IO review the procedures and forms before they are submitted to the IRB.
- b. Table 7 outlines information that must be shared with participants during informed consent procedures, in order for them to make a truly educated decision.
- c. Children under the age of 18 are unable to provide consent.
  - i. Simplified information should be shared with child participants and they should be asked to provide informed assent instead.
  - ii. A responsible guardian is then required to provide informed consent for their child to participate.
  - iii. Both child assent and guardian consent must be received before enrolling a child in the study.
- d. Consent and assent form templates are provided in sections 6.2–6.4 of the ACT Implementation Templates. These will need to be adapted to fit your local IRB requirements, but can serve as a starting point.
- e. A contact information postcard is also provided in section 6.5 of the ACT Implementation Templates. This can be given to research participants as part of ethical procedures.

## STEPS AND CONSIDERATIONS FOR STAND-ALONE IMPLEMENTATION

### 1. Identify the IRB.

- a. The ethical review process will depend on your context and on your LRP.
- b. Universities generally have their own IRB; if the LRP is a university (or a unit at a university), you will be required to obtain clearance from that university's dedicated IRB.
- c. Some countries have dedicated research approval organizations; the LRP should be aware of these.
- d. If no local IRB exists, there are certified global review boards that conduct ethical review of research involving human subjects for a fee.
- e. Depending on your context, multiple clearances may need to be sought. Some countries have both national and regional IRBs and require approval from each.

### 2. Assess the need for ethical review.

- a. The identified IRB should have guidelines to assess what approvals the research needs.

**Table 7: Required informed consent information**

<b>Informed consent must cover the following:</b>	<b>Description of the research</b>	Name of study
		Study objectives
		Sponsor or donor
	<b>Expectations of participants</b>	Duration of the interview
		Duration of the study
		Participation procedures
	<b>Risks and benefits</b>	Potential harm from participating
		Potential benefits from participating
		Compensation
	<b>Voluntary nature of participation</b>	No consequences for non-participation
		Option to stop participating at any point in the interview or study process
	<b>Protections</b>	Confidentiality procedures
		Privacy procedures
	<b>Contact information for follow-up questions</b>	Study lead
		Responsible IRB

**Considerations for Performing an ethical review under 'Integrated implementation'**



- If you elect to incorporate key indicators from ACT into your existing systems, ensure that data collection is being conducted ethically.



## STEP 7: CONDUCT FIELD WORK

Moving to the field work stage entails beginning the actual data collection processes. Required steps in this stage are:

### 7A: Organize field staff

### 7B: Train field staff

### 7C: Collect data

The LRP will be primarily responsible for these tasks. Your role as the IO is to provide guidance to the LRP.

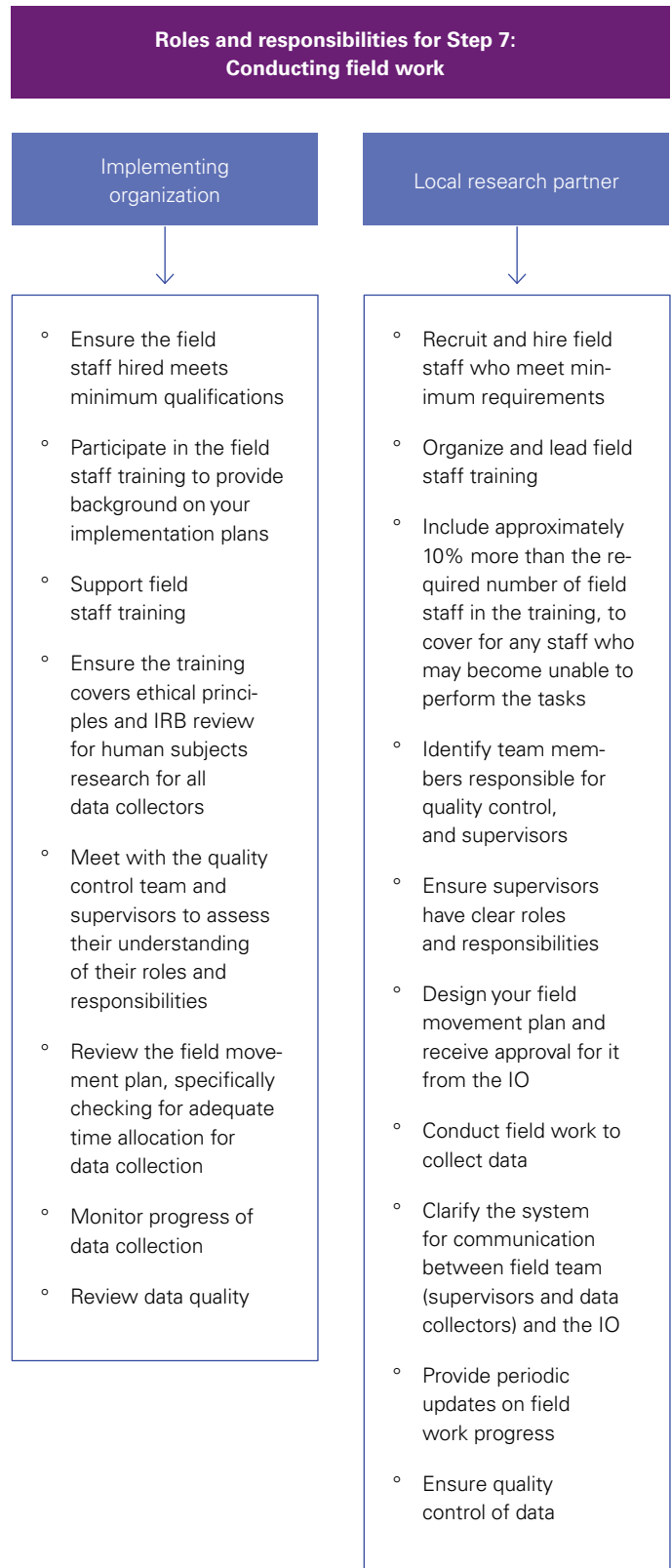
This section focuses on actual field work and hence mostly applies when implementing ACT as a stand-alone M&E framework. It is assumed that those employing an existing system will have already ensured that the M&E data collection systems are robust.

### STEP 7A: ORGANIZE FIELD STAFF

In addition to their core team, the LRP will need to hire field staff to conduct data collection. Field staff include field supervisors and data collectors, including interviewers for the quantitative interviews and facilitators for the qualitative activities (FGD and IDI), as well as notetakers for all components. *Table 8* lists the key responsibilities of the two main types of field staff: field supervisors and data collectors.



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**Table 8: Key responsibilities of supervisors and data collectors**

Field supervisors		Data collectors	
	<ul style="list-style-type: none"> <li>◦ Arrange logistics (field movement plans)</li> <li>◦ Interact with local authorities (letters of approval)</li> <li>◦ Solve problems that arise in the field</li> <li>◦ Make sure that data collectors transmit data on a daily basis</li> <li>◦ Communicate with the leadership team about progress and issues</li> <li>◦ Conduct back-checks (10 per cent of the interviews)</li> <li>◦ Lead briefing sessions with data collectors</li> <li>◦ Ensure that data collectors maintain privacy and confidentiality</li> </ul>		<ul style="list-style-type: none"> <li>◦ Ensure that respondents meet selection criteria</li> <li>◦ Conduct informed consent/assent procedures</li> <li>◦ Maintain a high standard of data collection</li> <li>◦ Encourage the respondent to answer questions</li> <li>◦ Alert supervisor immediately of any issues that arise</li> <li>◦ Check in daily with field supervisor</li> <li>◦ Maintain privacy and confidentiality</li> </ul>

## STEPS AND CONSIDERATIONS FOR STAND-ALONE IMPLEMENTATION

### 1. Decide field team size.

- a. The number of field staff required for implementation will depend on the overall sample size and timeline.
  - i. The LRP should be able to provide an estimate of the size of the field team needed once these decisions have been made.
- b. During pretesting of the instruments, the LRP should also be able to determine the amount of time required to administer the structured interview, FGD and IDI and calculate how many of each data collection instruments can be completed per interviewer or facilitator per day.
- c. In addition to these base estimates, the LRP should plan to recruit and train 10 per cent more data collectors than needed to allow for replacement of staff who may be unable to perform the work as planned

### 2. Recruit and hire field staff.

- a. The LRP is responsible for recruiting data collectors and field supervisors.
- b. Make sure that the LRP provides details on minimum qualifications for field staff and the manner of recruitment in their research proposal.
  - i. *Figure 15* lists some qualifications for data collectors and field supervisors.

### Considerations for Organizing field staff under 'Integrated implementation'

- Identify the additional time burden to integrate ACT questions and activities into the existing data collection activities.
  - Then existing data collection teams and timelines can be adjusted accordingly.

Figure 15: Lists some qualifications for data collectors and field supervisors.

Recommended qualifications and experience for data collectors	Recommended qualifications and experience for field supervisors
3–5 years of data collection experience	3–5 years of field supervision experience
Familiar with CAPI	Familiar with CAPI
Experience with similar studies (social norms, attitudes, FGM)	Experience supervising similar studies (social norms, attitudes, FGM)
Fluent in the language(s) of data collection	Fluent in the language(s) of data collection
Knowledge of the region(s) where data collection will occur	Knowledge of the region(s) where data collection will occur
Ability to tactfully and respectfully discuss sensitive topics	Strong organizational skills



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## STEP 7B: TRAIN FIELD STAFF

Field staff training allows field supervisors and data collectors to become familiar with the data collection instruments. It is also an opportunity to identify and mitigate any biases that they may have.

Field staff training should be participatory in nature, allowing those attending as much time as possible to practise implementing the instruments and to receive feedback. Table 9 outlines the four main sections that should be included in the field staff training.

**Table 9: Suggested field staff training topics**

<b>Theoretical orientation</b>	<ul style="list-style-type: none"> <li>◦ Purpose of the research</li> <li>◦ Objectives of the training</li> <li>◦ Roles and responsibilities</li> </ul>
<b>Ethics training</b>	<ul style="list-style-type: none"> <li>◦ Ethical principles</li> <li>◦ Informed consent/assent procedures</li> </ul>
<b>Aspects of data collection</b>	<ul style="list-style-type: none"> <li>◦ Review of all instruments</li> <li>◦ CAPI training</li> <li>◦ Mock interviews</li> </ul>
<b>Sensitivity orientation</b>	<ul style="list-style-type: none"> <li>◦ Limiting bias</li> <li>◦ Managing discomfort</li> </ul>

### STEPS AND CONSIDERATIONS FOR STAND-ALONE IMPLEMENTATION

#### 1. Collaborate with the LRP to arrange logistics

- a. Logistics, such as refreshments, per diem, venue, audio-visual equipment, and print materials should have been budgeted for in the LRP’s proposal.

#### 2. Review the LRP’s training materials

- a. Each of the three ACT Instruments include training notes specific to certain questions and activities.
  - i. Structured interview: See the notes listed in the **‘Preparation & training instructions’** column, with the heading **‘TRAINING’**.
  - ii. FGD and IDI: See the text boxes labelled **‘TRAINING NOTES’**.

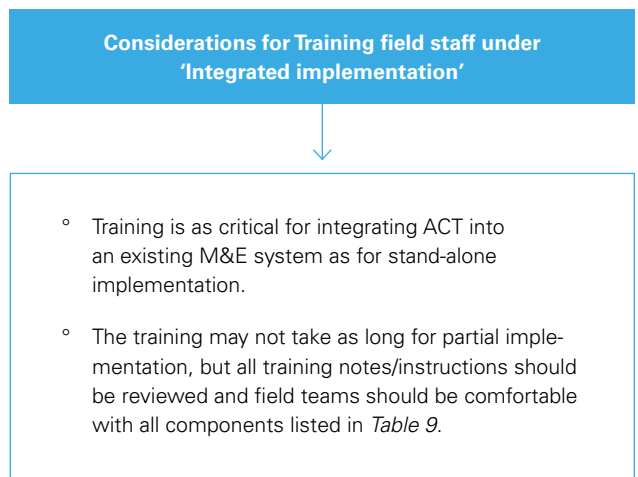
- iii. While all questions and activities should be reviewed in the training sessions, special attention should be given to these notes to make sure data collectors understand them.
- b. *Section 7.1* in the ACT Implementation Templates contains a sample training agenda that may be useful when planning field staff training.
- c. A training manual on ethical principles is provided in *section 7.2* of the ACT Implementation Templates.

#### 3. Conduct training.

- a. The LRP core team will lead the field staff training.
- b. At least one member of the IO team should be present throughout the whole event.
- c. During the training, the IO representative will take a lead on:
  - i. Providing an introduction to the work
  - ii. Presenting a session discussing tracking individual and social changes over time
  - iii. Answering technical questions
  - iv. Inviting a senior representative of the IO (e.g., chief of the relevant section, or other senior member of staff) to address the data collectors at the end of the training.

#### 4. Evaluate field team performance.

- a. Use the training as an opportunity to assess the quality of the field staff engaged by the LRP.
- b. Discuss with the LRP how they will determine if recruited staff have successfully completed the training.
- c. Review the results after the training is complete, and help the LRP select the field teams before their deployment.



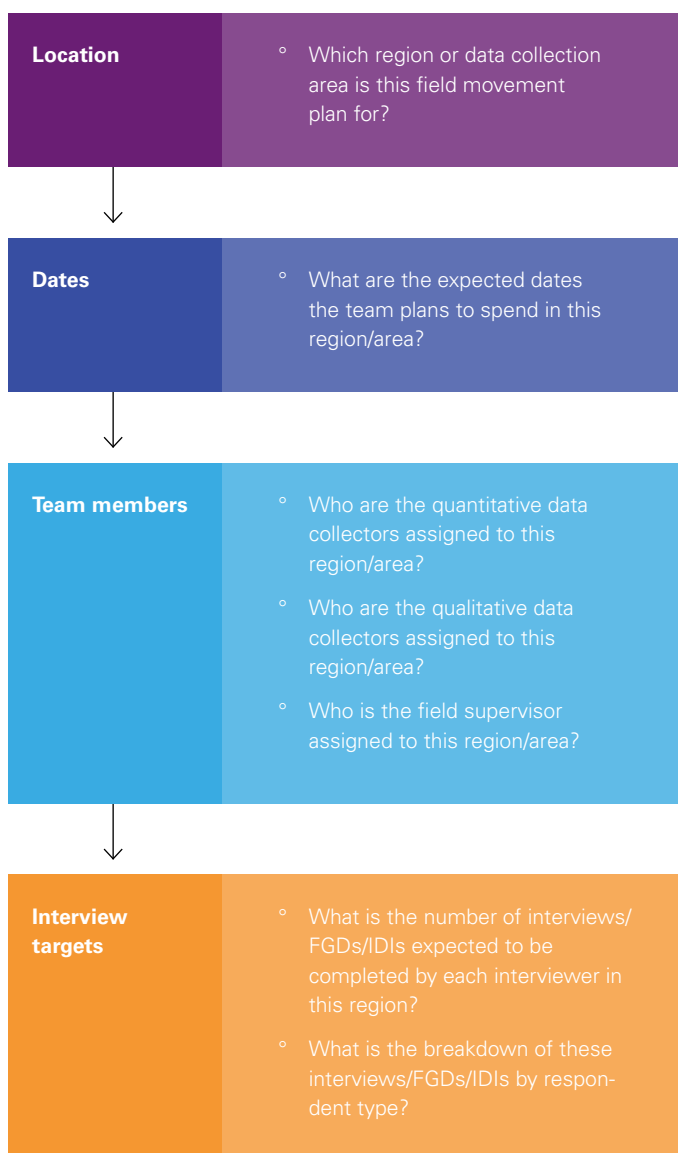
## STEP 7C: COLLECT DATA

Field work involves travelling to the study sites to administer the research instruments and collect data. It includes:

- **Mapping households within the sites**
- **Selecting and recruiting specific participants**
- **Conducting the structured interviews, FGDs and IDIs.**

While the LRP leads this step, the IO must be involved in monitoring progress and quality throughout.

**Figure 16: Components of a field movement plan**



## STEPS AND CONSIDERATIONS FOR STAND-ALONE IMPLEMENTATION

### 1. Review the LRP's field movement plan.

- a. The plan may be very detailed with day-by-day plans or may only provide a basic outline.
- b. *Figure 16* lists items that should be described in the field movement plan.
- c. An example of a field movement plan is provided in *section 7.3* of the ACT Implementation Templates.

### 2. Monitor field work.

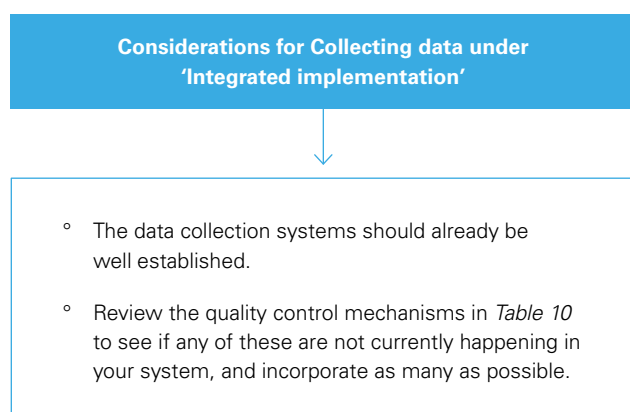
- a. Field supervisors should send daily updates to the LRP management team about data collection progress and any issues faced.
- b. The LRP should send you weekly updates on the progress, including
  - i. The number of each type of data collection activity conducted (interview/FGD/IDI), with each type of respondent group
  - ii. A summary of problems faced and how they were addressed
  - iii. Any anticipated schedule changes based on whether data collection tasks are proceeding at the expected rate.
- c. A template for weekly field work updates is included in *section 7.4* of the ACT Implementation Templates.

### 3. Ensure quality of data.

- a. The LRP should describe their quality control mechanisms in their proposal.
  - i. Discuss these plans thoroughly with the LRP before field work begins.
  - ii. In particular, agree with the LRP on the percentage of interviews that supervisors will observe and the percentage of interviews on which supervisors will perform back-checks. These are usually set at 10 per cent or 15 per cent.
- b. *Table 10* outlines some of the quality control mechanisms that should be in place during field work.
- c. Quality control checklists for the structured interview, FGD and IDI are available in *sections 7.5–7.7* of the ACT Implementation Templates.

**Table 10: Field work quality control mechanisms**

<b>1. Field staff daily check-ins</b>
<ul style="list-style-type: none"> <li>◦ Field supervisors should debrief with each data collector at the end of each day to provide them with feedback and collect study materials.</li> </ul>
<b>2. Observing data collection</b>
<ul style="list-style-type: none"> <li>◦ Field supervisors should ensure that data collectors are following research protocols for recruitment, consent/ assent and administration of the research tool.</li> <li>◦ Typically about 10 per cent of interviews are observed.</li> </ul>
<b>3. Verifying data</b>
<ul style="list-style-type: none"> <li>◦ Field supervisors conduct back-checks, or verification interviews, which involve returning to previously interviewed respondents to ask them a small subset of the interview questions. These responses are compared to those recorded by the data collector for accuracy.</li> <li>◦ Supervisors should conduct back-checks on at least 10 per cent of the interviews.</li> </ul>
<b>4. Monitoring data transfer</b>
<ul style="list-style-type: none"> <li>◦ When CAPI is used, only electronic methods of data transfer are required. Field supervisors should make sure that data collectors transmit their data at the end of each day and ensure that it has been received by the LRP's central team, especially when data is being collected offline.</li> <li>◦ For qualitative data, pictures of participatory materials and audio recordings can also be shared electronically through encrypted files. Supervisors should ensure that any identifying information is kept separately but that the pictures and recordings are labelled correctly to match the unique FGD or IDI identifier.</li> </ul>



## STEP 8: CLEAN AND ANALYSE DATA

The LRP quality control team should review the data to ensure it is clean and ready for analysis as it comes in. Once all the data collection is completed, the LRP should run basic checks, including for missing data, incorrect codes and skip patterns. Checklists are provided in sections 8.1 and 8.2 of the ACT Implementation Templates to assist the LRP with data cleaning.

As noted earlier, one of the benefits of using CAPI is that it reduces the data entry and cleaning times. For the qualitative data, the LRP should record and label all materials for clear identification. Only once all the data are considered clean should the LRP commence analysis.

Beyond calculating results for individual indicators, the data analysis should examine the constructs holistically, including making comparisons between related indicators, such as knowledge, attitudes and behaviours, and the social norms constructs. These results must then be related with the output, outcome and exposure indicators from the 'Track individual and social change over time' section (Section 12 of the interview) to determine attribution and contribution associated with specific programme components. Then, examining everything all together, the programme approaches, channels and messages can be adapted and altered to increase change where needed, focusing on programme components that address the ACT constructs in need of the most attention. Figure 17 lists the types of information that can be deduced through different types of data analysis.

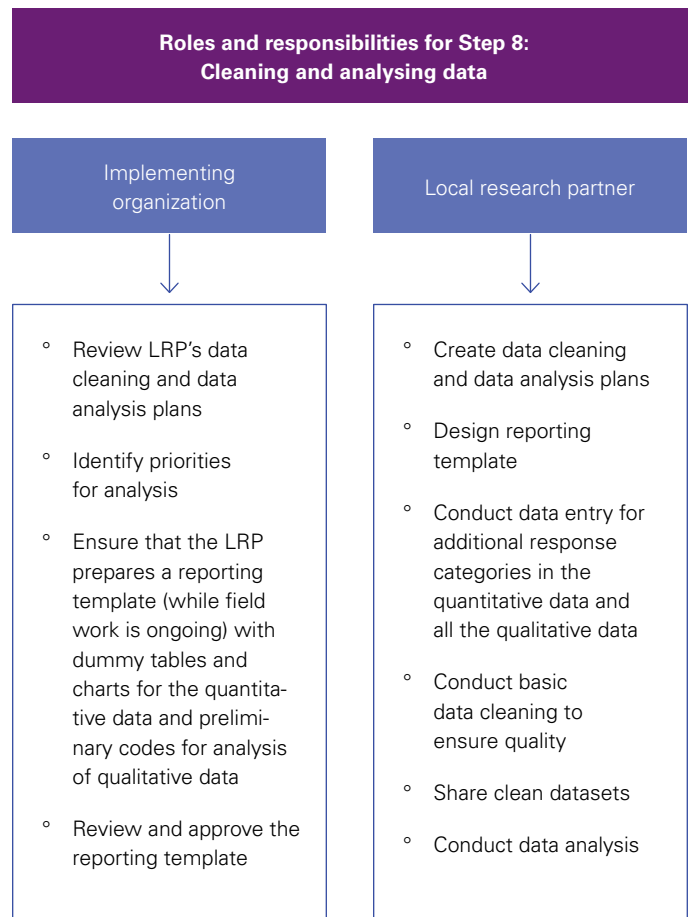
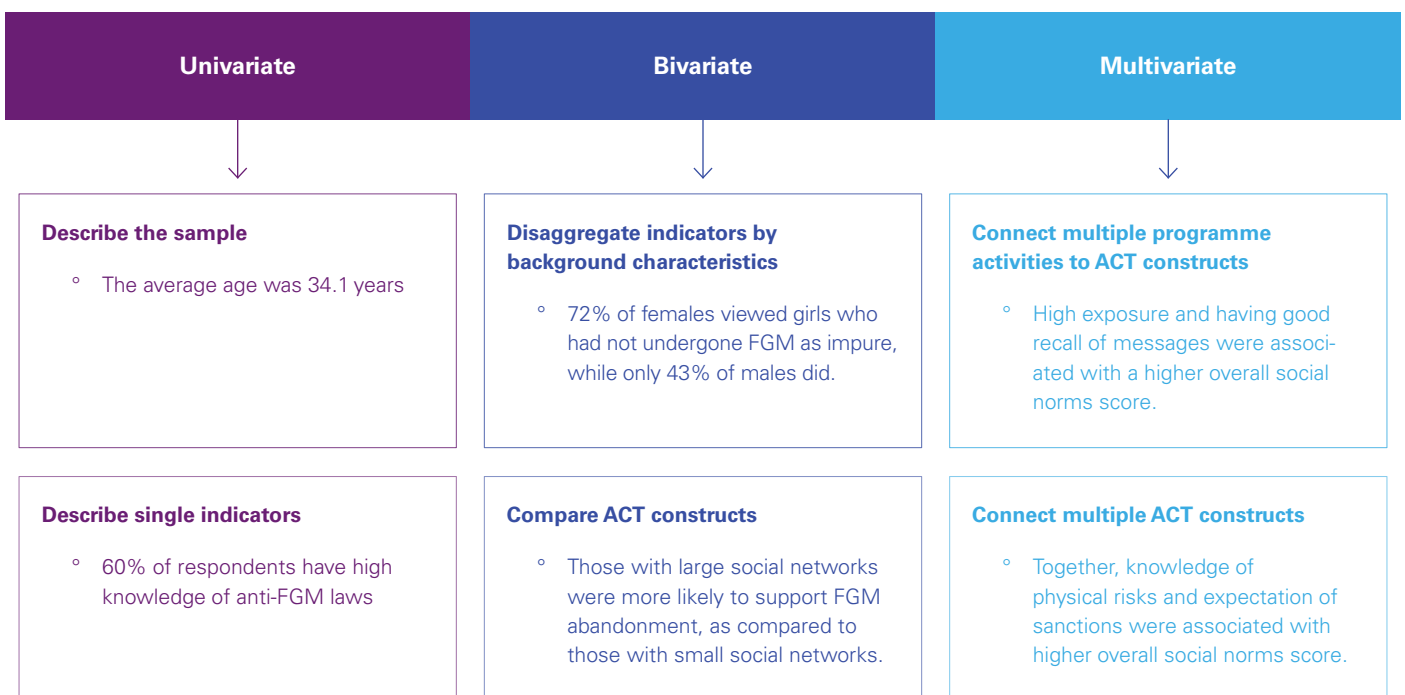


Figure 17: Examples of analysis for ACT data



## STEPS AND CONSIDERATIONS FOR STAND-ALONE IMPLEMENTATION

**1. Create and review a reporting template.**

- a. During field work, have the LRP create a reporting template with dummy tables and charts for the quantitative data, and preliminary codes for analysis of qualitative data.
- b. Use this template to collaborate and agree on the format and content of the final deliverables.

**2. Review the LRP's data cleaning plan.**

- a. An experienced LRP should know how to create a 'clean' dataset, but even when using CAPI, it is critical to make sure data are cross-checked. Qualitative data must also be carefully reviewed for quality.
- b. For the quantitative data, checking skip patterns to establish correct denominators for indicators is especially important.
- c. For qualitative data, examine missing data and responses that do not fit thematic analysis codes.
- d. Make sure the LRP has allocated time and resources for data cleaning.

**3. Review the LRP's data analysis plan.**

- a. How the indicators will be disaggregated by different background variables, for example:
  - i. All variables will be reported by respondent type and region, or
  - ii. Variables in 'Consider the context' should be reported by age and gender.
- b. Which constructs from 'A' and 'C' will be compared (see Figure 7, *section 2.2*), for example:
  - i. What is the connection between knowledge and injunctive norms?
  - ii. How are attitudes and power related?
  - iii. Note: It is the similarities and differences between constructs that tell a complete story of change.
- c. Which indicators are to be stratified by the output, outcome and exposure indicators from the 'Track individual and social change' section, for example:
  - i. Do those with higher exposure to the intervention have a higher overall social norms score?
- d. The way in which qualitative data will be included.



- i. Not all LRPs have experience with this type of data, so you should ensure that they have a plan, including codes for thematic analysis, that will make best use of the qualitative data collected.
- ii. Use quotations from the qualitative activities to confirm, reject and/or explain results found through the quantitative questionnaire.

In the tables *Section 4* of this document, for each indicator listed in the left column, the corresponding questions from the structured interview questionnaire are also listed, along with a description that outlines how the indicator should be calculated from the data gathered using those associated questions.

**Considerations for Cleaning and analysing data under 'Integrated implementation'**

- Add considerations for analysing the new ACT indicators into your existing data analysis plans.

## STEP 9: DISSEMINATE RESULTS

Reporting and dissemination serve many critical functions:

- **Sharing results with stakeholder groups involved in the research can connect them with the programme on a deeper level, which can in turn increase engagement and community buy-in.**
- **Providing programme implementers with results allows them to incorporate the findings into their programmes and increase intervention effectiveness.**
- **Disseminating results at a regional and global level creates the opportunity to develop future programming using a strong evidence base.**

### STEPS AND CONSIDERATIONS FOR STAND-ALONE IMPLEMENTATION

#### 1. Ensure that the LRP has a clear dissemination plan, outlined in their proposal and elaborated during the inception phase.

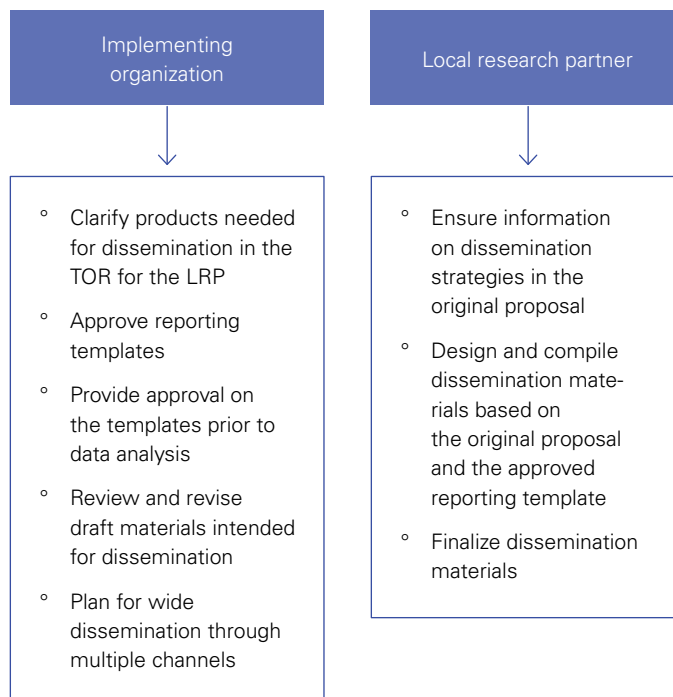
a. Ideally, their plan will include a variety of dissemination products for different stakeholders who may need information in different formats.

#### 2. Create a full list of stakeholders with whom the information should be shared. At a minimum, these will include:

- a. Programme implementers
- b. Government partners
- c. Research participants
- d. Regional programme coordination bodies.

#### 3. Develop a timeline for disseminating results among different groups of stakeholders.

### Roles and responsibilities for Step 9: Disseminating results



### Considerations for Disseminating results under 'Integrated implementation'

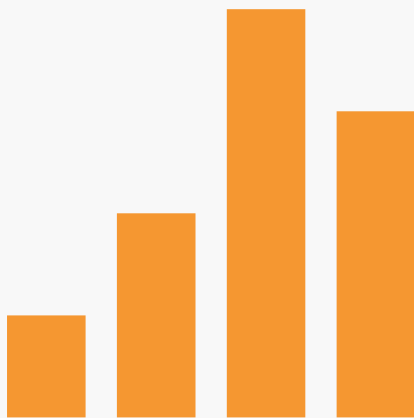
- Use existing reporting templates to guide dissemination.
- Highlight information on the specific social and behaviour change communication efforts and how they are linked to results.
- Link social norms results with the 'track individual and social change' information to account for contribution and attribution of the results.
- Highlight the social norms results within the larger report to build support for social norms work.
- Highlight how communication efforts complemented and supplemented additional activities in multi-level programmes.

# SECTION 4

# THE ACT

# FRAMEWORK

# INDICATORS



The six subsections below (4.1–4.6) are structured around the ACT Framework constructs (A-C-T) (see *Figure 7, section 2.2*). Each subsection describes the indicators associated with each construct and how these indicators can be operationalized, to assist with data analysis and interpretation. Information on why the indicators should be measured, as well as how they relate to one another and the larger continuum of change is provided. Use this section to select all or key indicators you would like to use during implementation of the ACT Framework (stand-alone or integrated implementation) for M&E of your programme.

*Tables 4–17* present the quantitative methods for measuring the indicators; all questions in these tables are from the structured interview questionnaire. Qualitative means of assessing the indicators in *Tables 4–17* are presented in *section 4.6: ‘Triangulate all data and analysis’*, including *in Table 18*.

Once relevant indicators have been selected (see *Section 3, Step 2*, earlier in this document), use the ACT Instruments to include the questions and qualitative activities corresponding to your chosen indicators.

Note: Not all of the indicators listed in this section may appear to be the most robust measures for individual constructs from an academic standpoint. As a priority, all questions and indicators were weighed in terms of (i) feasibility for an implementing organization (IO) and (ii) the ability to create a holistic picture around FGM-related social norms change. In-depth studies on complex constructs, such as social networks, gender and social norms, may provide more robust measures than those presented here.

## 4.1 ASSESS WHAT PEOPLE KNOW, FEEL AND DO

This section concerns individual-level factors relating to the ‘Assess what people know, feel and do’ construct of ACT. The indicators in this section focus on people’s knowledge about FGM, attitudes towards FGM, and FGM-related behaviours. Knowledge, attitudes and behaviours are all interdependent, and measurement of these indicators is important to identifying the pathways to change, outlining a clear set of steps that individuals and communities go through when choosing, adopting and maintaining a harmful practice, such as FGM.

Having correct, factual knowledge about FGM, including an accurate understanding of the short- and long-term risks, can help to challenge myths and shift attitudes away from support for FGM, towards favouring FGM abandonment and elimination. Attitudes can influence knowledge and actual behaviour and social change. Essentially, those with more negative attitudes towards FGM are more likely to abandon the practice. Behaviour change is the final step on the individual-level change continuum. Each person or family that chooses to abandon FGM means that the community is one step closer to community-level change, and the region or country is ultimately closer to social change on a broader scale.

The subsections below address ‘know’, ‘feel’ and ‘do’ in turn.

### 4.1.1 ASSESS WHAT PEOPLE KNOW

The 'Assess what people know' indicators focus on awareness of FGM, classification of FGM as a harmful practice, and factual information about the types of FGM and laws around FGM, as seen in *Table 11*. Generally, the higher the level of knowledge individuals hold in these domains, the greater the likelihood that they will adopt more favourable attitudes towards the elimination of FGM, and eventually choose not to have FGM performed on their daughters and instead promote abandonment of FGM in the community.



**Table 11: Indicators, questions and calculations to assess what people know**

Indicator	Structured interview questions	Description and notes
<b>Percentage of the population who know about FGM</b>	C.1 In some countries there are traditional practices that may be harmful for girls and women. Have you heard of any such traditional practices? What are they?	<p><b>DESCRIPTION:</b> Percentage who respond "FGM" to C.1 and "Yes" to C.2</p> <p><b>NOTE:</b> C.3 and C.4 are included to determine if the respondent is eligible to participate in the survey and should not be used to calculate this indicator.</p>
	C.2 In some countries, there is a practice in which a girl may have part of her genitals cut. Have you ever heard about this practice?	
	C.3 This practice is often referred to as female genital mutilation or FGM. Have you ever heard of this term – FGM?	
	C.4 Can you describe the different ways that FGM might be done on a girl? (use a diagram of external genitalia)	
<b>Percentage of the population who identify FGM as a harmful traditional practice</b>	C1. In some countries there are traditional practices that may be harmful for girls and women. Have you heard of any such traditional practices? What are they?	<b>DESCRIPTION:</b> Percentage who respond "FGM" to C.1
<b>Percentage of the population who know about the four types of FGM</b>	C.4 Can you describe the different ways that FGM might be done on a girl? (use a diagram of external genitalia)	<p><b>DESCRIPTION:</b> Percentage who name all four types</p> <p><b>NOTE:</b> This should be included if your programme activities focus on educating people about the four types of FGM.</p>



n/a	C.5 What are the local words that are used to refer to this practice (FGM)?	<b>NOTE:</b> This is for programming purposes and to allow the interviewer to know how to refer to FGM for the remainder of the interview.
<b>Percentage of the population who are aware of any laws related to FGM</b>	F.1 Are you aware of any laws about FGM?	<b>DESCRIPTION:</b> Percentage who respond "Yes" to F.1
<b>Percentage of the population who can name at least one anti-FGM law</b>	F.2 What are the international, national or local/traditional laws about FGM that you are aware of?	<p><b>DESCRIPTION:</b> Percentage who name at least one law in F.2</p> <p><b>NOTE:</b> Even though this question has a skip pattern, the denominator should still be the total sample.</p> <p>This indicator can be adapted based on the extent to which the objectives and messaging of the communication efforts focus on increasing knowledge of specific laws.</p> <p>This question can also be used to validate responses to F.1.</p>
<b>Percentage of the population who are aware of legal penalties for continuing FGM</b>	F.3 What are the penalties for offenders (people who practise FGM)?	<b>DESCRIPTION:</b> Percentage who name at least one penalty for offenders in F.3
<b>Percentage of the population who report awareness of enforcement of FGM laws</b>	F.4 Are you aware of any individuals or families being punished by laws for practising FGM?	<b>DESCRIPTION:</b> Percentage who respond "Yes" to F.4
n/a	F.5 Can you describe what happened?	<b>NOTE:</b> If including the indicator associated with F.4, F.5 helps to validate the specific legal actions taken.
<b>Average number of risks of FGM about which the population knows</b>	F.6 What are the physical risks for girls and women associated with FGM?	<b>DESCRIPTION:</b> Average number of total risks mentioned across the three questions
<b>-OR-</b>	F.7 What are the psychological risks associated with FGM?	<p><b>NOTE:</b> F.8 should be reverse coded when including it in this indicator, as desired response for F.6 and F.7 is to list more risks, while the desired response for F.8 is to list fewer risks.</p> <p>You may also look at these three risks as individual indicators: physical, psychological and social risks.</p>
<b>Percentage of the population who know about at least one risk associated with FGM</b>	F.8 What are the social risks associated with not undergoing FGM?	

n/a

F.9 How can you tell if a girl has undergone FGM just by looking at her?

**NOTE:** This question serves to help programme implementers and researchers identify 'cultural markers' of FGM, which can be used to triangulate data on the incidence of FGM.

## 4.1.2 ASSESS WHAT PEOPLE FEEL

The 'Assess what people feel' indicators measure attitudes related to FGM. Measuring affect is inherently challenging; hence ACT provides multiple options to capture 'what people feel' (Tables 12–14). ACT has indicators to capture beliefs about FGM as a function of several domains (e.g., identity, religion), perceptions of girls and women who have and have not undergone FGM, perceptions of communities with and without FGM, stated support for FGM continuation or abandonment, behavioural intentions and self-efficacy.

The first set of 'Assess what people feel' indicators assess beliefs around FGM as a function of several domains: gender/power/control, personal identity, religion, health and

human rights (see Table 12). Note, that the gender questions here are meant to examine the beliefs people have about FGM that are directly tied to gender. A larger, contextual consideration of gender occurs through the 'Consider the context' section (section 4.3 of this document). If gender is a priority in your programme, be sure to include the indicator 'Average score on beliefs about FGM and its relationship to gender/power/control' and the associated questions, G.1–G.10. Furthermore, qualitative activities allow for a deeper understanding of gender, so you should prioritize the inclusion of as many qualitative activities (FGD and IDI) as possible. Section 4.6 below, 'Triangulate all data and analysis', describes ACT's qualitative activities.

**Table 12: Indicators, questions and calculations to assess what people feel – beliefs about FGM**

Indicator	Structured interview questions	Description and notes
<b>Average score on beliefs about FGM and its relationship to gender/power/control</b>	G.1 FGM marks the transition of a girl from childhood to being identified as an adult.	<b>DESCRIPTION:</b> Average score across the 10 questions  <b>NOTE:</b> G.10 should be reverse coded when including it in this indicator, as the high-score responses to this question indicate the opposite beliefs about FGM as the other nine questions.
	G.2 FGM teaches girls to be obedient.	
	G.3 FGM ensures that girls/women retain their cleanliness.	
	G.4 FGM ensures that girls/women remain pure before marriage.	
	G.5 FGM ensures that girls/women retain their femininity.	
	G.6 Girls can be socialized even without undergoing FGM.	
	G.7 FGM teaches girls to be respectful.	
	G.8 FGM helps a girl/woman stay a virgin until she marries.	

	G.9 FGM makes a girl/woman less promiscuous.	
	G.10 Men enjoy sex more with women who have not undergone FGM.	
<b>Average score on beliefs about FGM and its relationship to identity</b>	G.11 FGM has always been a part of our traditions.	<b>DESCRIPTION:</b> Average score across the three questions
	G.12 FGM is a part of our culture.	
	G.13 FGM is part of our identity.	
<b>Average score on beliefs about FGM and its relationship to religion</b>	G.14 It is a religious duty/requirement to perform FGM.	<b>DESCRIPTION:</b> Average score across the six questions
	G.15 The Bible contains verses that make FGM obligatory.	<b>NOTE:</b> G.15 and G.16 should only be asked if the population that practises FGM is Christian, and G.17, G.18 and G.19 should only be asked if the population that practises FGM is Muslim.
	G.16 The Bible contains verses that recommend FGM.	
	G.17 The Qur'an provides hadiths that recommend FGM.	
	G.18 The Qur'an provides hadiths that make FGM obligatory.	
	G.19 Islam prohibits the infibulation type of FGM.	
<b>Average score on beliefs about FGM and its relationship to health</b>	G.20 FGM prepares girls for future childbirth.	<b>DESCRIPTION:</b> Average score across the eight questions
	G.21 FGM is a completely safe practice.	<b>NOTE:</b> G.20, G.21 and G.25 should be reverse coded when including them in this indicator, as the high-score responses to these three questions indicate the opposite beliefs about FGM as the other five questions.
	G.22 FGM is very painful.	
	G.23 FGM can cause a person to bleed too much.	
	G.24 FGM can cause serious problems with childbirth.	
	G.25 FGM is safe if done by a trained health-care professional.	
	G.26 FGM can carry the risk of tetanus if performed with a rusted iron implement.	
	G.27 FGM can spread HIV/AIDS.	

<b>Average score on beliefs about FGM and its relationship to human rights</b>	G.28 The law supports people who abandon FGM.	<b>DESCRIPTION:</b> Average score across the three questions
	G.29 FGM is a violation of girls' human rights.	
	G.30 FGM is a form of violence against women.	

This 'Assess what people feel' subsection also assesses and allows for comparison of attitudes towards girls and women who have and have not undergone FGM, as well as communities where FGM is practised vs. FGM-free communities (Table 13). These questions focus on the general attitudes participants hold using a series of semantic differential scales with positive and negative categories. This facilitates comparisons between girls who have and

have not undergone FGM and communities with and without FGM, as well as attitudes towards individual girls vs. whole communities. Note that while pretesting is crucial for all questions, it may be especially important on the semantic differential questions (H.1–H.20), as the attributes to compare girls who have and have not undergone FGM and communities with and without FGM may vary.

**Table 13: Indicators, questions and calculations to assess what people feel – attitudes towards FGM**

Indicator	Structured interview questions	Description and notes
<b>Percentage of the population who view girls who have not undergone FGM more positively than girls who have</b>  <b>-OR-</b> <b>Average score for girls who have undergone FGM compared with those who have not</b>	H.1/H.6 Unhealthy–Healthy	<b>DESCRIPTION:</b> Percentage who rate girls who have not had any form of FGM (H.6–H.9) higher than girls who have had any form of FGM (H.1–H.4)  -OR- Difference between average participants' scores across H.1–H.4 and across H.6–H.9
	H.2/H.7 Unclean–Clean	
	H.3/H.8 Impure–Pure	
	H.4/H.9 Unequal–Equal	
<b>n/a</b>	H.1–H.4 are about girls who have undergone FGM  H.6–H.9 are about girls who have <b>not</b> undergone FGM	<b>NOTE:</b> H.5 and H.10 can be part of the previous indicator, if programmatic messages suggest that abandoning FGM is 'modern'. These questions must be interpreted with caution, though, because modernity may not be seen as a 'desirable' trait by all audiences.
	H.5/H.10 Traditional–Modern	

<b>Percentage of the population who view FGM-free communities more positively than communities in which FGM is practised</b>	H.11/H.16 Unhealthy–Healthy	<b>DESCRIPTION:</b> Percentage who rate communities that have abandoned FGM (H.16–H.19) higher than communities that practise FGM (H.11–H.14)
<b>-OR-</b>	H.12/H.17 Unclean–Clean	<b>-OR-</b>
<b>Average score for communities that do and do not practise FGM</b>	H.13/H.18 Impure–Pure	<b>DESCRIPTION:</b> Difference between average participants’ scores across H.11–H.14 and across H.16–H.19
	H.14/H.19 Unequal–Equal	
	H.11–H.14 are about communities where FGM is practised	
	H.16–H.19 are about communities where FGM is not practised	
<b>n/a</b>	H.15/H.20 Traditional–Modern	<b>NOTE:</b> H.55 and H.20 can be part of the previous indicator, if programmatic messages suggest that abandoning FGM is ‘modern’. These questions must be interpreted with caution, though, because modernity may not be seen as a ‘desirable’ trait by all audiences.

This subsection also includes a crucial indicator: stated support for FGM abandonment (*Table 14*). Beyond supporting abandonment, believing in oneself as an agent of change can impact the ultimate decision to abandon FGM, as well as promote abandonment in a community. Thus, an indicator for a sense of ownership in abandoning FGM in the community is included.

In addition, two indicators focus on behavioural intention – a precursor to enacting behaviour – concerning having FGM performed on one’s own daughters and marrying a woman who has not undergone FGM. The final indicator in this section focuses on self-efficacy, or self-confidence to make decisions around FGM. Having a higher score on the self-efficacy scale makes a case for higher odds of supporting FGM abandonment even in the face of outside pressure.

**Table 14: Indicators, questions and calculations to assess what people feel – support for abandonment and behavioural intention**

Indicator	Structured interview questions	Description and notes
<b>Percentage of the population who support FGM abandonment</b>	I.1 Do you think that FGM should be continued or should it be abandoned?	<b>DESCRIPTION:</b> Percentage who respond “abandoned” in I.1
<b>n/a</b>	D.1 On a scale of 1 to 5, where 1 is completely oppose and 5 is completely support, how would you rate your opposition to or support for the continuation of FGM?	<b>DESCRIPTION:</b> Percentage who respond “completely” to D.1 <b>NOTE:</b> D.1 can be used to validate responses from I.1. Analysis can look at “completely oppose” or “completely support”.

<p><b>Percentage of the population who report alignment between their personal opinion and their entire social network’s opinion on FGM continuation</b></p>	<p>On a scale of 1 to 5, where 1 is completely oppose and 5 is completely support...</p>	<p><b>DESCRIPTION:</b> Percentage who respond “completely oppose” to D.1–D.7 or who respond “completely support” to D.1–D.7</p>
	<p>D.1 ...how would you rate your opposition to or support for the continuation of FGM?</p>	
	<p>D.2 ...how would you rate the opposition to or support for the continuation of FGM among your immediate family members?</p>	
	<p>D.3 ...how would you rate the opposition to or support for the continuation of FGM among your extended family members?</p>	
	<p>D.4 ...how would you rate the opposition to or support for the continuation of FGM among your friends and peers?</p>	
	<p>D.5 ...how would you rate the opposition to or support for the continuation of FGM among your community members?</p>	
	<p>D.6 ...how would you rate the opposition to or support for the continuation of FGM among other individuals whose opinion matters to you?</p>	
	<p>D.7 ...how would you rate the opposition to or support for the continuation of FGM among society in general?</p>	
<p><b>Percentage of the population with a sense of ownership in stopping FGM</b></p>	<p>I.2 Whose responsibility is it to stop FGM in your community?</p>	<p><b>DESCRIPTION:</b> Percentage who respond “myself” or “everyone” in I.2</p>
		<p><b>NOTE:</b> Denominator is only those who say “FGM should be abandoned” in I.1.</p>
<p><b>Percentage of the population willing to publicly support someone who has decided not to have FGM performed on their daughters or female family members</b></p>	<p>N.15 Would you publicly support someone who has decided not to accept FGM for their daughters or female family members?</p>	<p><b>DESCRIPTION:</b> Percentage who respond “Yes” to N.15</p>

<p><b>Percentage of the population with no intention to have FGM performed on their daughters</b></p>	<p>J.1 Imagine you have a daughter of age in your community at this moment who has not undergone FGM. Using a scale from 1 to 10, with 1 being not at all likely and 10 being very likely, what is the likelihood or chance that you will arrange for your daughter to undergo FGM?</p>	<p><b>DESCRIPTION:</b> Percentage who respond 1 (“not at all likely”) to J.1</p>
<p>-OR-</p>		<p>-OR-</p>
<p><b>Average level of intent to have FGM performed on a daughter who is of age</b></p>		<p>Average of scores for J.1</p>
<p><b>Percentage of the population who believe all boys/men are willing to marry girls/women who have not undergone FGM</b></p>	<p>J.2 Using a scale of 1 to10, where 1 is none and 10 is all, about how many boys/men in your community do you think are willing to marry girls/women who have not undergone FGM?</p>	<p><b>DESCRIPTION:</b> Percentage who respond 10 (“all”) to J.2</p>
<p>-OR-</p>		<p>-OR-</p>
<p><b>Average perception of the percentage of boys/men willing to marry girls/women who have not undergone FGM</b></p>		<p>Average of scores for J.2</p>
<p><b>Percentage of the population with self-efficacy related to decisions about FGM</b></p>	<p>Using a scale of 1 to 5, where 1 is not at all confident and 5 is very confident...</p>	<p><b>DESCRIPTION:</b> Percentage with total score of at least 15 across the five questions</p>
<p>-OR-</p>		<p>-OR-</p>
<p><b>Average self-efficacy score</b></p>	<p>K.1 How confident are you that you can continue/abandon FGM, even if your family opposes you?</p>	<p>Average score across the five questions</p>
	<p>K.2 How confident are you that you can resist pressure from others to get you to continue/abandon FGM, if you try hard enough?</p>	<p><b>NOTE:</b> The use of the word ‘continue’ or ‘abandon’ in the questions will depend on the respondent’s answer to question I.1.</p>
	<p>K.3 How confident are you that you possess the coping abilities to remain calm when facing pressure to continue/abandon FGM?</p>	
	<p>K.4 If you are in trouble because you want to continue/abandon FGM, how confident are you that you can find a solution?</p>	
	<p>K.5 How confident do you feel to stand up to someone who is pressuring you to continue/abandon FGM?</p>	

### 4.1.3 ASSESS WHAT PEOPLE DO

To 'Assess what people do' involves measuring self-reports of actual behaviours around FGM. We recognize that self-reported data are less reliable than, for example, clinical examinations, to determine actual incidence and prevalence of behaviours/practices with complete accuracy. However, collecting clinical data to assess behaviour is not practical. Further, prevalence data from the Demographic and Health Surveys (DHS) and the Multiple Indicator Cluster Surveys (MICS) also rely on self-reports. Given the existence of global, regional, country and local-level efforts (e.g., declarations and campaigns) confirming FGM as a human rights violation, the possibility of under-reporting (rather than over-reporting) prevalence of FGM is more likely, especially in cases where girls undergo FGM as infants or young children. An attempt is made to partially address any social desirability bias resulting from self-reporting, by measuring the percentage of the population reporting that at least one family member has undergone FGM. Hence, social desirability can be better understood by asking about other women in addition to the individual themselves. Likewise, data can be compared between different 'do' indicators to determine how decisions to practise FGM vary among families.

The five indicators in this section provide information on the perceived prevalence of FGM, shifts towards FGM abandonment evident from caregivers' behaviours, who makes the ultimate choice whether or not daughters undergo FGM, and the proportion of people willing to support someone who chooses to abandon FGM (see Table 15). A reduction in FGM prevalence and a shift towards greater support for FGM abandonment as measured by these indicators represents the final step in the individual-level change continuum.



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**Table 15: Indicators, questions and calculations to assess what people do**

Indicator	Structured interview questions	Description and notes
<b>Percentage of girls and women who have undergone FGM</b>	<p>L.1 Have you undergone FGM?</p> <p>L.2 Has your spouse undergone FGM?</p>	<p><b>DESCRIPTION:</b> Percentage who respond "No" to L.1 or L.2</p> <p><b>NOTE:</b> Denominator is only female respondents and married male respondents.</p> <p>If it is especially important to your programme focus to track different age groups separately, this indicator can be split into multiple indicators, e.g., for young adolescents (10–14), older adolescents (15–19) and women (20+).</p>



<b>Percentage of the population with a female family member who has undergone FGM</b>	L.3 Has your eldest daughter undergone FGM?	<b>DESCRIPTION:</b> Percentage who respond “Yes” to L.3, L.5, L.7 or L.9
	L.5 Has your youngest daughter undergone FGM?	
	L.7 Has any female member in your immediate family undergone FGM?	
	L.9 Has any female member in your extended family undergone FGM?	
<b>Percentage of caregivers demonstrating behaviour shift towards abandoning FGM</b>	L.3 Has your eldest daughter undergone FGM?	<b>DESCRIPTION:</b> Percentage who respond “No” to L.5
	L.5 Has your youngest daughter undergone FGM?	<b>NOTE:</b> This question is only asked to those with more than one daughter. Denominator is only those who respond “Yes” to L.3. In other words, if a parent has FGM performed on their eldest daughter but not their youngest, this can be used as a proxy measure to indicate shifting behaviours.
<b>Percentage of the population reporting they personally made the final decision for their female family member to undergo FGM</b>	L.4 In your house, who made the final decision for your eldest daughter to undergo FGM?	<b>DESCRIPTION:</b> Percentage who respond “mainly respondent” to L.4, L.6, L.8 or L.10
	L.6 In your house, who made the final decision for your youngest daughter to undergo FGM?	
	L.8 For that female in your immediate family, who made the final decision for her to undergo FGM?	
	L.10 For that female in your extended family, who made the final decision for her to undergo FGM?	
<b>Percentage of the population reporting they publicly supported someone who has decided not to have FGM performed on their daughters or female family members</b>	N.16 Have you publicly supported someone who has decided <b>not</b> to accept FGM for their daughters or female family members?	<b>DESCRIPTION:</b> Percentage who respond “Yes” to N.16

## 4.2 ASCERTAIN NORMATIVE FACTORS

Social norms are the unwritten rules that guide human behaviour; in other words, what we do, what we believe others do, and what we believe others think we should do (or expect us to do).<sup>13</sup> The social norms components measured in ACT are descriptive norms (empirical expectations), injunctive norms (normative expectations), and positive and negative outcome expectancies (see *Figure 6* in *section 2.1* for definitions of these components).

It is crucial to measure all of these normative components to holistically examine the role of social norms approaches in promoting social and behaviour change. Those who believe others approve of abandonment are more likely to approve of abandonment themselves. Likewise, those who believe others are abandoning FGM and believe that others expect them to abandon FGM are more likely to do so. When discrepancies between perceived approval, perceived behaviour and perceived behavioural expectations exist, individual- and community-level progress towards abandonment will be slow. These indicators allow researchers to

identify such discrepancies, as well as shifts in social norms so that programming can be tailored to address these shifts. For example, if approval of abandonment is high but perceived prevalence of abandonment is low, programming should focus on increasing communication so communities become aware that others in fact want to abandon FGM, increasing the likelihood they will feel emboldened to abandon the practice themselves.

### 4.2.1 DESCRIPTIVE NORMS/EMPIRICAL EXPECTATIONS

Descriptive norms/empirical expectations are operationalized as perceptions about what other people do, specifically beliefs about whether individuals in one's community are practising FGM or not. These indicators ask about perceived prevalence generally, as well as whether prevalence is perceived to be decreasing (*Table 16*).

<sup>13</sup> World Health Organization, [Violence Prevention: The evidence](#), WHO, Geneva, 2010, accessed 11 November 2020.

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Table 16: Indicators, questions and calculations to ascertain descriptive norms

Indicator	Structured interview questions	Description and notes
Average perceived prevalence of FGM	Using a scale from 1 to 10, where 1 is none and 10 is all...	<p><b>DESCRIPTION:</b> Average of all scores in N.1, N.2 and N.3</p> <p><b>NOTE:</b> These questions can also be assessed individually and compared to look for respondents' perceptions of trends in the practice of FGM.</p> <p><b>This is the key indicator for assessing descriptive norms (empirical expectations).</b></p>
	N.1 ...about how many girls aged 10–14 years in your community have had any form of FGM?	
	N.2 ...about how many girls aged 15–19 years in your community have had any form of FGM?	
n/a	N.3 ...about how many adult women in your community have had any form of FGM?	<p><b>NOTE:</b> This is for programming purposes, and to allow the researchers to validate responses from N.1, N.2 and N.3.</p>
	N.4 ...about how many people do you personally know who have chosen not to have FGM done on their daughter, or other immediate female family member?	
Percentage of the population who believe FGM is decreasing	N.11 Think about five years from now. Do you think the number of girls in your community who undergo FGM will be much less (1), a bit less (2), about the same (3), a bit more (4), or much more (5) than now?	<p><b>DESCRIPTION:</b> Percentage with total score 6 across both questions</p>
	N.12 How, if at all, have the opinions of people in your community changed on the practice of FGM over the past 12 months? Do you think people are a lot more (1), a bit more (2), about the same (3), a bit less (4) or a lot less (5) supportive of FGM?	

## 4.2.2 INJUNCTIVE NORMS/NORMATIVE EXPECTATIONS

Injunctive norms/normative expectations are operationalized as beliefs about what behaviours others approve of or think people should do (or expect them to do) regarding FGM continuation and abandonment (see Table 17). The indicator to measure injunctive norms in ACT is 'Percentage of the population who believe that people in their social network expect them to abandon FGM'.

**Table 17: Indicators, questions and calculations to ascertain injunctive norms**

Indicator	Structured interview questions	Description and notes
<b>Percentage of the population who believe that people in their social network expect them to abandon FGM</b>	N.5 Do you think your immediate family expects you to continue or abandon FGM?	<b>DESCRIPTION:</b> Percentage who respond "abandon" to every question: N.5, N.6, N.7, N.8, N.9 and N.10  <b>NOTE:</b> This is the key indicator to measure injunctive norms (normative expectations).
	N.6 Do you think your extended family expects you to continue or abandon FGM?	
	N.7 Do you think your friends and peers expect you to continue or abandon FGM?	
	N.8 Do you think your community expects you to continue or abandon FGM?	
	N.9 Do you think other individuals whose opinions matter to you expect you to continue or abandon FGM?	
	N.10 Do you think society in general expects you to continue or abandon FGM?	

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## 4.2.3 OVERALL SOCIAL NORMS SCORE

A composite indicator for an overall social norms score combines data from norms questions, to obtain an average social norms score. A higher number denotes more positive normative perceptions (see *Table 18*). Calculating an average social norms score for individuals and/or communities will allow for the measurement of changes in perception of social norms over time or difference in perceptions of social

norms by levels of exposure to programme interventions. This aggregate indicator, if standardized across different contexts and programmes, can address the question of the effectiveness of social and behaviour change interventions addressing social norms around FGM.

**Table 18: Indicators, questions and calculations to ascertain overall social norms**

Indicator	Structured interview questions	Description and notes
<b>Average overall social norms score</b>	Using a scale from 1 to 10, where 1 is none and 10 is all...	<p><b>DESCRIPTION:</b> Average total score across N.1, N.2, N.3, N.5, N.6, N.7, N.8, N.9 and N.10</p> <p><b>NOTE:</b> This indicator is a composite of descriptive and injunctive social norms.</p> <p>To give these norms equal weight you must first reverse code questions N.1–N.3 and then divide that score by 5. The maximum total score a single respondent could get on N1–N3 would then be 6, the same for the maximum total score for N5–N10. Thus, these scores are added together for a range of 0–12 points, with a higher score indicating more positive social norms (i.e., social norms more supportive of abandonment).</p>
	N.1 ...about how many girls aged 10–14 years in your community have had any form of FGM?	
	N.2 ...about how many girls aged 15–19 years in your community have had any form of FGM?	
	N.3 ...about how many adult women in your community have had any form of FGM?	
	N.5 Do you think your immediate family expects you to continue (0) or abandon (1) FGM?	
	N.6 Do you think your extended family expects you to continue (0) or abandon (1) FGM?	
	N.7 Do you think your friends and peers expect you to continue (0) or abandon (1) FGM?	
	N.8 Do you think your community expects you to continue (0) or abandon (1) FGM?	
	N.9 Do you think other individuals whose opinions matter to you expect you to continue (0) or abandon (1) FGM?	
	N.10 Do you think society in general expects you to continue (0) or abandon (1) FGM?	

## 4.2.4 OUTCOME EXPECTANCIES

Outcome expectancies (positive and negative) are the perceived social benefits and sanctions for enacting a particular behaviour. Here the behaviour of interest is FGM abandonment. The benefits associated with abandonment and the sanctions imposed for continuation are one way that norms of abandonment are promoted and ultimately have the potential to out-compete continuation. Thus, the ability of individuals to articulate and identify the benefits of FGM abandonment increases the likelihood of actually abandoning the practice. Alternatively, those who believe there are numerous sanctions associated with FGM abandonment are more likely to continue the practice. The relevant indicators measure the numbers of benefits/sanctions associated with FGM abandonment and the likelihood of them being enacted, and the questions for these indicators allow participants to reflect on these benefits and sanctions (see Table 19). For researchers, this reveals which social sanctions and benefits can be promoted and combated through social and behaviour change programming.



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**Table 19: Indicators, questions and calculations to ascertain outcome expectations**

Indicator	Structured interview questions	Description and notes
<b>Average number of social sanctions associated with abandoning FGM</b>	N.13 In your opinion, what are the social sanctions (punishments) associated with abandoning FGM?	<b>DESCRIPTION:</b> Average number of responses to N.13
<b>Average number of social benefits associated with abandoning FGM</b>	N.14 In your opinion, what are the social benefits (rewards) associated with abandoning FGM?	<b>DESCRIPTION:</b> Average number of responses to N.14
<b>Average likelihood that the population will sanction an individual who has decided to abandon FGM</b>	N.17 Using a scale from 1 to 10, where 1 is very unlikely and 10 is very likely, how likely are you to sanction an individual who has decided to abandon FGM?	<b>DESCRIPTION:</b> Average response for N.17
<b>Average likelihood that the population will reward an individual who has decided to abandon FGM</b>	N.18 Using a scale from 1 to 10, where 1 is very unlikely and 10 is very likely, how likely are you to reward an individual who has decided to abandon FGM?	<b>DESCRIPTION:</b> Average response for N.18
<b>Average population that believes others are likely to sanction them if they abandon FGM</b>	N.19 Using a scale from 1 to 10, where 1 is very unlikely and 10 is very likely, how likely are you to be sanctioned by others if you decided to abandon FGM?	<b>DESCRIPTION:</b> Average response for N.19

<p><b>Average population that believes others are likely to reward them if they abandon FGM</b></p>	<p>N.20 Using a scale from 1 to 10, where 1 is very unlikely and 10 is very likely, how likely are you to be rewarded by others if you decided to abandon FGM?</p>	<p><b>DESCRIPTION:</b> Average response for N.20</p>
<p>n/a</p>	<p>E.6: Do the people you have mentioned above approve or disapprove of the abandonment of FGM?</p>	<p><b>NOTE:</b> E.6 can be used to validate responses to N.5–N.10.</p>

While it is important to capture knowledge of benefits and sanctions, knowledge alone is not an adequate measure of outcome expectancies as they relate to social norms change. A willingness to actually apply benefits for abandonment and impose sanctions for continuation provides a more nuanced measure. These indicators allow programmes to move beyond increasing knowledge of benefits and sanctions, to measure willingness to bestow socially defined rewards and impose punishments. When examined as a whole, these indicators show how behavioural expectancies shift along the change continuum from knowledge to attitudes to willingness to change one’s practices. Ultimately, those who are willing to bestow rewards for abandonment and punishments for continuation of FGM are more likely to actually abandon FGM themselves and vice versa.

### 4.3 CONSIDER THE CONTEXT, ESPECIALLY GENDER AND POWER

Gender and power dynamics are closely linked with social norms. This is especially true when the societal roles and responsibilities for individuals of each gender drive a practice such as FGM. ACT is guided by the dynamic model of social change proposed by Cislaghi and Heise (2019), which places gender and power at the heart of a multilevel model for social change.<sup>14</sup> While acknowledging that gendered roles and responsibilities influence all components of ACT, this framework includes some gender-related indicators without professing to provide a holistic explanation of gender norms as a social determinant.

Gender is highlighted throughout the ACT Framework in several ways. For example, several indicators under the ‘Assess what people know, feel and do’ section (see section 4.1 above) focus on personal beliefs around gender. Section 4.6 on ‘Triangulate data collection and analysis’ includes several activities that provide a nuanced look at gender dynamics. Finally, the ‘Consider the context’ indicators in ACT (presented in this section) attempt to link FGM continuation directly with gender and power imbalances. The indicators presented in ‘Consider the context’ (see Table 13) are intended to create a picture of the larger context; they are not about gender beliefs directly corresponding to FGM (which are included in ‘Assess what people know, feel and do’). ACT draws upon CARE’s theoretical framework for empowerment, which identifies three key overlapping domains that must be addressed for any meaningful change to occur.<sup>15</sup> These domains are:

- **Individual agency:** Attitudes and beliefs concerning gender and women’s rights and self-efficacy



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<sup>14</sup> Cislaghi, B., and L. Heise, L., ‘Using social norms theory for health promotion in low-income countries’, *Health Promotion International*, vol. 34, no. 3, 2019, pp. 616–623.

<sup>15</sup> CARE, WE-MEASR: A new tool for measuring women’s empowerment in health programs technical update, CARE, 2013.

- **Relations:** Decision-making power, spousal communication and mobility
- **Structure:** Ownership of/contribution to household assets, social cohesion, community support in times of crisis, collective efficacy, community participation/help received from the community, and participation in collective action.

ACT proposes indicators on mobility, decision-making power regarding household decisions and finances, traditional gender role beliefs (operationalized as violence towards women), and support for gender equity (see *Table 20*). The inclusion of these indicators is based on the assumption that changes in these broader empowerment domains will be positively correlated with individuals and communities choosing to abandon FGM. These indicators and the associated questions were selected from previously validated gender study scales, from the DHS and a compendium of gender scales.<sup>16</sup> However, based on issues around translation, pretesting results, feedback from the validators and analysis of the ACT data, these had to be adapted for ACT. The ACT Global Validation Process Report provides more details on tool creation, adaptation and finalization.



<sup>16</sup> Nanda, G., *Compendium of Gender Scales*, FHI 360/C-Change, Washington, D.C., 2011.

**Table 20: Indicators, questions and calculations to consider the context**

Indicator	Structured interview questions	Description and notes
<b>Percentage of women reporting no restrictions on mobility</b>	O.1 Has anyone in your family ever stopped or restricted you from going outside of your house?	<b>DESCRIPTION:</b> Percentage who respond “No” to O.1, O.2, O.3, O.4 and O.5  <b>NOTE:</b> The denominator is only female respondents.
	O.2 Has anyone in your family ever stopped or restricted you from going outside of your house alone?	
	O.3 Has anyone in your family ever stopped or restricted you from going outside of your community?	
	O.4 Has anyone in your family ever stopped or restricted you from going outside of your community alone?	
	O.5 Has anyone in your family ever stopped or restricted you from working outside the house?	



<b>Percentage of women reporting control over their own finances</b>	<p>O.6 Do you have any cash savings?</p> <hr/> <p>O.7 Has anyone in your family taken your money or possessions, even if you did not want them to?</p>	<p><b>DESCRIPTION:</b> Percentage who respond “Yes” to O.6 and “No” to O.7</p> <p><b>NOTE:</b> The denominator is only female respondents.</p>
<b>Percentage of women with decision-making power in their household.</b>	<p>Who in your family usually has the final say on the following decisions?</p> <hr/> <p>O.8 Making large household purchases?</p> <hr/> <p>O.9 Making household purchases for daily needs?</p> <hr/> <p>O.10 Decisions about major family investments?</p> <hr/> <p>O.11 Visits to family and/or relatives/friends?</p> <hr/> <p>O.12 Your family’s health care?</p> <hr/> <p>O.13 Your own health care?</p> <hr/> <p>O.14 Choices around family planning?</p>	<p><b>DESCRIPTION:</b> Percentage who respond “mainly respondent” or “jointly” to all questions from O.8–O.14</p> <p><b>NOTE:</b> These questions are asked to male respondents also, but the indicator is restricted to female respondents, so the denominator must be adjusted accordingly.</p>
<b>Percentage of the population who never condone violence towards women</b>	<p>On a scale of 1 to 5, with 1 being strongly disagree and 5 strongly agree, to what extent do you agree or disagree with the following statements?</p> <hr/> <p>O.15 Physical violence (such as hitting, beating, slapping, etc.) is sometimes the only way to solve a disagreement.</p>	<p><b>DESCRIPTION:</b> Percentage who respond “strongly disagree”</p>
<b>Percentage of the population supportive of gender equality</b>	<p>O.16 It is important that sons have more education than daughters.</p> <hr/> <p>O.17 Daughters should be sent to school only if they are not needed to help at home.</p> <hr/> <p>O.18 If there is a limited amount of money to pay for education, it should be spent on sons first.</p> <hr/> <p>O.19 Daughters should have the same chance to work outside the homes as sons.</p>	<p><b>DESCRIPTION:</b> Percentage with total score 24</p> <p><b>NOTE:</b> O.19, O.20 and O.23 should be reverse coded when including them in this indicator, as the high-score responses to these three questions indicate the opposite beliefs about FGM as the other five questions.</p>

O.20 I would like my daughter to be able to work outside the home so she can support herself if necessary.

O.21 The only thing a woman can really rely on in her old age is her sons.

O.22 A woman's most important role is to take care of the home, the children, and cook for the family.

O.23 Men and women being equal is entirely compatible with my tradition and culture.

In addition to gendered power issues, age-related power structures may also be of importance to understanding FGM in your context. If this is the case, the questions and indicators for this section can be disaggregated by age to report on specific age groups. It is also important to remember that gender is not just about women. Responses can be disaggregated by gender and additional indicators added, if relevant to the implementing organization (IO). In addition to the indicator 'Percentage of women with decision-making power in their household', the percentage of men with decision-making power in their household can also be reported. Further, indicators from other sections can be used to help construct a broader picture of the gender context. One such indicator – 'Percentage of the population who believe all men are willing to marry women who have not undergone FGM' (see *Table 14*) – highlights gender dimensions.

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## 4.4 COLLECT INFORMATION ON SOCIAL NETWORKS AND SUPPORT

The content of individuals' social networks and the level of social support they receive from these contacts directly affect shifts in social norms.<sup>17</sup> The Theory of Bounded Normative Influence builds upon Rogers's 'Diffusion of Innovations' model by highlighting that an innovation, if sufficiently diffused through a social system via communication over time, establishes itself as a social norm.<sup>18, 19</sup> As such, social norms exist as a function of communication (or lack thereof) within social networks. In environments without active communication regarding perceptions around FGM, this can result in a state of 'pluralistic ignorance', which is a situation where most people personally do not approve of FGM but continue to practise it due to the false belief that others approve of and practise it.<sup>20</sup> Promoting communication that is supportive of the abandonment of the norm of practising FGM within social networks is one way to uncover what others really think, feel and do, to shift norms towards abandonment and ultimately elimination of FGM. In addition, receiving social support for FGM abandonment – informational and instrumental support from within their social networks – makes it more likely that individuals will abandon FGM.

### 4.4.1 COLLECT INFORMATION ON SOCIAL NETWORKS

Recognizing the linkages between social networks and social norms, ACT proposes different pathways to examine social networks when addressing FGM-related norms. Understanding and leveraging social networks is essential to planning and designing social and behaviour change interventions that address norms. As such, ACT advises that social network data be obtained prior to the design phase. Such data can help with identifying and understanding different audiences and the roles they can play in addressing FGM-related norms.

<sup>17</sup> Lapinski, M.K., and R.N. Rimal, 'An Explication of Social Norms', *Communication Theory*, vol. 15, no. 2, 2005, pp. 127–147.

<sup>18</sup> Rogers, E., *Diffusion of Innovations*, 5th ed., Simon & Schuster, New York, N.Y., 2003.

<sup>19</sup> Kincaid, D.L., 'From Innovation to Social Norm: Bounded normative influence', *Journal of Health Communication*, vol. 9, Suppl 1, 2004, pp. 37–57, doi:10.1080/10810730490271511.

<sup>20</sup> Miller, D.T., B. Monin, and D.A. Prentice, 'Pluralistic Ignorance and Inconsistency Between Private Attitudes and Public Behaviours', in *Attitudes, Behaviours and Social Context: The role of social norms and group membership*, edited by D.J. Terry, and M.A. Hogg, Lawrence Erlbaum Associates, Inc., Mahwah, N.J., 2000, doi:10.4324/9781410603210-6.

ACT was designed as a social network study based on the social-ecological model (SEM). It involves a mapping activity to identify key network contacts at each level of the SEM (family, peers, community) and the subsequent inclusion of these contacts into the study, both as respondents in the structured interviews and participants in the qualitative activities. Therefore, including all questions in ACT can be useful for conducting network analysis. However, given that ACT is meant to be an adaptable framework, it is possible that these data already exist or that it is not feasible to collect them due to context-specific constraints. The ACT Framework therefore proposes a minimum set of three social network indicators, corresponding to interpersonal communication, frequency of such communication, and number of network contacts. One modification to afford more nuanced information requires that network information be disaggregated by type of network contacts across the SEM. However, this suggestion is optional, and depends on the extent to which communication objectives and results are contingent on active social networks.

In order to 'Collect information on social networks and support' (the ACT construct addressed in this subsection), indicators focus on the degree to which FGM is discussed by capturing the number of people who report discussing FGM, the frequency with which it is discussed, and the number of people with whom individuals are discussing it (see *Table 21*).



Table 21: Indicators, questions and calculations to collect information on social networks

Indicator	Structured interview questions	Description and notes
<b>Percentage of the population that is discussing FGM</b>	M.7 Aside from this research, have you ever engaged in a conversation about FGM?	<b>DESCRIPTION:</b> Percentage who respond “Yes” to M.7  <b>NOTE:</b> If it is more relevant to the programme, this indicator can be time-bound (e.g., percentage of the population that has discussed FGM in the past 12 months).
<b>Average number of network contacts with whom the population engages in discussion about FGM</b>	M.8 Who have you engaged in a conversation about FGM with?	<b>DESCRIPTION:</b> Average number of responses for M.8
n/a	M.9 What are the most common topics concerning FGM that you have discussed?	<b>NOTE:</b> This is for programmatic purposes and also to validate answers to M.7 and M.8.
<b>Percentage of the population who engage in a conversation about topics related to FGM at least weekly</b>	M.10 Aside from this research, how often have you engaged in a conversation about FGM over the past 12 months?	<b>DESCRIPTION:</b> Percentage who respond “weekly” or “daily” to M.10
<b>Percentage of the population who believe spouses discuss FGM</b>	M.11 In your opinion, do husbands and wives in your community discuss FGM?	<b>DESCRIPTION:</b> Percentage who respond “Yes” to M.11
<b>Percentage of married population that is discussing FGM with their spouse</b>	M.12 Have you ever discussed FGM with your spouse/partner?	<b>DESCRIPTION:</b> Percentage who respond “Yes” to M.12
<b>Percentage of married population who agree with their spouse regarding FGM</b>	M.13 do you agree with your spouse/partner in relation to FGM?	<b>DESCRIPTION:</b> Percentage who respond “Yes” to M.13  <b>NOTE:</b> The denominator is only married respondents.
n/a	M.14 What are the common topics concerning FGM that you have discussed?	<b>NOTE:</b> This question is for programmatic purposes and to confirm the validity of responses in M.12.
n/a	E.1 This next circle represents your family. Who in your family do you talk to about FGM? E.2 ...among your friends and peers...? E.3 ...in your community...? E.4 Are there any other individuals whose opinions matter to you, and whom you talk to about FGM? E.5 Who in the community do you consider to have influence when it comes to FGM?	<b>NOTE:</b> E.1 through E.5 do not support indicators; rather they are used to identify social network contacts and community influencers for sampling.

Due to the fact that FGM decisions are often made at the family level, three indicators in this section focus on spousal communication in particular: perceptions that others discuss FGM with their spouse, engaging in spousal conversation about FGM, and agreement with spouse about FGM. (Note: The spousal communication indicator can also provide insights into gender dynamics.) These indicators determine whether social and behaviour change interventions are promoting and/or impacting spousal communication.

#### 4.4.2 COLLECT INFORMATION ON SOCIAL SUPPORT

Beyond who they talk to, the level of social support individuals receive has direct effects on individual-level factors (e.g., attitudes and behaviours) and normative factors.<sup>21</sup> ACT operationalizes social support in two ways: informational support and instrumental support (see Table 22). Informational support encompasses advice regarding FGM, while instrumental support includes tangible help such as the exchange of goods, supplies or services related to FGM.

<sup>21</sup> Holt-Lunstad, J., and B.N. Uchino, 'Social support and health', in *Health Behavior: Theory, research, and practice*, 5th ed., edited by K. Glanz, B. Rimer, and K. Viswanath, Jossey-Bass, San Francisco, Calif., 2015.

**Table 22: Indicators, questions and calculations to collect information on social support**

Indicator	Structured interview questions	Description and notes
<b>Average number of people with whom the population shares advice (informational help)</b>	M.1 Who do you turn to for advice about FGM? M.2 Who turns to you for advice about FGM?	DESCRIPTION: Average number of responses across M.1 and M.2
n/a	M.3 What specific types of advice do you share about FGM?	NOTE: This is for programmatic purposes and to validate responses to M.1 and M.2.
<b>Average number of people with whom the population shares help (instrumental support)</b>	M.4 Who do you turn to for help (beyond advice, e.g., supplies, money, transport) relating to FGM? M.5 Who turns to you for help (beyond advice, e.g., supplies, money, transport) relating to FGM?	DESCRIPTION: Average number of responses across M.4 and M.5
n/a	M.6 What specific types of help do you share, relating to FGM?	NOTE: This is for programmatic purposes and to validate responses to M.4 and M.5.

## 4.5 TRACK INDIVIDUAL AND SOCIAL CHANGE

Tracking individual and social change allows programmatic activities to be directly and indirectly linked to the changes observed when using the 'A' and 'C' indicators over time. The indicators in this section and corresponding means of verification are provided as examples of indicators to track the effects of social and behaviour change interventions. These indicators must be adapted to each programme's specific social and behaviour change interventions. This measurement starts with tracking the messages, materials and activities. For example, mass media programmes may have the following outputs: number of television commercials produced, number of television commercials aired, and frequency of airing television commercials in a given time period. Note that this information can contribute to social and behaviour change but does not examine the changes themselves. Instead, these programme components are linked to outcomes, which are in turn linked to the social and behaviour changes observed using the 'A' and 'C' indicators.

### 4.5.1 EXPOSURE

Measuring exposure is critical to link the contribution of communication activities to social and behaviour change. Exposure is generally understood as the contact between the intended population/audience and the intervention outputs (e.g., radio or television spots, interpersonal counselling, public forums). However, simplistic measures of access and exposure are not enough to link programme activities and outcomes. Connecting your communication interventions with programmatic results with claims of attribution (i.e., claiming that the change is a direct result of programme activities) or contribution (i.e., claiming that the programme activities helped to bring about the observed change) requires more thoroughly capturing audience involvement and engagement with the messages they have been exposed to. Thus, ACT encourages measuring 'encoded exposure', capturing access, reach, exposure and engagement (see Figure 18).

Figure 18: Definitions of exposure, dose and recall

Access	Reach	Exposure	Dose	Recall
<p><b>Definition:</b></p> <ul style="list-style-type: none"> <li>The ability of the population to engage with the intervention</li> </ul> <p><b>Examples:</b></p> <ul style="list-style-type: none"> <li>For a media intervention, that might be the percentage with radios or TVs at home.</li> <li>For community interventions, that might be the total population in the entire community.</li> </ul>	<p><b>Definition:</b></p> <ul style="list-style-type: none"> <li>The coverage of the intervention</li> </ul> <p><b>Examples:</b></p> <ul style="list-style-type: none"> <li>For media interventions, radio and TV broadcasters have information on reach.</li> <li>For community interventions, this requires tracking the number of participants who participate or are reached by implementers.</li> </ul>	<p><b>Definition:</b></p> <ul style="list-style-type: none"> <li>The degree to which programme outputs actually reached the population</li> </ul> <p><b>Examples:</b></p> <ul style="list-style-type: none"> <li>For media interventions, this could be the percentage who report listening to or seeing your messages on radio or TV.</li> <li>For community interventions, this could be participants who remember engaging in specific programming efforts.</li> </ul>	<p><b>Definition:</b></p> <ul style="list-style-type: none"> <li>The level and intensity of exposure to the programme - how long, how often and how many channels</li> </ul> <p><b>Examples:</b></p> <ul style="list-style-type: none"> <li>For media interventions, this could be how long audiences have been exposed.</li> <li>For community interventions this could be number of activities or events that audiences have participated in.</li> <li>For multi-channel interventions, dose also measures the number of components audiences are exposed to.</li> </ul>	<p><b>Definition:</b></p> <ul style="list-style-type: none"> <li>The extent to which programme messages were understood and remembered</li> </ul> <p><b>Examples:</b></p> <ul style="list-style-type: none"> <li>For both media and community interventions, this can include asking about specific materials and messages and calls to action.</li> </ul>

Table 23 presents indicators to calculate exposure. However, exposure indicators and questions are directly tied to specific interventions. The actual types and content of the questions will need to be designed to match the established objectives and results of the social and behaviour change interventions. Programmes should refer to their logic models/ logical frameworks for this information.

One specific adaptation is to make the indicators and questions time-bound. For example, if the behaviour change intervention has been going on for one year prior to data collection activities, the indicator 'Percentage of the population who has engaged in community-based activities linked to FGM abandonment' could become 'Percentage of the population who has participated in community-based

activities linked to FGM abandonment in the past year'. The associated structured interview questions would then need to be adjusted accordingly, with P4 becoming "Have you participated in community-based activities linked to FGM abandonment *in the past year?*"

Additional adaptations include specifying the exact activities, messages and materials. For example, if your intervention involves peer counselling, you could adapt P25 to say, "Have you ever heard about abandoning FGM through a peer counsellor?" You may also choose to ask further probing questions to gain more detail about exposure. For example, you might ask what the context of the media was (news, blog, forums, opinion) or who the author/presenter was for P9, P13, P17 and P21.

**Table 23: Indicators, questions and calculations to track exposure**

Indicator	Structured interview questions	Description and notes
<b>Percentage of the population who has participated in community-based activities linked to FGM abandonment</b>	P.4 Have you ever participated in community-based activities linked to FGM abandonment?	<b>DESCRIPTION:</b> Percentage who respond "Yes" to P.4
n/a	P.5 What community-based activities linked to FGM abandonment did you participate in?	<b>NOTE:</b> These are for programmatic purposes and to validate responses to P.4.
	P.6 What did you do during these community-based activities linked to FGM abandonment?	
<b>Percentage of the population who has been reached by mediated communication messages</b>	P.9 Have you ever heard, seen or read about abandoning FGM through the radio?	<b>DESCRIPTION:</b> Percentage who respond "Yes" to at least one of these questions (P.9, P.13, P.17, P.21)
<b>-OR-</b>	P.13 ...through the TV?	<b>-OR-</b>
<b>Average number of platforms by which communication messages have reached the population</b>	P.17 ...through a printed publication?	Average number of "Yes" responses across P.9, P.13, P.17 and P.21
	P.21 ...through social media?	
n/a	P.10 What kind of radio show was it?	<b>NOTE:</b> These are for programmatic purposes and help to validate responses to P.9, P.13, P.17 and P.21.
	P.14 What kind of TV show was it?	
	P.18 What kind of print publication was it?	
	P.22 What kind of social media platform was it?	

n/a	P.11 When was the last time you heard about abandoning FGM on the radio?	<b>NOTE:</b> These are for programmatic purposes and help to validate responses to P.9, P.13, P.17 and P.21.
	P.15 ...through the TV?	
	P.19 ...in a print publication?	
	P.23 ...on social media?	
n/a	P.12 What were the specific messages about abandoning FGM you heard on the radio?	<b>NOTE:</b> These are for programmatic purposes and help to validate responses to P.9, P.13, P.17 and P.21.
	P.16 ...saw on TV?	
	P.20 ...read in print?	
	P.24 ...saw, heard or read on social media?	
<b>Percentage of the population who has heard about FGM through interpersonal counselling</b>	P.25 Have you ever heard about abandoning FGM through interpersonal counselling?	<b>DESCRIPTION:</b> Percentage who respond “Yes” to P.25
n/a	P.26 Who counselled you?	<b>NOTE:</b> These are for programmatic purposes and help to validate responses to P.25.
	P.27 When was the last time you received counselling that included discussion of or information about abandoning FGM?	
	P.28 What was the specific information about abandoning FGM you received through counselling?	

One final note on exposure: It is difficult to take credit for abandonment/elimination of FGM by examining only one specific social and behaviour change intervention. Access and utilization of other education, promotion and communication activities must be considered before making any claims around causality.





## 4.5.2 OUTCOMES

Outcomes examine the degree to which the population engages with the social and behaviour change interventions and has started to shift in a positive direction, as a precursor to FGM abandonment (see Table 24).

Table 24: Indicators, questions and calculations to track short-term outcomes

Indicator	Structured interview questions	Description and notes
<b>Percentage of the population who has encouraged someone to abandon FGM</b>	P.1 Have you ever encouraged anyone to abandon FGM?	<b>DESCRIPTION:</b> Percentage who respond “Yes” to P.1
n/a	P.2 Who did you encourage? P.3 How did you do it?	<b>NOTE:</b> These are for programmatic purposes and to validate responses to P.1.
<b>Percentage of people with self-reported [INSERT OUTCOME OF INTEREST, E.G., INCREASED KNOWLEDGE ABOUT FGM] resulting from participating in a community-based activity linked to FGM abandonment</b>	P.7 What happened to you at a personal level as a result of participating in the community-based activities linked to FGM abandonment? P.8 What happened at a community level as a result of participating in the community-based activities linked to FGM abandonment?	<b>DESCRIPTION:</b> Percentage who respond with “[DESIRED OUTCOME]” to P.7 or P.8



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The exact expected outcomes will vary by the theory of change, as well as the objectives and results for a given social and behaviour change intervention. Therefore, the indicators and associated questions provided here must be adapted in accordance with the specific programme activities being measured. For example, if your programme has created school clubs and organized public declarations, you may choose to break out question P.7 (“What happened to you at a personal level as a result of participating in the community-based activities linked to FGM abandonment?”), into two questions corresponding to your community-based activities, e.g., “What happened to you at a personal level as a result of participating in a public declaration of FGM abandonment?” and “What happened to you at a personal level as a result of participating in the school club?” Similarly, you may need to add versions of question P.7 for the other social and behaviour change approaches, e.g., “What happened to you at a personal level as a result of listening to radio messages about FGM?” The connected indicator would then be ‘Percentage of people with self-reported [outcome of interest] resulting from listening to radio messages about FGM’. Outcomes also include measurement of precursors to behaviour change. Hence all the indicators in ACT corresponding to the ‘A’ and the ‘C’, can be used to measure them.

## 4.6 TRIANGULATE ALL DATA AND ANALYSIS

The final section of the ACT Framework does not contain a set of indicators but instead reflects upon the importance of data triangulation and how triangulation is inherently facilitated by ACT.

Triangulation is essentially the use of multiple sources of data to measure a single indicator and offers several advantages including validation of findings, enrichment of data, supporting a holistic interpretation of results, and facilitating a feedback loop (see *Figure 19*).

To support triangulation, ACT contains both quantitative (structured interview) and qualitative, participatory (FGD and IDIs) components.

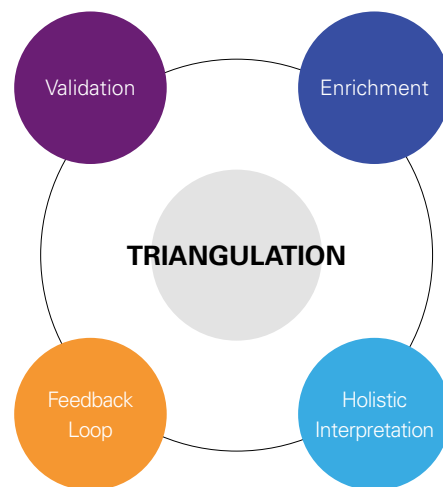
### This allows ACT to:

- Produce validated data. FGM research is particularly vulnerable to response bias where respondents provide socially desirable answers. Triangulation is built into the fabric of ACT to improve the validity of findings.
- Encourage nuanced analysis. Triangulation of data and analysis provides a level of nuance that is critical to accurately examining the complexities of the ACT constructs. The quantitative data provide numerical information for individual ACT indicators. The qualitative data from participatory activities include data on several indicators simultaneously. Together they tell a complete story.
- Generate a feedback loop. Triangulation through behavioural monitoring creates a feedback loop to understand what does not work, which allows for mid-course corrections in programming, and also to understand what does work, informing replication and scale-up.

*Table 25* shows how ACT quantitative indicators are examined by participatory qualitative means. Rather than listing specific qualitative indicators, *Table 25* shows the subconstructs (aggregate concepts of indicators) that are covered by each qualitative activity. It is important to note that, as qualitative activities are open-ended, it is likely that information on other indicators will arise from activities, even though they may not be denoted here with an 'X' in the row. The subsections that follow introduce the qualitative data collection methods, which are designed to be participatory. More information on participatory research activities is provided in the Participatory Research Toolkit.<sup>22</sup>



Figure 19: Benefits of data triangulation



<sup>22</sup> Sood, Suruchi, Kelli Kostizak, and Sarah Stevens, Participatory Research Toolkit for Social Norms Measurement, United Nations Children's Fund, New York, N.Y., 2020.

Table 25: ACT qualitative activities to triangulate quantitative indicator data

ACT construct	Subconstructs		Body mapping	Social network maps	2x2 tables	Free listing	Gender boxes	"I am..."	Lifeline	Vignettes	
What people know	Awareness of FGM		x						x		
	Awareness of FGM as a harmful traditional practice					x					
	Knowledge of types of FGM		x								
	Knowledge of risks of FGM		x								
	Knowledge of laws of FGM					x					
What people feel	Beliefs about FGM	As a function of gender, power and/or control	x		x	x	x		x	x	
		As a function of identity	x		x	x	x		x	x	
		As a function of religion	x		x	x	x		x	x	
		As a function of health	x		x	x	x		x	x	
		As a function of human rights	x		x	x	x		x	x	
	Attitudes towards those that do not practise FGM (both girls and communities)						x			x	
	Support for FGM abandonment	Personal support for FGM abandonment			x						x
		Beliefs about social network's support for FGM		x							x
	Sense of ownership in abandoning FGM										x
	Willingness to support those who abandon FGM										x

	<b>Behavioural intent</b>	Intention to cut								<b>x</b>
		Willingness of boys and men to marry uncut girls								
	<b>Self-efficacy to abandon FGM</b>									
<b>What people do</b>	<b>Prevalence of FGM</b>			<b>x</b>					<b>x</b>	
	<b>Behaviour shift towards abandoning FGM</b>									
	<b>FGM decision-making</b>									
	<b>Public support of those who abandon FGM</b>									

Table 26: ACT Qualitative activities to triangulate quantitative indicator data

ACT construct	Subconstructs	Body mapping	Social network maps	2x2 tables	Free listing	Gender boxes	"I am..."	Lifeline	Vignettes	
<b>Social norms</b>	<b>Descriptive norms/ empirical expectations</b>	Perceived prevalence		<b>x</b>						
		Perceived change in prevalence		<b>x</b>						
	<b>Injunctive norms/Normative expectations</b>			<b>x</b>						
	<b>Overall social norms</b>			<b>x</b>						
	<b>Outcome expectancies</b>	Existence of benefits and sanctions			<b>x</b>					<b>x</b>
		Willingness to apply benefits and sanctions to others			<b>x</b>					<b>x</b>

		Expectation of experiencing benefits and sanctions				<b>x</b>					<b>x</b>
<b>Consider context</b>	<b>Female agency</b>	Female mobility					<b>x</b>	<b>x</b>	<b>x</b>		
		Financial control					<b>x</b>	<b>x</b>	<b>x</b>		
	<b>Female decision-making power</b>						<b>x</b>	<b>x</b>	<b>x</b>		
	<b>Gender role beliefs</b>	Violence towards women					<b>x</b>	<b>x</b>	<b>x</b>		
		Gender equality					<b>x</b>	<b>x</b>	<b>x</b>		
	<b>Discussion about FGM</b>				<b>x</b>						
<b>Spousal communication about FGM</b>				<b>x</b>							
<b>Social networks, support</b>	<b>Social support (instrumental and informational)</b>	Instrumental support									<b>x</b>
		Informational support									<b>x</b>
<b>Track change over time</b>	<b>Engagement in programme activities (e.g. community based, interpersonal, etc)</b>										
	<b>Reach of programme messages</b>										
	<b>Encouraging others to abandon FGM</b>										
	<b>Self-reported outcome of interest</b>										

### 4.6.1 FOCUS GROUP DISCUSSIONS

The ACT Instruments available in the ACT Framework Package include an FGD guide with instructions for conducting FGDs with primary and secondary audiences using five participatory activities.

The participatory activities include the use of visual aids and interactive discussions to facilitate the sharing of knowledge and perceptions that might otherwise be concealed or overlooked. They provide a way to probe deeper than the

traditional discussion format and therefore allow for richer data to be collected.

Generally, FGDs consists of 8–12 participants. However, given the length and content, we are recommending only 5–9 participants, plus the facilitator and note-taker. Each of the five FGD activities are summarized below.

### ACTIVITY 1: BODY MAPPING

Body mapping in the ACT context involves the use of a visual aid – an image of at least one ‘typical’ girl from the local community – and several questions to reveal what girls see, hear, smell, feel, do, think and say when undergoing FGM. The visual aid helps prompt participants by pointing to different parts of the body while asking each question. This activity allows the understanding of the immediate physical and psychosocial risks of FGM to be measured.

The FGD guide in the ACT Instruments includes example images that were used in the validation process in Guinea (see Figure 20); however, images of girls should be created and pretested for your unique context. The visual aids must present a ‘typical’ girl in the community so that responses will align with participants’ own experiences.

Figure 20: Examples of body mapping visual AIDS



### ACTIVITIES 2 AND 3: SOCIAL NETWORK MAPPING AND 2x2 TABLES

The 2x2 tables activity (Activity 3) measures injunctive norms, descriptive norms and outcome expectancies through a participatory format. In order to define the referents whom the 2x2 tables activity asks about, participants first complete a social network map (Activity 2), where they state whose thoughts and opinions regarding FGM matter to them at the family, peers and community levels. The responses are recorded on a blank diagram of the social-ecological model (see Figure 21). This diagram or ‘map’ is then displayed throughout the subsequent 2x2 tables activity to remind participants who is in their networks, when answering questions about what others think, do and expect. The social network mapping activity also allows researchers to determine and analyse the participant’s reference groups.

Participants complete two 2x2 tables, one for descriptive norms/empirical expectations (labelled as ‘Behaviour’) and another for injunctive norms/normative expectations (labelled as ‘Approval’) (see Figure 22). The participants are first asked whether they and others approve of FGM continuation, and each of their pairs of responses are placed into the appropriate quadrant of the ‘Approval’ 2x2 table. Next they are asked whether they are expected to continue FGM and whether others are actually continuing FGM, and each of their pairs of responses are placed into the correct quadrant of the 2x2 ‘Behaviour’ 2x2 table. The results are tallied for each table and then compared using probing questions. Other discussion questions address outcome expectancies or the social benefits and sanctions for continuing and abandoning FGM.

Figure 21: Examples of body mapping visual AIDS



Note that the social network mapping activity (Activity 2) is not designed to support an in-depth social network analysis by itself. However, data from the 2x2 tables and the social network maps can be compared to the social norms and social networking data collected in the structured interviews to facilitate holistic assessment of social norms and social networks and to help validate the data.

**Figure 22: 2x2 Tables Template 1 (Approval) and Template 11 (Behaviour)**

		OTHERS: APPROVAL	
		YES	NO
SELF: APPROVAL	YES	<b>(YES, YES)</b>	<b>(YES, NO)</b>
	NO	<b>(NO, YES)</b>	<b>(NO, NO)</b>

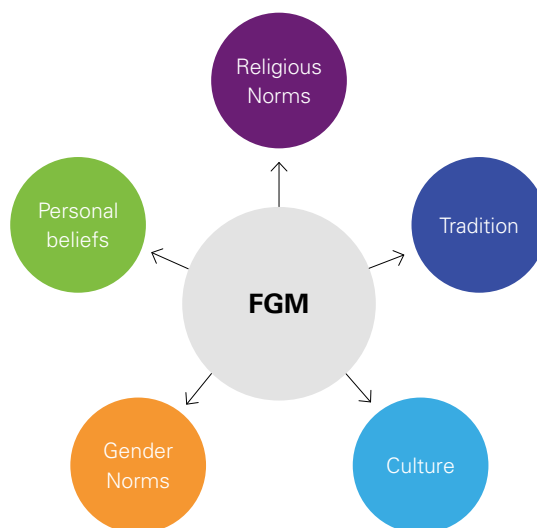
		OTHERS: BEHAVIOUR	
		YES	NO
SELF: BEHAVIOUR	YES	<b>(YES, YES)</b>	<b>(YES, NO)</b>
	NO	<b>(NO, YES)</b>	<b>(NO, NO)</b>

**ACTIVITY 4: FREE LISTING**

In this activity, participants are asked to state words and phrases that come to mind when asked the reasons why FGM exists. Responses are recorded onto the ‘free listing’ diagram (see Figure 23). Once all reasons are given by the group, participants are asked to categorize them in ways that makes sense to them. Participants then identify the top three reasons why they believe FGM exists and which of the categories they created is the most important.

The data from Free Listing highlight what people feel about FGM. The way that participants group the reasons reveals how they are conceptualizing FGM and whether FGM is mainly guided by religious, cultural/traditional, gender or moral norms. Depending on whether the reasons are positive or negative, these data can be compared to the positive belief indicators in the ‘what people feel’ section of ACT.

**Figure 23: Free listing diagram**



## ACTIVITY 5: GENDER BOXES

Gender boxes provide a participatory, qualitative way to assess knowledge and attitudes around gender norms. Participants are split into two groups; one completes the activity for the 'typical' man in their community while the other completes it for the 'typical' woman. The groups are asked to write the expected qualities, roles and behaviours of a 'typical' man/woman inside the box. On the outside of the box, the groups write what happens when the man/woman violates the expected qualities, roles and behaviours. The groups are then brought together to discuss their boxes.

Participants are asking probing questions to determine which of their responses relate to FGM and why someone would choose to stay in the box or go outside of it.

This activity allows gender to be examined in the context of FGM and also more broadly, aligning with the ACT conceptual model. The data gathered from the gender boxes activity can be used to illuminate and add to responses on the 'Consider the context' section of the structured interview questionnaire.

### 4.6.2 IN-DEPTH INTERVIEWS

In-depth interviews (IDIs) involve one facilitator, one note-taker and one participant; they are conducted with individuals from the primary and secondary audiences of the research. The IDIs differ from the structured interview in the open-ended format and the participatory activities that allow for the collection of qualitative data. The participatory activities are more engaging because they use visual aids and lead participants through an interactive discussion. This encourages participants to more freely share their views on a sensitive topic like FGM. The following subsections describe the five activities included in the IDI guide as part of ACT implementation. The IDI guide is available in the ACT Instruments.

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### ACTIVITY 1: "I AM..."

As the first activity, "I am..." serves to build rapport between the facilitator and the participant and to ease them into the interview. Participants are asked to respond to the prompt "I am..." using descriptive words or phrases. Probes are used to prompt them to give deeper responses that shed light on how they conceptualize themselves as a person. Depending on the responses given, the data from "I am..." can also provide insight into the participant's level of agency, decision-making power and gender role beliefs.



### ACTIVITY 2: LIFELINE

This activity asks participants to fill out a timeline with important events in the life of a 'typical' woman in their community. A diagram of a timeline marked with intervals from ages 0–50 (from birth until the woman reaches the age of 50) is used as a visual aid (see Figure 24). As participants complete the activity, they or the facilitator writes the events on the timeline at the appropriate age point. The types of events included are up to the participant; they can be things a woman does, things that happen to her, or even significant thoughts and feelings. If participants do not name FGM as a significant event on the lifeline, they are asked whether FGM occurs for this 'typical' woman, and if so at what age. Participants who have FGM on their lifeline are further probed for how FGM affects the other events they have listed.

Calculating the proportion of participants who have put FGM into their lifelines provides an indirect way to measure awareness of FGM and prevalence of FGM in that community. The probing questions concerning the way in which FGM affects the other events in the lifeline can shed light on beliefs about FGM in the 'what people feel' section of ACT. The events included on the lifeline holistically illustrate the 'Consider the context' indicators because they allow researchers to examine agency, decision-making power and gender role beliefs indirectly as a reflection of what events participants consider important and typical.

**Figure 24: Lifeline diagram**

#### LIFELINE OF A 'TYPICAL' WOMAN



### ACTIVITY 3: SOCIAL NETWORK MAPPING

Measuring reference groups is important for understanding the types of people who have the most influence when it comes to FGM. Social network mapping is a participatory activity that facilitates measurement of the interviewee's reference groups. The participant is shown a blank diagram of the social-ecological model (see Figure 25) and asked whose thoughts and opinions they care about at each level (family, peers and community) and who they would discuss FGM with at each level, which illustrates the flow of communication across networks. Finally, looking at all the types of people documented in the diagram, participants are asked to circle who supports FGM continuation in one colour and who supports FGM abandonment in another colour.

The social network mapping data can be compared to the quantitative structured interview data for the social networks indicators concerning discussion of FGM and spousal communication. This activity is also designed to prepare participants to be better able to provide responses to the final activity: Vignettes/complete the story.

**Figure 25: Social network mapping diagram**



### ACTIVITY 4: VIGNETTES/COMPLETE THE STORY

There are three parts to the 'vignettes' activity. In the first part, the interviewee completes the story by answering a series of questions after listening to a short story. The story is about a couple deciding whether or not to have FGM performed on their daughter. The participant is asked how the couple feels in this situation, who makes the final choice, how they themselves would feel in the couple's place, and what advice they and others in their community would give the couple regarding the decision to have FGM performed on the daughter.

In the second part of the activity, participants are told that the couple decided not to have their daughter undergo FGM, regardless of the answers given in part one. They are then asked about the social benefits and social sanctions the family might face after making this choice and how other people at different levels of the social-ecological model will react to the family's decision.

The final part of this activity invites the participant to imagine a community free from FGM. They then write, draw or describe what they and others would think, feel and do in such a community. Lastly, the interviewee reflects on the obstacles that exist to creating such a community and the resources that exist in their community that could be leveraged to move towards abandonment and eventually elimination of FGM.

The data from all three parts of the vignettes activity can relate to numerous indicators depending on how participants respond including: beliefs about FGM, attitudes towards girls who have not undergone FGM/FGM-free communities, support for FGM abandonment, intention to practise FGM, outcome expectancies and types of social support.

# SECTION 5

# FOR MORE

# INFORMATION



This document has described the entire ACT Framework, including the constructs, indicators and means of verification that comprise it, as well as guidelines for adapting and implementing it based on research and programmatic needs, resources and context.

Additional resources referenced throughout this document, which you will need to implement the ACT Framework, can be found in the **ACT Framework Package**. They include:

- **The ACT Instruments:** Here you will find the three data collection instruments – the structured interview questionnaire, focus group discussion guide, and in-depth interview guide
- **The ACT Implementation Templates:** Templates related to ACT implementation, such as TORs, protocols, sampling calculations and focus group discussion materials
- **Social Norms Desk Review:** Contains more information on the conceptual background of ACT
- **ACT Global Validation Report:** Details on the validation of the ACT Framework in two countries – Guinea and Ethiopia
- **Peer-reviewed journal article on the ACT Framework:** For those interested in the academic theories and concepts behind the ACT Framework, the work has been featured in *Frontiers in Communication*,<sup>23</sup> which can also be [accessed online](#) in the ACT Framework Package.

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<sup>23</sup> Sood S., K. Kostizak, C. Lapsansky, C. Cronin, S. Stevens, M. Jubero, et al., 'ACT: An Evidence-Based Macro Framework to Examine How Communication Approaches Can Change Social Norms Around Female Genital Mutilation', *Frontiers in Communication*. vol. 5, 2020, p. 29. doi: 10.3389/fcomm.2020.00029.



