

Pilot toolkit for replacing approaches to ending FGM in the EU : implementing behaviour change with practising communities

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Published version deposited in CURVE October 2012

Original citation & hyperlink:

Barrett, H.R. , Brown, K. , Beecham, D. , Otoo-Oyortey, N. and Naleie, Z. (2011) Pilot toolkit for replacing approaches to ending FGM in the EU : implementing behaviour change with practising communities. Coventry: Coventry University (Replace project).

http://ec.europa.eu/justice/fundamental-rights/programme/daphne-programme/index_en.htm

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REPLACE

**Researching Female Genital Mutilation (FGM)
Intervention Programmes linked to African
Communities in the EU**

**Pilot Toolkit for Replacing Approaches
to Ending FGM in the EU:
Implementing Behaviour Change
with Practising Communities**

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JLS\2008\DAP3\AG\1193-30CE03118760084

The production of this pilot toolkit was financially support by the European Commission under the 'DAPHNE III' Programme. The sole responsibility for the content of this pilot toolkit lies with the authors. The views adopted in this publication do not reflect the opinion of the European Communities.

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More information on the REPLACE project is available on the internet
(www.replacefgm.eu)

ISBN: 978-1-84600-0430

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Printed in Belgium

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Executive Summary

Introduction

REPLACE was a 12 month Daphne III funded project aiming to contribute to efforts to end Female Genital Mutilation (FGM) across the EU amongst practising communities. It was a pilot project which applied a health behaviour change approach, combined with participatory action research methods (PAR) to identify particular behaviours and attitudes, which contribute to the perpetuation of FGM within the EU. The EU Parliament in 2009 estimated that 500,000 women in the EU had been subjected to FGM, with a further 180,000 at risk. Despite being illegal across the EU, FGM is a trans-European problem. REPLACE aimed to supplement and/or 'replace' existing approaches to the ending of FGM with health behaviour change approaches to end the traditional harmful practice of FGM in the EU.

The REPLACE pilot project aimed:

- To understand the barriers preventing the ending of FGM amongst Somali and Sudanese communities in the Netherlands and the UK, using a participatory action research approach.
- To produce a toolkit which provides a practical guide on how to use health behaviour change with targeted communities to end FGM.

This pilot toolkit is based on work undertaken with Somali and Sudanese communities residing in the Netherlands and the UK. The research was undertaken using participatory action research methods by FSAN in the Netherlands and FORWARD UK in the UK.

Background

FGM is sometimes labelled Female Genital Cutting, Female Genital and Sexual Cutting or Female Circumcision. The term most commonly used in the EU is FGM and this will therefore be the term used in this toolkit.

FGM is a deep rooted traditional practice that adversely affects the health and well-being of millions of girls and women worldwide. Despite the fact that in 1979 the World Health Organisation (WHO) recommended that the practice be totally eradicated, thirty years later there is little evidence of a reduction in the practice. In 1997 WHO, Unicef and UNFPA issued a joint statement against the practice of FGM. A new statement, with wider UN support, was issued in February 2008 to support increased advocacy for the abandonment of FGM (WHO, 2008).

It is estimated that 100-140 million females worldwide have been subjected to FGM, with 3 million girls at risk each year (PRB, 2010). The practice is common in at least 30 countries in Africa, as well as parts of the Middle East and Asia.

With increasing globalisation and many people from FGM practising communities migrating to the EU and other developed regions, for economic reasons or asylum,

the practice of FGM is no longer restricted to the traditional practising countries. There are now substantial populations of women living in the EU who have been subjected to FGM or who are at threat from FGM.

The exact number of women and girls living with FGM in Europe is not known, however, in 2009 the European Parliament estimated that up to half a million women living in Europe had been subjected to FGM with a further 180,000 at risk of being subjected to the practice every year (EC, 2010). This data has been extrapolated from the prevalence data in countries of origin and the number of women from those countries living in the EU. These estimates are not reliable as they do not include asylum seekers or undocumented migrants. It also makes it hard to estimate the numbers of second generation migrants who might be at risk of FGM.

Whilst we do not have reliable statistics for the prevalence of FGM in the EU, the European Commission suggest that it is a serious issue in those member states with significant numbers of migrants from traditionally practicing countries. Anecdotal evidence and criminal prosecutions involving FGM, particularly in France and Sweden, indicate that FGM is an issue within the EU (as well as being performed outside the EU on EU citizens, which in many EU countries is illegal). This has led to the implementation in the EU and other developed world regions (such as North America and Australia) of a number of campaigns aimed at ending FGM.

FGM decisions are made within and influenced by the broader social and political context. Because there are often multiple decision makers involved in a decision to perform FGM on an individual girl, individuals are often not able to refuse to conform. FGM is thus a procedure undertaken on individuals which is condoned by families in order to conform to social norms and to allow their daughters to access social networks and resources, including marriage partners. The social norms perpetuating FGM vary between regions, ethnic groups and communities. It is important to recognise that interventions designed to end FGM must appreciate the different attitudes towards FGM by different communities in the EU and tailor the intervention to that particular group.

WHO Reports (2000; 2006) conclude that FGM has negative implications for women's health, with women who have undergone FGM more likely than others to have adverse obstetric outcomes. The health approach has become an essential component of anti-FGM campaigns operating within EU and beyond. Overwhelmingly, this has been embedded into a wider framework that emphasises bodily integrity and human rights.

In their use of the health approach, anti-FGM campaigners have been reluctant to make a clear distinction between the health consequences of less severe forms of FGM such as 'clitoral pricking or nicking' (Type IV) and more severe forms such as infibulation (Type III). From a campaigner's perspective, to differentiate between the types of FGM on the basis that one type poses less of a health risk than another, might be seen as condoning 'milder' forms of the practice and thus undermines their efforts to eliminate all forms of FGM.

Despite the excellent intervention material on the medical impacts of FGM on females who have been subjected to the procedure, the response of many

communities is to perform less serious forms of FGM, i.e. changing from undertaking Type III to Type II FGM, sending their daughters to countries where the procedure has been medicalised and by calling for the medicalisation of FGM in the countries in which they live. The effectiveness of the health approach in reducing or ending FGM has been questioned by many scholars and activists but little attention has been paid to social-cognitive assessments of why this approach has not been as successful as would be expected. REPLACE explores the deficiencies of the health approach from a health behaviour change perspective (see Section 1.7).

The EU frames FGM as violence against women and girls, which occurs in the family or domestic unit. Violence against women and girls is understood by the EU as a violation of human rights and a form of discrimination against females. The most concrete action taken so far by the EC to combat violence against women is through the Daphne Programme which funded the REPLACE pilot study.

There have been few FGM related convictions in the EU and in some countries, including the UK and the Netherlands, no convictions. This has meant that many FGM practising communities in the EU do not take the law seriously, or take their daughters to other EU countries where it is perceived that the law is less rigorously applied, in order to have their daughters subjected to FGM. REPLACE have found that there is trans-EU mobility to take advantage of differences in EU country legislation and application of legislation concerning FGM. There is a need to harmonise FGM legislation across the EU and to ensure harmonisation of the application of the legislation.

The ending of FGM has proven very difficult. This deep rooted cultural tradition is very resistant to change. Despite campaigns to explain to communities the health implications of the rite and the criminalisation of the practice in many countries, FGM has continued. If we are going to end FGM then it is imperative that we understand why these campaigns have failed and recognise the importance of socio-cultural pressures for communities to continue with the practice.

In 1999, the Program for Appropriate Technology in Health (PATH) undertook a review of Female Genital Mutilation (FGM), 'Programmes to date: What works and what doesn't' for the World Health Organisation' (WHO). The review made a series of recommendations for the way forward in developing anti-FGM programmes. In particular the review called for the re-orientation of, "communication strategies from awareness raising to behaviour-change intervention approaches" (pg. 2).

This REPLACE pilot toolkit is designed to introduce behaviour change approaches to those working to end FGM amongst practising communities in the EU. This approach replaces the dominant approaches to eliminating FGM which focus on raising awareness of the health and human rights issues associated with the practice and then expecting individuals to change their behaviour concerning FGM. The behaviour change approach helps individuals and communities through a series of steps or stages which enable changes in behaviour to become sustainable and thus change community norms. The toolkit is grounded in participatory action research with Somali and Sudanese communities in the Netherlands and the UK. However, it is hoped that this toolkit and the behaviour change approach it advocates will be relevant to other practising communities across the EU.

The REPLACE research worked with Somali communities in Bristol and The Netherlands and the Sudanese community in Bristol. Whilst there were many similarities between these groups in terms of FGM practice, belief systems and barriers to change, there were many subtle differences. It is often these subtle differences, which are less understood, which could impact on the success of an anti-FGM intervention. We thus recommend that before any behaviour change intervention is devised and implemented, that research is undertaken with the communities you plan to work with, or are working with, to determine what the belief systems are concerning FGM and what barriers there are to ending FGM within that community.

Understanding FGM Practising Communities

The REPLACE research used a Participatory Action Research (PAR) approach to collecting information concerning practices and beliefs concerning FGM and the barriers to ending FGM in the Somali and Sudanese communities with whom we worked. We chose this approach as it differs from other means by which data and information can be collected. As the information is co-generated with the researched, interpretations are debated with the researched community, providing the opportunity for community members to contribute to the research process. The collaborative aspect of PAR means that it is empowering to those taking part. PAR has, at its core, a sustained dialogue between external and community researchers, which allows the exchange of information and ideas as well as feelings and values. Thus, community members become research partners and contribute to the formulation of the research and the discussion of its outcomes. As such PAR is highly appropriate as an approach to research FGM with practising communities.

Conducting research using a PAR approach can be time-consuming, but it can yield valuable insights into the lives of individuals within FGM practising communities, and the reasons why the practice may persist or have been abandoned. By gathering data specifically relating to a target group using the PAR approach, interventionists can identify the current state of beliefs and practice that will help them to tailor their intervention work to promote and support real behaviour change.

Section 2 of the toolkit explains how to go about conducting PAR with FGM practising communities. It covers relevant methods, and issues associated with ethics and confidentiality.

Barriers to Ending FGM: Results of REPLACE Participatory Action Research (PAR) with Practising Communities

Section 3 of the toolkit reports on the barriers to ending FGM as identified through analysis of the REPLACE PAR data. Four major themes emerged from the analysis as major barriers to the ending of FGM amongst the communities we worked with. These are: terminology; religious beliefs; communication; and issues associated with choice and consent.

Terminology

REPLACE believe that the use of terminology around FGM is important. Because of our findings, we believe that sometimes it is appropriate for those working with FGM practising communities to use the term FGM and that sometimes it is appropriate to use other terms.

Religious beliefs

REPLACE found that religious beliefs were important in relation to FGM for those who took part. Religious beliefs can either support the ending of all forms of FGM or provide support for the continuation of the practice. Religious beliefs, particularly those relating to the 'sunna' type of FGM, pose a significant barrier to behaviour change. The findings suggest that 'sunna' type of FGM has become more associated with Islam, whereas Type III (infibulation) has not.

Communication

REPLACE found that communication around FGM was important. Communication of various sorts is one of the many behaviours that people who are motivated to end all forms of FGM could identify and be supported to engage in. Issues that affect successful communication are therefore highly relevant to the design of good behaviour change strategies.

Consent & choice

Some of the counter-arguments that community members mentioned relate to issues of being given the opportunity to provide consent and have a choice around FGM. We give some details about these counter-arguments and make recommendations for the best ways those working to end FGM in the EU can respond.

Next step:

Those working with FGM practising communities may find similar issues are relevant to the people they are working with or they may find very different issues. Whatever the outcomes of exploring the relevant beliefs and barriers to change, this information should be used in designing messages and campaign strategies using the behaviour change approach that the toolkit goes on to introduce.

The REPLACE Framework cyclic model: Introduction to Behaviour Change for FGM

When the REPLACE project addresses the issue of ending FGM with a behaviour change approach, we are mindful of the fact that ending FGM is a goal and not a behaviour. Existing research and theorising in this field seems to have treated FGM as a behaviour that requires changing, and this is problematic because it is not a single behaviour. In a society where people are already aware of anti-FGM messages, whether or not FGM is carried out on any given individual is a consequence of potentially a whole series of behaviours, which themselves are the consequences of many thoughts and decisions, by many people and influenced by the wider community. In section 4 of the toolkit, the REPLACE approach aims to get to grips with this.

REPLACE believe that combining individualistic approaches to behaviour change within a broader framework that encompasses socially-based change approaches may offer an effective approach to eliminating FGM

REPLACE recognises that the practice of FGM occurs within a wider socio-cultural context and the behaviours and decisions of others are critical in relation to the outcome of whether or not FGM is carried out. We also understand that some individuals are in less powerful positions than others and therefore are unable to implement certain behaviours that will lead to the abandonment of FGM.

The REPLACE behaviour change approach to ending FGM uses a range of individualistic and socially-based models and theories designed to account for the likelihood of behavioural action from individuals, but REPLACE applies them to the issue of FGM which involves individual, family and community pressures.

The REPLACE Framework is a cyclic model based on a combination of individualistic and socially-based behaviour change models, which describes how a community is influenced by the behaviour change of influential individuals. It is a cyclic model as it recognises that in order to achieve the goal of ending FGM, a number of cycles of behaviour change will need to take place within the community.

The REPLACE cyclic model comprises four elements that represent the flow of motivation and behaviour change we are aiming for in relation to achieving the goal of ending FGM in a given practicing community.

The REPLACE Framework cyclic model is shown in Figure 7 and Table 6 reproduced below.

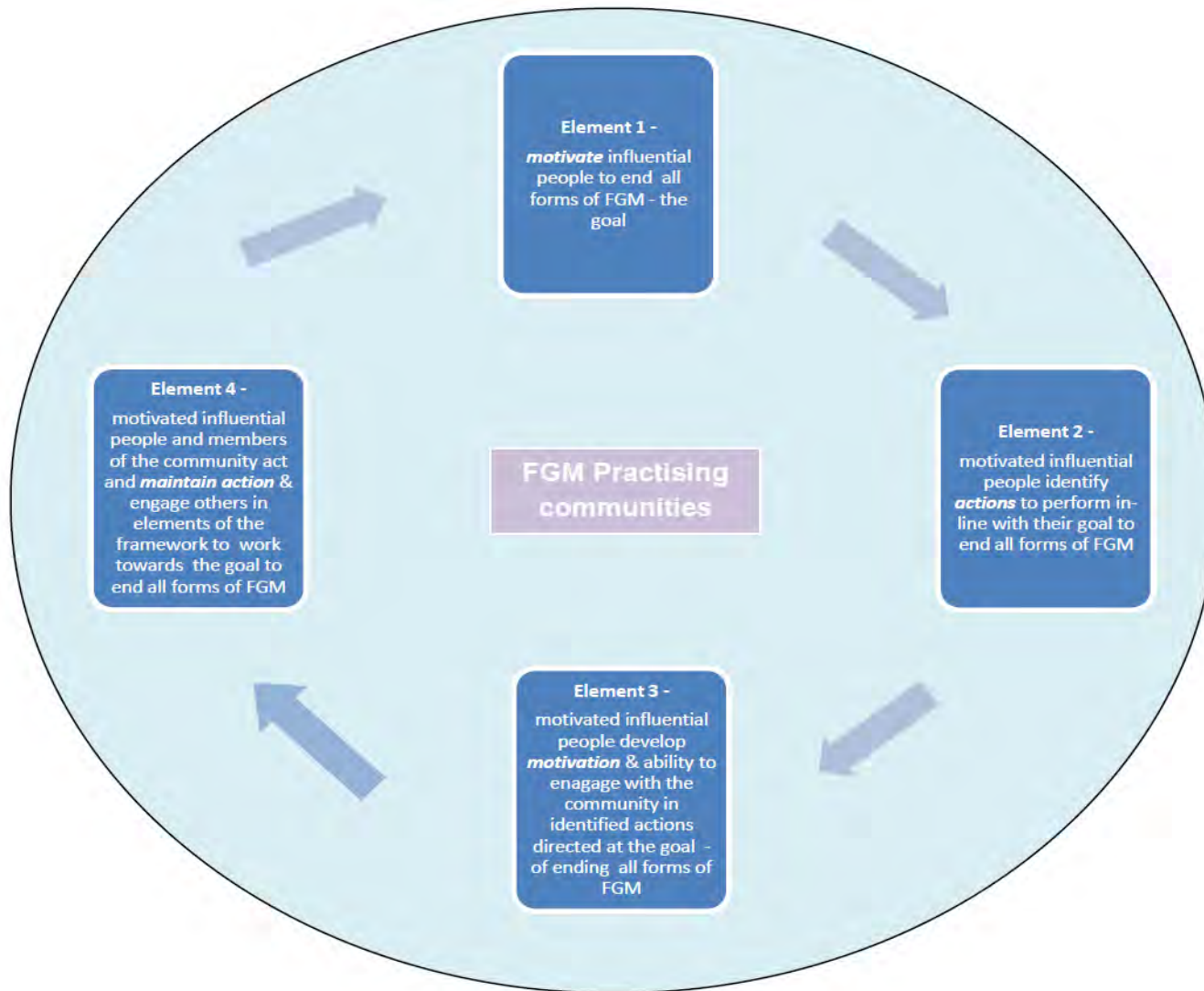


Figure 7: The REPLACE Framework: Ending FGM through a Behaviour Change Approach

Table 6: An Illustration of Behaviour Change Concepts that Relate to the Elements in the REPLACE Cyclic Model

REPLACE cyclical framework elements	What needs to happen	Examples and further explanations
<p>Element 1 Here, interventionists work to MOTIVATE people (from practising communities) to want all forms of FGM to end. This is about motivation towards the GOAL of ending FGM and not behaviour change.</p>	<p>Things that affect people’s motivation need to be addressed, these are:</p> <ol style="list-style-type: none"> 1. People’s beliefs about the good and bad things that are a consequence of FGM continuing in their community. 2. People’s beliefs about how much power they have over FGM ending in their community. 3. People’s beliefs about what other people do, and what they think other people think they should do, and what it is right to do. 	<ol style="list-style-type: none"> 1. You might find that people think performing some types of FGM within the community (e.g. Sunna type) is a good thing because it brings positive consequences such as cultural identity, marriageability and honour to those who have had it done and avoids many of the negative health consequences. Strategies for behaviour change need to identify what positive beliefs about FGM exist and work to change those (e.g. work to convince people that cultural identity can be achieved in other, better ways, or work to make them feel that family honour can be established in other ways). Beliefs about negative consequences should also be enhanced, but based on an understanding of what those beliefs are and which forms of FGM are prevalent. There is no point in talking about horrific negative health consequences to people who only perform minor cuts to the clitoris. When people view FGM in their community as having largely negative consequences that outweigh any positive outcomes they will feel more motivated. 2. Some people lack power over decision-making relating to FGM, and may feel that they have no power to change things on this issue. Helping people to identify the things that they can do (see element 2 below) and working to make them feel more empowered will help. Interventions should also target people who are actually in more powerful community positions and getting them to want all forms of FGM to end is important. 3. People will be influenced to become motivated on this issue by other people, and helping them to see that other people want FGM to end, and other people approve of the idea that all forms of FGM should end in their community is important. To be motivated about this people have to truly believe others want this to end as well.

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<p>Element 2 Here, motivated people need to identify behaviours/actions that they can perform that will lead to the goal of ending all forms of FGM</p>	<p>To begin the process of change, community members who are motivated to want FGM to end in their community must think about and share ideas about all the different behaviours they can perform, or all the actions they can carry out which will help lead to the goal of ending all forms of FGM.</p>	<p>An interventionist can help people to identify the things they could do and help them begin to think about how and when they will do them.</p> <p>Some suggested actions are provided below:</p> <ul style="list-style-type: none"> • Talk openly to family members about opposition to FGM, including milder forms • Start or join a community group who are open about and/or campaign against all forms of FGM • Talk at community gatherings about opposition to all forms of FGM • Refuse to have own daughters subjected to any form of FGM • Act in some way to prevent daughters or other family members being taken to another country to have any form of FGM done • Openly tell other people that own daughters have not and will not have FGM done <p>These are just some suggestions and there are no 'right' or 'wrong' behaviours if they are genuinely targeted at working towards ending all forms of FGM and they come from within the community. There may be many much smaller scale behaviours that people could perform as well. The role of an interventionist is to help motivated and, particularly motivated influential people, to identify what these behaviours are.</p> <p>There may be a particular order in which behaviours need to be performed too. So members of the community may identify many behaviours, and some of which may not be possible until others have been put into place. This element may require a lot of time and thought, and may need re-visiting often. Are there any more things that people could do that hadn't been thought of before and so on?!</p>
<p>Element 3 Here, motivated people need help to begin to perform identified</p>	<p>Once behaviours and actions that people can carry out have been identified, things that affect their motivation to carry out these actions need to</p>	<p>So the same motivating factors identified in element 1 are important but now we are talking about the motivating factors that relate to identified action(s) (from element 2). As an example let's take one behaviour from the suggestions in element 2.</p> <ul style="list-style-type: none"> • Openly tell other people that own daughters have not and will not have FGM done

REPLACE Pilot Toolkit Version 1

<p>behaviours/actions from element 2</p>	<p>addressed. These are:</p> <ol style="list-style-type: none"> 1. People’s beliefs about the good and bad things that are consequences of carrying out identified actions. 2. People’s beliefs about how much power they have over performing identified actions. 3. People’s beliefs about what other people do, and what they think other people think they should do, and what it is right to do. 	<ol style="list-style-type: none"> 1. If you were planning on carrying out this behaviour you might hold positive and negative beliefs about the consequences of doing it. E.g. others will shun me and my family (negative) or others may feel they can abandon the practice too (positive). Whatever the action, people need help to feel that the positives of the behaviour outweigh any negatives. Identifying all the positive and negative perceptions about consequences may be needed (could be done in group work) and ideas about how to address them need to be thought up and implemented. 2. People may perceive difficulties or barriers in telling other people this, and need help to overcome those barriers. If there are genuine barriers that cannot be overcome, then other actions or behaviours may need to be performed first before this action becomes possible. 3. People will feel more motivated to tell other people this if they think important others like them would approve of them doing it and if they think other people like them would do the same thing and if they think it’s right to do so. People may need support in developing feelings about the acceptability of telling people something of this nature.
<p>Element 4</p> <p>Here, motivated people need support in maintaining the behaviours/actions from element 3 and will influence others through their actions</p>	<p>Once people have become motivated to engage in actions identified and perhaps started performing those actions they need further support to maintain action.</p> <p>Maintained action once achieved will engage others from the community in the cyclic process.</p>	<p>Just because a person is motivated does not mean that they stay motivated and carry out the action identified without problems or issues.</p> <ul style="list-style-type: none"> • Motivation can change – interventionists need to help people to stay motivated • People may fail to recognise opportunities to act – interventionists can help people identify good opportunities • People can forget to act – planning carefully how and when to act will help here • People may lack skills and confidence to act – interventionists can work to enhance skills required and build people’s confidence.

Taking Action

The REPLACE framework cyclic model provides a new approach to tackling the practice of FGM in the EU. The behaviour change concepts (see Table 6) that map onto the REPLACE framework elements provide targets for the actual content of the messages designed, which should be firmly based in a knowledge and understanding of the issues particular to various FGM practising communities.

Section 5 of the toolkit provides some illustrations of basic behaviour change techniques that can already be found in some campaign literature and provides some information about evaluation of interventions work to assess whether changes that were intended actually happen!

REPLACE hope to start a process of people beginning to apply this behaviour change approach to their thinking, planning and implementation of anti-FGM campaign and intervention activities, and then feeding back on that process. In this way, this toolkit can be an evolving document that is built on and improved over time.

REPLACE: Project Partners



Professor Hazel Barrett (BA hons, MA, PhD, CGeog)

Professor Hazel Barrett is Associate Dean for Applied Research within the Faculty of Business, Environment & Society at Coventry University. She is a development geographer and member of the African Studies Centre. Her main research interests are the socioeconomic aspects of development, in particular rural development in sub-Saharan Africa. Recent research and consultancy has focused on health especially HIV/AIDS and its socio-economic impacts on children. Research has been undertaken with child sex workers in Sierra Leone, child-headed households in Rwanda and street children in Uganda. She has also undertaken research on the link between HIV/AIDS and primary education in particular curriculum development and delivery in Malawi and The Gambia. More recently she has undertaken research on knowledge, attitudes and practice concerning STIs and in particular HIV amongst African migrant communities in the UK. Her research on gender and income generation including horticultural production and organic agriculture has involved data collection in The Gambia and Kenya. She is an expert on participatory action methods and has published a number of refereed papers on this methodology. Hazel has published a number of books and chapters on development issues, in particular the HIV/AIDS epidemics in sub-Saharan Africa. She has also published over 40 research papers in refereed journals. She is recognised as an international expert on FGM in The Gambia and has produced over 20 expert reports on this issue. She has presented her research at numerous conferences and is frequently invited to do keynote lectures on her research. She has received research funding from a range of bodies including ESRC, DfID and the EU.

Dr. Katherine Brown

Katherine is a Senior Lecturer in Psychology, and a registered Health Psychologist. She leads the Studies in Adolescent Sexual Health (SASH) Research Group within the Applied Research Centre in Health & Lifestyle Interventions (ARC-HLI) and is Course Director of the MSc Health Psychology programme. Her research interests include theory and evidence based approaches to behaviour change. Current major include the development of a theory-informed and evidence-based 'Serious Game' for relationships and sex education (RSE), the evaluation of a web-based intervention designed to enhance condom and contraceptive pill use in sexual health clinic attendees, and work looking at integrating behaviour change approaches into

education campaigns designed to end the cultural practice of Female Genital Mutilation. She has published papers in a range of journals, presented at numerous psychology and medical conferences and obtained research funding from a range of sources including research councils, the EU, commercial companies and the NHS.

Dr. David Beecham

David was appointed to the role of Postdoctoral Research Assistant in April 2010 after completing his ESRC funded doctoral research within the Department of Sociology at the University of Warwick. His doctoral thesis was a qualitative exploration of the impact of intimate partner abuse on women's experience of the workplace. David's research interests include poststructural feminist theory, symbolic interactionism and social theory. He is also interested in bringing together sociological and psychological perspectives relating to intimate partner abuse. He has presented numerous papers at academic and non-academic conferences, produced publications for the Welsh Equalities and Human Rights Commission and has advised public organisations on developing their Domestic Violence Workplace policies.



Foundation for Women's Health Research and Development (FORWARD) is an African Diaspora led UK registered campaign and support charity dedicated to advancing and safeguarding the health and rights of African girls and women, in particular female genital mutilation (FGM) and child marriage. Naana Otoo-Oyortey is the Executive Director of FORWARD UK. For the last 20 years Naana has worked in the field of sexual and reproductive health and rights and women's issues as an advocate, trainer and consultant. Naana has a particular interest in tackling gender based discriminatory practices including FGM, child marriage and sexual violence which impact adversely on the sexual and reproductive wellbeing and dignity of African women and girls. Naana holds an MPhil in Development Studies from the Institute of Development Studies, Sussex University.



The Federation of the Somali Associations in the Netherlands (FSAN) is a non-profit, non-political organisation founded in the Netherlands in 1994. 52 regional and district organisations in the Netherlands fall under the umbrella of FSAN. One of the main programmes of FSAN is FGM, which involves working together with African

community based organisations in the Netherlands and Dutch professional institutions. FSAN considers FGM as gender-related violence and as infringing women's rights as well as the rights of female children. FSAN's mission therefore is the abolition of all forms of FGM.

Zahra Naleie is one of the founders of FSAN and FGM project coordinator for the Somali community in the Netherlands. Since 2000 she has given training in the prevention of FGM to Somali and Sudanese communities in the Netherlands. She is internationally known for her campaigning to prevention of female circumcision among black migrant women and as a founding member of the Euro Net FGM network. Zahra has received the Avicenna Prize in 2004 and the Zami-award in 2005. She is the co-author of the paper *Zware dingen moet je voorzichtig duwen* 'Heavy things you should carefully push' (Nienhuis et al, 2008). Zahra was recently appointed by State Secretary Bussemaker ambassador in the fight against female circumcision in the Netherlands.



Centre based in Brussels is responsible for the dissemination aspects of the project and will help to ensure that the project recommendations are passed to national and European policy makers to help stem the tide of FGM in Europe.

Overview of Researching Female Genital Mutilation (FGM) Intervention Programmes linked to African Communities in the EU (REPLACE) Project

REPLACE is the latest Daphne III project addressing female genital mutilation (FGM). The project involved partners from the UK, the Netherlands and Belgium. The direct beneficiaries of the research and toolkit produced by REPLACE are the children and young women at risk of FGM within the EU. Launched in April 2010, REPLACE was selected from amongst hundreds of applications to develop a highly innovative approach to tackling FGM within the EU. The partners are taking a psycho-social approach in undertaking new research with practising communities in Bristol (UK) and The Netherlands with a focus on behaviour change. The REPLACE project is innovative for many reasons. Firstly, the methodological approach – Participatory Action Research (PAR) - facilitates an inductive or ‘bottom up’ approach, thus producing a more nuanced and detailed description of the pressures that individuals face when deciding to continue or discard the practice of FGM. Secondly, with data being generated within two EU countries, there is scope for a comparative analysis to be conducted, to establish impact of host nation cultural differences. Finally, although research on the decision making processes relating to FGM has been conducted in Africa, very little research of this nature has been conducted with practising communities in the EU. By combining Participatory Action Research (PAR) methods with health psychology behaviour change approaches, this pilot toolkit makes a valuable contribution, not only in terms of furthering our understanding of why FGM continues to be practiced, but also in developing effective intervention programmes that can be utilised by interventionists across the EU.

Acknowledgements

REPLACE was funded by DAPHNE Reference No: JLS\2008\DAP3\AG\1193-30CE03118760084

In addition to DAPHNE, REPLACE would like to thank the following for their support and assistance in helping to produce this pilot toolkit. We would like to thank the Sudanese and Somali participants in the UK and the Netherlands for participating in a very sensitive and highly emotional piece of research examining FGM. Their experiences, beliefs and perceptions regarding FGM have been invaluable in producing the toolkit. A huge thank you also goes to the many researchers that were recruited by FORWARD UK and FSAN, which recruited, collected and, in some cases, transcribed transcripts. Not only did researchers contribute tremendously by collecting data, but they also provided valuable feedback and insights regarding the Somali and Sudanese communities in the UK and the Netherlands. REPLACE would also like to thank the REPLACE advisory board: Liz Lynne (MEP) and Alan Webster (Cross- Government FGM Co-ordinator, UK) for their continual guidance, support and input. We would also like to thank Commissioner Reding, Ms Svensson and Pierrette Pape for constructive advice on the project. REPLACE are also grateful to the Foreign and Commonwealth Office, Home Office, Department of Health, Department for Children, Schools and Families in the UK and Rutgers WFP/Pharos in the Netherlands for allowing us to use their materials. The REPLACE team would like to thank three Coventry University postgraduate students who assisted with the content analysis as part of their programmes of study. Thanks to Jennifer O'Donnell, Sara MacDuff and Taryn Bennett. We would also like to thank the Faculties of Business, Environment and Society and Health and Life Sciences for their support throughout the project. REPLACE would like to thank academics and practitioners who have provided feedback, comments and information throughout the project. Special thanks go to Els Leye for providing materials, information and support. Finally, REPLACE would like to thank all those individuals who are haven't been mentioned above, without your support, help and advice this project would have been unsuccessful.

Glossary

Anonymity - in the research process we want to protect people's identity, we don't use their names or any other information that might identify them when we report the findings to others. We make all of the information we collect anonymous.

Behaviour change approach - this is the approach that the REPLACE project is trying to apply to FGM. This toolkit aims to explain how this approach can be applied to trying to end FGM in communities in the EU.

Behaviour Change Theory - the ideas used in the behaviour change approach are known as theories or models and we explain these in the REPLACE toolkit.

Circumcision - a cultural practice that involves cutting or removing flesh from human genitals. It can refer to a practice performed on males and females.

Community - When REPLACE use this terms we mean a group of people who live close together and share some cultural or national heritage.

Confidentiality - when we carry out research or do other work with people we want to protect the information we get from them and not share it with others. In research situations we do have to share the findings we get, so things are not kept completely confidential. Instead however, we anonymise the information so that no-one knows who it came from.

Consent form - This is a form we ask people to read and sign to indicate that they agree to take part in research. They must always be fully informed about what is involved before being asked to do this.

Cultural 'Insiders' – When individuals share a similar social location. For example, a Somali researcher is more likely to share a cultural, social and linguistic understanding with another Somali than a white, European researcher.

Daphne - This is the funding source at the European commission that paid for the REPLACE project work.

Data - This is the word we use to describe the information that is collected from communities in the REPLACE project.

Data collection - This is the phrase we use to describe the process of gathering information from community members who took part in the REPLACE project.

De-brief sheet - After people have taken part in research they are given a de-brief sheet which explains more about the project, and gives contact details and sources of advice, support and information.

Drawing – This method of data collection is usually used in tandem with other methods, such as the in-depth interview or focus group discussions. Participants are asked to draw how they feel about a particular issue. For example, participants could draw those individuals who they feel close to and respect.

Diary Writing – This method of data collection is has become popular with social scientists when researching sensitive subjects. Participants are asked to keep a diary about their thoughts and feelings towards a particular issue. This method has many advantages, but it also has disadvantages, one being it is not very useful for people with a limited literacy skills.

Et al. – This term is used to mean 'and the rest' instead of listing all the authors. For example Shell-Duncan et al. (2010), the et al. refers to co-authors of the piece of work.

Ethno-National Heritage /Group – This term is beginning to be used by researchers and policy makers to refer to individuals who share a similar ethnic and national background. For example, there are differences between individuals born in the UK and Somali, however both can be perceived as sharing a similar ethno-national heritage.

European Commission (EC) - This is the organisation responsible for distributing the Daphne funding which paid for REPLACE.

Excisor - This term is used to refer to those individuals who conduct the practice of FGM.

Excision – General term used in Africa to refer to the practice of FGM

Facilitator - This is a word used to describe someone who carries out a focus group. They are there to help focus group members engage in discussion around the specified topic.

Female Genital Mutilation (FGM) - This is one of many words used to describe the practice of female circumcision or girls circumcision.

Focus Group - This is a way of collecting data. It involves a group of people getting together to discuss their thoughts and opinions and beliefs about a particular issue or subject. The discussion is often audio recorded so that what is said can be analysed later.

Focus Group Topic Guide – This is a list of topics that a focus group facilitator wishes to discuss during the focus group. This list of topics should not be prescriptive and facilitators should explore those issues raised by participants that are not on the topic guide.

Hadith – also spelled Hadīth (Arabic: “news,” or “story”), record of the traditions or sayings of the Prophet Muḥammad. For more information visit:

<http://www.britannica.com/EBchecked/topic/251132/Hadith>.

Homogenous – A group with similar characteristics i.e. age, gender, marital status, beliefs etc.

Heterogeneous – A group with difference characteristics.

In-depth interview - This way of collecting data involves usually one person taking part in a discussion with a researcher. The researcher asks questions, but they want to the person to talk freely and at length about the topic being researched

Infibulation – This term refers to the practice of FGM Type III, in that the woman’s external genital is removed and then the vaginal opening is then sutured closed.

Interview Schedule – This is a list of questions or areas of interests that are developed by researchers in order to use during an in-depth interviews. Questions should include ‘follow-up’ and ‘probing’ questions.

Interventionist - This is a term we use a lot in the toolkit. It comes from the verb to intervene. It refers to anyone who is interested in working to design campaign materials, messages, or activities that are aimed at creating some form of change.

Labiaplasty – Also known as ‘designer vagina’ or ‘cosmetic vaginal surgery’, includes a wide range of procedures that surgically alter the external aspects of the female genitalia. These procedures are carried out by medical professionals in a hospital setting.

NGO - Non-Government Organisation - often charitable organisations, they are generally set up to help people, campaign on important issues, and bring about change of some description. Forward UK and FSN are NGOs that amongst other things work to end FGM in the communities they are associated with.

Non-therapeutic Male Circumcision – This term is increasingly being employed by medical practitioners when referring to the circumcision of boys and young men for non medical reasons.

Participant Information Sheet (PIS) - This is written information given to people who are being asked to consider taking part in research. It tells them all about the project and what is involved.

Participants - This is the word used to describe people who take part in research

Participatory Action Research (PAR) - This is the approach that REPLACE used to engage people from FGM practicing communities in the project. It is an approach to collecting information that puts communities at the centre of the research process and enables them to contribute to the research, to be listened to and to be empowered by the process. Community members became researchers and carried out the data collection. They also contributed to analysing the data and contributed to discussions concerning the results.

Pharaonic circumcision - This is a term used to describe the most severe types of FGM Type III by community members. Often all external flesh is removed and the wound is stitched together leaving only a small hole

Pilot – This refers to a primary stage of the project.

Prevalence Rate – Percentage of female in a population who have had FGM.

Qualitative - This is a term which refers an approach to research. It involves data collection where verbal or written accounts are analysed.

Quantitative - This is a term which also refers to an approach to research. It involves data collection where numerical values are used to describe a phenomenon (e.g. use of a test score to represent level of intelligence)

REPLACE - This stands for Researching Female Genital Mutilation (FGM) Intervention Programmes linked to African Communities in the EU.

Re-infibulation – This term refers to the closing of the vaginal opening after childbirth.

Research - A general term which refers to any activity where information is obtained and used to inform other activities or work.

Researcher - A person who engages in the activity described above.

Sample - This is the term used to describe the people who take part in research as participants. They represent a sample of the population as a whole.

Societal - This is a term used to describe activity or thinking relevant to a whole society or population of people.

Storytelling – This is a research method whereby participants express their feelings, experiences and/or perceptions through storytelling. This method allows individuals to talk about their experiences without feeling as though they are disclosing personal information. With the oral tradition being popular within many African communities, this approach may be suitable. .

Sunna - Also 'Sunnah', is an Arabic word meaning "habitual practice" and refers to "the body of traditional social and legal custom and practice of the Muslim community" (www.britannica.com/EBchecked/topic/573993/sunna [accessed 01/04/11]). The term 'sunna' is used by the Somali and Sudanese communities to refer to a form of FGM. People tend to use it to describe less severe types of FGM, such as those classified as Types I, II and IV by the WHO. In this toolkit when the word 'sunna' is used it refers to FGM, unless otherwise stated.

Vulva – This term refers to the external female genitalia.

Introduction to the REPLACE Toolkit (Pilot)

REPLACE was a 12 month Daphne III funded project aiming to contribute to efforts to end FGM across the EU amongst practicing communities. It was a pilot project which applied a health behaviour change approach, combined with participatory action research methods to identify particular behaviours and attitudes which contribute to the perpetuation of FGM within the EU. The EU Parliament in 2009 estimated that 500,000 women in the EU had been subjected to FGM, with a further 180,000 at risk. Despite being illegal across the EU, FGM is a trans-European problem. REPLACE aimed to supplement and/or 'replace' existing approaches to the ending of FGM with health behaviour change approaches to end the traditional harmful practice of FGM in the EU.

The REPLACE pilot project aimed:

To understand the barriers preventing the ending of FGM amongst Somali and Sudanese communities in the Netherlands and the UK, using a participatory action research approach.

To produce a toolkit which provides a practical guide on how to use health behaviour change with targeted communities to end FGM.

This pilot toolkit is based on work undertaken with Somali and Sudanese communities residing in the Netherlands and the UK. The research was undertaken using participatory action research methods by FSAN in the Netherlands and FORWARD UK in the UK.

This pilot toolkit is available for download free of charge on the REPLACE website www.REPLACEFGM.eu in English and Dutch. The REPLACE team recognise that the toolkit is a pilot and we would be delighted to receive constructive comments on the toolkit from those who use it. Please send any comments to www.REPLACEFGM.eu All comments will be gratefully received and where appropriate will be incorporated into the toolkit.

Likewise any queries on REPLACE and the practical use of the toolkit itself should be directed to www.REPLACEFGM.eu.

The REPLACE team look forward to receiving your feedback on this new approach to ending FGM.

How to use this Toolkit

This toolkit is designed to be used by those working to end FGM (interventionists) with FGM communities in the EU. It comprises five sections as follows:

Section 1: gives some important background and contextual information concerning the practice of FGM in general. It demonstrates why a new approach to ending FGM is needed.

Section 2: gives interventionists a guide to undertaking participatory research (PAR) with FGM practising communities. A justification for the use of PAR to gather information with FGM practising communities is given and guidance is given to the use of various relevant PAR methods. Issues such as ethics and confidentiality are covered.

Section 3: presents some of the findings of the REPLACE PAR research to demonstrate some of the many barriers that individuals and communities face in ending FGM. These are presented under themes derived from the work undertaken with the communities involved in the research. Issues such as religion, terminology, communication as well as choice and consent are considered.

Section 4: the REPLACE behaviour change cyclic framework to ending FGM is described and explained. This framework derives from a combination of individualistic and socially-based behaviour change in order to produce a cyclic model of behaviour change relevant to ending FGM in the EU.

Section 5: This section gives interventionists guidance as to how to implement the REPLACE Framework.

Each section is designed to be self standing, but it is advisable to read the whole toolkit to enable you to understand the rationale of the approach and to see how both PAR methods and behaviour change approaches are linked in the REPLACE Framework.

Section 1: Background

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Introduction

The Background Section of this toolkit will give you important contextual information on the practice of Female Genital Mutilation (FGM). FGM is sometimes labelled Female Genital Cutting, Female Genital and Sexual Cutting or Female Circumcision. The term most commonly used in the EU is FGM and this will therefore be the term used in this toolkit.

FGM is a deep rooted traditional practice that adversely affects the health and well-being of millions of girls and women worldwide. Despite the fact that in 1979 the World Health Organisation (WHO) recommended that the practice be totally eradicated, thirty years later there is little evidence of a reduction in the practice. In 1997 WHO, Unicef and UNFPA issued a joint statement against the practice of FGM. A new statement, with wider UN support, was issued in February 2008 to support increased advocacy for the abandonment of FGM (WHO, 2008).

Whilst we do not have reliable statistics for the prevalence of FGM in the EU, the European Commission suggest that it is a serious issue in those member states with significant numbers of migrants from traditionally practising countries. Anecdotal evidence and criminal prosecutions involving FGM, particularly in France and Sweden, indicate that FGM is an issue within the EU (as well as being performed outside the EU on EU citizens, which in many EU countries is illegal). This has led to the implementation in the EU and other developed world regions (such as North America and Australia) of a number of campaigns aimed at ending FGM.

The EU is committed to putting into place policy frameworks which "eradicate female genital mutilation once and for all across Europe" as part of the Women's Charter adopted by the European Commission on 5th March 2010 and the Stockholm Programme adopted on 20th April 2010 (EC, 2010: 8). It is hoped that REPLACE and this pilot toolkit will influence policy in the EU that aims to end FGM as well as help those involved in ending FGM amongst practising communities in the EU be more effective in their intervention programmes. REPLACE believe that a combination of 'top-down' and 'bottom-up' approaches, that incorporate behaviour change as their core, will be more effective than previous approaches in reducing and ultimately ending FGM in the EU.

1.1 WHO Definition and Classification of FGM

The WHO Technical Working Group Meeting in July 1995 defined FGM as “the removal of part or all the external female genitalia and/or injury to the female genital organs for cultural or other non-therapeutic reasons.” (WHO, 2000:11). WHO recognise four types of FGM which are described in Table 1. Types I to III reflect increasing invasiveness of the cutting, whilst Type IV includes unclassified genital injuries.

<i>FGM Classification</i>	
Type I Clitoridectomy	Excision of the prepuce with or without excision of part or the entire clitoris.
Type II Excision	Excision of the prepuce and clitoris together with partial or total excision of the labia minora.
Type III Infibulation	Excision of part or all of the external genitalia and stitching/narrowing of the vaginal opening (infibulation).
Type IV Other	Unclassified. Pricking, piercing or incision of the clitoris and/or labia. Stretching or cauterisation of the clitoris/labia. Scraping or cutting of the vaginal orifice. The introduction of corrosive substances to narrow or tighten the vagina.

Table 1 WHO Classification of FGM (Adapted from UNFPA, 2007; WHO, 2000; 2008)

EndFGM (2010) estimate that globally, of females who have experienced FGM, 90% have been subjected to Types I, II and IV with 10% subjected to the more serious Type III (infibulation) which predominates in Sudan and Somalia. Table 2 shows the range in the type of FGM performed in a selection of countries where FGM is common. It shows that each country is different and within each country there will be differences between practising groups as to the type of FGM preferred.

Country	Nicked, no flesh removed.	Flesh removed	Sewn closed	% of females aged 15-49 who have had FGM
Burkina Faso	0.7	89.5	3.8	17
Djibouti	24.9	6.4	67.2	98
Eritrea	46.0	4.1	38.6	89
Mali	3.0	45.4	5.3	92
Nigeria	3.0	45.4	5.3	19
Somalia	1.3	15.2	79.3	-
Tanzania	1.9	91.3	2.0	15

Table 2 Type of FGM Performed in Selected Countries (Source: Compiled from PRB, 2010; Unicef, 2007)

In 2007 WHO revised their classification system in order to take account of the various nuances relating to the types of FGM practiced (WHO 2008). Nevertheless, the definition remains medical in nature and ignores the cultural aspects of the ritual.

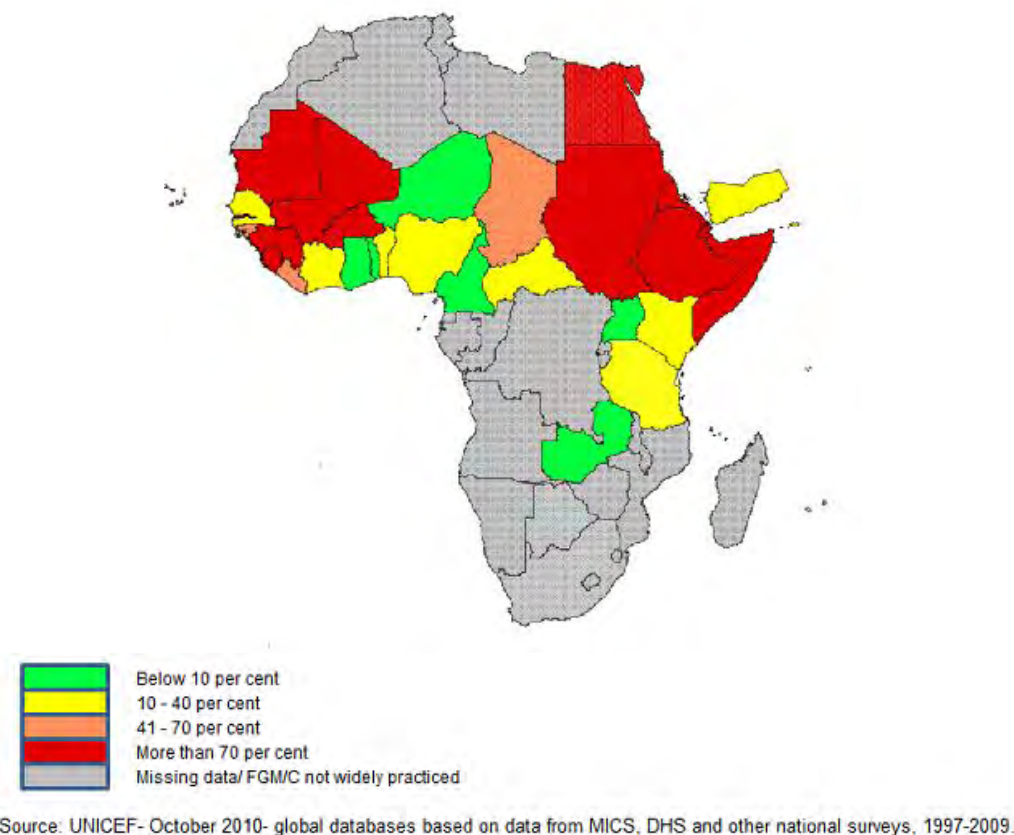
The WHO definition of FGM does not take into account that many FGM practising communities have their own definitions and preferred terminology for the various procedures, which make it difficult to relate the two (Elmusharaf et al. 2006). We engage in further discussion of this below (see Section 3). The disparity regarding terminology and the various meanings individuals and communities place on certain terminology, make it extremely difficult to determine the prevalence and extent of the various types of FGM.

1.2 Terminology

The practice of FGM is sometime referred to as 'Female Circumcision' or 'Female Genital Cutting'. Recently researchers have been employing terms such as 'female genital surgeries', 'female genital operations' and 'female genital alterations' (Pedwell, 2010). Scholars conducting research on this topic have adopted various terms, some prefer the use of the term 'female circumcision' because they believe it closely represents the perspective of women in practising communities (Boddy 2007). Others have argued that utilising the term FGM suggests that African women who are cut are passive victims of an oppressive practice (Njambi 2009). It is important to note that all labels are value-laden and are adopted for various political and social reasons. The term FGM is employed by the WHO, the European Commission and many NGOs campaigning against the practice because it is felt that the term 'mutilation' reflects the gravity, severity (physical and psychological) and irreversibility of the act. Furthermore, it is argued that the use of the term FGM differentiates the practice from male circumcision. Within this toolkit the term FGM is employed. However, REPLACE realise that practising communities, depending on their national heritage, employ various terms to refer to the practice. Section 3 of the toolkit explores the various terminologies utilised by the Somali and Sudanese communities within the UK and the Netherlands.

1.3 Numbers of females subject to FGM

It is estimated that 100-140 million females worldwide have been subjected to FGM, with 3 million girls at risk each year (PRB, 2010). The practice is common in at least 28 countries in Africa, as well as parts of the Middle East and Asia. Prevalence rates range from over 85% of women having been subjected to FGM in Egypt (91%), Eritrea (89%), Guinea (96%), Mali (92%), Djibouti (98%) and Sudan (89%); over 35% prevalence in Central African Republic (26%), Chad (45%) and Ivory Coast (45%); to figures of approximately 5% in Ghana and 2% in Niger (Statistics compiled from DHS 2011, Population Reference Bureau 2010 and UNFPA 2009). FGM has been documented outside Africa, including India, Indonesia, Iraq, Israel, Malaysia, United Arab Emirates, Colombia, and Peru.



Note: The boundaries and the names shown and the designations used on these maps do not imply official endorsement or acceptance by the United Nations.

Figure 1: Prevalence rates of FGM amongst women 1-49 in Regions of Africa

With increasing globalisation and many people from FGM practising communities migrating to the EU and other developed regions, for economic reasons or asylum, the practice of FGM is no longer restricted to the traditional practising countries. There are now substantial populations of women living in the EU who have been subjected to FGM or who are at threat from FGM.

The exact number of women and girls living with FGM in Europe is not known, however in 2009 the European Parliament estimated that up to half a million women living in Europe had been subjected to FGM with a further 180,000 at risk of being subjected to the practice every year (EC, 2010). This data has been extrapolated from the prevalence data in countries of origin and the number of women from those countries living in the EU. These estimates are not reliable as they do not include asylum seekers or undocumented migrants. It also makes it hard to estimate the numbers of second generation migrants who might be at risk of FGM.

The data also does not differentiate the type of FGM being experienced. It is assumed that the type of FGM performed in home countries will be performed by migrants from that country when they relocate to a host country in the EU. This assumption may not be correct. We therefore have no indication as to the types of FGM being experienced by females living in the EU and which groups are subject to the various types of FGM. This makes targeting intervention programmes very difficult indeed.

The EU data on FGM, which is an estimated figure, does not allow for comparison of the issue across the various countries of the EU. This makes it difficult to know the size of the problem in the EU, which types of FGM are most commonplace and in which countries it is particularly prevalent. This lack of reliable data makes it very difficult to monitor changes in the levels of FGM and type of FGM being performed in the EU and to measure changes in behaviour as a result of intervention programmes.

At the moment there is no systematic data collection on FGM in Europe. We have to rely on estimates. Collecting accurate data on FGM prevalence and type in the EU is essential for the effective planning of programmes and health services for those affected by FGM.

1.4 Socio-cultural Context of FGM

The origins of FGM are unknown. However, some scholars have suggested that it has been in existence for over 2000 years. For many it pre-dates any of the major monotheistic religions such as Christianity and Islam and thus it does not appear to be connected to any particular religion, culture, or socio-economic group. Even though its origins cannot be traced to any particular religious belief, the practice for some communities has assumed religious connotations.

According to Unicef (2007) “female genital mutilation/cutting has been perpetuated over generations by social dynamics” (pg.2). All communities where it is common are highly patriarchal, with FGM often defended as a rite of passage from girlhood into womanhood and preparation for marriage. It is used to curb female sexual desire and protect virginity. In some communities, it is justified for health and hygiene reasons, ‘purity’ being a word often used. It is a practice which occurs among all socio-economic groups with widespread support from mothers, mothers-in-law, fathers, religious and community leaders. We must also understand that FGM is considered an important part of a girl’s or woman’s cultural gender identity.

The procedure is usually performed on girls from infancy to 15 years, but in some communities takes place at an older age (WHO, 2008). This depends on local rituals and customs. The ritual is usually performed by traditional practitioners who have no formal medical training who perform the operation in non-sterile conditions. It very often is performed on groups of girls at the same time with risks of cross-infection. They then become 'sisters' and a social support network to each other.

The relationship between the experience of pain and FGM is particularly complex in that this in itself can be viewed as a positive and important part of the experience. For example, in research conducted with women who had undergone FGM in Chad, the experience, which they conceded involved pain, was viewed as a demonstration of the change from childhood to womanhood and as a positive and useful contribution to character development. Similarly, women have reported that to withstand the pain of excision is considered a preparation for childbirth and demonstration of maturity.

Shell-Duncan et al. (2010) explain that within the Senegambia region of West Africa most women supported the practice of FGM. This is because having FGM performed gives young women access to social capital, resources and networks that they can call upon in times of need or crisis. This is particularly important in poor communities where access and opportunities are determined by social networks. At the same time FGM gives older women power and prestige. FGM can thus be interpreted as a strategy by younger women to access social capital and by elderly women to gain power in patriarchal societies. Shell-Duncan et al. (2010) therefore describe FGM as 'a peer convention' which is perpetuated by intergenerational peer pressure.

FGM decisions are made within and influenced by the broader social and political context. Because there are often multiple decision makers involved in a decision to perform FGM on an individual girl, individuals are often not able to refuse to conform. FGM is thus a procedure undertaken on individuals, which is condoned by families in order to conform to social norms and to allow their daughters to access social networks and resources, including marriage partners.

Family honour and social expectations play a powerful role in perpetuating FGM. This makes it very difficult for individual families or individuals to stop the practice on their own. Failure to conform to FGM norms can lead to social exclusion, ostracism or even violence towards the individual or family and inevitably affects the standing of the family within the community. Conformity on the other hand, meets with social approval, brings respect and admiration and maintains social standing in the community. "Even when parents recognise that FGM/C can cause serious harm, the practice persists because they fear moral judgements and social sanctions should they decide to break with society's expectations. Parents often believe that continuing FGM/C is a lesser harm than dealing with these negative repercussions" (Unicef, 2010: 3).

The reasons for FGM vary between regions, ethnic groups and communities. It is important to recognise that interventions designed to end FGM must appreciate the different attitudes towards FGM by different communities in the EU and tailor the intervention to that particular group.

1.5 FGM in an EU Context

It is only over the last decade that research has started to be conducted on the issue of FGM within Europe. Of the research that has been conducted (Hemmings 2011; Norman et al. 2009; Johnsdotter et al. 2009; Johnsdotter, 2007; Johansen 2007 and Morison et al. 2004), it is clear that the socio-cultural context of EU member states plays a significant role in how practising communities respond to anti-FGM messages and legislation. Not only do practising communities react to external environmental issues, they also respond to internal changes within their communities. Because of the different socio-cultural environments associated with each EU member state, we cannot assume all practising communities hold similar beliefs regarding FGM. Furthermore, we should not assume that all individuals who identify as members of a practising communities wish to continue the practice. Indeed, Johnsdotter (2007) has suggested that Somalis living in Sweden, where the research was conducted, may find it a relief that they do not have to circumcise their daughter(s). Conversely, research has shown that residing in the EU may change the 'meaning' of the practice, for example, Johansen (2007) proposes that some individuals may perceive FGM as being an ethnic identifier, a means by which individuals can retain their ethnicity and 'culture' whilst residing in the EU. Interventionists should also be aware that the length of time that people have resided in the EU may change the beliefs they hold regarding FGM.

1.6 Health Impacts of FGM

There are a growing number of well conducted studies which demonstrate a significant association between FGM and various gynaecological and pregnancy complications. WHO Reports (2000; 2006) conclude that FGM has negative implications for women's health, with women who have undergone FGM more likely than others to have adverse obstetric outcomes. FGM has no health benefits and as Figure 2 shows it harms girls and women in many ways, both physically and mentally.

The health impacts on girls and women subjected to FGM occurs at the time of the procedure as well as later into adulthood, particularly motherhood. The effects are both physical as well as mental.

All types of FGM have immediate health risks such as excessive bleeding, septicaemia, death and HIV transmission. There are, however, differing long term health impacts between FGM types. Types I and IV, whilst presenting risks, do allow a speedy recovery, unimpaired urination, menstruation and sexual intercourse in later years. However Types II and III are likely to have the most serious health implications. These may include urinary tract infections, chronic pelvic infections resulting in infertility, scar and tissue cysts, painful intercourse, complications in pregnancy and childbirth, post partum haemorrhage, foetal distress and death and obstetric fistulae (a hole between the bladder or rectum and the vagina). Type III FGM is a significant causal factor in maternal death where delivery is unattended or obstructed labour is not appropriately treated. Studies suggest that vulva scarring associated with FGM is a significant contributory factor in many foetal deaths. Other

studies conclude that females who have been subjected to FGM may be more vulnerable to HIV infection than females who have not experienced FGM.

After childbirth, women from some FGM practising communities who have been subject to Type III FGM (infibulation), will have their vaginas stitched up to close them (re-infibulation). This will require cutting and re-stitching every time the woman is pregnant, resulting in the development of tough and painful scar tissue.

All forms of FGM can have psychological effects, particularly related to female sexuality and sexual relationships. Figure 1. 2 shows the possible impacts of Types I, II and III FGM on female health, infant and maternal mortality. There is little doubt that FGM (whatever type) has a negative effect on female health.

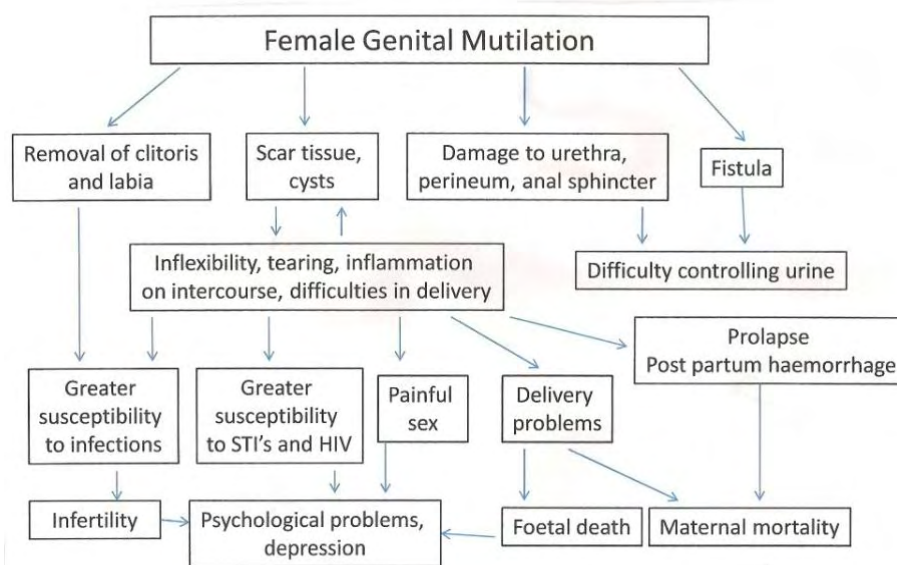


Figure 2 The Health Impacts of FGM Types I, II and III (Source: Adapted from Morison et al., 2001, 645; Cook et al., 2002 and WHO, 2008).

Many women living in the EU who have undergone FGM find it embarrassing, painful and stigmatising to undergo gynaecological examinations and to talk about their experiences. Research has shown that healthcare professionals in the EU have limited understanding of FGM and its potential complications during pregnancy and childbirth. Sensitisation of medical staff to FGM is necessary.

1.7 The Health Approach to Ending FGM

In 1976 the International Covenant on Economic, Social and Cultural Rights declared that everyone has the right to the “highest attainable standard of physical and mental health” (Vol 1, Chapter 5: Article 12 1966: 7). A focus by anti-FGM campaigners and NGOs on the immediate and long-term negative health consequences of FGM and the fact that the procedure is irreversible, is often referred to as the health approach. The use, impact and limitations of this approach are explored below.

It has been argued that the international community feels more comfortable employing a health approach when dealing with the issue of FGM. Because of colonialism, many African nations are skeptical of outside interference, therefore the health approach allowed international intervention, without seeming to undermine or threaten national sovereignty (Hernlund and Shell-Duncan, 2007). The health approach has become an essential component of anti-FGM campaigns operating within EU and beyond. Overwhelmingly, this has been embedded into a wider framework that emphasises bodily integrity and human rights.

Many African women's groups with the support of Unicef have adopted the health approach in 'sensitisation' workshops and national campaigns aimed at ending FGM. Research conducted with practising communities however, suggests that there is a discrepancy between the experiences of some women and these negative health messages. This 'credibility gap' where well intentioned information highlighting the dangers of FGM does not match the lived reality of women's experiences, is particularly likely when women are not infibulated (Type III) but have experienced 'milder' forms of FGM (Shell-Duncan et al. 2010).

In their use of the health approach, anti-FGM campaigners have been reluctant to make a clear distinction between the health consequences of less severe forms of FGM such as 'clitoral pricking or nicking' (Type IV) and more severe forms such as infibulation (Type III). From a campaigner's perspective, to differentiate between the types of FGM on the basis that one type poses less of a health risk than another, might be seen as condoning 'milder' forms of the practice and thus undermines their efforts to eliminate all forms of FGM.

Messages relating to a higher risk of contracting HIV/AIDS have been central to the health approach in sub-Saharan Africa. Unsterile equipment used during the process can directly cause HIV transmission, and tissue trauma and lacerations associated with FGM can leave girls more susceptible to sexually acquired infections (SAIs) including HIV/AIDS. Arguably, the threat of contracting HIV/AIDS has led to a mixed response from communities. Shell-Duncan et al.'s (2010) findings suggest that it has in many cases led practising communities in the Senegambia to adopt a 'one blade per girl' policy, amongst other things, as part of a 'medicalisation' of FGM (see discussion in Section 3.5.2 below). Their findings also suggest, however, that amongst those who have become willing and able to abandon the practice of FGM, this health message has been more effective than others because of its 'newness'. Abandoning FGM for this reason, "does not imply that their ancestors were wrong" as HIV/AIDS is a new disease and therefore avoids insulting community elders compared with abandonment for other reasons (Shell-Duncan et al. 2010: 62).

Conversely, there are religious and political groups that advocate the cutting of adult women on the grounds that it will prevent the spread of HIV/AIDS. There are reports that within Central Kenya men were forcing their wives to be cut in order to prevent the spread of HIV/AIDS (Ahlberg et al. 2000). This is due to the belief that FGM curbs women's sex drive, coupled with the perception that it was women who were carrying the virus, men demanded that their wives be circumcised. Clearly, the use of HIV/AIDS transmission messages as part of the health discourse in anti-FGM campaigns in sub-Saharan Africa is not a straightforward one, and should be given due consideration in its operationalisation.

It has been argued that one of the consequences of the health approach in anti-FGM campaigns, has led to the 'medicalisation' of the practice within some communities. Medicalisation or "clinicalisation" describes a variety of activities in relation to FGM, including the administration of antiprophyllactic antibiotics or anti-tetanus injections by traditional circumcisers or medical professionals, and the distribution of sterile razors or other cutting implements. It can also refer to bringing the practice under the jurisdiction of qualified medical practitioners in hospitals or family homes, including the provision of anaesthetics and aftercare. PRB (2010) estimate that 32% of FGM in Egypt is performed by a health professional, including doctors, nurses and midwives. In Guinea it is 10% and in Nigeria 9%. In many countries where FGM is practised some medicalisation of the procedure has taken place.

The issue of medicalisation is a controversial one. In 1982 the WHO declared that it was unethical and would contravene the Hippocratic Oath for a medical practitioner to conduct FGM because the procedure would cause 'harm' to the patient (WHO 1982). More recently, there was an outcry of protest when the Australian and USA Medical Associations proposed medicalisation of 'symbolic pricking' of the clitoris (Type IV). In some African countries the practice is heavily 'medicalised' with medical practitioners, such as nurses and doctors, performing the cutting during their annual leave. There are fears amongst anti-FGM campaigners that as well as presenting ethical issues, 'medicalisation' will institutionalise the practice and bestow it a level of legitimacy, making elimination more problematic. Researchers suggest that more attention be paid to the impact of 'medicalisation' of the practice on women's health. See Section 3 for further discussion on how medicalisation can be a barrier to ending FGM.

Despite the excellent intervention material on the medical impacts of FGM on females who have been subjected to the procedure, the response of many communities is to perform less serious forms of FGM, i.e. changing from undertaking Type III to Type II FGM, sending their daughters to countries where the procedure has been medicalised and by calling for the medicalisation of FGM in the countries in which they live. The effectiveness of the health approach in reducing or ending FGM has been questioned by many scholars and activists but little attention has been paid to social-cognitive assessments of why this approach has not been as successful as would be expected. REPLACE explores the deficiencies of the health approach from a health behaviour change perspective.

1.8 The FGM Legal Policy Environment

In 1979 the WHO held its first conference on FGM which recommended that the practice be totally eliminated. The conference also advocated the official involvement of the international health and development assistance communities in supporting programmes to stop FGM. In the fifteen years that followed, programmes aimed at reducing FGM emphasised the health risks of the practice, as this was felt to be the most acceptable and least sensitive way to approach the problem. In 1993 at the World Conference on Human Rights held in Vienna, gender-based violence was accepted as a violation of human rights. In 2008 the UN special report on torture stated that violence against women, including FGM, can be considered a violation of the Convention against Torture. The rights denied by the practice of FGM can be found in a range of treaties (see Table 3).

Convention against torture and other inhuman or degrading treatment or punishment.
Covenant on civil and political rights.
Covenant on economic, social and cultural rights
Convention on the elimination of all forms of discrimination against women
Convention on the rights of the child
African charter on human and peoples' rights (the Banjul Charter)
Protocol on the rights of women in Africa (Maputo Protocol)
Africa charter on the rights and welfare of the child
European convention for the protection of human rights and fundamental freedoms
Charter of fundamental rights of the EU
Beijing declaration and platform for action of the fourth world conference on women
UN General assembly declaration on the elimination of violence against women

Table 3: Range of Conventions and Charters which Classify FGM as a Violation of Human Rights (Source: adapted from EndFGM, 2010).

At an international level, eighteen African countries including Ethiopia, Uganda, Ghana, Senegal and Togo, together with Egypt and Djibouti and six of the federal states in Nigeria have effectively banned FGM.

The EU frames FGM as violence against women and girls, which occurs in the family or domestic unit. Violence against women and girls is understood by the EU as a violation of human rights and a form of discrimination against females. The most concrete action taken so far by the EC to combat violence against women is through the Daphne Programme which funded the REPLACE pilot study. The recent EU Strategy on Violence against Women (24.11.2010) stated that women and girls have the right to freedom from torture and inhuman or degrading treatment and advocates an EU-wide strategy to combat violence against women, including FGM.

Within Europe, most EU member states have criminal legislation which defines the practice of FGM as an offence, either as a specific criminal act or as an act of bodily harm or injury. Specific criminal provisions have been adopted in nine EU Member states (Austria, Belgium, Cyprus, Denmark, Italy, Portugal, Spain, Sweden and UK) with other EU member states, including the Netherlands, addressing FGM under

general criminal law provisions in their penal codes (EndFGM, 2010). Many countries also have an extra-territoriality clause which makes it illegal for their citizens to travel outside the EU to have FGM performed, such as parents taking their daughters to FGM practising countries to have the procedure undertaken and then returning home. It is worth noting that much of this legislation fails to cover emerging issues such as pricking, nicking or re-infibulation. Furthermore, the UK Female Genital Mutilation Act 2003, and the Dutch legislation only applies to those individuals with permanent residency. Therefore, individuals on temporary residency visas, such as student visas, as well as undocumented migrants and asylum seekers, are not bound by the legislation.

There have been few FGM related convictions in the EU and in some countries, including the UK and the Netherlands, no convictions. This has meant that many FGM practising communities in the EU do not take the law seriously, or take their daughters to other EU countries where it is perceived that the law is less rigorously applied, in order to have their daughters subjected to FGM. REPLACE have found that there is trans-EU mobility to take advantage of differences in EU country legislation and application of legislation concerning FGM. There is a need to harmonise FGM legislation across the EU and to ensure harmonisation of the application of the legislation.



Female Genital Mutilation Act 2003

CHAPTER 31

CONTENTS

- 1 Offence of female genital mutilation
- 2 Offence of assisting a girl to mutilate her own genitalia
- 3 Offence of assisting a non-UK person to mutilate overseas a girl's genitalia
- 4 Extension of sections 1 to 3 to extra-territorial acts
- 5 Penalties for offences
- 6 Definitions
- 7 Consequential provision
- 8 Short title, commencement, extent and general saving

Figure 3 Female Genital Mutilation Act 2003 UK Available From:
http://www.legislation.gov.uk/ukpga/2003/31/pdfs/ukpga_20030031_en.pdf

1.9 The Human Rights Approach to Ending FGM

The Human Rights Approach to ending FGM takes, as its starting point, the fact that the practice is harmful, an abuse of human rights and is illegal. The UN regard the practice of FGM as a violation of human rights, in particular a violation of female reproductive health rights. Unicef, UNFPA, UNIFEM and WHO all recognise FGM as a form of violence against girls and women. Unicef regard legislation and enforcement as a crucial component in the ending of FGM. Table 4 lists the main components of a human rights approach.

<i>Right to physical and mental integrity</i>
<i>Right to the highest attainable standard of health</i>
<i>Freedom from discrimination on the basis of sex including violence against women</i>
<i>Rights of the child</i>
<i>Freedom from torture, cruel, inhuman and degrading treatment</i>
<i>Right to life (when the procedure results in death)</i>

Table 4: Internationally Accepted List of Human Rights (Source: EndFGM, 2010)

Such an approach stresses the criminalisation of FGM, the penalties if prosecuted and found guilty. The emotive issue of child abuse is often used to sensitise communities in the EU concerning the illegality of FGM. However, many parents do not identify FGM with child abuse, as they believe they are doing what is best for their daughters.

To date there have been no studies conducted in the EU to determine whether or not legislation acts as a deterrent. Although there have been 42 documented criminal cases relating to FGM in France (Nijboer et al. 2010) it is unclear as to whether this has acted as a deterrent within France. Indeed, Nijboer et al. (2010) argue that parents and excisers simply become more aware of the legislation and find ways to thwart it. . Hernlund and Shell-Duncan (2007) have commented that legislation is a “poor tool for evoking behavior change” (pg.36). However, Shell-Duncan et al. (2010) highlight the fact that in Africa, legislation can provide an “enabling environment” in which anti-FGM campaigners can address FGM (pg. 86). Shell-Duncan et al. (2010) also suggest that legislation could empower those individuals who have already taken the decision to abandon the practice of FGM. Legislation therefore provides parents with a solid foundation from which they can reject family members’ demands for FGM to be performed, by highlighting the legal consequences of conducting FGM (Shell-Duncan et al. 2010). Indeed, this approach has been taken by the Dutch Ministry of Justice in their present campaign against FGM. They have produced a pocket sized leaflet called ‘Statement Opposing Female Circumcision’ summarising the Dutch legislation which can be placed within a passport and can be produced by parents, when visiting relatives outside of the Netherlands, in order to prevent FGM happening to their daughters.

(See http://www.ggd Kennisnet.nl/kennisnet/uploaddb/download_object.asp?atoom=55178&VolgNr=4 for an example of the booklet).

More research is required in order to establish the efficacy of FGM legislation within the EU. However, there is a fear that criminalising the practice will lead to the practice being conducted by inexperienced circumcisers (Shell-Duncan et al. 2010)

and girls and women not seeking health care for complications relating to FGM due to fear of prosecution.

1.10 Progress towards Ending FGM

Thirty years after the WHO recommended that FGM be eliminated, there is little evidence that the situation is changing. This is partly because there is limited data available to assess if there has been substantial change. Only in Egypt and Sudan is some data available to assess trends in FGM. In Sudan between 1979 and 1990 there appears to have been a decline in FGM from 96% to 89% of females. This has been accompanied by a 10% shift from Type III FGM to Type II. In Egypt surveys showed that between 1995 and 2000 girls were 10% less likely to be subject to FGM than their mothers. The reasons for these changes are contested. Some suggest that urbanisation and increased access to education for girls have been partly responsible; others suggest that the high international profile of the health impacts of the practice and the criminalising of the practice in some countries have also played a role.

The ending of FGM has proven very difficult. This deep rooted cultural tradition is very resistant to change. Despite campaigns to explain to communities the health implications of the rite and the criminalisation of the practice in many countries, FGM has continued. If we are going to end FGM then it is imperative that we understand why these campaigns have failed and recognise the importance of socio-cultural pressures for communities to continue with the practice.

1.11 The Call for a Behaviour Change Approach to Ending FGM

In 1999, the Program for Appropriate Technology in Health (PATH) undertook a review of Female Genital Mutilation (FGM), *'Programmes to date: What works and what doesn't for the World Health Organisation'* (WHO). The review made a series of recommendations for the way forward in developing anti-FGM programmes. The 19 recommendations covered a range of approaches aimed at ending FGM, including legal, political, organisational and administrative best practice for keeping the momentum towards reduction and elimination of the practice moving forwards.

The WHO review describes the evolution of health communication concerning FGM from "traditional information, education and communication (IEC) strategies to behaviour change communication (BCC) to behaviour change interventions (BCI)" (pg.26). They note the tendency for IEC to focus on awareness raising, that may lead to attitude change (important to behaviour change) but usually insufficient to change behaviour. In particular the review called for the re-orientation of, "communication strategies from awareness raising to behaviour-change intervention approaches" (pg. 2).

The report briefly identifies *development of the right kinds of messages and skill-building*, as elements of behaviour change communication, and *addressing the impact of the socio-cultural context* as central to behaviour change interventions. In

addition, reference is made to one of several 'stage' theories of behaviour change. In this case, it is the type of theory proposed by behavioural scientists such as Everett Rogers and William McGuire. They identify several stages or steps that must be passed through in order for people to adopt a particular behaviour. These are illustrated in Figure 4 below.

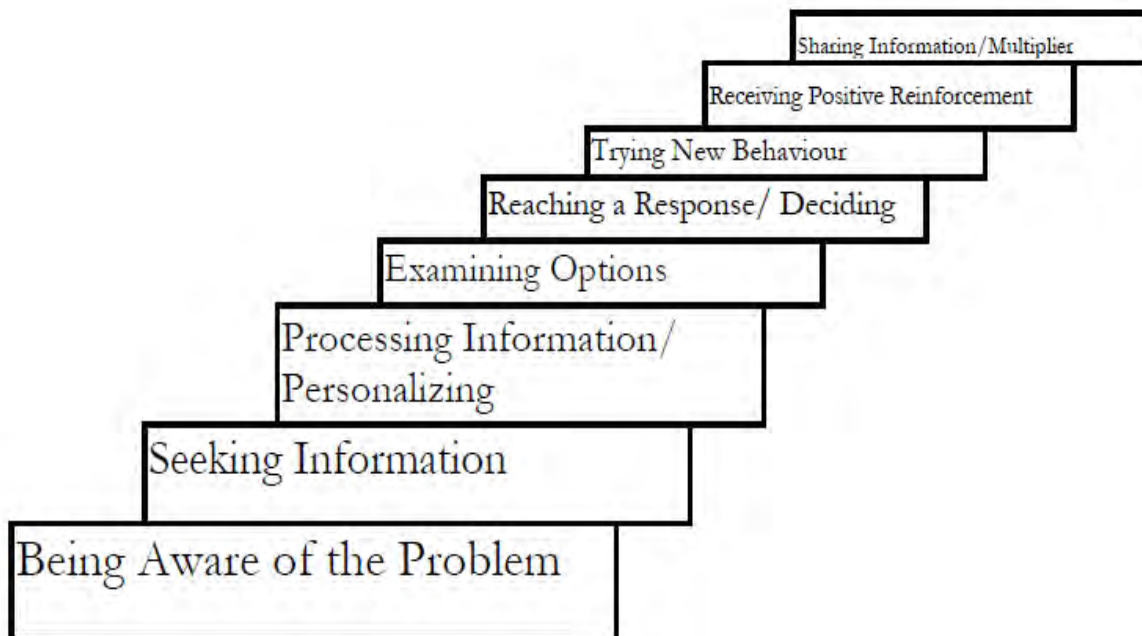


Figure 4 Stages of Behaviour Change (Source: WHO. 1999. *Female Genital Mutilation: Programmes to Date: What Works and What Doesn't*. Geneva, WHO: p. 28).

Figure 4 shows that before people can even contemplate changing their behaviour, they must be aware of the problem/issue and have information as to why they need to consider changing their behaviour. This is then followed by a number of steps when the individual examines their options concerning behaviour change. They balance up the positive and negative risks of changing their behaviour. Once they decide that there are significant benefits to changing their behaviour then this is actioned. If the positive benefits of the action are confirmed and outweigh the negatives then the new action will be continued and others will see the change in behaviour and also begin the behaviour change process. In short people need to be aware of the issue and have as much information as possible about it, be motivated to change their behaviour, decide on an action and perform it. Once they are convinced that the new action has benefits over the old action then the new action will become the norm.

It is important to note that this is a model based on individual stages of behaviour change. We must be aware that behaviour change is affected by the community norms in which we live. Whilst an individual may be motivated to change their behaviour they may not feel able to action this due to community or family pressures. This link between individuals and communities is integral to changing behaviour concerning FGM. Community norms will only change when enough individuals from that community action and accept the new behaviour. The big question for anti FGM campaigners is: how do we reach that 'tipping point' when enough individuals

change their behaviour to influence community norms on FGM (see Figure 5)? The answer to this will vary from community to community.

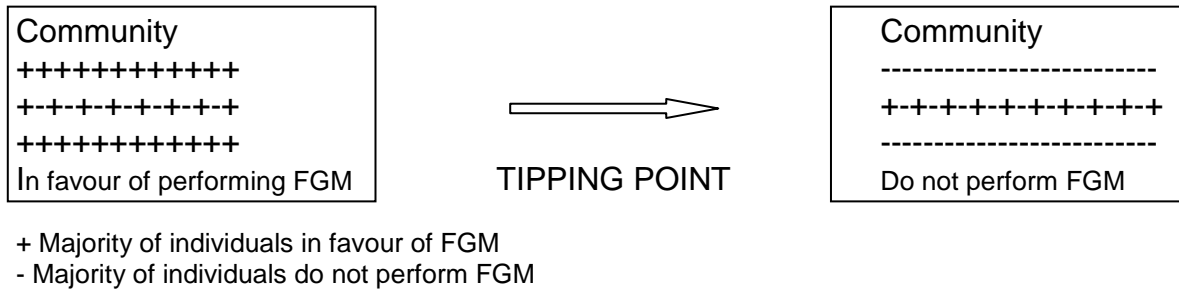


Figure 5 Diagram Demonstrating How Actions of Individuals within a Community can Lead to a Behaviour Change Tipping Point and Change in Community Norms

1.12 The FGM 'Mental Map'

An overarching theme of the WHO (1999) review was the need to incorporate into the design and development of anti-FGM programmes what the authors describe as the 'mental map' of why the practice of FGM continues. Their FGM 'mental map' demonstrates how beliefs (sometimes false beliefs or myths) surrounding religion, hygiene and aesthetics and social acceptance combine to support decision-making in communities in favour of carrying out FGM. It further illustrates that even when such beliefs are changed, overarching beliefs relating to the protection of chastity and family honour through FGM continue to influence decision-making in favour of FGM. Specific communication and actions relating to these beliefs called 'community enforcement mechanisms' are also illustrated (see Figure 6 below).

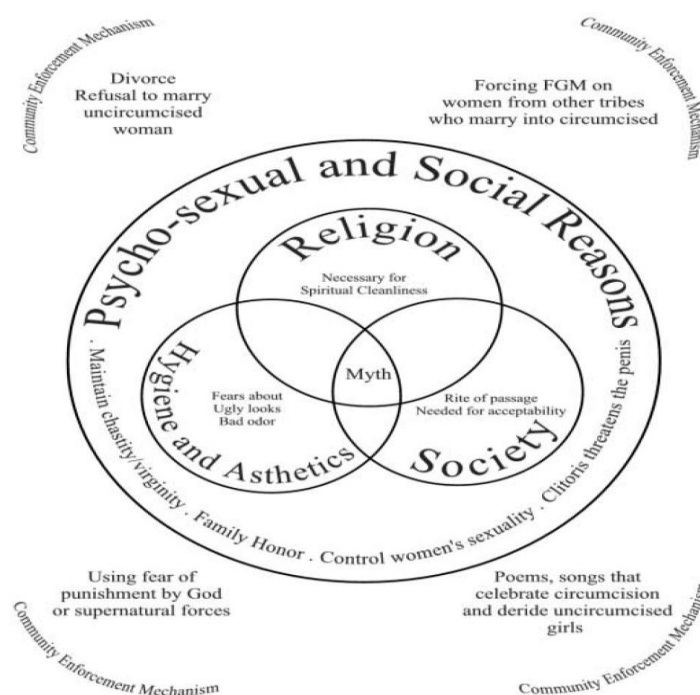


Figure 6 FGM 'Mental Map' (Source : WHO. 1999. *Female Genital Mutilation: Programmes to Date: What Works and What Doesn't*. Geneva, WHO: p. 7).

The authors state that understanding the elements of this 'mental map' and the relative strengths of each element, which will vary depending on the particular community and context, is important for any behaviour change intervention strategy. This must be done they say, if sustained behaviour change as described in the previous section (Figure 4) is to be achieved.

The WHO FGM 'Mental Map' acknowledges that FGM is not the decision of an individual but an act done to an individual (with or without consent) as a result of community convention or pressure, which will vary in different situations. As such Behaviour Change Approaches must take into account both the individual and

community reasons for the persistence of the practice if behaviour is to be changed to end FGM.

Taking the advice of the 1999 WHO review many scholars over the last decade, have called for a move away from awareness raising on FGM to developing intervention programmes that are designed to bring about sustainable behaviour change. Despite such calls, seemingly little progress has been made in implementing and/or evaluating behaviour change approaches where applied to ending FGM. This is possibly because those working as part of the campaign to end FGM, and academics in this field, have limited expertise and experience in behaviour change approaches, and the application of theory in practice. Likewise, those with behaviour change expertise have thus far failed to engage with the issue of FGM. A recent exception is work published by Shell-Duncan et al. (2010) which looks at the dynamics of decision-making and change relating to FGM in Senegambia. Their work specifically set out to assess whether theories of behaviour change corresponded with the dynamics of decision-making around FGM. Within their concluding remarks, Shell-Duncan et al. concede that the issue of behaviour change with respect to the practice of FGM “remains poorly understood” (2010: 130).

This REPLACE pilot toolkit is designed to introduce behaviour change approaches to those working to end FGM amongst practising communities in the EU. This approach replaces the dominant approaches to eliminating FGM which focus on raising awareness of the health and human rights issues associated with the practice and then expecting individuals to change their behaviour concerning FGM. The behaviour change approach helps individuals and communities through a series of steps or stages which enable changes in behaviour to become sustainable and thus change community norms. The toolkit is grounded in participatory action research with Somali and Sudanese communities in the Netherlands and the UK. However, it is hoped that this toolkit and the behaviour change approach it advocates will be relevant to other practising communities across the EU.

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Section 2: Understanding FGM in Practising Communities

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Introduction

When devising and implementing programmes based on behaviour change approaches, it is very important to understand the belief systems behind the behaviour and the barriers to any change. This is particularly important when designing interventions to end FGM, as this is a complex issue and is one that involves not just individuals and families but the practising community itself. The FGM Mental Map described in Section 1 demonstrates very well the complex nature of the practice of FGM and indicates that the elements of the mental map will vary in intensity in different communities. It is thus important not to make assumptions about the community you are working with. It is imperative that we make every effort to understand the reasons why the practice of FGM persists within the community in which we are working and appreciate the barriers to change. This can only be done by listening to community leaders and community members. It is important to stress that all communities are different and that 'one size does not fit all'. This toolkit is designed to allow you to tailor your behaviour change intervention to the needs of the community in which you are working.

The REPLACE research worked with Somali communities in Bristol and The Netherlands and the Sudanese community in Bristol. Whilst there were many similarities between these groups in terms of FGM practise, belief systems and barriers to change, there were many subtle differences. It is often these subtle differences, which are less understood, which could impact on the success of an anti-FGM intervention. For example the role of men in the FGM decision making process was markedly different between the Somali and Sudanese communities in Bristol (see Section 3). In the Sudanese community men played an active role in deciding whether their daughters and wives would be subject to FGM. In this case targeting intervention programmes at men in the Sudanese community might be very effective in facilitating behaviour change. This might be less effective amongst the Somali community where men have little if any role in the FGM decision making process. The REPLACE research also found subtle differences between the Somali communities in Bristol and The Netherlands, often based on the public profile given to FGM in the different countries. FGM is more publically debated in The Netherlands and sex education is compulsory for all children at school. This resulted in greater awareness of the issue and willingness to engage in public debates in the Netherlands than amongst communities in the UK. This means that different approaches would be needed when discussing these issues with these communities.

We thus recommend that before any behaviour change intervention is devised and implemented, that research is undertaken with the communities you plan to work with, or are working with, to determine what the belief systems are concerning FGM and what barriers there are to ending FGM within that community. It must be remembered that FGM, whilst performed on an individual is a community peer convention, with many complex aspects as outlined in the FGM mental map described in section 1. We must remember that barriers to ending FGM can be at the individual level, family level and community level. It is often difficult to classify in this

way as individuals and families are part of the community and in turn the community affects families and individuals.

The REPLACE research used a Participatory Action Research (PAR) approach to collecting information concerning practices and beliefs concerning FGM and the barriers to ending FGM in the Somali and Sudanese communities with whom we worked. We chose this approach as it “involves the study of a particular issue or phenomenon with the full engagement of those affected by it. Its most distinguishing features are a commitment to the democratization and demystification of research, and the utilization of results to improve the lives of community collaborators” (Clifford and Valentine, 2005: 162). PAR differs from other means by which data and information can be collected as the information is co-generated with the researched, interpretations are debated with the researched community and the research process is empowering to those taking part. PAR has at its core a sustained dialogue between external and community researchers which allows the exchange of information and ideas as well as feelings and values. Thus community members become research partners and contribute to the formulation of the research and the discussion of its outcomes. As such PAR is highly appropriate as an approach to research FGM with practising communities.

In this section of the toolkit we explain the participatory action research (PAR) approach as used by REPLACE. We suggest using this type of approach to help you begin to work with and understand the particular beliefs, behaviours and barriers to change relevant to FGM that are important to your community group(s). We start by giving an overview of what we did for the REPLACE project, and then go on to provide much more detailed information as to how you may use PAR to work with your communities.

2.1. Overview of REPLACE Methodological Approach: Participatory Action Research Method

The REPLACE project involved talking to people from the Somali and Sudanese communities in the UK and the Somali community in the Netherlands in order to find out about the community and individual factors influencing these communities to continue or abandon FGM. Working with community organisations already established in the UK and the Netherlands, REPLACE employed a Participatory Action Research (PAR) approach. The PAR method aims to be empowering, by including individuals from the community in which research is taking place. Members of the Sudanese and Somali communities were recruited and trained by REPLACE to collect data through interviews and focus groups. Researchers of different ages, sex, marital status and language capabilities were chosen, making it easier for REPLACE to engage people from all sections of the Somali and Sudanese communities. REPLACE researchers underwent training in in-depth interviews, focus groups and ethics relating to conducting research. In addition to collecting data, the REPLACE researchers also contributed towards the development of the research process, by recommending which topics should be explored. The PAR method facilitates co-ordination between those community based organisations, members of the community and those interested in conducting research within the community. It also allows for a more 'bottom-up' approach to conducting research. REPLACE wanted to find out the meanings that individuals' placed on the practice of FGM and other aspects related to ethnicity, religion and gender roles. REPLACE did not enter the Somali and Sudanese communities with a set of preconceptions about individuals' beliefs or behaviours regarding FGM.

Information was collected in two phases in the UK and the Netherlands. Phase 1 consisted of a number of focus groups. Each researcher recruited six to eight participants that closely matched their age and language capabilities. All focus groups were single sex, in line with local traditional norms. All focus groups were digitally recorded and the recording transcribed and analysed. Both the researchers and the REPLACE partners were involved in the analysis of these transcripts. Analysis was a collaborative process with researchers bringing their experience of conducting the interviews and their interpretation of the topics to the analysis. This analysis focused on bringing those community and individual influences preventing people from ending the practice of FGM to the fore. The findings from focus groups informed the development of an in-depth interview schedule that was employed in phase 2.

Phase 2 consisted of a number of in-depth interviews conducted with both men and women of various ages, marital status and length of time living in the UK/Netherlands from Sudanese and Somali communities. The interviews typically lasted 45-60 minutes and covered topics which all the REPLACE partners and researchers thought most needed exploration following the focus groups. Some interviews were conducted in English and some in Dutch and Arabic. All interviews were recorded, transcribed and where required, translated into English. The English version of the transcripts were then analysed and the findings were discussed with the researchers.

Collecting the data in two phases allowed REPLACE to reflect on the information during as well as after the process, allowing initial findings to inform the development of further research questions and areas of interest. The findings from focus group and interview data presented below (see Section 3), strongly support the assertion that ‘one size fits all’ intervention strategies are unlikely to be effective. Rather, intervention strategies need to be tailored so that certain beliefs, barriers to change and practices associated with particular community groups are addressed. Essentially, FGM practising communities are not homogenous rather they differ depending on many factors such as: age; religion; ethno-national heritage, language, whether they are new arrivals or established migrants; population density and underlying gender roles. Therefore, it is vital that interventionists conduct research with a particular group before implementing intervention strategies. Not doing this could result in the intervention strategies being unsuccessful, due to not appropriately addressing those individual and social influences preventing individuals and communities from abandoning FGM.

2.2 Identifying Individual and Community Level Influential Factors: Guidelines to Conducting Qualitative Research

FGM practising communities are heterogeneous, in that each cultural or community group will have different beliefs about and practices of FGM. Beliefs might differ dependent on political, economic and social environments in which FGM practising communities live. Beliefs and perspectives may also differ depending on whether individuals are born in or outside the EU. In order for an intervention to be successful, an understanding of the unique individual and community level factors associated with a target group can be invaluable. It is therefore recommended that interventionists undertake research with the targeted community, so that they can design more effective and bespoke intervention strategies.

This section of the toolkit provides interventionists guidelines for conducting qualitative research using the participatory action research (PAR) method.

2.2.1 What is Qualitative Research?

Research can take a **quantitative** or **qualitative** approach or a combination of the two, which is referred to as a mix method approach. Where quantitative research is primarily concerned with generating numerical data (e.g. from surveys), **qualitative** research is much more flexible. **Qualitative** research tends to be more exploratory and it allows researchers to uncover the perceptions and beliefs of individuals and how they make sense of their everyday lives. Whereas surveys are typically restrictive in terms of how people can respond, **qualitative** research can allow individuals to explain, in their own terms, how they believe things to be, their perceptions and feelings. In other words, it allows individuals to ‘say it as it is’ rather than being restricted to ticking a box or circling a number or word on a survey. The in-depth interview is widely accepted as the method most associated with qualitative research. However, there are other methods, such as focus groups, storytelling,

drawing and diary writing. Researchers can capture in-depth and rich information regarding things that prevent or help individuals within communities to stop practising FGM. There is opportunity to probe and explore some of the topics/issues that arise during interviews and focus groups and if people find discussions difficult, elicitation methods can also be used. For example, the researcher, or participant, can play music or discuss a picture, film, story or newspaper article during an interview/focus group. This can help generate more in-depth and thorough discussions.

Whereas quantitative research tends to involve large numbers of people, qualitative research generally uses smaller samples of individuals from a community. Small numbers may mean that findings do not represent everyone but the in-depth nature of the information collected allows real insight into what people think and feel. This is very important with a sensitive issue such as FGM.

The data collected from qualitative research can help interventionists identify the important issues for a particular FGM-practising group. Understanding the community you are working with better will allow you to develop more effective and appropriate intervention materials and strategies.

2.2.2 Participatory Action Research (PAR) Method

Participatory Action Research (PAR) was the approach used by the REPLACE project to establish a deeper understanding of the factors which constrain or enable the Somali and Sudanese communities to end the practice of FGM within the UK and the Netherlands. PAR allow members of practising communities to actively engage in gathering knowledge about individuals' experiences and the personal and community issues preventing them from abandoning the practice of FGM. Knowledge gathered during the research is used to inform action. This action is then evaluated to see whether or not it has been effective in terms of initiating change. If change does not occur, the previous action is evaluated and more data is collected to inform another form of action in order to achieve the goal change. Continual reflection and evaluation are fundamental elements of PAR.

Using trained members of the community (cultural 'insiders') to collect data can help to overcome some of the barriers which cultural 'outsiders' may encounter. For example, cultural 'outsiders' may be viewed with some suspicion by members of FGM practising communities. Researchers having a deep understanding of the cultural aspects of the community and who share cultural heritage can help diminish suspicion and facilitate a more open dialogue. With such a taboo issue as FGM, cultural 'insiders' will be more successful in gaining access to members of the community. Furthermore, recruiting individuals from the community to conduct information collection also allows for their experiences and insight to contribute to the knowledge generated. Having cultural 'insiders' collecting data also reiterates an essential aspect of PAR, and that is research is conducted 'with' as opposed to 'on' the community.

Although having cultural ‘insiders’ can be advantageous, interventionists also need to be aware that members of the community they are working with may not want to discuss the issue of FGM with other members of the community. Individuals may fear that any information they disclose will not be handled confidentially and that other members of the community may become aware of what they have discussed. This may therefore make it difficult for cultural ‘insiders’ to recruit members of the community. Also, researchers may be looked upon as being ‘outsiders’ by members of their community, particularly if they are associated with anti-FGM campaigns. Moreover, although cultural ‘insiders’ will understand the social and cultural etiquette and thus be able to gain entry into the community and recruit individuals, they may also feel constrained by these community and cultural rules. For example, a researcher may not ask an individual to expand on their beliefs about a particular issue because doing so would breach social/cultural rules regarding what can and cannot be discussed. There is also a danger that because cultural ‘insiders’ have a deep understanding of the beliefs regarding FGM, that certain aspects are taken for granted and not explored or explained. These are all issues that need to be borne in mind when undertaking PAR.

Using a PAR method means recognising that everyone involved has knowledge and expertise to bring to the project. PAR demands that all parties communicate openly with one another and share the responsibility for the success of the project. Diminishing power between all parties involved in the research process is an essential feature of the PAR approach and all parties should be involved in the analysis/interpretation of the data collected. There also needs to be mutual respect amongst partners and agreement about the goal of the research. Partners need to be open to unexpected findings and address them appropriately. The collaboration also needs to be seen as a long-term strategy and not a ‘quick-fix solution’. Essentially, the PAR method should enhance equality between the researched and researchers and all involved in the project.

2.2.3 Is Conducting Research Viable?

Before collecting data, interventionists need to ask whether they have the time and the resources to undertake research. It may be the case that a large amount of research has already been conducted with the particular community you wish to engage with. Therefore, conduct a search on the internet for information using specific terms (Google Scholar is a useful search engine). Also, familiarise yourself with the REPLACE findings (see Section 3). Even if you intend to collect data within the community, you should always familiarise yourself with other information as this will aid your analysis of the data collected. As the REPLACE project demonstrates, collecting data that is unique to specific communities can provide invaluable information. Below are a few factors which interventionists need to address before proceeding with research:

1. What is the reason for doing the research?
2. How much time is needed and are we able to commit to it?
3. Do we have the adequate skills to train researchers?
4. Is the study affordable and is there a budget to cover all aspects of the research?

5. Can we effectively manage the research project?
6. Do we have a strong partner at the local level?
7. Will the resulting information inform social change within the community?

2.2.4 What Information Is Required?

Who to recruit to collect data should be informed by what information interventionists require. For example, if information is required on English speaking young Somali women's perceptions of FGM, then one would need to recruit English speaking young Somali women from the community to collect data. It is vital that your rationale and the information that you require are clearly established, as this will fundamentally inform who you recruit to collect data. The REPLACE project wanted to gather information from men and women of various ages, marital status and length of time resident in the UK and Netherlands. Therefore, male and female researchers of various ages, marital status and length of time in the UK and Netherlands were recruited. Another issue that interventionists need to take account of is language. Older members of the community, particularly those who were born and migrated from African nations, will most likely be more fluent and comfortable about expressing themselves in their first language. Whereas younger members of the African diaspora, particularly those born or predominantly raised within Europe, will probably be more fluent in their local European language. For the REPLACE project bilingual or multilingual individuals were recruited to collect data. It is vital that researchers have a thorough understanding of the terminology predominately utilised within a particular group as various local terms are used by individuals when referring to the different types of FGM (see Section 3.1 for discussion on Terminology).

2.2.5 Identifying Researchers and Establishing a Research Team using PAR

It is important for intervention workers/community organisations to recruit confident and capable individuals to carry out data collection. Conducting any form of qualitative research requires a combination of good social and technical skills. In addition to possessing these skills, researchers also need to be understanding and non-judgemental. Depending on what information is required and who interventionists wish to engage, individuals from across the socio-economic spectrum may need to be recruited. Some interventionists may wish to collaborate with trained researchers, in order to acquire a good mix of skills. Indeed, a high number of REPLACE community researchers were recruited from Universities and had received training regarding social science research methods prior to joining the project.

2.2.6 Recruiting Researchers

Recruiting researchers can take time. Therefore, allow ample time to recruit and assess potential researchers. One method that interventionists could use to recruit

potential researchers is to conduct a series of focus-groups/community discussions within the community and recruit those individuals who display high levels of social skill and demonstrate a potential to conduct in-depth interviews and/or focus groups. To organise these focus groups, interventionists could advertise focus groups/community discussions through existing community communication networks, such as the local mosque, community meeting places, local shops and specific internet sites. Interventionists could approach the local University to see if any postgraduate students would be interested in contributing to the project. Researchers don't necessarily have to be engaged in anti-FGM campaigns, but they should be familiar with issues regarding the practice. Indeed, it could be counterproductive to recruit individuals known by the community to be engaged in anti-FGM campaigns.

Whatever approach is used, interventionists need to be confident that those recruited will successfully carry out the data collection in a sensitive and ethical manner. Furthermore, they need to be reassured that researchers are committed to the project, as training is time and resource intensive. Researchers should feel as though they are a full member of the project and that their opinions will be respected. When recruiting researchers, interventionists need to emphasise the importance of their contribution to the study, and should highlight the new skills that they will acquire. PAR method is about empowering researchers and those contributing to the research process.

2.2.7 Training Researchers

Before allowing researchers to collect data from individuals in the community they need to undergo a period of training. Training should cover the following aspects:

1. Recruiting participants
2. Conducting in-depth interviews and techniques for focus groups discussions
3. The Ethics of conducting research, such as establishing informed consent and ensuring participant confidentiality
4. Training in the use of research equipment
5. Training in data recording, transcribing and analysing qualitative data

Each of these points are addressed below.

Ideally, this training should be extensive and thorough; consisting of mock focus groups and interviews, where researchers take it in turn to be participants and interviewers/focus group facilitators. Interventionists may wish to collaborate with trained researchers, who can provide assistance and guidance during the training process. It is also important that training covers factual information regarding the different types of FGM as classified by the World Health Organisation (WHO) and the various terms employed by the community which describe the various forms of FGM. Many sources of information are available on this including Section 1 of this toolkit.

As already outlined above, PAR methods require researchers and interventionists to form a collaborative partnership, where divisions and hierarchies are broken down.

For a project to be successful, partners need to share information and listen to one another's concerns. Therefore, regular meetings should be arranged whereby researchers and interventionists can discuss issues arising from the research process. During the REPLACE project, meetings were held regularly throughout the research process. The meetings allowed researchers to discuss their experiences of recruiting and conducting focus groups/in-depth interviews with members of the community. These meetings were particularly useful for researchers to exchange interview techniques and receive feedback from their peers. They were also useful for discussing research findings. Therefore, regular meetings should be seen not only as a way of maintaining communication, but also as a continuation of the training and learning process for all parties.

2.2.8 Developing Focus Group Topic Guides and In-depth Interview Schedules

Before conducting any focus groups or in-depth interviews, you need to establish what information you require. In order to implement the REPLACE model of behaviour change, there is a need to find out about the beliefs people hold about FGM, the practice of FGM in the community and the barriers to ending FGM in the community. REPLACE found that terminology, lack of communication and certain religious beliefs prevent individuals from adopting positive motivational and behaviour change which could lead to ending FGM. A summary of the REPLACE findings are presented in Section 3. Although the REPLACE findings are related to the Somali and Sudanese communities, they, in addition to the information provided by researchers from the target community you are engaging with, will help you to develop your **interview schedule or topic guide**. For in-depth interviews your interview schedule should have a list of general questions addressing beliefs and perceived social pressures. For focus groups, a *topic guide* that broadly covers the issues that you are interested in exploring is helpful. An interview schedule is very different from a survey or questionnaire, in that the questions should be open-ended. Remember, you want individuals to 'tell it as it is' in their own words. Questions should also be placed in a careful order, for example, it is preferable to begin an interview with general questions that are not too personal or sensitive. A good way to open an in-depth interview is to ask the participant a very general and open-ended question, such as 'Tell me about what it's like living in [insert name of place]. We would advise getting community members to contribute to the development of questions and topics. Please see appendices 5 and 6 for examples of the focus group topic guide and in-depth interview schedules used in the REPLACE research.

Once you have developed your interview schedule or topic guide, it is important that you conduct a *pilot* interview and/or pilot focus group, to determine whether they generate the type of conversation and discussion of issues you are after. It may be the case that participants do not understand the questions or the language and/or terminology used is not appropriate. Pilots should be conducted first with fellow researchers or members of the intervention team. After listening to and analyzing the recordings of pilot interviews and/or focus groups, amend the schedule or guide, then re-pilot it with members of the targeted community. The issue of FGM is complex and intervention programmes need to address both the individual and wider community factors associated with its continuation. Interview schedules and topic

guides should try and address the personal as well as the community aspects and explore how these issues are connected. Reference to the FGM mental map described in section 1 could be helpful at this stage.

2.2.9 Recruiting Participants

When advising researchers on who they should approach, we recommend trying to include people who vary in their age, sex, marital status, authority status within the community and their linguistic ability. Researchers also need to be aware that because of the nature of the research, they may need to approach more people than are actually required. By doing this they will hopefully overcome the ‘no-show’ problem. Research has shown that individuals who are approached to take part in focus groups or interviews engage in a ‘diffusion of responsibility’, where they assume that other participants will contribute so they don’t feel responsible if they do not attend. When recruiting, potential participants may immediately agree to participate and say “yes, I’ll be there”. However, researchers should not simply take this ‘yes’ as a sign that the individual will turn up. Researchers may need to emphasize their genuine interest in hearing their views, and identify any barriers to attending, such as childcare needs or expenses incurred in travelling. Where possible, researchers need to help people to overcome such barriers by travelling to them, for example

How many participants do we need?

Social scientists often refer to the number and characteristics of a group of participants as a *sample*. For example, we could say that the REPLACE *sample* consisted of men and women of various ages, marital status and educational level from Sudanese and Somali heritage. REPLACE believed that this sample would generate insightful data from a cross section of the Somali and Sudanese communities. Also, with very little research being conducted with men within practising communities in the EU, REPLACE felt it necessary to include men in the sample. Therefore, the sample needs to relate to the aims of the research.

Sample Size

The size of the sample depends on the amount of time and resources available to you and whether you are going to conduct focus group discussions or in-depth interviews. However, you also need to take account of the size of the community/groups which you are engaging with. In some cities/towns there may only be a small number of individuals associated with a community that practise FGM. For example, according to data gathered by Palfreyman (2011) there were 1,630 National Insurance numbers issued to Somalis in Birmingham during 2002-7, whereas only 100 were issued to Ethiopians. Therefore, if interventionists wanted to gather data on the social and individual factors preventing Ethiopians from abandoning FGM, the sample would probably be very small. In this case, it would be more beneficial to conduct a few in-depth interviews with a small number of individuals over a period of time. This would produce very rich, but limited data. It is essential that interventionists and their researchers be realistic and pragmatic in terms of the research sample. Individuals involved in the project should not be disappointed if they do not recruit a large number of participants, any data is better

than no data. There are several methods that researchers can employ in order to recruit research participants. These are:

Snowballing sample:

The snowballing method is particularly effective when conducting sensitive research, as participants who are initially interviewed can then discuss their experience with other potential participants in order to persuade/encourage others to take part. In other words, participants are recruited through word-of-mouth recommendation, with one participant informing and recommending friends, relatives, co-workers, neighbours etc, to participate. Although this can be an effective means of recruitment, researchers have to be mindful that there is a strong possibility that participants will recommend, or pursue other individuals who share similar views. If this occurs the sample may consist of likeminded individuals and therefore will not generate varied insights regarding the practice of FGM.

Self Selection Sample:

Advertisements requesting participants come forward could be produced. Posters/leaflets could be placed in local meeting places, such as shops and community halls. Requests could also be relayed orally via the local mosque before or after prayers. Or a newspaper article could be placed within a local newsletter/newspaper. A call for participants could also be placed on the community web pages. All advertisements need to be clear, inoffensive and translated into the particular languages spoken within the community one is targeting. Careful consideration must also be given to the means by which potentially interested participants can contact the researchers. For example, will potential participants incur any costs and will their anonymity be preserved? One has to be strategic about where one places posters etc. If one is trying to recruit female members of the community, it might be more appropriate to place advertisements in locations that are frequented by females. Self-Selection sampling can be time consuming and costly in terms of advertising and printing costs.

Convenience Sampling:

This is where the researcher approaches individuals who they know and have easy access to, such as friends, family, co-workers, neighbours or members of a community group. Because participants are familiar with the researcher, they are more likely to feel comfortable about discussing sensitive issues such as FGM. Convenience sampling may be more effective in terms of recruiting individuals in a short timeframe. However, due to participants knowing the researcher, this could also prevent them from being open with them.

2.2.10 Methods of Data Collection

There are various ways you can collect data. Depending on what information is required, in-depth interviews and focus groups can be conducted or a combination of the two. Each of these approaches has their particular strengths. You could choose these methods or use written accounts if this seems more appropriate. The REPLACE project employed a combination of focus groups and in-depth interviews.

Focus groups were used to gather data so that an in-depth interview schedule that covered the most relevant topics could be developed. Each of these approaches are discussed in Sections 2.3 and 2.4.

2.3 Focus Group Discussions

This section provides information and guidelines on how to conduct focus group discussions on FGM.

2.3.1 What is a Focus Group?

A focus group is where a number of individuals are invited and agree to take part in a discussion in which they not only voice their opinions about certain issues, but also define their beliefs and identities in relation to others in the group. Rather than interviewing individuals within the groups, community researchers facilitate and guide a discussion. When facilitating a focus group, researchers need to be aware of what is and is not being discussed, how topics are either discussed enthusiastically or discarded by the group. Facilitators also need to observe which individuals are not contributing to the discussion and those whose contribution might be preventing others from contributing. It is advisable that researchers work in pairs when conducting a focus group, with one taking the role as lead facilitator asking questions, facilitating the debate and maintaining order and the other researcher adopting the role of assistant facilitator. The assistant does not actually engage in the discussion, rather they observe and take notes of the group dynamics and which topics of discussion provoke noticeable responses.

Unlike the individual interview, focus groups are more representative of social interaction that occurs within wider society. However, as noted by one young Dutch Somali female participant in the REPLACE project, rarely do a group of people sit down and discuss FGM within the community. Therefore, researchers need to be aware that focus groups on FGM do not happen within everyday life. Nevertheless, focus groups allow researchers to gain an insight into how individuals define themselves or their community when interacting with other members of their community. Individuals may define themselves by disassociating themselves with others in their community and wider society. For example, REPLACE found that those individuals who support the continuation of Type I or II FGM (or what they referred to as 'sunna' circumcision) differentiated themselves from those who continue to practice Type III FGM (Pharaonic circumcision). It is also the case that during focus groups certain individuals may wish to impose their beliefs or persuade others within the group that their perspective is more valid. With many individuals holding similar or different beliefs, opinions, etc, focus groups can give us an insight into how these differences are negotiated. Focus groups therefore offer a unique opportunity, not only to find out individuals' opinions about certain issues, but also to explore how identities and community beliefs are negotiated and formed.

Focus groups should consist of no more than eight participants, any more and some individuals might feel inhibited about speaking out. It is also very difficult to manage

large focus groups and it especially difficult to decipher what each participant is saying when transcribing. For the REPLACE project focus groups were conducted with individuals of a similar age, linguistic ability and ethno-national heritage within the UK/Netherlands. All focus groups were single sex. However, interventionists may want to conduct focus groups with participants from across the socioeconomic spectrum. For example, it could be very interesting to conduct a focus group with men and women to see how they discuss the issue of FGM. But, with discussions between the sexes of FGM and issues of sex being a taboo in certain communities, particularly in the Somali community, it might not be appropriate to conduct mixed sex focus groups.

2.3.2 Where to Conduct Focus Groups?

Facilitators should create a safe and positive atmosphere where individuals can talk openly, as the location or environment in which the discussion takes place can have an impact on the group dynamics. If the discussion is going to take place in a public building, make sure that the room where the discussion will take place will be private in order to ensure participant confidentiality. Focus groups should not be conducted at locations that are associated with anti-FGM campaigns as this could influence participant's opinions and dissuade them from discussing FGM openly. Facilitators should also make sure that there are no campaign posters (anti-FGM posters) that could influence the group discussion.

Cost can be a factor, but try and choose a location that people are familiar with that is not too inconvenient or difficult to get to or locate. The time and day that the focus group is to take place also needs to be carefully considered. Facilitators need to be aware that individuals have other responsibilities such as work, childcare and observing their religion etc.

The issue of childcare also needs to be taken into consideration. Because of the topics being discussed in the focus group, it would be inappropriate for children to be present. Therefore, facilitators need to make sure that the location provides adequate facilities, for example, an adjoining room, where children can be supervised. Make sure that the building has adequate toilet facilities. Finally, make sure you provide adequate refreshments for participants. Where possible, travel expenses should be paid.

2.3.3 Facilitating a Focus Group discussion

Below are some guidelines on how to facilitate a focus group discussion:

- Conduct a recording level check to make sure that the quality of the recording will be of a high standard.
- Check the room for any posters, particularly those addressing FGM, and arrange the setting so that all participants can see and interact with each other.
- The assistant facilitator should make a diagram of the setting and where individual participants sat. This will be useful for their future records.

- Start the focus group by establishing some guidelines as to how the session will be conducted. This is a perfect opportunity for participants to contribute to the format of the session, for example, the group could decide when it would be appropriate for breaks etc. Reconfirm aspects of confidentiality and explain to participants how this should be maintained.
- Facilitators should ask the group whether or not they wish mobile phones to be switched off.
- It is crucial to create an open atmosphere at the start of the meeting, therefore the lead facilitator should reiterate they are there to listen and not to criticize or condemn and that there are no right and wrong answers, but rather there are different points of view.
- Articles such as newspaper articles, music, photographs, stories or poems can be used to stimulate debate.
- Facilitators must appreciate when participants are active and let them know that their involvement and opinions are valued. Communicating this approval can be done through body language or verbally.
- Facilitators must validate the experiences and the meanings that participants place on the practice of FGM even if they disagree with them, they must not say 'no, that's not right'.
- After the focus group concludes, the facilitators should discuss the focus group and make notes on the issues that they felt were particularly interesting.

Focus groups can provide the space for individuals to talk about issues that are considered inappropriate by others. There is a 'safety in numbers' effect, where people feel as though they can discuss issues with similar individuals. Conversely, some individuals may feel intimidated about speaking openly about their beliefs and feelings regarding FGM, particularly if the rest of the groups have alternative perspectives. Authority relationships must also be avoided in focus groups, as individuals will seldom speak freely in front of those with power to reward or punish them. The lead facilitator needs to subtly manage those participants who dominate the discussion, as their presence or views could intimidate others and prevent them from disclosing their feelings about a particular matter. There are disadvantages with this method, particularly in relation to the topic of FGM when there can be tremendous social pressure to conform to the practice. Another disadvantage is that people could generalize about what happens in the community and not discuss issues that they have had to personally deal with.

Finally, facilitators need to be aware of the terminology that participants use to describe various types of FGM. The REPLACE project found that miscommunication frequently occurs within focus groups. This is due to participants employing similar or identical terminologies when discussing various types of FGM, but attributing different meanings and associations with these terminologies. Therefore, one participant could be using the term female circumcision in reference to all forms of genital cutting, whereas another participant could use this term only in relation to Type III (Pharaonic circumcision). Facilitators therefore should regularly ask participants to clarify what they mean when using certain terms. It is also important that facilitators be mindful of the terminologies they employ within a focus group.

2.4 The In-Depth Interview

This section of the toolkit provides information and guidance on how to conduct in-depth interviews on FGM.

2.4.1 What is an in-depth interview?

The semi-structured in-depth qualitative interview has been employed by many researchers within the social sciences as a means to gain an insight into how people make sense of their world. This method of data collection allows individuals to voice their beliefs and concerns in a manner most comfortable to them on a one-to-one basis. In other words, it allows participants to describe their lives and experiences in their own words and to 'tell it like it is' to a community researcher.

In-depth interviews allow researchers to explore individuals' experiences and how they attribute meaning to aspects of their everyday life. The in-depth interview goes 'deeper' by asking participants to expand on the 'taken for granted' aspects of their everyday lives and perceived social 'norms'. Only by exploring these 'taken for granted' aspects do we gain an insight into how complicated social reality really is. Furthermore, it is only by asking members of practising communities about FGM that we will be able to identify what they believe are the consequences of performing or not performing FGM. By exploring the wider social issues relating to the family, gender roles and their relationship with other members of their ethno-national community, we will understand the level of perceived control participants have over whether their daughters should be subject to FGM.

This approach can yield very insightful and rich data as to how people feel about the issue of FGM and why some individuals may wish to continue the practice and others want to end it. However, as with any method, the in-depth interview does have its limitations. Some participants may feel uncomfortable about discussing issues that are considered a taboo or are religion-sensitive. Others may feel uncomfortable about speaking about certain issues with individuals from their community, due to a fear that whatever is disclosed within the interview will not be kept confidential. Age, sex, language and the ancestral history of the researchers could prevent participants being open during the interview. Finally, those participants who have had FGM performed on their daughters might feel particularly uncomfortable about discussing FGM, not just because it is illegal within the EU, but it might make them reflect on their actions and this could cause some emotional discomfort.

2.4.2 Where to conduct in-depth interviews?

The location where in-depth interviews are conducted needs to be carefully considered. As with focus groups, the environment can have a tremendous impact on the interview process. This is particularly the case when dealing an issue as sensitive as FGM. People will be more open if they feel relaxed, at ease, and trust that what is disclosed is confidential. People are more likely to be at ease and willing

to talk if the interview can be conducted at a time and location that is convenient for them. It is therefore recommended that researchers be flexible and allow the participant to choose a time and location which best suits them. A participant might indicate that they would feel far happier for the interview to take place at their home. Although the participant might feel more comfortable, this could make the researcher feel uncomfortable. Ethically, it is the researcher's responsibility to make sure participants feel at ease during the interview. However, researchers also have an ethical responsibility regarding their own wellbeing. The safety of researchers is also a priority. Therefore, do not compromise it for the sake of an interview. Only conduct in-depth interviews at locations where you feel safe, and make sure someone knows where you are and when you will be back. Always have a mobile phone with you.

2.4.3 Conducting an In-depth Interview

Having piloted the interview schedule and refined it as required, you can now start conducting in-depth interviews with members of the community. Below are a few factors that researchers need be aware of when conducting in-depth interviews:

- Listen and work through the answers

You need to listen carefully to what the participant is saying, as their response might not actually answer the question. Alternatively, the participant may give you a vague response, to which, you might have to ask for clarification or further explanation. Listening is equally as important as asking the right questions.

- Use appropriate terminology when referring to FGM

You should conduct the interview in the language that the participant is most comfortable with. It is also advisable to avoid using complicated language. Not only is language important, but how you ask the question can influence a participant's response. Ask questions in a calm, non-aggressive manner and be sensitive when probing participants for more information.

- Let participants tell their story in their own way

Don't interrupt participants when they are in the middle of a sentence or when they stop in order to collect their thoughts, for some it could be the first time that they have had chance to express their opinions and experiences with someone who will actually listen and be interested in what they have to say.

- 'Could you tell me'

This is always a good way of starting an interview or asking a participant to explain a particular point of view. For example, 'could you tell me about your experiences in coming to the UK/Netherlands?'

- Reassure participants

If participants become uncomfortable during the interview, reassure them that these issues are hard to talk about, but talking about them may help. If the participant becomes very uncomfortable, move to another topic or stop the interview for a break.

- Take notes

The in-depth interview consists of more than just listening to participant's verbal responses, you should also take note of non-verbal cues such as hand gestures,

facial expressions and how a person is sitting. Sometimes body language can tell us more than the actual verbal answer to a question. During the interview take notes about particular aspects that made an impression on you, for example, when the participant's body language and the answer they give to a question seem mismatched. Laughter and silences can also be very informative. Do not feel uncomfortable about long silences, the participant could simply be reflecting on the things being discussed. Use your judgment about when to move the conversation forward.

2.5 Helpful Tips: things not to do during focus groups and interviews

- Don't rigidly stick to the interview schedule/Topic Guide

Interview schedules/topic guides are there to guide you, they are not prescriptive. If participants raise an issue which is very interesting ask them to expand on it. Do not be afraid of asking participants to explain a particular point of view or an answer to a question. It is through probing 'deeper' that we begin to gain an insight into the beliefs and barriers to the ending of FGM.

- Don't be busy taking too many notes and not listening

It is a difficult task taking notes, whilst listening and thinking about possible further questions to ask the participant. Don't worry about not being able to do all these things at once, you will improve with experience. After the end of the interview you could spend half an hour ensuring the notes are as full as possible.

- Don't simply listen for things that you want to hear

An interview/focus group is not about getting what you want to hear from individuals. You need to listen to everything that they say, even if you do not agree with it.

- Don't relate things back to yourself during the interview

Participants could ask you questions about your experiences and opinions regarding FGM. It is up to you whether you want to disclose this information. By disclosing certain aspects of your life, it can produce a better rapport with participants, which in turn, can make for a better interview/focus group. But it does have an impact on the data gathered. Within a focus group situation it is advisable for facilitators not to engage in a discussion about themselves as this could take up a large amount of time. If participants want to ask questions, simply ask them to save them to the end of the focus group/interview when you will be happy to discuss them.

- Don't tell the participant that they are wrong

Even if you fundamentally disagree with what the participant is saying, do not pass judgment on them by telling them that they are wrong. Be aware of your body language as this could give away your disapproval. However, this does not mean that you have to agree with them, rather ask the participant why they believe that to be the case.

- Don't interrupt or change the subject abruptly

If a participant is talking about something interesting or expanding on a particular point, don't just change the subject abruptly. Guide the interview subtly back to a topic you want to cover.

2.5.1 Helpful Tips: Difficult Situations

- If a participant becomes distressed or upset during the interview/focus group (see section on Ethics 2.9.1).
- Difficult stories to hear (See Ethics Section 2.9.2 for more information)
- The participant discloses that they are going to circumcise their daughters or know of someone who is going to circumcise their daughter (see section on Ethics Section 2.9.3).

During focus groups a participant may discuss a situation which highlights a distressing moment in their lives. For example, a woman who has had Type III FGM (Pharaonic circumcision) may disclose a horrific ordeal in terms of her experience of the health services. Although, these disclosures are informative and can stimulate intense discussion, it can also shift the focus away from other issues that need to be addressed. Therefore, facilitators need to sensitively manage the direction of these discussions, in a way that does not dismiss the negative experiences that individuals suffer. Facilitators should ask participants to reflect on these experiences and to consider how these relate to their perceptions and behaviour regarding FGM.

2.6 Other PAR Methods

In addition to focus groups and in-depth interviews, you might want to use *storytelling*, *drawing* or *diary writing*. With oral communication being the traditional means by which many African communities have passed on information, storytelling might be a very effective means by which participants can express themselves and their perception of the practice of FGM. The use of drawing has been used by anthropologists and sociologists to allow participants another means to express their emotions, feelings and beliefs, particularly if they are illiterate or semi-literate. Some sociologists have used drawing in conjunction with other qualitative methods, such as the in-depth interview and focus groups. Participants are asked to draw anything which they feel relates to a particular subject and then they are asked to describe and explain the drawing to the researcher. This method is particularly useful if participants have difficulty expressing themselves within a particular language. Diary writing can be very effective, however, participants have to have a level of literacy in order to participate in this form of research. Therefore, it may not be appropriate for every community. Also, one has to take into consideration language and whether diaries will need to be translated. Essentially, these methods aim to empower participants to contribute to research that will benefit their community. However you will need to decide if these methods are appropriate for collecting information on FGM.

In addition to using these methods, you could adopt a Participatory Ethnography Evaluation Research (PEER) approach. PEER has been used by various

organisations in the UK to research FGM at a community level. Essentially, it shares the same philosophical foundations as PAR, in that it aims to empower members of a particular community through research and engagement. Like the PAR method, researchers are recruited from the community and undergo training in how to conduct interviews and learn about research ethics. Researchers are then asked to talk to members of their peer group; for example, a young female Somali researcher would interview her friends, relatives and community members who are of a similar age and social status. Interviews take the form of a conversation rather than a standard interview (see section 2.4.1) and are not digitally recorded. PEER, like PAR, is particularly useful when working with hard to reach communities on sensitive issues. For more information see www.options.co.uk/peer.

2.7 Transcribing and Coding Data

Collecting data is only the first step to acquiring useful information. After conducting focus group discussions and in-depth interviews, you will need to transcribe the digital recordings. Transcriptions are then analyzed for familiar patterns and themes which is called coding.

This section of the toolkit provides guidelines for transcribing and coding of transcriptions.

2.7.1 Transcribing

In order to gather accurate data during the research process, it is important that all focus groups/interviews are recorded. These recordings are then transcribed (typed up word for word) and translated if necessary. There is a danger that valuable information can be lost during the transcribing and translation process. It is important that all the information is transcribed and translated, even the pauses, laughter and contemplative 'umms' made by participants. REPLACE found that the terminology employed by participants is important for how individuals make sense of FGM, it is therefore essential that any translation is cross-checked by native speakers. When cross-checking, ask the individuals to listen to the recordings to see if what is being said is accurately represented in the translated transcription. Some suggest that translations should be then translated back into the original language to see if it has retained the original meaning, however, this can be time and resource intensive. It may be sensible to not translate those words or phrases which are unique to the particular language used by the targeted group. Retaining the original language will help retain the meaning of these words and how participants' use and interpret them. REPLACE found that it is particularly useful to maintain the original terminology employed by participants in reference to the various types of FGM and the physiological descriptions of the consequences of these types of FGM. However, all words and phrases should be explained in a glossary of terms. To maintain a constant standard of interpretation, translation issues should be discussed and agreed upon during research meetings (see Section 2.2.7 for information about regular meetings). Notes taken by researchers during focus groups/interviews can

inform these discussions relating to translation and the terminology used by participants to discuss various aspects of FGM.

2.7.2 Making Sense of the Data Collected

The size of your sample will determine the amount of data collected. But even the data gathered from a small sample can be quite substantial in terms of density. Analysis of transcripts and research notes is time-consuming and challenging. To make sense of pages and pages of transcript requires patience and skill. Therefore, it is recommended that interventionists acquire the services of experienced individuals which can assist them with this process. It is best that these individuals are involved throughout the research process and not simply given the task of analyzing the data once it has been collected. The REPLACE research used a computer software package called Nvivo 8 to analyse the transcripts. Preliminary findings were regularly presented to the REPLACE partners and researchers in order to receive feedback. Thus, regular meetings where preliminary findings are presented to the researchers and interventionists and discussed should be arranged. Using the PAR method, it is important that all partners contribute towards understanding and interpreting the data. (For more information about Nvivo 8 or 9 see Bryman, A. (2008) *Social Research Methods* 3rd ed. Oxford: Oxford University Press)

We recommend using a good textbook guide to conducting the analysis, but we provide some basic guidelines on how to analyze your data:

- Familiarise yourself with the transcripts by reading and re-reading them several times
- When familiar with a transcript you can start to summarise its content by identifying initial codes or themes that describe what is being said.
- We don't want to be too prescriptive about how to code or describe data but you could try to look for expressions of beliefs as represented by behaviour change theories
 - Look for expressions of perceived consequences of FGM, this could be negative aspects such as health risks, or it could be positive things such as protection of family honour.
 - In addition to looking for what individuals believe about the consequences of FGM or not performing FGM, you should also look for beliefs about what other people are doing and what other people expect of each other (normative beliefs).
 - Beliefs about things that prevent change or help people to change (control beliefs) are also important.
 - Individuals may describe behaviour which is relevant to ending FGM and this should be noted.
 - Try to identify individual, family and community beliefs and barriers.
- Look for frequently used words and expressions and note these and try to identify things that just seem to be important to your participants.

2.7.3 Conclusion

Conducting qualitative information using a PAR approach can be time-consuming, but it can yield valuable insights into the lives of individuals within FGM practising communities, and the reasons why the practice may persist or have been abandoned. By gathering data specifically relating to a target group using the PAR approach, interventionists can identify the current state of beliefs and practice that will help them to tailor their intervention work to promote and support real behavior change.

2.8 Ethical Considerations

All research has to be conducted ethically and in accordance with certain standards. From recruiting researchers to handling and storing the final transcripts, ethical standards must be adhered to. Within this section we shall highlight the ethical considerations that interventionists need to adhere to.

2.8.1 Recruiting Researchers

Due to the sensitive nature of the subject and the fact that researchers will be discussing a practice that is illegal to perform in the EU (or overseas on an EU national), project managers should ensure they recruit carefully. If recruiting individuals through the use of focus groups/community discussion groups, project leaders should apply the same ethical standards as if they were collecting data from the targeted community.

2.8.2 Recruiting Participants: Providing information and getting consent

On initial contact with potential interviewees/focus group participants, researchers should explain the nature of the research project and any benefits or disadvantages of participation. Care must be taken to ensure that participants fully understand what they are being asked to do, and why they have been approached to participate. If someone wants to take part, full informed consent needs to be established, and to aid this a participant information sheet (PIS) should be produced (in an appropriate language(s)). A PIS explains what the study is about, why the participant has been chosen, what will happen if they take part, the possible disadvantages and risks of taking part and informs them how the information they disclose will be kept confidential and anonymous. It includes the contact details of the researcher. An example that you can adapt is provided in Appendix 2. It is important that participants are reassured that all identifiable information, such as their names, geographical location, name of friends/acquaintances etc will be removed or changed in transcription of the data, providing anonymity. In addition to the PIS, a consent form should be produced in an appropriate language. All participants need to indicate that they are willing to take part. This is usually done with a consent form. An example consent form is provided in Appendix 3. If participants are not willing or

are unable to give written consent, it is acceptable to ask them to provide this verbally at the beginning of an audio recording of an interview or focus group. All information on a PIS and consent form should be read out to participants to make sure they understand it. In particular, it is important that permission to audio record a focus group or interview is provided.

Researchers should emphasize the fact that participants are under no obligation to take part in the study or answer any questions which they feel uncomfortable with and that they can withdraw from the project at anytime without giving any reason. Finally, participants should be informed that all audio recording of focus groups/interviews will be erased after all the data is transcribed.

2.8.3 Confidentiality in Focus Groups

Conducting a focus group can pose particular problems in maintaining individual participant's confidentiality. Indeed, this is one of the disadvantages of employing this method, particularly for a subject as sensitive as FGM. With tremendous social pressure for individuals to perform FGM, it may be extremely difficult for focus group participants to express their feelings and beliefs due to the fear that a fellow participant will divulge this information to others. Researchers cannot prevent participants from disclosing information but should ask everyone who takes part to respect another's right to confidentiality and not discuss anything that is said outside of the focus group.

During a focus group or an interview a participant may ask researchers what other participants have said about a particular issue or topic. It is important that personal information pertaining to other participants' is not disclosed. This not only breaches past participants' confidentiality, but also indicates to the present participant that their confidentiality may be breached. Furthermore, this could influence how the current participant answers. If participants do ask what others have said, it is better to respond by talking in generalities, for example, 'well, a number of participants have stated'. However, it is best if researchers get participants to ask questions of this nature at the end of a focus group/interview.

2.8.4 De-Briefing

At the end of a focus group/interview participants should be given a de-briefing sheet (this should also be explained verbally) that includes information regarding organizations specialising in the field of FGM who can provide advice or support if required. An example is provided in Appendix 4. During de-briefing it is an opportune moment to ask the participants if they have any questions or concerns regarding the issues raised or their participation. Some participants might indicate that they wish to withdraw from the project at this stage. If this is the case, inform the participant that all information that they have disclosed will not be included in the project and the digital recording will be deleted. If a focus group participant wishes to withdraw, explain that their contribution will not be transcribed. During debriefing, researchers should re-confirm participant's consent by informing participants of their right to

withdraw from the research or to omit anything which they have disclosed/discussed from the final transcript.

2.8.5 Handling Data and Confidentiality

Each participant should be allocated a unique identification code or pseudonym, that allows data from a single participant to be matched up and enables data to be identified for withdrawal at a later date if required. The unique identification code could be the researcher's initials plus the month and day of birth of the participant (for example, JS initials, 12 day, 10 month).

Recordings, transcripts and consent forms must be stored in a secure location, such as locked cabinets in a secure office. If data is going to be stored electronically, it should be password protected. Consent forms which have identifying information on them should be stored separately from all other data. After data have been transcribed and translations checked with the audio recordings, the recordings should be erased. All researchers must comply with the data protection legislation applicable in their country.

2.9 Ethics Continued: Participants' Safety and Emotional Wellbeing

The well-being of participants and researchers is an ethical priority in any piece of research. In focus groups there is a possibility that participants can become offended or upset by the comments or opinions of others. In order to minimise participants' emotional distress, focus group facilitators should emphasise the requirement to be respectful of others' views. Facilitators need to be able to identify when a discussion is becoming problematic and step in to either redirect discussion or in serious situations terminate the focus group. It is possible that during focus groups or in-depth interviews participants may disclose certain events or feelings that they have not yet come to terms with; this may particularly be the case for those women who have experienced FGM. In these circumstances participants may become distressed. (See Section 2.9.1 below: Distressed Participants).

2.9.1 Distressed Participants

If a participant becomes distressed during a focus group or interview, facilitators/interviewers need to ascertain whether the participant wishes to continue. Within a focus group situation, the facilitator should temporarily stop the discussion and sensitively remove the participant and refer to them to an appropriate source of help. In a very serious situation, the focus group may need to be terminated. In less serious situations, the facilitator should determine whether others wish to continue or terminate the discussion. Information relating to counselling services and sources of support and information, should be distributed to all participants during debriefing.

2.9.2 Researchers' Wellbeing

Investigating sensitive topics can have an impact on researchers' emotional well-being. It is paramount that researchers also have access to support and guidance. Researchers should be able to seek support from their research peers and project managers in addition to other sources. Judgements about what arrangements are required must be made by those organising the research. The safety of researchers must also be considered, when going out to collect data. Researchers must always ensure someone knows where they are going, when, and when they are expected to be back. Whenever possible, they should avoid collecting data alone in the home of participants, as this may put them at risk. Neutral venues where other people are close by are much better (e.g. private room at a community centre). Having access to a mobile phone during data collection sessions is recommended.

2.9.3 Participants disclosing intent to practice FGM or recent FGM

All forms of FGM are illegal in the UK, the Netherlands and other EU nations (see Section 1). In many countries it is also illegal to take someone out of their country of residence to have it performed in another country. Evidence suggests however, that the practice continues in many African migrant communities within the EU. The

REPLACE project and other research projects have found anecdotal evidence which suggests that children are taken outside the EU to have FGM performed. Indeed, REPLACE found anecdotal evidence which suggests that FGM continues to be practised in the UK and the Netherlands. Because REPLACE gathered data on individuals' opinions and perceptions relating to FGM, and did not ask participants direct questions about their intentions to perform, or whether they have performed FGM, no individual disclosed their intention to perform FGM. Many of the participants in the REPLACE project were aware of the illegality of FGM within UK/Netherlands. It is very unlikely that participants will disclose a direct intention to perform FGM. Nevertheless, project leaders and researchers need to have contingency measures in place to deal ethically and sensitively with a disclosure of intent, or disclosure of recent FGM.

Project managers/researchers need to consider the following:

- Seek advice on this issue before commencing any research. Have a clear plan, and make sure all researchers know what they should do in the event of disclosure of intent or actual FGM.
- If you intend to inform legal or child protection authorities in the event of a disclosure of this nature then you **MUST** make sure participants in your research are aware of this through information provided in the PIS and consent forms, when they agree to take part. It is worth considering however that this could discourage participants from discussing issues openly within focus groups/interviews. It could also impact on the level of trust between the researchers and members of the community.
- Make sure you have information and sources of help and advice to hand during data collection.
- Be ready to answer questions about the law and FGM if they are asked.

2.10 References and further reading

We hope that the information in this section has provided you with a helpful starting point for how to go about conducting research on FGM amongst practising communities using a PAR approach, and how to do this ethically, with community groups that are known to practice FGM. Below are some references for further reading that you may find useful:

Bryman, A. (2008). *Social Research Methods*. 3rd ed. Oxford: Oxford University Press

Clifford, N.J. and Valentine, G. (eds.) (2005). *Key Methods in Geography*. London: Sage.

International Institute for Environment and Development. (ed). (2000). *Participatory Learning and Action: Sexual and Reproductive Health*. London, International Institute for Environment and Development.

Izett, S. and Toubia, N. (1999). *Learning about Social Change: A Research and Evaluation Guidebook Using Female Circumcision as a Case Study*. New York: Rainbo Publication.

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Section 3: Barriers to Ending FGM: REPLACE Findings

Section 3: Barriers to Ending FGM: REPLACE Findings

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Introduction

This section of the toolkit reports on the barriers to ending FGM as identified through analysis of the REPLACE focus group and interview transcripts. The information collected from the PAR phase of the research was analysed using Nvivo. Three major themes emerged from the analysis as major barriers to the ending of FGM amongst the communities we worked with.

These are:

Terminology (Section 3.1)

Religion (Section 3.2)

Communication (Section 3.3)

Choice and Consent (Section 3.4)

We explore each of these in this section of the toolkit and show how these barriers can affect behaviour change. Whilst the issues discussed in this section came out of the PAR work with Somali and Sudanese communities in the UK and Netherlands, some of the issues may be applicable to the communities you are working with, and others may not. Indeed there may be issues that were not picked up in our PAR research. As we have emphasized in this toolkit, each community is different, whilst there are often many similarities there are often subtle differences that interventionists need to be aware of and consider when designing a behaviour change programme aimed at ending FGM.

As with any piece of qualitative research, the REPLACE findings are interpretations of what participants talked about in focus groups and in-depth interviews. Sometimes it was difficult to tell whether people were expressing their own beliefs, or simply reporting on a belief-system that is upheld and talked about by community members. This confirms the complexity of the issues as expressed in the FGM mental map described in Section 1. In addition, there is some ambiguity regarding the terminology used to talk about FGM (see Section 3.1 on Terminology below). This, coupled with the fact that the sample is not representative of all of the people in the community, means it is wise to act cautiously in response to the findings. Interventionists working with community groups are likely to be gaining new information and learning more about the groups they work with, all of the time, and new information and knowledge should always be taken on board and used to update and inform future work.

Throughout this section we provide suggestions for how the findings might inform your practise - look out for the **TAKE ACTION** headings.

Please note: In the sections that follow all quotes provided from our interviews and focus groups are written word for word. We have not changed what was said as this could change the meaning from the perspective of the participant. Furthermore, all participants are identified by the terms which they used to describe their ethnicity, for example, some participants interviewed in the UK identified as Dutch Somalis, due to have resided in the Netherlands for most of their lives. All quotations have been anonymised to protect the confidentiality of participants.

3.1 Terminology as a Barrier to Behaviour Change

One of the major themes that emerged from our analysis of the transcripts was around the use of terminology to describe or name FGM. REPLACE believe that the use of terminology around FGM is really important. Because of our findings we believe that sometimes it is appropriate for those working with FGM practising communities to use the term FGM and that sometimes it is appropriate to use other terms. We explain further below.

3.1.1 Terms used by the Somali and Sudanese Communities

REPLACE found that different terms were used by members of the Sudanese and Somali communities to refer to the different types of FGM. The terms 'circumcision' and 'sunna' were mostly frequently used. The term 'circumcision', was sometimes qualified with the word 'female'. For many participants the word 'circumcision' was used as a 'catch-all' term, just as FGM is used by campaigners and NGOs to refer to all types of FGM. Many participants used the Somali term 'Gundniin/Gudnink', which translated means 'circumcision'. Similarly, Sudanese participants tended to use the word 'Khatan' which also means 'circumcision'. When reading the transcripts it is sometimes difficult to determine what practices individuals are referring to when they use the term 'circumcision'. For example, during interviews with both the Somali and Sudanese communities and participants, it was not always clear whether they were referring to male or female circumcision when they used the terms Gudniin, Kutairi, Khatan or Halaalayn (purification).

Table 5 lists the terminology used by participants, the translation of the terms REPLACE's interpretation of how these terms map onto the WHO FGM classification system.

Interventionists need to be aware that individuals may identify themselves as belonging to a particular 'community', but their place of birth, length of time within a particular country, etc, may have a bearing on their use of terminology when referring to FGM. For example, although most of the Somalis interviewed used the term 'Gudniin/Gudnink', those born or raised outside of Somalia used other terminology, such as the Arabic 'Khitan' or 'Tahoor' when referring to FGM. Therefore, interventionists need to establish the most appropriate terminology for communicating with their target group(s).

Taking Action

Interventionists need to be aware of all the terms that are used by the various groups that they work with and work to try and understand the meaning that they assign to the words. This is because it makes a difference to the way people understand information and messages. If you use the same terminology as the people you work with, they may be more willing and able to take your messages on board. Think about the early steps described in Section 1 (Figure 4, the Stages of Behaviour Change) and the need to motivate people to want all forms of FGM to end.

Table 5 Understanding Participant Terminology Concerning FGM

Participants' Terms	English Translation	WHO Classification
Gudniin/Gudninka (Somali)	Female or Male Circumcision	
Gudninka gabdaha (Somali)	Female Circumcision	
Gudninka Pharaonica (Somali)	Pharaonic Circumcision	Type III
Kutairi	Usually refers to male circumcision, but is also used to refer to female circumcision	
Kukeketwa	Female Circumcision	
Khatan or Khitan (Sudanese)	Circumcision (can be used to refer to male circumcision)	
Khitaan Al-Rejaal (Sudanese)	(Male circumcision)	
Khitaan Al Enaath	(Female circumcision)	
Halaalayn (Sudanese)	Purification (can refer to female and male circumcision)	
Aladdla (Sudanese)	Re-infibulation	Re-infibulation Women are closed after childbirth (Type III)
Pharoni Tahoor (Sudanese)	Pharaonic Circumcision/infibulation	Type III
Tahoor (Sudanese)	Female and male circumcision	
Tahara (Sudanese)	Cleanliness or Purification	
Extreme, Heavy or Bad One (Somali)	Pharaonic circumcision/infibulation	Type III
Old One (Somali)	Pharaonic circumcision/infibulation	Type III
Big Sunna (Somali)		Type III or II
Small Sunna (Somali)		Type II or I
Light, Small, Soft or half Sunna (Somali and Sudanese)		Type I
Sunna (Somali and Sudanese)	Can also refer to male circumcision	Type II, I
FGM (Somali and Sudanese)	Pharaonic circumcision/infibulation	Type III

(See Section 1.1. WHO Definition and Classification of FGM, for more information)

3.1.2 Negative Perceptions of the term FGM

There were a few participants who supported the use of the term FGM because they believed that it gave an accurate representation of what the practice does to women's bodies. But FGM was not a term used by the majority of participants. When asked what terms are frequently used within their communities, participants indicated that the term FGM is very rarely used, with 'female circumcision' (Gudniin/Gudninka or Tahoor/Khitan) or 'sunna' being commonly used. For many participants, the term FGM was very negative and was associated with individuals and organisations campaigning to end FGM. Many did not perceive FGM Types I and II as mutilation and a minority believed FGM Type III was aesthetically pleasing and therefore not mutilation. Interventionists need to be careful about the use of terminology as the perceived negative and political aspects of the term FGM may alienate your community and result in antagonism at worse or misunderstandings at best.

The following statements are in response to the question: How does hearing the word 'mutilation' make you feel?

"Something abnormal. There are many women who went through khitan, have children, have normal lives and nothing wrong with them. They have no illnesses. This term is used to stop people holding to khitan, especially girls" (Somali Woman: 24-29 UK).

"FGM means disabling and mutilation of private parts of a person. It is a term known for female circumcision, but I have been circumcised and I am not disabled in that part, I have desire for sex like everybody, I have no problems having children...So, it is not possible or fair to say that I have been disabled or mutilated as I function fully...Female circumcisions and FGM, are just names that are portrayed negatively to circumcision and which is generally ideas meant to finish the practice" (Somali Woman, 24-29: The Netherlands).

Interviewer: One of the definitions is Female Genital Mutilation. Do you know or use this term?

Participant R: *"we can't call it mutilation because it was our loved families who did this out of culture not hate"*

Participant H: *"It is a correct definition (FGM), but it can't be used because of the word mutilation. I think the 'West' want to use these terms to shock the world and campaign against. So I understand why they would use this term, but in the daily use, I prefer the word circumcision" (Sudanese Women, Focus Group: UK).*

Taking action

Interventionists should consider that the terms FGM and ‘mutilation’ may be inappropriate in certain contexts, particularly when working with women who have undergone the practice, as they may not perceive themselves as being ‘mutilated’ or ‘defaced’. Research conducted by Khaja et al. (2009) in which 17 Somali born North American women were interviewed about FGM, also found that many of the women did not consider themselves to be ‘mutilated’ and perceive this term to be ‘insulting’. If the word you are using to talk about this issue with community members is inappropriate for the audience or perceived negatively, your message may not be accepted.

3.1.3 FGM referring to Type III (Pharaonic Circumcision)

Overwhelmingly, participants associated the term FGM with the ‘extreme’ or ‘bad’ forms of circumcision. In other words, the vast majority of participants believed that the term FGM referred to Type III (Pharaonic circumcision).

“Mutilation is going to the extreme of circumcision... I believe, you know, that some people that say that are doing circumcision to females...do it to the extreme way and it is basically seen as mutilation” (Somali Male, 18-23: UK).

“As we know, (FGM) is an abbreviation of female genital mutilation, it is pharaonic circumcision cutting the natural organs of the girls. The difficulties of FGM are physically and mentally incapacitating. It is continuous difficulty of the women health wise. I say may God bless the women” (Somali Male 30-35: Netherlands).

“The word FGM is mutilation, infibulations! All Somali adult where ever they come from, they know that FGM has consequences for women’s health. FGM reduced the sexual enjoyment of the women” (Somali Male, 18-23: Netherlands).

“There are two kinds of purification: In the pharaonic one, the whole clitoral hood and both labias have been removed then they pour malmal (a traditional herb) and other flora in order to attach it together. So I think some of the people know that as FGM” (Somali Woman, 60-65: Netherlands).

It has been noted that the use of the term FGM within intervention workshops can be problematic due to translation difficulties (Leye 2000a). Translation issues aside, we found that our data clearly demonstrate that community members understand the term FGM to relate to more severe forms of the practice, labelled as Type III by WHO. Almost every participant recited the health consequences associated with

FGM, such as difficulties during childbirth, menstruation and urinary problems and difficulties associated with sexual intercourse, and attributed them to Type III (or Pharaonic circumcision). Less severe forms of FGM labelled by the WHO as Types I, II and IV are not thought of as being encompassed by the term FGM in the communities we spoke to. Thus the use of the term FGM amongst the communities you are working with might give you false results, as most participants in the REPLACE research agreed with the ending of Pharaonic circumcision/FGM Type III, but were less motivated to end other types of FGM (such as ‘sunna’ see discussion below) which they did not consider to be FGM. Worryingly some participants believed that UK law banning FGM was only referring to FGM Type III (as they do not regard other forms as FGM). Such misunderstandings can have serious consequences for the success of anti-FGM interventions.

3.1.4 ‘Sunna’

After ‘circumcision’ the most frequently used term by participants was ‘sunna’. Some participants used adjectives such as ‘small’, ‘big’, ‘light’, ‘heavy’, ‘soft’ or ‘half’ to differentiate the various forms of ‘sunna’. Nevertheless, the term is very ambiguous, particularly when participants were asked to describe the physiological practice of ‘sunna’ as these statements illustrate:

“The second one and some of shakers are saying it’s ok that we can do that, is basically to cut the small thing it’s not big it just, it’s just, just pip [said with expression to emphasis the smallness] and that is what we call ‘sunna’” (British Somali Male, 24-29: UK).

“The Physical practice...for a woman...she’s...you know...cutting a bit of foreskin off her vagina...a little bit, not a lot, not mutilating, you know, the organ, however just cutting off a little bit...and that’s the ‘Sunna’ (Dutch Somali Male, 18-23: UK)

“Sunna it’s the same thing as the man, like in Islam we do cut the begin things of the man, and the women as well, just a tiny bit just to clean it that’s all” (Sudanese Woman, 18-23: UK).

“I think the Sunna circumcisions have fewer problems as compared to the firhoni (Pharaonic). This is because in the Sunna the procedure involve slight or partial cutting of the upper tip of the clitoris and the surrounding areas while holding them together to avoid excess bleeding” (Somali Woman, 24-29: Netherlands).

What is clear is that participants make a fundamental distinction between ‘sunna’ and Type III (Pharaonic circumcision). Although it is difficult to determine what ‘sunna’ really means, a clear distinction for most participants was that ‘sunna’ did not involve any ‘stitching’, but even this was debated by some, who suggested that ‘sunna’ did involve ‘stitching’, but only for ‘hygienic’ or ‘health’ purposes.

“With the Sunnah type small part of clitoris are taken off and sometimes there are no need to sew anything” (Sudanese Female Focus Group Participant: UK).

“They see ‘cut off a piece of the clitoris’ or ‘sew something together’, as being less worse than the method that sews everything together” (Dutch Somali Woman, 24-29).

Many of the REPLACE participants made a fundamental distinction between ‘sunna’ and other forms of FGM. Participants rejected FGM Type III (Pharaonic circumcision or infibulations) for its negative impact on women’s health and wellbeing, but considered ‘sunna’ as being less harmful; some even believed it had no negative consequences.

“With the Sunna version only the upper part of the clitoral hood has been cut, the labias are intact and are not be sutured. There is a clear difference between them and no one can deny it” (Dutch Somali Woman, 60-65: Netherlands).

“This is the difference. And then the one who is circumcised has more problems with her health than the non-circumcised one. But Sunna circumcision is something simple and therefore is better...that is something simple...it doesn’t cause mutilations...down there, I mean” (British Sudanese Male, 42-47: UK).

“Sunnah circumcision is safer than Firooni [Pharaonic] because Sunnah is not about cutting the whole clitoris but only to be made little blood on its head and causes no problem” (Somali Male, 30-35: Netherlands).

“There are some scientific evidences that the Sunnah type is beneficial for keeping women clean and eliminating bad smells” (Focus Group Participant, Sudanese Woman: UK).

“I swear to God, there is a big difference and they see the difference, it isn’t like the pharaonic one because it hasn’t any consequences for the girl, for instance, because it is something which doesn’t have any stitching and such” (British Sudanese Woman, 30-35: UK).

“It is not comparable. There are a lot of differences between the two. Sunna is much better than firhooni [Pharaonic] on its bodily effect” (Somali Male 30-35: Netherlands).

“The circumcision is divided into two types as I have told you earlier; the Firooni [Pharaonic] circumcision is the one that causes problems to the

women and many of them experienced its difficulties but the Sunnah circumcision causes no damage” (Somali Male, 30-35, Netherlands).

“It’s totally different. One, there is no pain if you are put under anaesthesia and you’re able to work soon after. It’s very different from Kukeketwa as you cannot even walk for a week after it’s been done” (British Somali Woman, 24-29: UK).

Taking action

We believe the clear distinction people draw between FGM III (Pharaonic circumcision or infibulations) and other types of FGM (such as sunna) has important implications for the way community members listen to and understand anti-FGM messages. These findings suggest that miscommunication between interventionists and members of a targeted community could easily occur when the term FGM is used. For example, interventionists could be discussing health complications, or how FGM is a violation of human rights and individuals may attribute the message to type III FGM only, when it is relevant to all forms of FGM. In short, we suggest that the use of community terminology does help to deliver clear messages on this issue and reduces misunderstandings.

3.1.5 Conclusion

This section has demonstrated the need for interventionists to gather information and understand the meanings attributed to the FGM related terminology used by communities they work with. Without a thorough understanding of the terminology used by particular groups, there is an increased risk of misunderstanding between interventionists and community members. This can lead to campaigns and strategies failing to engage people. REPLACE found that ‘sunna’ and FGM are thought of as two different practices. People hold very different perceived consequences, perceived risk/threat, and normative beliefs about them, and therefore different messages and strategies are required to engage with people about them. The REPLACE research demonstrated that in terms of the stages of behaviour change model described in Section 1 (Figure 1.4), that the communities we worked with were more motivated to change behaviour concerning FGM Type III than other types of FGM. Thus any intervention programme needs to bear this in mind and ensure that programmes are very clear about what types of FGM they are referring to. Using local terminology can help in this.

3.2 Religion

3.2.1 Introduction

REPLACE found that religious beliefs were important in relation to FGM for those who took part. Religious beliefs can either support the ending of all forms of FGM or provide support for the continuation of the practice. In this section we look at those religious beliefs, particularly those relating to the 'sunna' type of FGM, which pose a significant barrier to behaviour change. The findings suggest that 'sunna' type of FGM has become more associated with Islam, whereas Type III (infibulation) has not.

3.2.2 Religion and FGM: Important to note

This section explores the religious beliefs held by REPLACE Somali and Sudanese participants. The findings presented are REPLACE's interpretations of the religious beliefs expressed. Interventionists must remember that although a number of practising communities are followers of Islam, some are Christian or hold other religious beliefs. Conducting research with your targeted groups in order to gain a better insight as to the importance of religious beliefs will be helpful in designing campaign messages and programmes. It is important that religious beliefs are respected, but the message that FGM is not required by Islam or any other religion should be promoted.

3.2.3. The 'Sunna' Issue

Some people use the word 'sunna' to refer to a type of FGM (as discussed above). However, REPLACE are aware that 'sunna' is very important in Islam and we need to be mindful of the fact that the term 'sunna', when referring to the religious teachings of the Hadith (see Glossary for meaning), has nothing to do with FGM. Consequently, there is a danger that some Muslims may be offended by the use of the term 'sunna' to describe a form of FGM. Interventionists should ask individuals to clarify what they mean when they use the term 'sunna', as some individuals may be referring to the religious teachings rather than to 'sunna' type of FGM. Understandably, individuals may become extremely defensive if they believe their deeply held religious beliefs are being questioned or challenged and therefore caution and sensitivity are required here.

3.2.4 Religious Understanding and 'Sunna'

A number of participants commented that due to a 'better understanding' of their religion, many individuals now realise that FGM is not required by Islam. REPLACE found however, that although a 'better understanding' of Islam was mentioned as the reason for rejecting all forms of FGM, a sizable number of participants indicated that this has led them to reject Type III only (Pharaonic circumcision or infibulation). For the latter group of participants, there was some variation as to how they perceived 'sunna' type of FGM. Some believed that if FGM was done 'correctly' and was not

too 'extreme' then this was in keeping with the 'sunna' (habitual practice). Others suggested that conducting the 'sunna' form of FGM is not an obligatory religious requirement, in that parents can choose to have their daughters cut. But, as one participant stated, if parents choose not to have their daughters cut, this could result in their daughter having it 'tough'. (See Section: 'Choice' 3.4.3 for more information).

*"If it's done upon the **Sunna** it shouldn't, it won't, because I told you...it's not to the extreme that is done in some parts of Somalia...If it's done upon the **Sunna** and really simple and that...if it's done upon the **Sunna** by the way of the Prophet it will be ok"* (Dutch Somali Male, 18-23: UK).

"You don't have to do it and if you do not do it, it's gonna be tough for them" (British Somali Male: 24-29: UK).

Interviewer: *It is sunna, so there are no obligations, which means you can do it or avoid it. Is this right?*

Participant: *"But we want the best for our girls, so if you do it then it is better. I personally want the best (Laughter)".* (Sudanese Male, 42-47: UK).

*"Some people believe that, but as I read in some **Hadith** as they said it's not part of religion you can leave your child, you can leave your daughter"*

Interviewer: Did you read a **Hadith** before that.....

Participant: *Saying you do not have to do it to a girl, boys yeah, but to a girl you can do it if you want it, it's your choice to do the modern one or to leave them"* (British Somali Female, 18-23: UK).

"The modern one [Sunna], but all the old ladies are the Pharony [Pharaonic] one all of them. But since you know about ten fifteen years or more than that people understand the religion and they learn that not the good one [Pharaonic]" (British Somali Woman, 18-23: UK).

The REPLACE findings seem to indicate that there has been a shift in terms of how FGM is associated with religion. Overwhelmingly, participants held the belief that 'sunna' type of FGM, or the 'modern' or 'light' form of FGM has a religious association; some even referred to the Hadith¹ when discussing this issue. Although many participants indicated that 'sunna' type of FGM was not obligatory, there are

¹ There are many Hadiths which purport to capture the Prophet Mohammed's teachings. However, Islamic scholars continue to debate the authenticity of those Hadiths which supposedly refer to the issue of female circumcision.

perceived benefits, mainly social, to performing it.

3.2.5. The belief that FGM indicates that a woman is a ‘good Muslim’

REPLACE found that as a result of this shift in practice and the religious beliefs, the ‘sunna’ type of FGM is viewed positively. Participants believed and perceived that others within the community would consider those women who have had ‘sunna’ type of FGM to be ‘a good Muslim woman’.

*“So if that woman rejected it, then I see the one who accepted it a higher degree and you just see her faith from that...a higher degree of faith following everything, following the Qur'an, the **Sunna**, upon the understanding of the companions, as I reiterate, and if she follows that it just shows that she's more...religious, she's practising, she's not fake, you know, I can use that word fake because there's some Muslims that just say “I'm Muslim”, or you see in different religions as well this, you see a Christian and has, you know, the badge, the cross hanging out, but they don't actually practise...so yeah, if the one that practises this...circumcision and the other one doesn't and both of them know that the Prophet ordered it, I see the one who done it...I see that one with...I see that one with having a higher degree of faith to the one who doesn't” (Dutch Somali Male, 18-24: UK).*

“It depends the way if she is religious must be done” (British Somali Male, 24-29: UK).

Although participants indicated that it is a ‘choice’ and not obligatory, many parents perceived positives aspects of having their daughter cut, i.e. being considered a ‘good Muslim’ and increasing her and the family’s status in the wider community, as outweighing the possible negative implications of ‘sunna’ type of FGM. Participants also commented that young women who have not had the ‘sunna’ type of FGM may face difficulties marrying. Marriage is perceived as preserving the family ‘honour’, securing the economic and social welling being of young women, and signals a transition from childhood to adulthood as a full member of the community. This makes it difficult for parents, families and the wider community to cease the practice.

3.2.6 Type III (Pharaonic Circumcision) considered Non-religious

Many of the REPLACE participants commented that those who continue to perform Pharaonic circumcision/infibulation or FGM Type III do not have a good understanding of the religion, or were interpreting the religion in the wrong way. What is interesting is that many participants perceived, or believed that the community perceived those individuals who continued to practise Type III (Pharaonic circumcision) as being ‘uncivilized’, ‘ignorant’ and generally ‘uneducated’. For participants, those who continued this ‘uncivilised’ practice were back in the ‘homeland’, particularly in rural areas.

“Sunna is big to me, basically we got the Qur’an and the sunna and if I only believe the Qur’an and don’t believe the Sunna then that means I don’t believe the Qur’an so, its big to me it’s like the Qur’an I have to follow the sunna”

Interviewer: What reason could be in your thought of its continuity to the present time?

“Wullahi (by God), it is just the mentality of people, I mean, the selfishness, I mean, no, no more than that, and the distancing away from religion. When people get closer to the religion (Kuwaiyis = well), they will be able to understand and will probably not accept this issue, as they will get aware of all packages. All these things are against religion and science itself and you can only find them taking place in primitive societies; those which are uneducated, unaware, and unreligious” (British Sudanese Male, 42-47: UK).

Interviewer: What are the ideologies attributed to female circumcision and how does FGM differ from Sunna?

“As I told you, FGM is ignorance that means to be paralyzing to women and that is not allowed in our religion. We do not accept it. I do not accept”

Interviewer: How does Sunna differ from FGM?

Participant: *“FGM is different from Sunna. As mentioned in our religion men should be circumcised and women also should be circumcised as sunna. But you have to make research in that issue” (Somali Male, 30-35: The Netherlands).*

Taking Action

It is possible to view this shift in religious perspective as positive, in that it demonstrates religious beliefs regarding the practice of FGM can change over time. If individuals no longer associate FGM Type III (Pharaonic circumcision/infibulation) with Islam, then there is a possibility that they could also be dissuaded from believing that ‘sunna’ type of FGM has a religious grounding. Changing deeply held religious beliefs about the positive consequences of having ‘sunna’ circumcision however, will always be challenging.

3.2.7 Conclusion

Interventionists need to bear in mind that although certain religious beliefs and perspectives may be a barrier to changing behaviour relevant to ending FGM, it can also enable individuals to totally abandon all forms of FGM. A minority of REPLACE participants attributed their abandonment of all forms of FGM to a deeper understanding of Islam by studying the Qur'an and various Hadiths and conducting their own research on the topic. Therefore, religious discussion that addresses the beliefs people hold, and the engagement of powerful religious and community leaders on this issue has the potential to be really useful in bringing about change, and ending FGM.

These findings also highlighted the role of community leaders in advocating the continuation or abandonment of the practice of FGM. In the communities with whom we were working religious leaders and prominent community leaders were seen as 'influential' in setting the norms of the community, and as such could be effectively used in anti FGM programmes. Targeting such influential people and moving them through the stages of behavior change (see Section 1 Figure 1.4) could be a highly effective way of getting members of FGM practising communities to the tipping point where not performing FGM becomes acceptable and a social norm.

3.3 Communication about FGM

REPLACE found that communication around FGM was important for several reasons, and these are outlined below. Communication of various sorts is one of the many behaviours that people who are motivated to end all forms of FGM could identify and be supported to engage in. Issues that affect successful communication are therefore highly relevant to the design of good behaviour change strategies.

3.3.1 Awareness and the Media

People were keen to stress that awareness levels about the issue of FGM were high in their communities. This sometimes led them to suggest communication was no longer needed on the issue.

“In the UK I don’t think so [it is not practiced] I think the message is received everyone, everyone got the message” (British Somali Female, 24-29: UK).

“Now people are more aware and some families have already stopped this practice” (Sudanese Female, 36-41: UK).

Participants identified the health complications associated with FGM, such as, menstruation, urinal and childbirth complications and difficulty consummating marriage. It therefore seems as though ‘the health message’ regarding the negative implications of Type III (Pharaonic circumcision) has been received. Also, a shift from FGM Type III to other less ‘invasive’ forms of FGM (‘sunna’ type) suggests that individuals have responded to these health messages. Participants identified the media as contributing to the higher level of awareness regarding FGM Type III.

“I have never heard about it [FGM], I swear to God...particularly, people are conscious...I have never heard about it before, I have no idea if they did it or not, for instance...this thing doesn't exist anymore because of the TV and the media...I don't believe that this happened, I mean” (British Sudanese Male, 42-47: UK).

“But, I see there is a difference between generations, in the early time female circumcision was not spoken specially in Somalia. People started talking about circumcision in the last 25 years through information and media” (Dutch Somali Male, 30-35: The Netherlands).

The media can be a powerful disseminator of information. Documentaries or commentaries regarding FGM can spark debates and make individuals reflect on their beliefs and perceptions regarding the practice. In some cases, the media can

inform individuals of the legislation regarding the practice within the EU. Indeed, many of the Dutch participants identified the media as the source from which they gained knowledge of FGM legislation.

Interviewer: How did you know that laws exist that prohibit FGM in Holland?

Participant: *“I heard that information when it was passed through in the parliament. I also heard it from the media, such TV (Universal TV)”* (Dutch Somali Female, 42-47: The Netherlands).

“I came to the Netherlands in 1993 and since then I lived here, so my grandchildren are born in here. I heard that it is prohibited. I listened and watched it from the media, so I know that there is a law that forbids it” (Dutch Somali Female, 60-65: The Netherlands).

The media can raise awareness and disseminate positive messages. But interventionists also need to be aware people can interpret information in various ways. Thus, a documentary or news report covering the topic of FGM may be interpreted negatively by some individuals. For example, we found that some participants believed that the media, particularly in the ‘West’, ‘exaggerated’ the issue of FGM. It is difficult to know whether they believed that the media ‘exaggerated’ the prevalence or the severity of the practice. With a few individuals mentioning that the media only document the ‘extreme’ type of FGM, one could infer that individuals believe the ‘Western’ media focus on Type III FGM. By contrast media messages, particularly from outside the EU via satellite TV and the internet, may confirm individuals’ positive perceived consequences regarding the practice of FGM. For example:

“Yesterday, in the Tiba TV Channel, a Sudanese Sheikh (imam) was asked FGM and whether or not it is right. His opinion was that it is Sunna

Interviewer: What type of FGM?

“No, he did not give details. He was only asked about the religious point of view on FGM...He quoted a hadith (

. The meaning of the hadith (If you have two circumcised parts meet, then ghusl: meaning cleanness). This means that cutting existed in the Prophet era with this hadith is an evident. This is what I wanted to say when [other participant] mentioned for example that FGM is campaigned against in Sudan ...So I wanted to ensure if someone has [this] information” (Female Focus Group Participant N, Sudanese, UK).

“I swear to God, this is something I heard on TV, it was broadcast...once a

woman said that this circumcision is simple and not the one performed in Sudan...tahoor is something simple, but not the one used once upon a time, the tahoor is different than the one used a long time ago” (British Sudanese Male, 42-47: UK).

“There is media propaganda about female genital mutilations. Only 1% of people here are actually doing the practices and 99% of others falling victim and who are actually against the idea” (Female Participant, Dutch Somali, The Hague).

“The media and the West exaggerate about FGM” (Older Sudanese Female, Focus Group Participant: UK).

“The common day circumcision that you see regularly on TV or in the media is extreme one [Type III]” (Dutch Somali Male, 18-23: UK).

Because mass media (e.g. tv, internet) messages tend to be good for awareness raising they are an important part of the anti-FGM campaign work. They offer a communication method that avoids face-to-face communication which can be appealing and useful in addressing a sensitive issue such as FGM. The mixed messages that the media may present need to be understood however, so that interventionists can correct messages that support the continuation of the practice. In addition, given how often people have cited media influence, it may be the case that it should be increasingly considered as a mechanism for delivering behaviour change techniques and approaches to address this issue.

3.3.2 Lack of Communication within the Family

REPLACE found that although participants believed that everyone was aware of the dangers of FGM, there was little communication or discussion of these issues within the family. The nature of parenting within the Somali and Sudanese communities means that it is considered inappropriate for mothers to discuss FGM or issues of a ‘sexual’ nature with their sons. Likewise, fathers are not expected to discuss these issues with their daughters. Participants suspected that other families in their communities did discuss the issue of FGM, although those who held this belief indicated that the topic was never discussed in their family. Interestingly, participants commented that the issue of FGM was not discussed because there is no reason to discuss it as it is something that ‘simply happens’. In other words, it is a social norm and expectation that young girls are circumcised, so there is no need to discuss it with young girls. Others indicated that because girls are very young when they are circumcised, it would not be appropriate to discuss this with them.

“In the family, I’m not sure because they do the circumcise when the child is young, and they don’t have to discuss with them, ‘do you want me to Gudniin you?’ You know, they don’t have to communicate with that

subject, if they [parents] want to [do it] it's their choice, they can do it" (British Somali Female, 18-23: UK).

"It is known in Somalia that girls and boys are subject to khitan without discussing the issue with them. Khitan is practices as a tradition and sunna. Children since they are too young, they talk about who had khitan and who is going to have it, so it is something normal as things that happening on daily basis" (Somali Female, 24-29: UK).

"Circumcision or purification for a girl hmmm, girls are circumcised when they are very young, I mean, she has no say in this matter" (Sudanese Male, 42-47: UK).

A number of participants, both men and women, indicated that they have discussed issues relating to FGM with same sex siblings and/or extended family members.

"I remember the difficulties encountered by my sisters at the menstruation time. They used to complain about pain and it is not a good thing" (Dutch Somali Male, 30-35: Netherlands)

"Usually if there is a young aunt who can talk to the girl or if there is an old sister who can listen to the sister and give advice, but for the mother to talk about sex with her daughter, is difficult"

Interviewer: Why is it difficult for the mother to speak about sex?

"Yes, because she was not used to it but it is possible for the aunt to discuss these issues" (Somali Female, 24-29: UK).

"Sometimes when I used to come home, I would find that my sister has been out visiting neighbours to attend a purification party and on such occasions this topic is opened and debated and we all discuss it" (Sudanese Male, 42-47: UK).

3.3.3 FGM Considered Taboo

FGM, or more specifically, ‘Gudniin’, ‘Tahoor’, ‘Khitan’ or ‘Sunna’, is often not discussed because it is considered taboo. Some participants commented that to talk about such matters is shameful. Others suggested that it was against their ‘religious’ or ‘cultural’ beliefs to discuss FGM.

“In my community is this issue hardly talked about, actually it is taboo. If and when this issue is being discussed I notice that most people use the word ‘sunna’” (Dutch Somali Female, 18-23: Netherlands).

“We don’t really talk about it”

Interviewer: Why is that do you think?

“Because of shame. It is not appropriate to discuss such things especially not when you are from a family with two brothers. You don’t just talk about it. There is a taboo” (Dutch Somali Female, 24-29: Netherlands).

“No, they are allergic to this issue; parents may think about this thing but never discuss it with their children. I think this is why this practice is continuous” (Sudanese Female, 36-41: UK).

Interviewer: Do parents talk about sexuality and female circumcision with their children?

“No, it is taboo. It has to do with the way parents used to deal with sexuality” (Dutch Somali Male, 24-29: Netherlands).

3.3.4 Gender as a Barrier to Communication

REPLACE found that little communication on FGM occurs between men and women. This was particularly noticeable within the Somali community, but the Sudanese participants did indicate that married couples do discuss FGM and particularly the sexual difficulties associated with Type III (infibulation). FGM enhancing men’s sexual pleasure was a belief expressed by older married Sudanese women. Sudanese women also displayed a more assertive attitude toward sexual enjoyment compared with their Somali counterparts. Indeed, a number of participants discussed how Sudanese men traditionally gave their wives gifts in return for them to agree to be re-infibulated after child birth.

Many Somali participants believed that married couples do not speak about this issue, but the decision to circumcise a young girl *is* discussed. REPLACE also found that Somali and Sudanese women believed that men desired ‘circumcised’ women, whereas many of the male participants indicated that they wanted to marry an ‘uncircumcised’ woman or one that had had ‘sunna’.

“The majority sees it as a good thing, even in the UK when I hear people talking about purification, women support it on the basis that men like it and women feel proud... I think they prefer purified women” (Sudanese Female, unassigned: UK).

“I think its men in Somalia who demand for circumcisions involving stitching.

They think stitching is virginity. What they don't know is virgin membrane is located inside and natural” (Older Somali Female Focus Group Participant: Netherlands).

“I swear to God, they [women] think this idea...they are circumcised and know what the circumcision is...they approach these things only regarding sexual relationships. They see that despite difficulties the circumcised girl is better than the non-circumcised one, for reasons that they only know, because the habubat [grandmothers] know it better than other people, despite the difficulties and the suffering, but they know this thing... they think this thing is useful for the daughter in her life...for this reason they are determind to do this thing” (British Sudanese Male, 42-47: UK).

Interviewer: is there any relationship between female circumcision and virginity?

“No. Only women think it is related” (Somali Male, 30-35: Netherlands).

Taking action

This lack of communication between men and women concerning FGM is unsurprising. There is no simple way to change this, but gradually working to find ways to make this an easier topic to discuss is worth spending time doing. Only when people (particularly those with powerful positions) communicate that they want change to happen will complete and consistent abandonment of FGM be possible.

Although REPLACE found that siblings and extended family members can communicate about FGM and its consequences, this may not be the case in all communities. Interventionists therefore should conduct research in order to find out about the ways in which the issue is discussed, if at all, and work to enhance communication between family members in-line with the view that all forms of FGM should end. Cultural norms about people of different genders communicating within the family may make this harder but identifying barriers and ways to overcome them is part of the process towards change.

REPLACE found that both men and women did occasionally discuss the issue of FGM with their same sex friends. This suggests that it is possible to discuss FGM amongst close friends of the same sex. Peer networks can be an effective way of getting messages out amongst people. In other words, individuals are more likely to be persuaded by someone they trust or can relate to rather than a cultural ‘outsider’. Getting people to identify communication about FGM as a set of behaviours they can perform is an important part of behaviour change.

Taking Action Continued

There are of course other behaviours besides communication, but communication is important. All individuals who become motivated about ending all forms of FGM need to be supported to identify the different communication behaviours they can enact. They will need support in getting motivated to engage in such communication behaviours and in overcoming any genuine barriers to communication. Those in the community in positions of power or influence, will experience fewer genuine barriers to communicating on the issue.

3.4 Consent and Choice

These are examples of some of the barriers and counter arguments that people presented in interviews and focus groups that may be drawn upon by community members. Many of these related to the notion of ‘choice’, consent and religious freedom. The interventionist needs to explore how they will respond to these arguments, as they will inevitably come up during discussions. Some of these arguments relating to ‘choice’ and consent are particularly hard to challenge, especially when non-therapeutic male circumcision or labiaplasty (designer vagina) are not prohibited by law in many EU states (see Glossary for explanation of these terms). Within this section we look at arguments relating to ‘sunna’ type of FGM being compared to male circumcision, the perceived double standard that ‘Western’ women can consent to labiaplasty, whilst African women are unable to consent to FGM and the perception of ‘choice’ regarding ‘sunna’ type of FGM.

3.4.1 Male Circumcision

A small number of participants interviewed during the REPLACE research made the comparison between ‘sunna circumcision’ and male circumcision. This was particularly expressed in the terminology that they used to describe the actual practice.

“Physical practice...for a woman...she's...you know...cutting a bit of foreskin off her vagina...a little bit, not not not a lot, not mutilating, you know, the organ, however just cutting off a little bit...and that's the Sunna” (Dutch Somali Male, 18-23: UK).

“ Sunna it's the same thing as the man, like in Islam we do, we cut the begin things of the man, and the woman as well, just a tiny bit just to clean it that's all, which is, it is something alright, in fact the girl, like when you cut her, like when you do the sunna she could run and [...] in the same day” (Sudanese Female, 18-23: UK).

Participants interviewed in the REPLACE project did make a distinction between all forms of FGM and male circumcision. But there were a very small number of participants who suggested there were medical benefits of FGM, such as reducing the likelihood of developing cancer or contracting HIV/AIDS. With the World Health Organisation supporting the practice of male circumcision within Africa, as a means of preventing the spread of HIV/AIDS, there is a possibility that some individuals may employ the supposed benefits of male circumcision to support the continuation of FGM. Intervention workers/community leaders can challenge the latter arguments by emphasizing the fact that there are no medical benefits associated with any type of FGM.

With participants indicating an increase in the ‘medicalisation’ or ‘clinicalisation’ of ‘sunna circumcision’ (Types I and II), there is a danger that this will strengthen individuals beliefs that this form of FGM has no health consequences. There is also the possibility that more people may start to use the comparison between this form of

FGM and male circumcision. Indeed, a small number of REPLACE participants made reference to male circumcision when discussing the physiological aspects associated with 'sunna circumcision'. With male circumcision being legal within the majority of EU countries², individuals may start to ask why it is perfectly acceptable for their sons to be circumcised by a medical practitioner, but not for their daughters to have 'sunna circumcision?' This argument poses a significant challenge to interventionists, especially if 'sunna circumcision' Type I or II FGM is highlighted as the most prevalent form within a targeted community.

With Type III (Pharaonic circumcision) it is evident that this practice is not comparable to male circumcision, but with other less 'invasive' types of FGM, this it is difficult to refute the comparison argument. The KNMG (Royal Dutch Medical Association) published an official viewpoint regarding the non-therapeutic circumcision of male minors, which states that this practice conflicts with the child's right to autonomy and physical integrity (KNMG, 2010). The KNMG also state that circumcision of male minors is not without physical and psychological complications and that these should be thoroughly explained to parents wishing to have their sons circumcised. A similar publication was produced by the British Medical Association (BMA), in which ethical and legal guidance on male circumcision was provided (British Medical Association, 2006). Like the KNMG, the BMA recommend that medical practitioners should explain the negative aspects of male circumcision to parents wishing to circumcise their sons. A common theme throughout these two documents is the possible negative impacts of male circumcision on sexual and emotional health, as well as the physical implications and that human rights and bodily integrity arguments can apply to this practice.

Taking action

Interventionists face a difficult challenge in making the argument against FGM on human rights/bodily integrity grounds, without acknowledging that these arguments could also be applied to male circumcision. If individuals within a target community do raise the issue of male circumcision, interventionists should not avoid discussing this issue. It is only by having an open dialogue about the medical complications of FGM and male circumcision and how human rights and bodily integrity arguments can be associated with both, that interventionists will gain the respect and trust of the targeted community. This is not to say that overcoming the comparison arguments will be unproblematic. However, interventionists should facilitate a discussion amongst members of the target community, where human rights, health and legal aspects regarding FGM and male circumcision can be discussed.

² Sweden is the only EU country which has implemented legislation relating to male circumcision. This legislation restricts the practice to those male minors below the age of 2 months and must be carried out under local or general anaesthetic. According to Evans (2011) Finland is the only place where male circumcision is illegal and even this legislations seems to be ambiguous.

3.4.2 Consent

A number of individuals interviewed for the EPLACE project commented that women over the age of 18 should be able to consent to FGM and to re-infibulation. Sudanese women tended to raise the issue of re-infibulation, as this is commonly practised by Sudanese communities. Depending on the targeted community, re-infibulation might be an issue that interventionists need to address within workshops. But the issue regarding consent, particularly with genital cosmetic surgery being freely available to women and men in many countries across the EU, could pose a significant challenge to behaviour change. Young Somali women in the UK who took part in a focus group, were aware of the double standards in terms of the legality associated with the practice of FGM and genital cosmetic surgery. The fact that women over the age of 18 from non FGM practising groups in the UK can 'consent' to genital cosmetic surgery, whilst adult women from practising communities cannot consent to any form of FGM, has been highlighted by many activists and scholars (Braun, 2009; Johnsdotter & Essen, 2010; Tiefer, 2010). Some have even argued that cosmetic genital surgery should be made illegal, as it is the mutilation of women's genitals in order to conform to cultural perceptions of female sexuality and beauty.

Interventionists need to understand that there may be contradictions regarding the legality of practises within their country. For example, the UK Female Genital Mutilation Act (2003) does have its limitations, in that women can still opt for the practice on medical grounds, if their physical and mental wellbeing is jeopardised. However, findings from the REPLACE project suggest that very few individuals are fully aware of the various clauses of the legislation. Therefore, as Guiné & Moreno Fuentes (2007) state, although it is theoretically possible that women from practising communities could ask for a type of FGM based on these grounds, the REPLACE findings suggest that this is unlikely to occur. Conversely, in the Netherlands, women can consent to hymen reconstructive surgery, the costs of which are covered by some health insurance policies (Saharso, 2003). These contradictions regarding what women can and cannot consent to may provide important barriers to people deciding that they genuinely want all forms of FGM to end in their community. Interventionists need to be aware of these arguments in order to respond appropriately. Instead of offering a counter argument, interventionists could ask individuals to question why someone would want to consent to such practices. This approach shifts the focus from why some practices are seen as ok and permitted and others are prohibited, to why one would want to conduct these practices at all. These discussions may be difficult, but it is important that interventionists enter into these discussions rather than avoid them. Not debating these issues could impact on the credibility of the intervention process.

3.4.3 Choice

The findings from the REPLACE project suggests that there has either been a shift in perception of the practice, or there has been a tangible shift in the actual practice of FGM from Type III (Pharaonic circumcision) to FGM Types I and/or II ('sunna circumcision'). Because of a lack of prevalence data, it is difficult to ascertain whether there has been an actual shift in the practice, but, research by Talle (2008) also suggests a shift from FGM Type III to Type I and/or II. Even if this shift in practice is merely perception, i.e. the use of different terminology to refer to the practice or change in beliefs regarding FGM, what is apparent is that individuals who support or are indifferent to the practice of 'sunna circumcision' believe that this is a matter of 'choice'. FGM Type I or II is now considered a 'choice', although a choice made by parents on behalf of their daughters.

The REPLACE findings suggest that this perception of 'choice' has occurred as a result of a supposedly 'deeper understanding' of, or being more educated about, Islam. In discussing this idea of 'choice', many of the REPLACE participants made reference to other individuals, rather than specifically stating that practising 'sunna' is a 'choice' for them. It was described as a 'choice' that people in general have and that parents make on behalf of their daughters.

It is interesting that this notion of 'choice' has arisen in the Sudanese and Somali communities based in the UK and the Netherlands. In order to understand the nature of this perception of 'choice' one has to take account of the wider social, political and economic environmental aspects within which practising communities reside. Within the UK and the Netherlands, great emphasis is placed on individual responsibility and how individuals make 'choices' within their everyday lives. Communities respond to internal and external sources and subsequently continually evolve (Modood 2008), Therefore, this perception of 'choice' regarding 'sunna' type of FGM, may be in response to the wider social environments within which communities reside and to arguments regarding the dangers of more severe forms of FGM.

On the one hand this can be seen as a positive idea, in that it allows for the possibility that parents will choose **not** to have their daughter(s) cut. However, REPLACE see this as problematic, in that the notion of 'choice', is itself viewed as a positive thing. The practising community members also appear to view less severe forms of cutting, as a good thing, especially in relation to their religious beliefs. Consequently, those who make a 'choice' to be cut or have their daughter cut are viewed as even more committed to Islam or even more honourable because they 'chose' the action voluntarily and did not have to do it (see Section 3.2.5 above). In other words, with the practice becoming a 'choice' may work to encourage its continuation rather than offer routes to abandonment.

Taking action

Community members are likely to talk about consent and choice. As with other counter-arguments people may bring up when discussing FGM, we suggest that interventionists should be knowledgeable about the issue, and willing to engage and discuss it. By discussing these issues, interventionists will learn more themselves about beliefs people hold that may be barriers to change. This will provide insights into beliefs that need to change in order for behaviour to change. When you know what the beliefs are then you are better placed to think about messages and strategies that will target those beliefs.

3.4.4 Religious Freedom Vs Human Rights

One of the questions we explored as part of the REPLACE project was whether participants considered FGM to be a human rights issue. Interestingly, almost all the Dutch participants expressed the view that FGM was a human rights (including child rights) issue. However, it is unclear as to whether they believed all forms of FGM are a human rights issue, or if this only applies to FGM Type III (Pharaonic circumcision).

Some individuals categorically stated that Pharaonic circumcision is a human rights issue, whilst for others, the ambiguity regarding their use of the terms 'circumcision' or 'female circumcision' makes it difficult to determine what type of FGM they are referring to. Nevertheless, with individuals overwhelmingly disagreeing with Type III circumcision (Pharaonic) due to the health consequences, but commenting that 'sunna circumcision' is not 'that bad' or that there are no health complications associated with this type, then it is possible that only the 'extreme' forms of FGM are considered a human rights issue. If individuals only associate Type III FGM or, what they describe as the 'extreme one', 'bad one' or 'old one', then interventionists will need to discuss how less invasive types of FGM or 'sunna circumcision' are also a human rights and child abuse issue.

With the findings from the REPLACE also suggesting a shift from Type III (Pharaonic circumcision) to Types I and/or II 'sunna circumcision' with the latter form acquiring a more religious justification, could lead to a situation where individuals with practising communities could argue that they have the right to practise their religious beliefs. Coupled with the belief that 'sunna' type of FGM is less harmful and that it is an issue of 'choice' whether they practice it (see Section 3.4.3: Choice), the argument that it is an individuals or communities right to practise their religion will be difficult to challenge. It is particularly problematic to counter this argument when the non-therapeutic circumcision of male minors for religious or cultural purposes can be conducted legally within many EU countries.

Each EU country has different socio-political environments and legal frameworks, which regulate what individuals' and communities' can do in terms of practising their religion. In addition to national political and legal frameworks, there is the European Convention of Human Rights and the UN Declaration of Human Rights, which also play an important role. However, the difficulty interventionists face is addressing those arguments which state that communities have the right to practise FGM as it is part of their religious beliefs. The UK Human Rights Act 1998 states:

“Freedom to manifest one’s religion or beliefs shall be subject only to such limitations as are prescribed by law and are necessary in a democratic society in the interests of public safety, for the protection of public order, health or morals, or for the protection of the rights and freedoms of others” (Article 9, Human Rights Act 1998).

Therefore, individuals' religious beliefs are subject to the “limitations as are prescribed by law” and because FGM is illegal under the UK FGM Act (2003), interventionists could counter this argument of religious freedom by highlighting the UK law regarding FGM.

Taking action

It may be useful to draw on religious and community leaders to help communicate messages about FGM not being required under religious laws, and to promote positive aspects of not performing FGM in-line with the beliefs predominantly held by the community that you have researched and worked to understand.

3.5 Other arguments

Here are examples of other arguments to ending FGM you may come across.

3.5.1 Human Rights

In the last decade or more, activists campaigning against FGM have adopted a human rights based approach (see Section 1 above). Article 5 of the Universal Declaration of Human Rights prohibits torture or inhuman treatment, and many activists have argued that FGM is a form of torture, due to the physical and psychological trauma imposed on the young girl. Campaigners have also highlighted that young girls have no choice as to whether they are circumcised or not and it is the lack of consent, which violates Article 2 of the Convention on the Rights of the Child.

Taking action

As with all arguments against FGM, there are counter-arguments and this is certainly the case with the human rights argument. There are those who argue that the Declaration of Human Rights and the Convention on the Rights of the Child are designed to challenge 'cultural and religious practices'. Community members may challenge human rights arguments with their right to religious freedom. Again rather than continuing to push the human rights argument when it meets with opposition, it may be more helpful to work with the community around the idea that the practice is required by religion, and that the practice is an immovable part of their culture. Cultures change and develop all the time, and this can be seen as a positive and beneficial thing.

3.5.2 Medicalisation

One of the consequences of telling people about the health risks involved in cutting girls and women, is that as well as shifts to less severe forms of FGM, some communities appear to have adopted medicalisation procedures. These include use of sterile equipment, antibiotics and anti-tetanus injections to prevent infection, and the procedure being performed in clinical settings and by medical professionals. (see Section 1 above). Some community members are likely to view this as an appropriate compromise, and it may present a challenging counter-argument to the interventionists who want all forms of FGM to end

Taking action

Part of the issue here is that people who favour medicalisation have clearly not been persuaded that all forms of FGM should end. Again, an understanding of the particular perceived positive consequences that FGM has, and negative consequences perceived for not performing FGM will be essential to developing messages and strategies for change that target appropriate beliefs of those in this position. For example, if the community members tend to believe that 'sunna' is necessary to protect the virginity of girls until they are married, then a strategy you might pursue is promoting the idea that protecting virginity of girls is done much more effectively through other measures. You could suggest that promoting moral values in the family through talking about how important it is to remain a virgin until marriage is better, and by demonstrating all the ways in which this leads to better outcomes for those involved (e.g. happier, more confident daughter who is able to better understand her important cultural heritage).

3.6 Summary and conclusion

In this section we have given you some insight into the findings from the REPLACE focus groups and interviews with members of the Somali and Sudanese communities in the UK and the Netherlands. This has highlighted some of the particular beliefs and barriers to change that people from these community groups hold. Clearly, other types of beliefs and barriers may well be relevant to these and other groups. It is also very likely that, over time, relevant beliefs and barriers change within communities. We hope that you gained an insight into the way people think and feel about the issue of FGM, as well as, how their relative power and control in relation to others is likely to motivate their decision-making and their behaviour in many ways. By identifying these barriers and considering them in terms of behaviour change, we should be better placed to tackle these barriers to ending FGM.

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Section 4: The REPLACE Framework: Behaviour Change Approaches relevant to Ending FGM

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Section 4: The REPLACE Framework: Behaviour Change Approaches Relevant to Ending FGM

Introduction

The WHO 1999 review of anti FGM programmes discussed in Section 1 of this toolkit clearly advocated the adoption of behaviour change approaches to ending FGM. However whilst the report outlined a simple model of stages of behavioural change applicable to individuals outlined in Section 1 (Figure 1.4) they failed to show how this model could be applied to the complex FGM 'mental map' which is reproduced in Section 1 (Figure 1.6). Thus whilst the WHO (1999) report called for the application of behaviour change approaches to ending FGM, the report did not provide detailed information about how this could be done.

A review of the application of behavioural change approaches to FGM in Africa and the Europe was undertaken by Leye in 2005. This showed the limited application of behaviour change approaches to FGM and the lack of agreement as to which approach or approaches were most relevant. This lack of agreement stems from the fact that behavioural change approaches broadly fall into two groups:

Behavioural Change theories which focus on the individual (section 4.1)

Behavioural Change theories which concentrate on the role of society and communities (section 4.2)

FGM does not fit neatly into either of these groupings. As the findings from the REPLACE PAR research clearly show (Section 3), FGM is performed on an individual within the confines of family and community beliefs and norms. Yet, we know community norms can be changed if enough individuals question those norms and adopt a different behaviour, which will in turn become the norm. Figure 5 shows how when enough individuals within a community action behaviour change, then a tipping point will be reached and community norms will change in favour of the change in behaviour. It is thus likely that elements from both individually focussed behaviour change theories and theories that concentrate on the role of society will need to be employed in ending FGM.

Behaviour change approaches go beyond information and education communication and awareness raising. They aim to elicit and support actual behaviour change. We explain the development of ideas about using this approach in work aimed at ending FGM and show how the REPLACE behaviour change framework takes this further. We hope that by explaining this approach and how it can be used to understand and explain FGM, we will provide interventionists with a starting point from which to build better and more effective strategies for helping to bring about change and an end to the practice of FGM.

When the REPLACE project addresses the issue of ending FGM with a behaviour change approach, we are mindful of the fact that ending FGM is a *goal and not a behaviour*. Existing research and theorising in this field seems to have treated FGM as a *behaviour* that requires changing, and this is problematic because it is not a single behaviour. In a society where people are already aware of anti-FGM messages, whether or not FGM is carried out on any given individual is a consequence of potentially a whole series of behaviours, which themselves are the consequences of many thoughts and decisions, by many people and influenced by the wider community. The REPLACE approach aims to get to grips with this reality in its approach.

4.1 Individualistic Theories of Behaviour Change

4.1.1 Introduction

Behaviour change theory that takes an individualistic approach to understanding and explaining behaviour developed in the discipline of Social Psychology throughout the latter part of the 20th century. Much of the work in this field has taken a 'Western' view that where people are in control of their own lives, they engage in rational decision-making processes about behaviours that are within their control. Two types of theory have tended to dominate when thinking about how people change their behaviour; they are theories that focus on describing and measuring the thought processes which precede behaviour; and stage models, which try to describe the change process and represent the change in stages. One such model, the stages of change model (also known as the transtheoretical model) has been considered in relation to the issue of FGM (see Shell-Duncan et al., 2010).

4.1.2 Stages of Change Model

The Stages of Change Model was originally developed to explain smoking cessation (Prochaska & DiClemente, 1982). It proposes that people go through five distinct stages on their journey from not performing to consistently performing a health-relevant behaviour such as giving up smoking. These stages are:

- Precontemplation: the person is not yet thinking about changing their behaviour.
- Contemplation: the person has become aware of and has begun to think about behaviour change.
- Preparation: the person is getting ready to change their behaviour.
- Action: the person has begun to change but has been doing so for a short time period (often cited as 6 months or less)
- Maintenance: the person is said to have been performing the new behaviour successfully for a substantial time period (often cited as 6 months or more).

The model also provides a 'relapse' element to describe the fact that people may go backwards as well as forwards in the journey to permanent behaviour change. In addition, the Stages of Behaviour Change Model draws on wider theoretical ideas regarding behaviour change and proposes that people weigh up the positive and negative aspects of behaviour change and will perceive greater negatives and fewer positives in the early stages compared with fewer negatives and greater positives in the later stages (known as decisional-balance). Self-efficacy (a person's confidence in their ability to do something) is also said to increase as people advance through the stages and the effect of temptation is said to decrease as they progress.

4.1.3 Using the Stages of Change Model to end FGM

Shell-Duncan et al. (2010) used the Stages of Change Model in their evaluation of interventions to end FGM in the Senegambia region of West Africa. Their work involved collecting interview, focus-group and survey data, and led them to identify five stages that describe readiness to change in relation to FGM. However, they report that their data reveals a more complex structure than is proposed in the original 'Stages of Change' model. Consequently, they include two additional dimensions: *preference* and *actual behaviour* in their analysis. The five categories of readiness to change behaviour relating to FGM that they identify are:

1. Supporters of FGM (willing practitioners)
2. Reluctant practitioners of FGM
3. Contemplators (practitioners considering the abandonment of FGM)
4. Reluctant abandoners of FGM
5. Willing abandoners of FGM

The two dimensions of *preference* and *actual behaviour* identified illustrate the fact that decision-making and behaviour relating to FGM are rarely under individual control. Decision-making is often at a family or community level, and certain individuals will have more power and sway in the decision-making process than others. This leads to some individuals having a preference for abandonment, but feel compelled to continue the practice (reluctant practitioners of FGM). Shell-Duncan et al. have identified this as problematic when applying individualistic behaviour change approaches (such as Stages of Change Model) to the issue of FGM.

Shell-Duncan et al. (2010) were also interested in understanding what motivated people to change in relation to the practice of FGM. In order to assess this, they focussed on people's assessments of the positive and negatives of FGM (decisional balance - see above in this section) for girls and others. They found that as people change from supporters to opponents of FGM, the values they place on these positive and negatives changed in-line with the stages as identified above. Interestingly, they found that health risk messages and the acceptance of them, were associated with abandonment of FGM. This had not been expected, because wide-scale use of health risk messages seemed to have been largely ineffective in reducing FGM elsewhere. However, they identified that new information about HIV transmission and risk due to FGM was having an impact, because it could be used as a reason to abandon the practice now, and simultaneously maintain that the elder generations had not been wrong to practice FGM, because HIV/AIDS did not exist when they were circumcised.

A final assessment from a behaviour change perspective within the report by Shell-Duncan et al. (2010) concluded that, whilst the Stages of Change Model had much to commend it when working to end FGM in the Senegambia region, it did not take enough account of community and social aspects. They found FGM in this region was maintained by intergenerational peer pressure to which people were conforming. In short, women felt under pressure from other women to continue the practice of FGM in order that they receive social support from female peers in their community. In particular, the views of the elder female generations were respected in

decisions to perform or undergo FGM. This aspect of the FGM social environment is difficult to take into account in an individualistic behaviour change approach.

4.1.4 Conclusion

The Shell-Duncan et al. (2010) report represents an important contribution to understanding how behaviour change approaches might be relevant to ending FGM. The findings show that elements from some individualistic behaviour change theories do reflect the mechanisms by which change occurs or does not occur, and important characteristics specific to the population of Senegambia have been identified. It shows the complex nature of ending FGM, due to links between individuals, families and the wider practising community. It clearly demonstrates that individual motivations to change behaviour are affected by community beliefs and norms and the balance of benefits and costs of performing the change in behaviour. Thus individualistic theories of behaviour change whilst contributing to ending FGM cannot do so in isolation.

4.2 Socially Based Behavioural Change Theories

4.2.1 Introduction

Behaviour change theories that we describe in this section differ from individualistic approaches and theories because they are concerned with how change in common practice and norms occurs across communities, societies and cultural groups rather than how an individual's thoughts might relate to their own change in behaviour

4.2.2 Social Convention Theory

Social Convention Theory holds that a social convention such as having daughters' (or other female relatives') genitals excised, is carried out because it provides those involved with certain benefits. In the case of FGM, those benefits are likely to be for example, family honour, community acceptance and marriageability of female relatives (leading to further respect/acceptance as well as economic stability).

The theory focuses on the costs and benefits to individuals and their families in changing their behaviour in a way that their community does not accept. The theory concentrates on changing community attitudes to behaviour such as FGM, by changing enough people's behaviour to make the changed practice acceptable. Eventually, so many people will have adopted the new behaviour that a tipping point is achieved and the new practice becomes the norm amongst the community. Thus Social Convention Theory focuses on the individual as a member of a community, who when acting in large enough numbers, can change community convention.

Social Convention Theory suggests that where FGM is concerned, there is little benefit for a single family to abandon FGM, as the family will be ostracised, excluded or even physically harmed by their own community. What is required instead is some form of co-ordinated abandonment, whereby, a 'critical mass' of people/families agree to act together to abandon FGM, so that they can continue to provide each other with the original benefits such as respect, social acceptance and marriage partners. If the initial 'critical mass' of people wish to continue to be part of the original societal group, they must convince more people to join them in abandonment until a 'tipping point' is reached, where it becomes much more socially acceptable to not perform FGM than to perform it. For further information regarding 'tipping points' see Gladwell (2000).

Central to Social Convention Theory is the idea of organisation of the abandonment through communication, and public acknowledgement or declaration so that people feel assured if they stop they will not be alone, and therefore not risk losing the community benefits they achieved through continuing the practice. Evidence from Senegambia suggests that public declarations supporting the ending of the practice of FGM may in fact not be actioned in reality. Or the good intention is soon abandoned and a relapse takes place. One of the criticisms of Social Convention Theory is that social change is deemed to take place if enough people declare they

are in favour of the change, rather than evidence that the behaviour change is happening in reality.

Social Convention Theory treats all members of the community as equally important in the change process, whereas in reality it is clear that some individuals within a community are more influential in affecting behaviour change than others. Thus targeting influential individuals or groups may be an effective way to achieve behavioural change.

Interestingly, Shell-Duncan et al. (2010) argue that Social Convention approaches (social or group based approaches) have an advantage over individualistic approaches, because consideration is given to “individual decision makers in their social context and recognizes decision making as contingent on actions of others” (p65). However Social Convention Theory provides little in explaining how change occurs. Furthermore, Social Convention Theory fails to address the nuanced behaviour of individuals.

Social Convention Theory has been used in parts of Africa by the NGO Tostan as the underlying theoretical basis of their work in ending FGM. For further details please see PRB, 2001; Melching, 2004 and Mackie and LeJeune 2009. However whilst Social Convention Theory may well be relevant to FGM practising communities in Africa, there is some debate as to the relevance of this approach to FGM practising communities in the EU, where the role of society and communities are very different, and where the expectation is that individuals have agency and can take control of their own decisions and actions. (See Section 3.4.3. ‘Choice’ for more information). Also conversely, rather than wishing to conform to social norms in their new homes, people from FGM practising communities in the EU may well regard FGM as a way of retaining their ethnic identity and support the practice on the grounds of cultural and religious identity (Johansen 2007).

4.2.3 Diffusion of Innovation Theory

Diffusion Theory proposes that an innovation (such as the abandonment of FGM) is communicated over time through members of a social system, and that it involves a series of five 'stages' (Rogers, 1995). The first stage, 'knowledge' involves members of the social system being made aware of the innovation, and gaining some understanding of what it involves. The second stage, 'persuasion' is where decision-makers decide whether or not they find the innovation favourable or unfavourable. Following this, a 'decision' is made by the decision maker(s) about whether to reject or adopt the innovation. The fourth stage involves the 'implementation' of the innovation and the fifth, 'confirmation' involves decision makers seeking reinforcement of their choice, which may lead to eventual rejection if dissatisfaction or conflict over the innovation are present.

Similarly to Social Convention Theory (see above), a key concept within Diffusion Theory is that the decision of one member of a social system depends on the choices of others, namely that an individual is a member of a wider community and there is interaction between both. This idea is however expanded on by identifying

that different people have different characteristics that make them more or less likely to engage with an innovation and proceed through the five stages towards implementation and confirmation. Scholars of Diffusion Theory have proposed that some people, who are perhaps on average, less averse to risk than others, may become 'innovators' as they suspect that the innovation will have benefits. As 'innovators' reach the implementation and confirmation stages, they will begin to affect 'early adopters' who will also become persuaded. It is suggested that important opinion leaders are often part of the 'early adopter' category of people and their influence persuades others known as the 'early majority' and 'late majority' to begin to change. An example of an 'opinion leader' could be a community leader, religious figure or another individual that is influential within the community. In addition to the influential people within the community, ideas are also more likely to be adopted if individuals can personally identify with the person adopting or promoting the new idea. Rogers (1995) suggested that a person is more likely to listen and adopt a new idea if it is promoted by an individual who occupies a similar social position, i.e. are the same age, gender and share similar political, religious and cultural views. New ideas and ways of doing things are often diffused amongst peers. It is here that the 'tipping point' , often talked about in relation to social change, is said to occur and change in favour of the innovation happens much more rapidly. Finally, only one group of people, 'laggards' are left to adopt the innovation. They will follow much more slowly, as they are likely to be isolated from knowledge compared with others or hold very traditional views. The argument here is that individuals are more likely to listen and mimic people they respect or relate to than cultural outsiders or people perceived to be different or to have a different status.

4.2.4 Conclusion

Social Convention Theory and other socially based behaviour change theories such as Diffusion Theory provide very useful and evidence-based frameworks for understanding the way in which a social norm or convention may become embedded as a practice within a cultural group, and how a new idea or innovation may spread through a societal or cultural group. They do not however, provide insight into how you begin to develop a 'critical mass' of people who may be willing to change or how those first 'innovators' become persuaded to change. Also, these theories provide no insight into what messages or what types of intervention strategies will be most effective in starting change. There is also a lack of insight into the barriers to diffusion or change that might be encountered with an innovation such as abandoning the practice of FGM.

REPLACE believe that combining individualistic approaches to behaviour change within a broader framework that encompasses socially-based change approaches may offer a more useful approach to eliminating FGM.

4.3 The REPLACE Framework to Ending FGM

4.3.1 Introduction

REPLACE recognises that the practice of FGM occurs within a wider socio-cultural context and the behaviours and decisions of others are critical in relation to the outcome of whether or not FGM is carried out. We also understand that some individuals are in less powerful positions than others and therefore are unable to implement certain behaviours that will lead to the abandonment of FGM.

The REPLACE behaviour change approach to ending FGM uses a range of individualistic and socially-based models and theories designed to account for the likelihood of behavioural action from individuals, but REPLACE applies them to the issue of FGM which involves individual, family and community pressures.

REPLACE aims to go beyond assessing the positive and negative aspects of FGM and 'Stages of Change' by applying behaviour change theories to FGM practising communities and in particular to influential people in those communities, who are role models to others and who may become diffusers of behaviour change.

The REPLACE Framework is a cyclic model based on a combination of individualistic and socially-based behaviour change models, which describes how a community is influenced by the behaviour change of influential individuals. It is a cyclic model as it recognises that in order to achieve the goal of ending FGM, a number of cycles of behaviour change will need to take place within the community.

4.3.2 The REPLACE cyclic model of behaviour change (Figure 7)

The REPLACE cyclic model comprises four elements that represent the flow of motivation and behaviour change we are aiming for in relation to achieving the goal of ending FGM in a given practising community.

In some ways it is similar to the societal/cultural models of change outlined in section 4.2 above in that it illustrates how already motivated people may motivate others to abandon FGM, who in turn, will motivate others, such as is described by Social Convention Theory. The difference, as we will explain, is that this framework allows for individual-focused behaviour change theory to be incorporated into the framework, by targeting influential individuals and groups of individuals within FGM practising communities in the EU.

Element 1: Motivating People

In **element 1** of the cyclic model the role of the interventionist is to engage with members of the FGM practicing community, and, with an understanding of the specific context and assuming awareness levels about anti-FGM messages are

already high, work to motivate people, particularly influential and respected people, including men and community leaders, to want to act to end FGM in their community.

Element 2: Identify Actions to Implement Motivation

In **element 2** of the cyclic model, the role of the interventionist is to help the influential and motivated people identify the actions or behaviours that they need to perform, in order that they act in-line with their overall motivation to end FGM. The specific behaviours and actions will differ dependent on the particular person. For example, an Imam or other community leader could decide to talk to their community group or mosque attendees about their belief that FGM should end and why. An elderly female could talk to other elderly females in her community about her belief that FGM should end. This could be as a result of personal experience, a death from FGM or conviction as a result of a motivation to stop the practice. Even community members with less influence in their community can decide on actions they can take. The list of actions that demonstrate and work towards ending FGM is potentially endless, and an activity that community groups can engage in together is establishing a list of the different behaviours and actions that lead to FGM taking place (or not taking place).

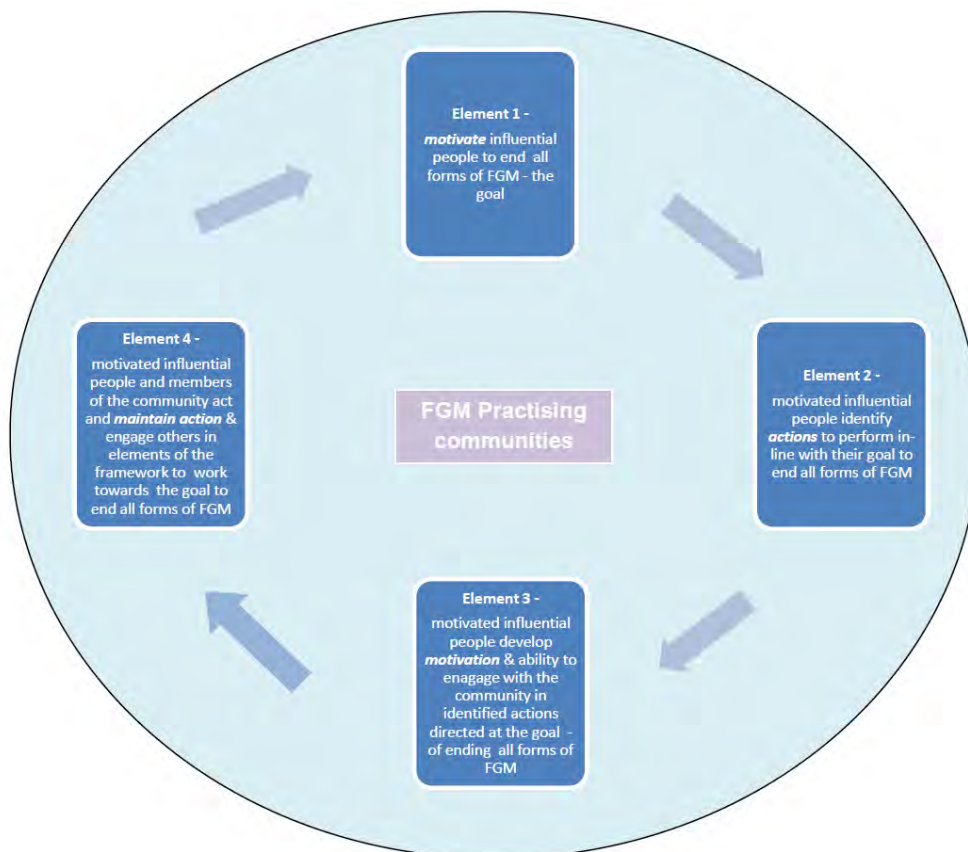


Figure 7 The REPLACE Framework: Ending FGM through a Behaviour Change Approach

Element 3: Take the Identified Action

In **element 3** of the cyclic model, the identified behaviours from element 2 must be considered, and interventionists must work to help people achieve them. Specific detail is again provided in section 4.3.3 in relation to this, but in basic terms, for people who are motivated to end FGM, there may be barriers, both perceived and real, to performing the identified behaviours/actions.

Element 4: Maintaining the Action

People will reach **element 4** when they have overcome and addressed barriers to their identified actions and are acting and maintaining action in-line with their belief that FGM should end. When enough people reach element 4 then the social beliefs and norms concerning FGM will change and the goal of ending FGM will have been achieved.

As people move through the elements they will engage with others in their community and others should also become motivated and enter the framework - with of course, the guidance of those using this approach.

Interventionists should be aware that changes in behaviour might only go some way towards achieving the goal of ending FGM. Evidence from the REPLACE research showed that the communities with which we worked had largely abandoned FGM Type III in favour of 'sunna' types of FGM, so the cycle will need to be revisited to tackle 'sunna'. It is a cycle. It is possible that communities may take very small steps in behaviour change meaning several cycles will have to be performed before the goal of ending FGM is achieved.

Each element of the model links to behaviour change concepts. These are summarised in Table 6 below. The interventionist needs to be aware of not only the elements of the cyclic model but also the behaviour change concepts which are associated with each element and thus facilitate movement of a community between the elements.

Table 6 An Illustration of Behaviour Change Concepts that Relate to the Elements in the REPLACE Cyclic Model

REPLACE cyclical framework elements	What needs to happen	Examples and further explanations
<p>Element 1</p> <p>Here, interventionists work to MOTIVATE people (from practising communities) to want all forms of FGM to end.</p> <p>This is about motivation towards the GOAL of ending FGM and not behaviour change.</p>	<p>Things that affect people's motivation need to be addressed, these are:</p> <ol style="list-style-type: none"> 1. People's beliefs about the good and bad things that are a consequence of FGM continuing in their community. 2. People's beliefs about how much power they have over FGM ending in their community. 3. People's beliefs about what other people do, and what they think other people think they should do, and what it is right to do. 	<ol style="list-style-type: none"> 1. You might find that people think performing some types of FGM within the community (e.g. Sunna type) is a good thing because it brings positive consequences such as cultural identity, marriageability and honour to those who have had it done and avoids many of the negative health consequences. Strategies for behaviour change need to identify what positive beliefs about FGM exist and work to change those (e.g. work to convince people that cultural identity can be achieved in other, better ways, or work to make them feel that family honour can be established in other ways). Beliefs about negative consequences should also be enhanced, but based on an understanding of what those beliefs are and which forms of FGM are prevalent. There is no point in talking about horrific negative health consequences to people who only perform minor cuts to the clitoris. When people view FGM in their community as having largely negative consequences that outweigh any positive outcomes they will feel more motivated. 2. Some people lack power over decision-making relating to FGM, and may feel that they have no power to change things on this issue. Helping people to identify the things that they can do (see element 2 below) and working to make them feel more empowered will help. Interventions should also target people who are actually in more powerful community positions and getting them to want all forms of FGM to end is important. 3. People will be influenced to become motivated on this issue by other people, and helping them to see that other people want FGM to end, and other people approve of the idea that all forms of FGM should end in their community is important. To be motivated about this people have to truly believe others want this to end as well.

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<p>Element 2</p> <p>Here, motivated people need to identify behaviours/actions that they can perform that will lead to the goal of ending all forms of FGM</p>	<p>To begin the process of change, community members who are motivated to want FGM to end in their community must think about and share ideas about all the different behaviours they can perform, or all the actions they can carry out which will help lead to the goal of ending all forms of FGM.</p>	<p>An interventionist can help people to identify the things they could do and help them begin to think about how and when they will do them.</p> <p>Some suggested actions are provided below:</p> <ul style="list-style-type: none"> • Talk openly to family members about opposition to FGM, including milder forms • Start or join a community group who are open about and/or campaign against all forms of FGM • Talk at community gatherings about opposition to all forms of FGM • Refuse to have own daughters subjected to any form of FGM • Act in some way to prevent daughters or other family members being taken to another country to have any form of FGM done • Openly tell other people that own daughters have not and will not have FGM done <p>These are just some suggestions and there are no 'right' or 'wrong' behaviours if they are genuinely targeted at working towards ending all forms of FGM and they come from within the community. There may be many much smaller scale behaviours that people could perform as well. The role of an interventionist is to help motivated and, particularly motivated influential people, to identify what these behaviours are.</p> <p>There may be a particular order in which behaviours need to be performed too. So members of the community may identify many behaviours, and some of which may not be possible until others have been put into place. This element may require a lot of time and thought, and may need re-visiting often. Are there any more things that people could do that hadn't been thought of before and so on?!</p>
<p>Element 3</p> <p>Here, motivated people need help to begin to perform identified behaviours/actions from element 2</p>	<p>Once behaviours and actions that people can carry out have been identified, things that affect their motivation to carry out these actions need to be addressed. These are:</p> <ol style="list-style-type: none"> 1. People's beliefs about the good and bad things 	<p>So the same motivating factors identified in element 1 are important but now we are talking about the motivating factors that relate to identified action(s) (from element 2). As an example let's take one behaviour from the suggestions in element 2.</p> <ul style="list-style-type: none"> • Openly tell other people that own daughters have not and will not have FGM done <ol style="list-style-type: none"> 1. If you were planning on carrying out this behaviour you might hold positive and negative beliefs about the consequences of doing it. E.g. others will shun me and my family (negative) or others may feel they can abandon the practice too (positive). Whatever the action, people need help to feel that the positives of the behaviour outweigh any negatives. Identifying all the positive and negative perceptions about

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	<p>that are consequences of carrying out identified actions.</p> <ol style="list-style-type: none"> 2. People’s beliefs about how much power they have over performing identified actions. 3. People’s beliefs about what other people do, and what they think other people think they should do, and what it is right to do. 	<p>consequences may be needed (could be done in group work) and ideas about how to address them need to be thought up and implemented.</p> <ol style="list-style-type: none"> 2. People may perceive difficulties or barriers in telling other people this, and need help to overcome those barriers. If there are genuine barriers that cannot be overcome, then other actions or behaviours may need to be performed first before this action becomes possible. 3. People will feel more motivated to tell other people this if they think important others like them would approve of them doing it and if they think other people like them would do the same thing and if they think it’s right to do so. People may need support in developing feelings about the acceptability of telling people something of this nature.
<p>Element 4</p> <p>Here, motivated people need support in maintaining the behaviours/actions from element 3 and will influence others through their actions</p>	<p>Once people have become motivated to engage in actions identified and perhaps started performing those actions they need further support to maintain action.</p> <p>Maintained action once achieved will engage others from the community in the cyclic process.</p>	<p>Just because a person is motivated does not mean that they stay motivated and carry out the action identified without problems or issues.</p> <ul style="list-style-type: none"> • Motivation can change – interventionists need to help people to stay motivated • People may fail to recognise opportunities to act – interventionist can help people identify good opportunities • People can forget to act – planning carefully how and when to act will help here • People may lack skills and confidence to act – interventionists can work to enhance skills required and build people’s confidence.

The REPLACE Framework describes the individual beliefs and perceptions that may need to be considered in putting the cyclical framework for ending FGM into practice. The beliefs and perceptions described can be identified amongst individuals in relation to FGM generally and the goal of ending FGM (relevant at element 1). Critically, they can also be thought of as relating to the smaller behaviours identified as relevant to achieving the goal of ending FGM (e.g. talking openly about wanting it to end; relevant at elements 2, 3 and 4).

4.4 Conclusion

The REPLACE Framework for ending FGM combines relevant aspects of both individualistic and socially-based behaviour change theories to present a framework that can be used to help interventionists wishing to work with practising communities to end FGM. It is very generalised, as it must be, to ensure that the framework can be used with communities that are very different. Its use is predicated on the interventionist having a sound knowledge of the barriers and communication networks concerning FGM in the community in which they are working. This can be most effectively achieved using PAR methods as described in Sections 2 and 3 of this toolkit. Thus the REPLACE framework for ending FGM will be constantly refined following PAR work with the community. PAR research with FGM practising communities and the REPLACE Framework for ending FGM go hand-in-hand and are cyclic in nature.

This section of the toolkit has demonstrated the way in which individualistic and socially-based behaviour change approaches can be combined to understand the thinking and actions of community members, and in particular influential individuals within these communities who contribute to practising or abandoning FGM. We hope this forms the beginning of a new way of thinking about devising and implementing interventionist programmes with FGM practising communities with the goal of ending FGM.

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Section 5: Putting the REPLACE Framework into action

Section 5: Putting the REPLACE Framework into Action

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5.1 Introduction

This section of the toolkit is designed to help those of you working with FGM practising communities to implement the REPLACE Framework described in Section 4 of this toolkit. It is designed in such a way that it can be adapted to different FGM practising communities and interventionists can enter the process at any stage of the process outlined below, depending on how far a community's behaviour has changed. The process of behaviour change might become a staggered process. For example, interventionists might decide to focus on a group of influential people first, and then follow this with a programme aimed at other less influential members of the community. It should be noted that this is a pilot toolkit [1] and has not yet been trialled with an FGM practising community. The REPLACE team therefore appreciate any feedback and comments on how this toolkit can be improved.

5.1.1 Stages in the Implementation of the REPLACE Framework

The implementation of the REPLACE Framework described in Section 4 of this toolkit can be implemented in a number of discreet stages as described below.

5.1.2 Stage 1. Understanding the Community with which you are Working

Conducting PAR research with your communities and gathering evidence about the genuine beliefs held by people concerning FGM and the barriers they face to change is essential if you want to implement the REPLACE Framework. It is important to be informed about the nuances and particular issues that affect the community. See Section 2 of this toolkit.

This is also a great opportunity to start to engage with community elders, religious leaders and others who have status and the power to facilitate change. At this stage it is important to be very open and not to make judgements or change anything – listen and try to understand.

Getting to grips with what terminology people use is also critical. Knowing what they mean when certain terms are used is very important too. See Section 3 of this toolkit.

Identify who will be targeted with messages and interventions. You need to consider who is important to target and not just who it is easy to access. One way of doing this is to use information collected through PAR data. See Section 3 of this toolkit. Figure 8 is an example of how this might be done. The figure focuses on the communication networks within Somali families and what external influences might impact on the family.

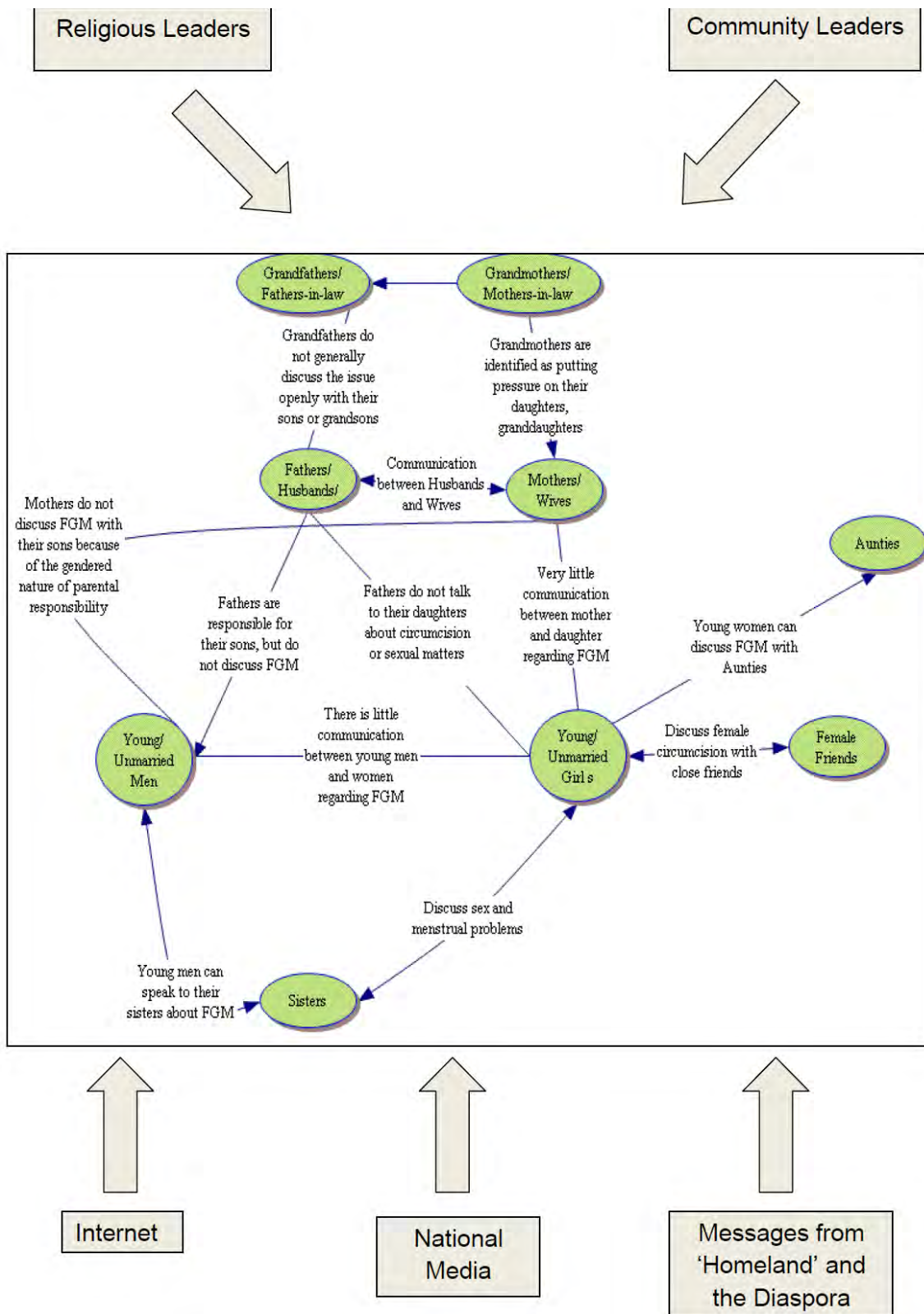


Figure 8 Communication Networks within Somali Families and External Influences

5.1.3 Stage 2. Motivating People to End FGM

From the PAR findings, identify particular beliefs that align with the behaviour change approach (see table 4.1 above) about FGM and use them to help design messages targeted appropriately for the audience. This aligns with **element 1** of the REPLACE framework cyclic model (Figure 7). What you want to achieve is to motivate people to want all forms of FGM to end in their community (i.e. motivate them to want the same goal as you). This is much easier said than done. This is particularly problematic when individuals publically state that they want FGM to end, but privately subscribe to the practice. Therefore, interventionists should not assume that declarations condemning the practice are indicative of a change in behaviour and motivation. Motivating individuals and communities to consider the possibility of not performing FGM will be difficult and time consuming. Individuals will need continual support during this stage.

5.1.4 Stage 3. Identifying the Behaviours People can Adopt to End FGM

When people have become motivated to ending all forms of FGM, then, the groups for whom this has happened should be targeted with **element 2** of the REPLACE framework cyclic model. These people should be helped to identify the behaviours they can perform which will lead to FGM ending. As discussed in Section 4 of the toolkit, these will be many and varied, and will vary dependent on each individual and their context and relationships. This process will be continuous because as change happens and behaviour changes, new behaviours may become appropriate.

Identified behaviours from this stage can then be fed into the REPLACE Framework. The focus for the interventionist is to then help motivate people to perform these behaviours. This may involve changing perceptions about the consequences of performing the behaviour identified, or perceptions about what other similar people do in respect of that behaviour. It may involve helping people feel more confident or helping them to overcome barriers to performing the action.

5.1.5 Stage 4. Undertake Behaviours to End FGM

As people start to perform a behaviour or behaviours in-line with their belief that all forms of FGM should end (**element 3 of the REPLACE Framework cyclic model**), they may need further support maintaining their motivation, planning exactly how, when or where they will act, and recognising opportunities to act.

5.1.6 Stage 5. Sustaining Behaviours to End FGM Leading to Community

Tipping point

As motivated people continue to act out the identified behaviours they will reach **element 4 of the REPLACE Framework cyclic model** and through the process of getting to this stage they should be reaching others and helping them become motivated towards ending all forms of FGM. The cycle will continue.

5.1.7 Conclusion

The main point to take away here is that the REPLACE framework cyclic model should provide you with the structure to think about how best to target the work being done to end FGM. The behaviour change concepts (see table 4.1) that map onto the REPLACE framework elements should provide targets for the actual content of the messages designed, but these should be firmly based in a knowledge and understanding of the issues particular to the community or communities working with you.

5.2 Having Clear Messages

It is important that when implementing the REPLACE Framework that the messages and programmes that are implemented are clearly targeted at the community or members of the community with whom you are working as well as to a particular element of the REPLACE Framework cyclic model. It is also important to ensure that the behavioural concepts associated with each element (see Table 4.1) are the focus of the intervention. Mixed messages which are not focussed on a target group are not likely to be effective. It is important that you constantly appraise your intervention materials against the REPLACE Framework. One way is to do a behaviour change content analysis of the materials you are using (see Appendix 7 for an explanation of how this can be done). An illustration is provided below.

5.2.1 Behaviour Change Content Analysis of Two Anti-FGM Leaflets

In this section we provide reproductions of two leaflets used by organisations who aim to end FGM, and explain what the content is addressing from a behaviour change perspective.

Before we look at the leaflets we need you to think about the behaviour change concepts which affect people's motivation, that were identified in table 4.1 above. These were:

4. People's beliefs about the good and bad things that are a consequence of FGM continuing in their community, or a consequence of performing an action that may lead to the goal of ending FGM.
5. People's beliefs about how much power they have over FGM ending in their community or how much power they have to carry out actions that will lead to FGM ending in their community.
6. People's beliefs about what other people do, and what they think other people think they should do, and what it is right to do (either regarding FGM ending or regarding actions that may lead to FGM ending).

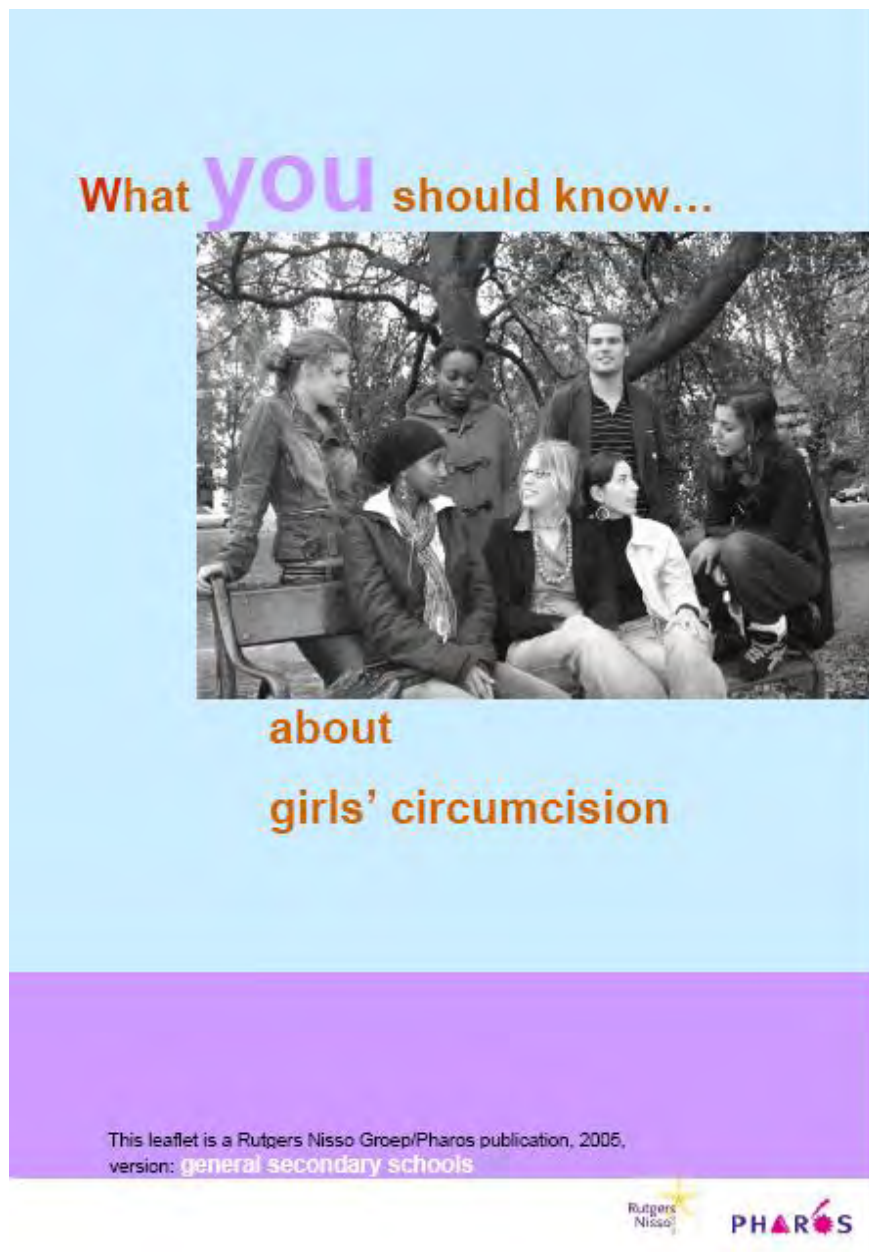
Bearing these things in mind, below is a list of techniques that research has identified as commonly used behaviour change techniques, that could be relevant to the issue of FGM. We show how the techniques listed below might help address the

three major concepts (listed above) associated with people's motivation to change by numbering them 1, 2 or 3 to match.

- **Information about health outcomes relating to FGM [1]**
- **Information about legal outcomes relating to FGM [1]**
- **Information about psychological consequences of FGM [1]**
- **Information about human rights and FGM [1]**
- Information about the advantages of NOT performing FGM [1]
- Information about the disadvantages of performing FGM [1]
- **Information about others' disapproval of FGM [3]**
- Information about others' approval of NOT performing FGM [3]
- Prompting people to form intentions to take action
- **Identification of barriers to change and suggestions of possible solutions [2]**
- **Provide instruction on how to act**
- Modelling of behaviour - show people how to perform an action [2]
- Social comparison - show a non-expert other person performing a relevant behaviour relevant to ending FGM
- Identify people as role models themselves - suggest how they could help others to change
- Empowerment messages - making people feel that they have power and control [2]

The **bold** techniques above can be found in the leaflets below – we've annotated the leaflets to flag up what some of the messages seem to be targeting in relation to behaviour change. These are simple messages in a leaflet so it is unlikely they would ever be enough to actually change people's behaviour, they might help at element 1 of the REPLACE cyclic framework though, when you are working to motivate people to want all forms of FGM to change.

The first leaflet is part of the Prevention Girls' Circumcision (FGM)' teaching toolkit of Rutgers WPF (formerly Rutgers Nisso Groep) and Pharos, the Netherlands. We should make it clear that the leaflet was developed for use in secondary schools or other similar settings for (sexuality) education concerning FGM. The authors ask that anyone using this leaflet in their work does not distribute it or put it on show without discussing its content with those who see it.



The front page of this leaflet provides information about the source of the messages within Rutgers WPF (formerly Rutgers Nisso Groep) and Pharos, Dutch health organisations that are both involved in policies on and campaigning against FGM. It also gives information about the target audience. In this case it is young people/teenagers. These may of course include young people from communities with a tradition of circumcision/FGM. The title of the leaflet also tells us something about the aims of the leaflet; it clearly sets out to provide knowledge/information. It is not aimed at eliciting behaviour change.

Figure 9 Dutch Leaflet (Source: Rutgers Nisso Groep/Pharos 2005).

Health consequences are outlined - this could address **perceived consequences** from a behaviour change perspective

Fact giving about FGM

Female circumcision

Female circumcision is a tradition that is still carried out in many countries in Africa and a few countries in Asia. Most girls are circumcised before they have their first period. Circumcision is an important ritual; once a girl has been circumcised, she really belongs!

How is it done?

There are many different types of circumcision. Here are the four most important types:

- A small cut or hole in the clitoris, the little, sensitive bump at the top of the inner labia.
- Removal of the clitoris. This type is the most common: *picture 1*
- Removal of the clitoris and all or part of the inner labia: *picture 2*
- Removal of the clitoris, the inner labia and all or part of the outer labia. After sewing together what's left of the outer labia, only a very small opening is left for menstrual blood and urine:



Why are girls circumcised?

Parents have their daughter circumcised because they want the best for her and want to give her a good future. In the countries where circumcision occurs, it is traditional that girls remain virgins until their wedding night. Parents think that female circumcision protects their daughter's virginity and that this will give her a better chance of marrying a good man. Many parents also think that Islam requires girls to be circumcised, but nothing can be found in the Koran (the holy book of the Islamic religion) about this. There are also Christians who carry out female circumcision.

What are the consequences?

Girls' circumcision causes **health problems**.

This may lead to:

- Soon after circumcision:
 - Pain, blood loss and infections. If something goes wrong, a girl could become seriously ill.
- Later:
 - Period pains
 - Problems with and/or pain when urinating
 - Regular stomach aches
 - Pain on the wedding night
 - A difficult birth or even infertility
 - Girls who have been circumcised may be anxious and downcast

Here there is reference to psychological consequences

Female circumcision in the Netherlands

Female circumcision didn't used to occur in the Netherlands. Nowadays there are many circumcised girls and women from other countries living in the Netherlands. Some parents also take their daughter on holiday to have her circumcised somewhere else.

Legal consequences

Circumcising girls is banned in the Netherlands and many other countries

Female circumcision is now illegal in many countries where it was traditionally carried out and there is more and more resistance to it. Female circumcision violates **human rights**, the rights of women and children in particular. Many parents in the Netherlands do know this and don't have their daughters circumcised any more. That is often a very difficult decision because it is such an old tradition in many countries. Parents and young people can talk about it at information meetings on female circumcision.

Conflicting opinions

Female circumcision is also called female genital mutilation (FGM), but many people prefer to use the term female circumcision. If you come from a country where female circumcision is a tradition and many women are circumcised, then you don't always see circumcision as mutilation or something negative. A negative opinion of female circumcision may then clash with the beliefs that you grew up with. This could lead to confusing emotions, uncertainty and a girl feeling ashamed of her own body. On the other hand, it is often difficult for Dutch young people to understand why girls are circumcised.

Fact giving about FGM: amongst other things some reasons for its continued practice are explained both here and in the first paragraph above.

Physical description of FGM

Human rights information

Barrier identification - it's not easy to change

The potential **disapproval of others** is mentioned twice. This is referred to only briefly because it is a leaflet, but could be important to behaviour change

Within the last paragraph on this side of the page, the statement about circumcision not being in the Koran could be seen as a way to address perceived **consequences of performing FGM** - some think their religion requires it!

What can you do?

- Read about it
- Talk about it at school, with your friends, at the community centre and with your parents
- Try not to judge other people before you know how they feel
- Be part of the fight against female circumcision! Go to www.nogame.nl

Questions?

There are several people and organisations who can help you or answer your questions:

- **Your form teacher or counsellor**
- **The GGD, Municipal Health Services, Youth Health Care**
Department: They will keep everything strictly confidential. Find your nearest GGD by going to www.ggd.nl and clicking on your area. You can also phone them. Ask your form teacher or counsellor for the telephone number of the GGD doctor or nurse for your school or find their main telephone number in your local council guide or telephone directory.
- **The children's helpline.** They can also answer your questions about girls' circumcision. Phone calls are free on 0800-0432 (daily from 2 to 8 p.m.).
- The website www.meisjesbesnijdenis.nl (meisjesbesnijdenis = girls' circumcision) is full of information on the circumcision of girls and you can send an e-mail with your questions. So make sure you go there if you want to know more!



This last page of the leaflet focuses on **giving instruction.**

This is quite important in behaviour change approaches, because you can't leave people's knowledge and awareness raised, possibly having changed or added to their beliefs and perceptions, without giving them some indication of what potential actions they **COULD** perform.

This relates to element 2 of the REPLACE framework where an interventionist should help people identify the actions they can perform if they want to act in-line with a belief that FGM should end.

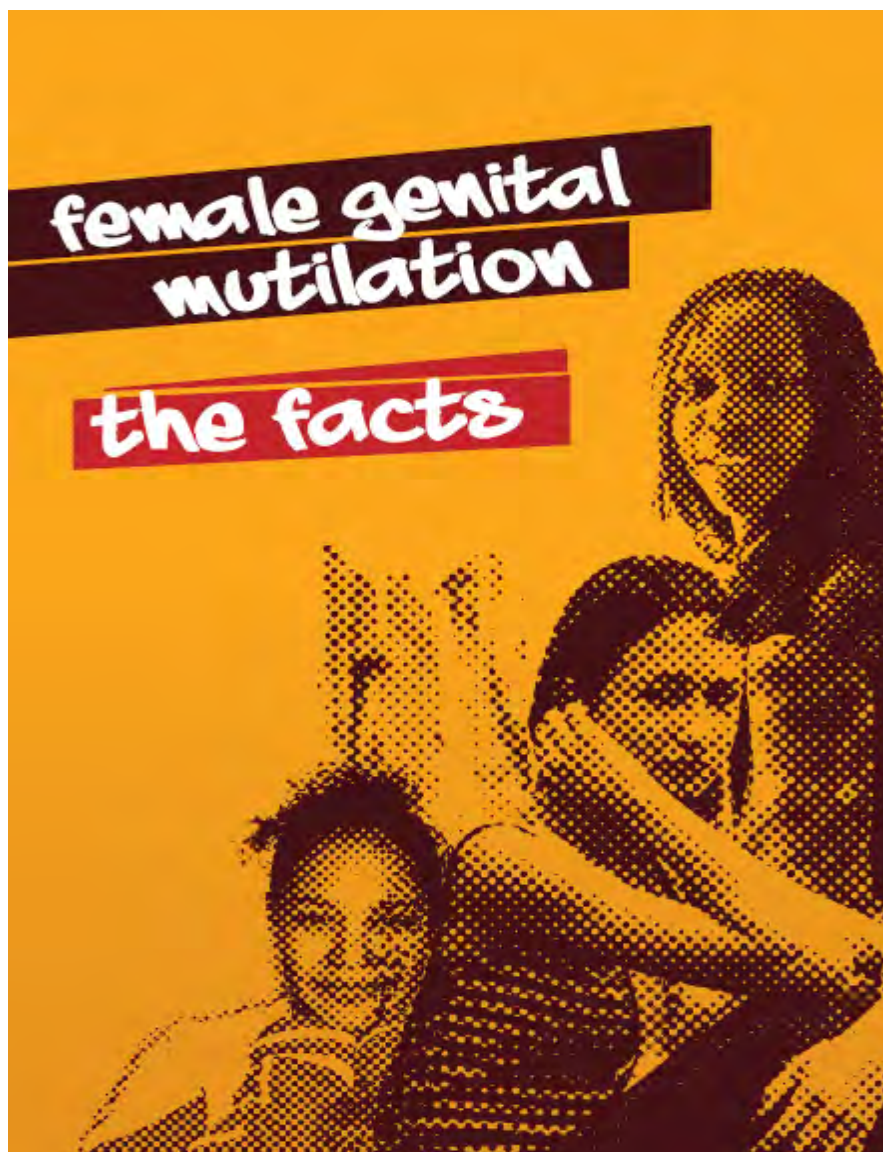


Figure 10 British Leaflet (Source: Foreign and Commonwealth Office, Home Office, Department of Health and Department for Children. United Kingdom)

This British example of an anti-FGM campaign leaflet sets out similar aims regarding information provision as the Dutch example.

No other information is provided on the front cover but the back cover (shown below) informs us that this has been produced by several UK Government offices.

The target audience is suggested through the pictures of young women and girls.

Over the following pages, we indicate some of the further message content and techniques relevant to behaviour change, but this is not an exhaustive identification because of the length of the leaflet and amount of content.

**female genital mutilation
is a violation of human rights**

Female Genital Mutilation comprises all procedures involving the partial or total removal of the external female genitalia or any other injury to the female genital organs for non medical reasons.

There are 4 known types of FGM, ranging from a symbolic prick to the clitoris or prepuce to the fairly extensive removal and narrowing of the vagina opening. All these forms of FGM have been found in the UK.

FGM is sometimes known as 'female genital cutting' or female circumcision. Communities tend to use local names for referring to this practice, including 'sunna'.

FGM is considered a grave violation of the rights of girls and women.

The first page gives facts about FGM and proclaims it as a violation of human rights.

The human rights message is often used as part of anti-FGM campaigns.

It is always important to consider the audience and the context when delivering specific messages like this.

If an audience is not ready to hear or take on board a particular message, it can have a very different effect from the one anticipated.

fgm affects girls and women in the uk

The World Health Organisation estimates that 3 million girls undergo some form of the procedure every year. It is practiced in 28 countries in Africa and some in the Middle East and Asia. FGM is also found in the UK amongst members of migrant communities. It is estimated that up to 24,000 girls in the UK, under the age of 15 are at risk of FGM.¹

UK communities that are most at risk of FGM include Kenyans, Somalis, Sudanese, Sierra Leoneans, Egyptians, Nigerians and Eritreans. Non African countries that practise FGM include Yemeni, Afghani, Kurdish, Indonesian and Pakistani.

¹ Dorkenoo et al. 2007.
Available from FORWARD UK.

fgm is illegal in the uk

The Female Genital Mutilation Act of 2003:

- ★ makes it **illegal** to practice FGM in the UK
- ★ makes it **illegal** to take girls who are British nationals or permanent residents of the UK abroad for FGM whether or not it is lawful in that country
- ★ makes it **illegal** to aid, abet, counsel or procure the carrying out of FGM abroad
- ★ has a penalty of up to **14 years in prison** and/or a fine.

These pages provide further factual information and deliver messages about the legal consequences of behaviours relevant to FGM.

It is of course important that people know about the law and FGM.

If people have **perceptions** though that the law is not acted upon or enforced, they may not see this as a real **threat or risk** in relation to having FGM performed.

On this page information about why the practice continues is provided, but when people tell you these things themselves, they may represent the **perceived consequences** they have about performing FGM.

fgm is child abuse

Usually it is a girl's parents or her extended family who are responsible for arranging FGM. Some of the reasons given for the continued practice of FGM include; protecting family honour, preserving tradition, ensuring a woman's chastity, cleanliness and as a preparation for marriage.

Whilst FGM is often seen as an act of love, rather than cruelty, it causes significant harm and constitutes physical and emotional abuse. **FGM is considered to be child abuse in the UK** and is a violation of the child's right to life, their bodily integrity as well as of their right to health.

More information about human rights and FGM.

fgm can kill

★ FGM can have serious consequences for a woman's health and in some instances can lead to death.

Infections, severe pain, bleeding and tetanus are just some of the short term consequences.

In the long term women can suffer pain and discomfort during sex, chronic pain, infection, cysts, abscesses, difficulties with periods and fertility problems. Women also often suffer severe psychological trauma, including flashbacks and depression.

Here detail is given about the physical and psychological **consequences** of having had FGM performed on them. It's important to realise that although information is presented as fact, some people may not accept it as such. Some women may have undergone FGM and not had these problems, and this message may not be believed by some.

This addresses more in the way of **perceived consequences** relevant to health

fgm can affect pregnancy and childbirth

Women who have had Female Genital Mutilation (FGM) are significantly more likely to experience difficulties during childbirth and their babies are more likely to die as a result of the practice. Serious complications during childbirth include the need to have a caesarean section, dangerously heavy bleeding after the birth of the baby and prolonged hospitalisation following the birth.²

fgm is not supported by any religious doctrine

Female Genital Mutilation is not a religious requirement or obligation. FGM has no link with Islam and is neither a requirement nor a Sunna in Islam. Globally most Muslims do not practise FGM.

FGM is not condoned by Christian teachings or the bible.

² World Health Organisation 2006

8

The message here about religion is interesting as it addresses **perceptions about consequences** (e.g. Circumcision provides 'sunna' and it targets **descriptive norms** - i.e. most Muslims do not practice FGM).

what are the signs that a girl may be at risk of fgm or has undergone fgm?

Suspicious may arise in a number of ways that a child is being prepared for FGM to take place abroad. These include knowing both that the family belongs to a community in which FGM is practised and is making preparations for the child to take a holiday, arranging vaccinations or planning absence from school. The child may also talk about a special procedure/ceremony that is going to take place.

Indicators that FGM may already have occurred include prolonged absence from school or other activities with noticeable behaviour change on return, possibly with bladder or menstrual problems. Some teachers have described how children find it difficult to sit still and look uncomfortable, or may complain about pain between their legs, or talk of something somebody did to them that they are not allowed to talk about.

This section provides **instruction** about what actions can be performed. It helps people know what actions they could perform if they felt motivated and are able to do so. Refer to element 2 of the REPLACE framework.

9

What to do if you are concerned about someone who is at risk of fgm

- ★ Talk to them about your concerns, but use simple language and straightforward questions.
- ★ Be sensitive and let them know that they can talk to you again.
- ★ Consult a child protection advisor and make a referral to Children's social care.
- ★ Go to www.fco.gov.uk/fgm for more information

What to do if you have had fgm done?

You can seek medical advice and help from specialist health services. There are 15 specialist clinics around the UK and in some of these you can have a reversal procedure.

Go to www.fco.gov.uk/fgm for more information

What to do if you are worried you may be at risk of fgm?

- ★ Talk to someone you trust, maybe a teacher or a school nurse. They are here to help and protect you.
- ★ Remember that no one is allowed to hurt you physically or emotionally and FGM is not allowed in this country.
- ★ You can get help. Go to www.fco.gov.uk/fgm for more information.

More provision of instruction.

This is a useful technique, but if people are not motivated to act or if they perceive barriers to action then they may not use this kind of information.

case study

When I was "circumcised" I was five or six. It started as a ceremony - I was bought clothes, gold earrings and bangles. I had henna put on my hands and feet, it was like a celebration and I was the centre of attention.

The equipment they use is handmade: a sharp curved knife which is not sterilised. And I was given no anaesthetic. They left a little hole for urination. There were no stitches but they treated the wound with herbs, salt and water. It bled a lot and I was in great pain. I was horribly frightened and crying.

I came to the UK to study and about the same time suffered a great deal of bleeding and pain, so I went to hospital. It turned out that when they carried out the procedure they left part of one of my labia inside me, so the UK doctors operated to get rid of it.

Many families in Britain take girls to their country of origin to have FGM carried out. It is a holiday, they see family and the countryside and are then "circumcised". When they return, they tell the girl not to talk about it. They say the government will take her away from her family and that she will lose all she has in the UK.

Many in my generation are fighting it. These days people are more aware, and I know many educated women who will not practice it. They say - "We have had enough!"

Bint al-Sultan - Manor Gardens Advocacy Project

The case study approach here provides a new message source from someone who has been affected.

It contains messages about **negative consequences**.

It also contains messages about the type of person who opposes FGM - targeting **normative influences**.

Specifically, people form 'my generation' and 'educated women' are said to oppose FGM. This may be an attractive message to some, but may be less attractive to others. (particularly those who are educated and still support FGM)

go to www.fco.gov.uk/fgm

for more information

**where to go for
further help or information**

Foreign and Commonwealth Office
020 7008 1500
www.fco.gov.uk/fgm

Metropolitan Police
Child Abuse Investigation
Command/Project Azure
020 7161 2888

Child Protection Helpline
0808 800 5000 (advice for adults
worried about a child)

**Foundation for Women's Health
Research & Development (FORWARD)**
www.forwarduk.org.uk
020 8960 4000

**National Society for the Prevention
of Cruelty to Children (NSPCC)**
www.nspcc.org.uk
0808 800 5000

Childline
www.childline.org.uk
0800 1111 (24 hr free helpline for children)



Sources of further information are then provided. And the back page contains the Government department names involved and the web address relating to further Government related information.

REPLACE Pilot Toolkit Version 1

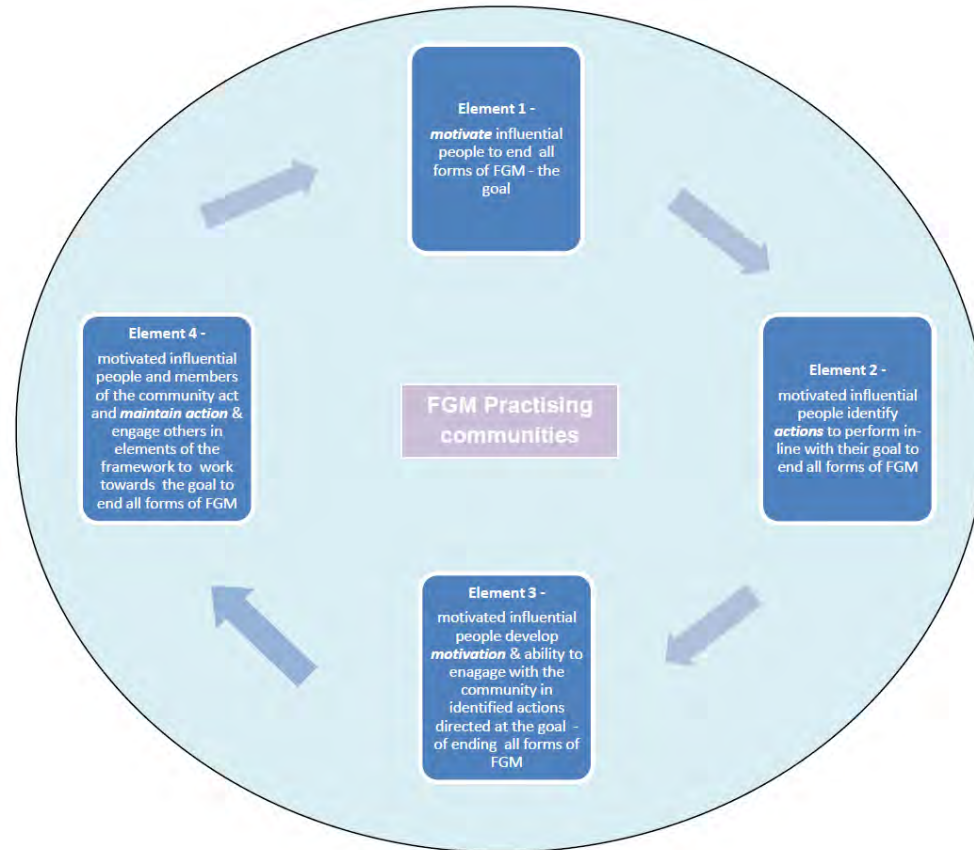


Figure 7: The REPLACE Framework: Ending FGM through a Behaviour Change Approach

5.3 Evaluating the Success of the REPLACE Framework in Changing the Behaviour of FGM Practising Communities.

In order to establish whether change is actually occurring in a particular community and whether intervention strategies and campaigns are actually having the desired effect it is important to engage in evaluation. By evaluation we mean measuring things that you expect or want to change before you start trying to change them, and then measuring them again later on after you have begun your work to see if change is actually happening.

Clearly, anyone working in the anti-FGM field wants to see a decrease in rates of FGM, so you might want to try and take a measure of prevalence in the community. This is of course much easier said than done, but it doesn't mean you can't try! If you are able to offer people complete anonymity, they might tell you about prevalence they are aware of. One way of doing this is with anonymous surveys or questionnaires.

Other things you might want to change through your work and should therefore measure to see if they change:

- genuine desire or motivation to end all forms of FGM
- perceived consequences of FGM
- perceived threat/risk of FGM
- what people think others are doing regarding FGM
- what people think they are expected to do regarding FGM
- how confident people feel about ability to help stop FGM

- perceived consequences of talking to relatives about stopping FGM
- perceived consequences of talking to peers about ending FGM
- perceived consequences of other identified behaviours people have identified (element 2 of REPLACE framework cyclic model)
- desire or motivation to carry out identified behaviours

5.3.1 Designing an evaluation programme

Designing measures that genuinely assess these things is not easy to do but here are some example questions that you might ask people on a questionnaire or survey:

1. Example measures of desire or motivation to end all forms of FGM:

When we use the term **FGM** we mean **all types of cutting** of the female genitals. Please tell us by circling a number from 1 to 7 on the scale below how much you agree with the following statement:

All forms of FGM should be stopped from happening

Strongly agree	1	2	3	4	5	6	7	Strongly disagree
----------------	---	---	---	---	---	---	---	-------------------

OR you can use negatively phrased items:

I do not want all forms of cutting of female genitals to end in my community

Strongly agree	1	2	3	4	5	6	7	Strongly disagree
----------------	---	---	---	---	---	---	---	-------------------

2. Example measures of perceived consequences of talking to relatives about FGM and wanting it to end. These should be designed around the perceived consequences you know exist in the community.

Talking to my mother/aunt/sister about wanting all forms of FGM to end will make them upset

Strongly agree	1	2	3	4	5	6	7	Strongly disagree
----------------	---	---	---	---	---	---	---	-------------------

OR

Starting a conversation with my father/uncle/brother about wanting all forms of FGM to end would mean I got laughed at

Strongly agree	1	2	3	4	5	6	7	Strongly disagree
----------------	---	---	---	---	---	---	---	-------------------

3. Example measures of descriptive norms (what other people are perceived to be doing) about performing FGM.

I believe that people like me are rejecting FGM and choosing not to cut their daughter(s).

Strongly agree	1	2	3	4	5	6	7	Strongly disagree
----------------	---	---	---	---	---	---	---	-------------------

OR

I believe that people like me are having their daughter(s) cut.

Strongly agree	1	2	3	4	5	6	7	Strongly disagree
----------------	---	---	---	---	---	---	---	-------------------

4. Example measures of confidence in speaking out about wanting FGM to end.

I am confident that I can use opportunities when they arise to speak to people about wanting all forms of FGM to end in my community.

Strongly agree	1	2	3	4	5	6	7	Strongly disagree
----------------	---	---	---	---	---	---	---	-------------------

OR

Speaking out about wanting all forms of FGM to end in my community is something I don't feel I can do.

Strongly agree	1	2	3	4	5	6	7	Strongly disagree
----------------	---	---	---	---	---	---	---	-------------------

5. Example measures of asking about prevalence and actual levels of FGM - this is of course not accurate but can help to give an idea about change

In your opinion, how many of the girls in your community are being cut these days?

None	Very few	Some	Less than half	Half	More than half	Many	Most	All
------	----------	------	----------------	------	----------------	------	------	-----

OR

Approximately how many girls do you know of that have been cut in the last 3 years?

0	1-2	3-4	5-10	11-20	21-30	31-50	51-100	100+
---	-----	-----	------	-------	-------	-------	--------	------

When designing a survey or questionnaire to assess change and intervention effectiveness, you need to follow all the ethical principles outlined earlier in the toolkit in section 2. You need to tell people what you are doing and why, and ensure they consent to take part. It is very important that you ensure the questionnaire is **anonymous**. People will also be more likely to respond truthfully if they are anonymous.

People may not want to respond to a survey or questionnaire for fear of getting into trouble or getting someone else into trouble, so the more you can do to assure people that no-one will ever know what answers they provided, the better.

We recommend that in order to maintain anonymity but be able to link a before and after questionnaire from someone you can get people to produce anonymous but individually produced codes:

e.g. ask them to give some numbers and letters that are personal to them that they can easily remember and provide again, but that will not enable them to be identified

Date of the month born = 09 (9th day of month)

Last 3 numbers of mobile phone number = 438

last 2 letters of last name = wn

code = 09438wn

Having this code will also allow a researcher to identify anonymous data should a participant later wish to withdraw the information they provided.

Evaluation questionnaires should be undertaken before an intervention is implemented and after it has finished. Interim evaluations could also be undertaken after specific phases of the intervention. These can then be compared (i.e. using the coding system described above) to see if the intervention has indeed changed people's beliefs and affected their behaviour concerning FGM in their community.

The REPLACE team would be very interested in getting any evaluation results you produce to allow us to improve this toolkit.

5.4 Conclusion

Behaviour change approaches and messages that map onto them can already be seen within some existing anti-FGM campaign materials. In order to develop this approach as part of the work done by anti-FGM campaigners and NGOs, it is necessary for those working in the field to engage with communities and carry out primary research to inform exact message content and intervention approaches that will work.

Once armed with a thorough knowledge and understanding of the targeted community, and in collaboration with them, it should be possible to use the knowledge gained to apply the REPLACE framework and associated behaviour change approaches identified in Section 4 above.

In order to achieve the thorough knowledge and understanding required, we believe a participatory action research (PAR) approach is important. REPLACE carried out research work with Somali and Sudanese communities in the UK and the Netherlands and applied a participatory action research (PAR) approach. Refer to section 2 for information about conducting PAR and to section 3 for an insight into these communities' beliefs, perceptions and the barriers they face in moving towards eliminating FGM.

We hope that sections 4 and 5 of this toolkit provide an insight into how a behaviour change approach can be applied to the issue of working to end FGM amongst practising communities, and that it is a starting point for replacing a predominantly awareness-raising approach with a strategic and targeted behaviour change approach. This will only work however with the involvement of the communities themselves and with assessment and evaluation of applying this approach.

We hope to start a process of people beginning to apply this approach to their thinking, planning and implementation of anti-FGM campaign and intervention activities, and then feeding back on that process. In this way, this toolkit can be an evolving document that is built on and improved over time.

5.5 References and Further Reading

Abraham, C., and Michie, S. (2008). A taxonomy of behaviour change techniques used in interventions. *Health Psychology*, **3**: 379-87.

Bartholomew, L.K., Parcel, G.S., Kok, G., Gottlieb, N.H. and Fernandez, M.E. (2011). *Planning Health Promotion Programs*. 3rd ed. John Wiley & Sons Ltd

Conner, M. and Norman, P. (eds.) (2005). *Predicting Health Behaviour*. 2nd ed. Maidenhead: Open University Press.

Norman, P., Abraham, C., and Conner, M. (2000). *Understanding and Changing Health Behaviour: From Health Beliefs to Self-Regulation*, Harwood Academic Publishers: Amsterdam: Netherlands.

Rutter, D., and Quine, L. (2002). Social cognition models and changing health behaviours. In D. Rutter and L. Quine (eds.) (2002). *Changing Health Behaviour*. Buckingham: Open University Press.

Appendices

Appendix 1: REPLACE - Intervention Evaluation Content Analysis Manual

This manual lists the coding categories for the content analysis of existing intervention and educational materials aimed at raising awareness about the issue of FGM. It is an evolving document which categories can be added to as analysis progresses.

Intervention number:

Arbitrary numbering of materials to make them quickly identifiable in the dataset

Intervention title:

The major title of the materials as given on front page/cover - identification

Material type:

DVD/film/video = 1

CD/music = 2

Leaflet/flier = 3

Poster = 4

Book/booklet = 5

Other = 6

Duration:

If the material is a film or CD, how many minutes does it last for? If it is not something that can be measured in minutes then enter -1 to indicate not applicable.

Length:

If the material is a leaflet or booklet or some other form of written text, give the number of pages of text. If the material can not be described in this way then enter -1 to indicate not applicable.

Authors:

Write in the name(s) of the main authors/organisation who developed the materials

Country:

Write in the name of the country where the materials were made/developed/set

Message source:

Identify who is delivering the message; this may be actors/presenters representing a particular source.

Community/Religious leader/scholar = 1

Male member of the community = 2

Female member of the community = 3

Female child/children = 4

Male child/children = 5

Group of females = 6

Group of males = 7

Person from outside practising community = 8

Police/Law makers = 9
Health professional = 10
Teachers or others working in schools = 11
Other = 12
Charitable organisation = 13
Ex-circumciser = 14
EU anti-FGM campaign = 15
National/Government anti-FGM campaign = 16

Target audience:

Who are the messages/contents of the material targeted at? Who is meant to hear this message?

Any general target audience/difficult to know = 1

General practising community = 2
Children or young people in practising community = 3
Men in a practising community = 4
Women in a practising community = 5
Local government/council/legal authority leaders = 6
Police/crown prosecution service or similar = 7
Health professionals = 8
Members of non-practising communities = 9
Teachers or others working in schools = 10
Other = 11
Practising community leaders (e.g. Imam or non-religious leader) = 12

Context setting information (not re: FGM):

Facts and figures about populations and other issues related but not directly about FGM.

Aims of campaign – descriptions & similar

Need for awareness in medical professionals = 1
Need for standard medical protocols = 2
Advocates human rights = 3
Awareness raising in general = 4
Working with women/empowerment = 5
Involvement of men = 6
Working with Youth/skill development = 7

Fact giving re: FGM:

Facts or stats given about FGM
Prevalence rates/scale of problem = 1
Explains reasons for its continued practice (e.g. traditional practice; honour, chastity, cleanliness etc) = 2
Not religious practice = 3
Which communities practise FGM/what countries = 4
Cost to health services = 5
Use as grounds for asylum = 6
Happens in the UK/other EU country = 7

Gives examples of other names for FGM (e.g. Circumcision, Sunna) = 8

Explains who facilitates/organises FGM = 9

Explains celebratory nature of s= 10

Signposting to further information = 11

Girls go outside UK to have procedure = 12

Age at which procedure carried out = 13

Physical Description/ of FGM:

Removal of clitoris = 1

Removal of labia minora = 2

Removal of all external flesh = 3

Small cuts/incisions = 4

Infibulation/stitching together = 5

General harm to female genitalia for non-medical purposes = 6

Partial removal of flesh = 7

Symbolic prick = 8

Reference to 4 main Types/WHO classification = 9

Description of what is left (e.g. small hole to urinate/menstruate from = 10

Description/Depiction of practical procedure:

Use of unsterile equipment = 1

Use of glass = 2

Use of razors = 3

Performed in 'bush' = 4

Homemade knife = 5

Lack of anaesthetic/pain relief = 6

Errors/mistakes (e.g. labia left inside!) = 7

Group circumcision = 8

Depiction of FGM being carried out = 9

Info FGM health:

Does the material provide any information or messages about the link between FGM and health outcomes? Indicate which ones

Death = 1

Blood loss = 2

Pain = 3

Infection = 4

Urination problems = 5

Obstetric/childbirth problems = 6

Sexual dysfunction = 7

Gynaecological/menstrual problems = 8

Scarring = 9

Health/harm general = 10

Distinction between short/long-term consequences = 11

Disease (e.g. tetanus) = 12

Info FGM Law:

Does the material provide information about the link between FGM and the law?

Illegal to perform FGM = 1

illegal to take girls or women out of the country to have FGM done = 2

Info about prosecution/jail terms = 3

other = 4

illegal to assist FGM to be carried out abroad = 5

Info FGM Psych:

Does the material provide information about psychological consequences of FGM?

*Emotional/**Psychological** problems = 1*

Anxiety = 2

Phobia = 3

Stress = 4

Other = 5

Memories/flashbacks = 6

PTSD = 7

Embarrassment = 8

Psychological wellbeing = 9

Depression = 10

Experience of fear = 11

Human rights:

Providing information about FGM being a violation of human rights/abuse including child abuse

Expressing FGM as against sexual rights of women = 1

Expressing FGM as against bodily and/or mental integrity (people having a lack of choice about what happens to their own body/lack of own decision-making) = 2

FGM as against rights of women generally = 3

*FGM as violence/cruelty/**abuse** against women/girls/children = 4*

FGM as against the right to health/sexual health/or any right to health = 5

FGM as against the right to life (because it can cause death) = 6

Simple expression of FGM as against human rights = 7

Info cons adv:

Does the material provide information about any advantages of not performing FGM?

Stopping performing FGM makes you feel better = 1

Info cons disadv:

Does the material provide information about any disadvantages of performing FGM (other than health, legal issues and psychological consequences)?

Leads to tying women up to get them to have sex because they don't want the pain = 1

It is a harmful practice = 2

Act of circumcision is upsetting because of girls crying = 3

Circumcision puts pressure on women and girls = 4

Western doctors don't know how to resolve/extra financial costs with childbirth = 5

Issues around de-infibulation & re-infubulation & cost to health service = 6

Disapproval others

Does the material provide information about others disapproving of performing FGM?

Laughing at the idea of FGM = 1

Expressing belief that it is bad to perform FGM = 2

Expressing that it should not be carried out = 3

Expressing disapproval of consequences of FGM = 4

Laughing at false beliefs about FGM = 5

Approval others:

Does the material provide information about others approving of not performing FGM?

Expressing that they actively work against FGM = 1

Expressing that FGM is reduced now = 2

Expressing they want it to stop = 3

NB group noted similarity between 2 highlighted codes above – if issue raised then feel free to flag with group!

Prompt Intention formation:

The material prompts its audience to decide to take action or to set a goal

Barrier ID:

Barriers to change are identified and/or solutions to these are suggested

Acknowledgement that it's not easy to change = 1

Expression that it's difficult to discuss FGM/taboo topic (so discuss AIDS/other topic first and lead to FGM) = 2

Opposition from the local community = 3

Lack of knowledge in non-practising communities = 4

Girls told not to tell anyone they've had it done = 5

Communities don't engage with/deconstruct why it continues = 6

Shame/embarrassment as a barrier = 7

Provide Instruction:

(Telling the person how to perform anti-FGM behaviour and/ or preparatory behaviours Abraham & Michie, 2008).

Telling message recipient(s) what things need to be done/achieved to end FGM and/or what things to look out for to indicate that one could act.

Government & EU level = 1

Lower level (e.g. *practising* communities/groups/individuals) = 2

- a) *What to do if had it done*
- b) *What to do if at risk*
- c) *Speak out against it/act to protect your child*
- d) *Communities should question what FGM is for*
- e) *Abandon FGM now*

Lower level (non-practising community) = 3

- a) *Identify practising community*
- b) *Signs of going abroad for holiday*
- c) *Child talking about special event*
- d) *Child absent from school for long time*
- e) *Child changes behaviour after being away from school*
- f) *Signs of pain/discomfort*

Model behaviour:

Show the person how to correctly perform a behaviour e.g., in class or on video.

Social comparison:

Facilitate observation of non-expert others' performance e.g., in a group class or using video or case study

Social support change:

Prompting consideration of how others' could change their behaviour to offer the person help or (instrumental) social support, including "buddy" systems – and/or providing social support

ID role model:

Indicating how the person may be an example to others and influencing their behaviour or providing an opportunity for the person to set a good example

Empowerment

Teaching women to feel empowered to speak out on issues that affect them

Message about female solidarity - we have had enough! = 1

Appendix 2: Participant Information Sheet

Below is an example of a participant information sheet (PIS) used by REPLACE during phase one of the project - recruiting participants to attend focus group discussions - in the UK. Note the use of the term 'female circumcision/cutting' rather than FGM. REPLACE decided that this term was more appropriate and would not deter individuals from participating.

The PIS should provided participants with the following information:

- *Information regarding the aims of the project*
- *Why they have been chosen to take part*
- *The positive and negative aspects of taking part*
- *How the information they provide will be stored and used by the researchers.*
- *Emphasis confidentiality.*
- *Provide contact details of organisations such as FORWARD UK, FSAN, REPLACE etc, from which participants can gain more information.*

Participant Information Sheet

Study Title

Researching the FGM Intervention programmes linked to African communities in the EU (REPLACE)

What is the purpose of this study?

The aim of the study is to find out the beliefs regarding female circumcision/cutting among the Somali/Sudanese community and how people come to decisions about whether to circumcise their girls or not.

Why have I been chosen?

You have been asked to take part because you are connected with the Somali/Sudanese community and we are interested in your views and what you have to say.

Do I have to take part?

Participation in the research is voluntary and if you change your mind you can withdraw your consent at any time.

What will happen to me if I take part?

You will be asked to attend a focus group discussion consisting of no more than eight other people of the same sex. The meeting will take place at a location convenient to you. Refreshments will be provided and transport costs reimbursed. The focus group discussion will be tape recorded. At the end of the focus group discussion the facilitator will de-brief you about the research and you will be given an opportunity to ask questions and discuss matters relating to your participation. You will also be given contact details of the facilitator and the research team at Coventry University.

What are the possible disadvantages and risks of taking part?

There is a time cost as we will ask you to give up some of your time to take part in the focus group discussion. It might also be that you find talking about the subject difficult or uncomfortable. You do not have to talk about personal experiences unless you want to and you can stop the discussion at any time if you do not wish to continue.

What are the possible benefits of taking part?

By taking part in the research you will have the opportunity to have your say about the important issue of female circumcision/cutting. It will also give you the chance to contribute to research aimed at developing our understanding of female circumcision and best practice.

What if something goes wrong/I am not happy about something?

If there is anything you are unhappy about let us know (our contact details are at the end of this sheet). Alternatively you could speak to the facilitator, who will then contact us on your behalf. We will also give you contact information for sources of help and advice (see last page).

Will my taking part in this study be kept confidential?

The data we collect from you is anonymous; you will not be required to give your full name, only your first name if you are happy to do so. Any other information collected about you (e.g. your age) is only for the purposes of identification in case we need to delete any information if you withdraw your consent but this will not be shared with any third parties.

What will happen to the results of the research study?

The information that is recorded during interviews will be transcribed (written word for word) and analyzed using a computer software programme. You can see your transcript and a copy of the final report, if you so wish, by contacting FORWARD and/or the research team at Coventry University. The findings of the research will inform the development of a intervention toolkit that will be shared with professionals working in the area of female circumcision at a local level (such as community outreach workers, and community leaders).

Who is organising the research?

The research is being conducted by three partners Coventry University, FORWARD and the Federation of Somali Associations Netherlands (FSAN). Please visit the website for more information about the research:

www.replacefgm.eu

Who has reviewed the study?

The study was submitted to the Coventry University Ethics Committee for approval and was approved before we contacted you.

Contact for further information

(Contact details of the REPLACE partners has been omitted)

Other sites that might be of interest:

www.forwarduk.org.uk

www.fsan.nl

www.healthinterventions.co.uk

Appendix 4: Participant De-Brief Sheet

Below is an example of a participant de-brief sheet used by REPLACE within the UK. It is important that the de-brief sheet includes a contact number/address, so that participants can ask questions or withdraw from the research. De-brief sheets should also provide participants with information regarding services specialising in FGM. The de-brief sheet should also be translated accordingly.

Participant de-brief sheet

Thank you very much for taking part in this piece of research. Your contribution has been very important to us.

We will be transcribing your interview data and analysing it alongside all the other participants' data to look for common themes and outcomes.

If you have any questions about this or anything else to do with this research then please feel free to ask. We will be more than happy to answer any questions. Alternatively, if you think of something later and wish to get in touch with us, you can do so using the contact details provided below:

[Contact details of REPLACE researchers has been omitted]



List of Specialist Health Services in England & Wales

**African Well Women's Clinic
Guy's & St. Thomas's Hospital**
8th Floor – c/o Antenatal Clinic
Lambeth Palace Rd.
London, SE1 7EH
Tel: 0207 188 6872
Open: Monday – Friday, 9am – 4pm
Contact: Comfort Momoh MBE
(FGM / Public Health Specialist)
comfort.momoh@gstt.nhs.uk
Mobile: 07956 542 576

**African Well Women's Clinic -
Antenatal Clinic
Central Middlesex Hospital**
Acton Lane, Park Royal
London, NW10 7NS
Tel: 0208 963 7177 or 0208 965 5733
Open: Friday, 9am – 12pm
Contact: Kamal Shehata Iskander
kamal.shehataiskander@nwlh.nhs.uk

**African Well Women's Clinic -
Antenatal Clinic
Northwick Park & St. Mark's Hospital**
Watford Rd.
Harrow
Middlesex, HA1 3UJ
Tel: 0208 869 2870
Open: Friday, 9am – 5pm
Contact: Jeanette Carlsson

**African Well Women's Clinic
Whittington Hospital**
Level 5
Highgate Hill
London, N19 5NF
Tel: 0207 288 3482 ext. 5954
Open: Last Wednesday of every month,
9am – 5pm
Contact: Joy Clarke or Shamsa Ahmed
joy.clarke@whittington.nhs.uk
Mobile: 0795 625 7992

**Women's & Young People's Services
Sylvia Pankhurst Health Centre
Mile End Hospital**

Bancroft Rd.
London, E1 4DG
Tel: 0207 377 7898 or 0207 377 7870
Open: Monday – Friday, 9am – 5pm
Contact: Dr. Geetha Subramanian
(Consultant Gynaecologist)
geetha.subramanian@thpct.nhs.uk

**African Women's Clinic
University College Hospital**
Huntley St.
London, WC1E 6DH
Tel: 0207 387 9300 ext. 2531
Open: Monday afternoon
Contact: Maligaye Bikoo (Clinical
Nurse Specialist)
maligaye.bikoo@uclh.nhs.uk

**Gynaecology & Midwifery Departments
Chelsea & Westminster Hospital**
3rd Floor
369 Fulham Rd.
London, SW10 9NH
Tel: 0207 751 4488
Open: Tuesday, 10am – 6:30pm,
Second Thursday of every month, 3:30pm
– 6:30pm (by appointment only)
Contact: Gubby Ayida (Obstetrics
Service Director)
gubby.ayida@chelwest.nhs.uk

**Gynecology & Midwifery Department
St. Mary's Hospital**
Praed St.
London, W1 1NY
Tel: 0207 886 6691 or 0207 886 1443 or
0207 886 6763
Contact: Judith Robbins or Sister Hany
foong.han@imperial.nhs.uk

**Waltham Forest African Well Women's
Services
Oliver Road Polyclinics**
Upper Ground Floor
75 Oliver Rd, Leyton
London, E10 5LG
Open: Drop-In Thursday 10am – 3pm
Contact:
Dr. Faduma Hussein (Community
Health Advisor)
faduma.hussein@wf-pct.nhs.uk
Tel: 0208 430 7381 or 0788 785 4541

Minority Ethnic Women's & Girl's Clinic

Charlotte Keel Health Centre

Seymour Road

Easton

Bristol, BS5 0UA

Tel: 0117 902 7100

Open: Drop-In Last Wednesday of every month, 9:30am – 12pm

Contact: Dr. Hilary Cooling

Acton African Well Women Centre, Mill Hill Surgery Acton, West London **020 8383 8761**

Women & Girls Network, London (for Support & counselling for women and girls who have experienced gender based violence) Tel- **020 7610 4345**

African Women's Clinic, University College Hospital Central London 0845 155 5000 ext: 2531, or **020 7387 9300**

Other FGM support organisations

ACCM (Agency for Culture and Change Management) Sheffield **www.accmsheffield.org**

AFRUCA (Africans United Against Child Abuse) London **www.afruca.org**

Black Women's Health and Family Support London **www.bwhafs.com**

Eritrean Health Support Association London tel- **020 7419 1972**

FORWARD (Foundation for Women's Health Research and Development) London **www.forwarduk.org.uk**

Waltham Forest Somali Women's Association London tel- **020 8503 7121**

Somali Welfare Association London tel- **020 8968 1195**

Additional Contacts

Women's Aid – National charity working to end domestic violence against women and children. Provides domestic abuse directory and national helpline.

www.womensaid.org.uk

National Domestic Violence Helpline: **0808 2000 247 (24-hour free helpline)**

NSPCC – National charity working in child protection and the prevention of cruelty to children.

www.nspcc.org.uk

Childline (www.childline.org.uk): 0800 1111 (24-hour free helpline for children)

Child Protection Helpline: 0808 800 5000 (advice for adults worried about a child)

fpa – The UK's leading sexual health charity.

www.fpa.org.uk

fpa Helpline: 0845 122 8690 (Mon-Fri, 9-6)

Rights of Women – National charity working to attain justice and equality by informing, educating and empowering women about their legal rights.

www.rightsofwomen.org.uk

Legal Advice Line: **020 7251 6577**

(Tues/Wed/Thurs, 2-4pm/7-9pm; Fri 12-2)

Sexual Violence Legal Advice line: tel- **020 7251 8887** (Mon, 11-1; Tues 10-12)

Southall Black Sisters – A resource centre in West London offering a service to women experiencing violence and abuse.

www.southallblacksisters.org.uk

Tel- **020 8571 9595** (Mon-Fri, 10-5pm)

Appendix 5: REPLACE: Focus Group Guide

Focus Group Guide

REMEMBER! THIS IS ONLY A GUIDE. IF INTERESTING ISSUES ARISE DURING THE FOCUS GROUP, THEN ASK QUESTIONS TO FIND OUT MORE INFORMATION

Following on from Introduction the first question should open the discussion

- 1) Which term do you prefer: Female Genital Mutilation/Female Genital Cutting/Circumcision/Sunna?

1a: which term is more favourable and why?

1b: And what type of circumcision/cutting does this term describe i.e. Type 1, 2 or 3?

- 2) Could you tell us how the (preferred term) is viewed by the Somali/Sudanese community

2ai: If participants highlight negative perceptions, we could ask for them to clarify who holds these beliefs, for example, young or old men/women, those who have received little education and why they hold them?

2aii: What is the meaning of FGM (preferred term)?

2b: If participants highlight positive perceptions and meanings, then we could ask them for clarification. Again ask for them to clarify who holds these beliefs, for example, young or old men/women, those who have received little education and why they hold them?

2c: Are participants aware of the legal aspects relating to FGM within the UK/Netherlands?

2d: If participants mention other people's perceptions of the Somali/Sudanese community then these can be explored

2e: The group may be aware that there are people campaigning against FGM, we could explore how they feel about this?

- 3) From the last question, participants could discuss differences between their 'home' country and the UK/Netherlands. This could lead the facilitator to explore:

3a: The groups' experiences about coming to the UK/Netherlands

3ai: For those born in the UK/Netherlands, how do they feel about being Somali/British, Sudanese/British?

3b: Is there anything they like or dislike about living in the UK/Netherlands?

- 4) Can you tell me about your experiences of health and support services?

GPs

Hospitals (when discussion medical care, one could ask the group their opinion about reinfibulation after childbirth?)

Social Services

Community groups

Religious groups

Police

Leisure services

5) What are their experiences of raising a family in the UK/Netherlands?

5a: Is it different from Somali/Sudan? How is it different?

5b: What is your opinion of how the family is perceived within the UK/Netherlands?

5c: Is there any communication links between the Somali/Sudanese community in the UK/Netherlands and the 'homeland'?

5ci: What form do these communication links take? TV/Internet/travel/visits from family members/community networking (communication via mosque, informal networks etc).

5cii: Do the group think it is important to preserve these links to their 'homeland'?

5ciii: For those born in the UK/Netherlands, what are their perceptions of the homeland? And do they want to visit Somalia/Sudan?

3diii: If identity is raised by the group, facilitators should explore what this by asking:

5civ: How does FGM (preferred term) relate to Somali/Sudanese identity?

5cv: What are the personal disadvantages/advantages of performing or not performing FGM?

5cvi: What are the community disadvantages/advantages of performing or not performing FGM?

6) Which individuals are the most influential in the decision to conduct or resist practicing FGM

6a: Is it a man or a woman and why?

6b: Who are the key individuals you think about when thinking about performing or not performing FGM?

6c: Why do some older women decide to have FGM?

7) What constraints do people face when considering practicing or refraining from FGM? (This question is more about the material and social constraints that people face when making their decision to cut or not to cut their girls.)

Appendix 6: REPLACE Interview Schedule

The following interview schedule should be read carefully by all project interviewers before they begin conducting interviews. Please get in touch with the Coventry team if you have any comments/suggestions/feedback about this, because we very much want your input. If you disagree with anything or think something is missing - please let us know! Once we are all happy, interviewers should make sure they feel very familiar with this schedule before they begin conducting interviews.

During interviews, please let participants talk as much as they want; if they say something but do not expand on it use phrases like, 'Can you explain more about that?', or 'Tell me more', or 'that's interesting, can you expand on that?' or think up your own ways to get people to keep talking. The idea is that the schedule should not be rigid, that you should allow participants' talk to lead the interview (as long as they are within topic of course!). Don't feel you have to ask every single question that appears below - but do try to cover each of the topics - you may find that people venture into a topic of their own accord - let them and make a note to yourself that they've done this so that you don't ask them a question that they've clearly already addressed in great length!

1) Terminology:

Firstly, we advise the interviewers NOT to use the term FGM at the beginning of the interview. They should use the term 'female circumcision', as circumcision seems to be the most widely used term and therefore should not make any participant uncomfortable, which 'mutilation' seems to do. We risk alienating important community members if we use the term FGM from the outset.

Your first question should really focus on exploring what a participant's preferred term actually means in practice and what it means to them emotionally. With many of the comments made by participants in the focus groups such as 'FGM sounds quick and normal' or 'FGM are shocking and fearful word', we think it is vitally important to understand the meaning and emotional attachment of their chosen term. Only by having a deep understanding of this can one start to address it.

Therefore the first question should be:

1. Although we might use the words 'female circumcision', what word or words would you use when talking about it? (Make a note and use this term with them throughout interview) - from here [PT] refers to participant's term (If participants say, for example, 'circumcision', 'Gudniin' or 'sunna' the interviewer should ask them to describe what this actually means in terms of the actual physical practice).
2. Could you tell me what [PT] describes in terms of the actual physical practice?
3. What is your response to the term FGM, and what do you think it means in terms of actual physical practice?
4. What emotions or thoughts do you associate with [PT], how does this differ when you hear the term FGM?

5. Is [PT] frequently used within your community within the UK/Europe when discussing the issue?
(If participants say no, ask what term is used, and by whom, and why they think it is used)
6. Depending on the sex of the participant, ask them what they think [PT] means to men/women (Thus, if the participant is female you would say 'what does [PT] mean to women' and vice versa).
7. Are girls/women who have not had this done the same as those who have had [PT]? If not, how are they different? (For example - participants may mention cleanness, religious reasons, protects their daughters against western culture, marriage, curbs their sexual drive, indicates honour or indicates that they are a virgin, or something else - ask the participant to expand and explain this. For example, if they say it stops women having illegal sex, ask them how it actually stops them having illegal sex? If participants say that these women are the same, ask them to explain how they are the same? If they cite religious reasons, ask if they can tell you more about the origin of the religious reasons and how that has an impact on practicing their religion (if at a loss you can always just say - can you expand or tell me more about that?))

Sunna:

If the participant has not used the term 'Sunna' then can you try and explore their beliefs relating to this particular term? If a participant states that they believe that girls should have 'Sunna' we should explore the following things:

1. What does 'sunna' mean to you?
2. How is 'sunna' different from [PT]?
3. How is 'sunna' different from circumcision or FGM? (if appropriate to ask)

2) Family and Community Pressure

1. How is the issue of [PT] discussed within your community? (if not see below)
2. How is it discussed in your family? (If they say it is not, ask them why they think it is that it is not openly discussed).
3. What proportion of Somali/Sudanese women in the UK/Europe do you think have (PT)? Get them to expand on why they think that is (e.g. Can you tell me why you think that is?)
4. Are there pressures to have [PT]? Are there different pressures here (UK) than in Somalia/Sudan/other relevant country? (If yes or no, why do you think that is?)
5. What do people know about *and* think about the law and [PT]?
6. Do male and female perspectives differ in relation to [PT]? Explain how and in what ways similar/different...

7. What are the reasons [PT] continues to be practiced in the UK/Europe? (If they say it is or isn't continued in the UK/Europe, ask them why they think this is?)
8. Have you heard people speak openly about not performing [FC/PT]? How are such people treated by the Somali/Sudanese community? (Any support for it?)
9. Are you aware of anyone openly admitting to not having [PT] done? Community response to this? How have they been treated/responded to?

QUICK questions: Name as many people (e.g. mother, aunt, grandmother, grandfather, community leaders) or organisations as you can think of who would approve of/support you performing [PT] on your own daughter. Name as many people/organisations as you can think of who would disapprove of/be against you doing this. Which of these people/organisations is most important to you in making that kind of decision?

3) Health

1. Do you think [PT] has any effects for the girls/women relating to their health?
2. Do you think women have any physical or emotional problems from [PT]?
3. Are the health aspects attributed to [participant's term] correct? (Get the participant to explain why they think they are correct or incorrect). If they say that there are no health consequences relating to [PT], ask them why women refuse to continue the practice?
4. What do you think about [PT] reducing or enhancing women/men's sexual pleasure?
5. Are there any positive outcomes of practicing [PT] for people in relation to health?

4) Legislation

1. What do you think of UK legislation around [PT]?
2. What aspects of the UK legislation do you think have had an impact on the practice of [PT]?
3. If participants raise the issue of 'designer vaginas', piercings etc, ask them to explain how they feel about these issues, whether they feel they are the same as [PT] and how physically they are the same? If they say something about choice, that women in the 'west' have a choice to get 'designer vaginas', ask them to explain what they mean by 'choice' and is this 'choice' taken without pressure? In discussion 'choice' ask participants how this applies to young girls?

4. Do you think that Somali/Sudanese girls get checked within schools in the Bristol/ the UK/Europe? (How do they feel about this? What are their concerns?)

5) Marriage

1. Does [PT] have a bearing on marriage in the UK/Europe? (For example, 'Pharonic circumcision' is seen as physically preventing 'illegal sex', so what meanings are associated with 'less severe' forms of [PT] in relation to marriage?)
2. Do women in the UK/Europe who are not [PT] face difficulties marrying? (What are these difficulties? Do people overcome them? How do potential husbands or their families respond when they know a woman is not [PT]?)
3. Does marriage have an impact on one's identity, for example, does marrying improve people's sense of belonging to the Sudanese/Somali community? And is this different for men and women?

6) Decision Makers:

1. Who tends to make decisions in families/ your community about [PT]?
2. Do you think it is easier or more difficult for families in the UK/Europe not to circumcise their daughters? If not, why not and if it is difficult then why? And how does one cope with these difficulties?
3. Do the mother and the father discuss the issue of [PT] in UK/Europe? If so who makes the decision? And who has the overall power to implement that decision? (For example, if money is involved, who controls the money?)
4. If a family has decided that they are going to have their daughter done, is the actual physical procedure i.e. how much they want cut agreed with the circumciser?

7) UK Culture/identity:

1. Is [PT] associated with identity? (Get participants to explain their answer, for example, does this differ depending on whether they were born here or in the 'homeland'. Also ask about how this sits with UK/European cultural identity?)
2. How does place of birth relate to [PT]? How does place of birth affect feelings of identity? Are the three things related?
3. Do you feel comfortable about your children attending school within the UK/Europe? (If they mention sex education, mixed sex schools or any other aspect, ask them to expand on why they feel uncomfortable/comfortable).

4. Do parents talk to their daughters/sons about the differences between Somali/Sudanese and UK/European women's genital appearance? (If so, how do they explain the difference)?

QUICK questions:

- Name as many advantages as you can think of, of performing [PT]
- Name as many disadvantages as you can think of, of performing [PT]
- name as many things as you can think of that make it easy to continue performing [PT]
- Name as many things as you can think of that make it difficult to continue performing [PT].
- Are there any cultural practices/alternative options that have the same advantages as [PT]?

Appendix 7: How to undertake a Behaviour Change Content Analysis.

In Leye et al.'s (2005) report, they observed consensus in that Daphne funded projects up until that time had focussed on awareness raising and advocacy, and that outputs to date had been engaged solely with information and education communication (IEC).

Given that in the six years since that report was published and interest in behaviour change approaches applied to FGM has been growing, we wanted to see if there was any evidence of this in materials currently used by two major anti-FGM campaign organisations.

How did we do the Content Analysis?

The two anti-FGM campaign organisations who were part of the REPLACE team; FSAN in the Netherlands and FORWARD UK in the UK, sent copies of campaign materials including leaflets, posters, DVDs and music CDS that they use or have recently been using in their work to the team at Coventry University.

The Coventry team then sifted through the materials and selected those that were meant to communicate information to the public, including members of FGM practicing communities. Training manuals or other materials aimed at Health professionals, the police or NGO workers or similar, were not included in the analysis.

A special coding manual was developed to allow researchers to categorise the content of the materials. This was adapted from Abraham and Michie's (2008) taxonomy classification of behaviour change techniques. This was an iterative process, with the team re-visiting the number and nature of the codes many times over several months, for adaptation and development. Below however, is an overview list of the main content categories. Behaviour change techniques/messages are highlighted in blue.

- Material type (e.g. leaflet, DVD)
- length/duration of material
- Authors/creators
- Country of origin
- Message source (who is delivering the message)
- Intended audience
- Context/background information
- Aims of campaign
- Fact giving re: FGM
- Physical description of FGM
- Description/depiction of practical procedure

- Information about health outcomes relating to FGM
- Information about legal outcomes relating to FGM
- Information about psychological consequences of FGM
- Information about human rights and FGM
- Information about the advantages of NOT performing FGM
- Information about the disadvantages of performing FGM
- Information about others' disapproval of FGM
- Information about others' approval of NOT performing FGM
- Prompting people to form intentions to take action
- Identification of barriers to change and suggestions of possible solutions
- Provide instruction on how to act
- Modelling of behaviour - show people how to perform an action
- Social comparison - show a non-expert other person performing a relevant behaviour relevant to ending FGM
- Identify people as role models themselves - suggest how they could help others to change
- Empowerment messages - making people feel that they have power and control

Within these categories we coded for specific content and messages (e.g. pain as a health consequence of FGM).

The research team coded the materials individually and met at regular intervals to check that they were in agreement about the coding framework and analysing the material. The coding manual was adapted if and when necessary. We used spreadsheets to record our coding, and an example of one is provided below (Figure 11)

REPLACE Pilot Toolkit Version 1

Intervention title What you should know secondary
 Intervention number 17.2
 Material type 3
 Authors Pharos
 Country Netherlands
 Coder name KB

Approx time on dvd/cd (in mins) OR page/para. number of written document	Message Source	Target Audience	Context setting information	Aims of campaign - descriptions and similar	Fact giving re: FGM	Physical description of FGM
page 1	13	3,9	title	4		
page 2	13	3,9			4,13,2,3	4,1,7,3
page 3	13	3,9			7,12	
page 4	13	3,9				

Description of practical procedure	Info FGM Health	Info FGM Law	Info FGM Psych	Info Human rights	Info cons adv	Info cons disadv	Disapproval of others	Approval of others	Prompt intention formation	Barrier ID	Provide instruction
	10,11,3,2,4,8,5,6,7	1	2,5	7,3				2		1	
											2,2a

Model behaviour	Social comparison	Social support change	ID role model	Empowerment	Other categories identified - see manual
					section on conflicting opinions

Figure 11 Example of Spreadsheet for Content Analysis Coding

ABOUT THE PARTNERS



REPLACE is being led by Professor Hazel Barrett, Associate Dean within the Faculty of Business, Environment & Society at Coventry University with a multidisciplinary team that includes a health psychologist and sociologist and partnership with FORWARD UK and FSAN. Together they are trialling a new approach to addressing FGM.

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FORWARD (Foundation for Women's Health Research and Development) is an African Diaspora led UK-registered campaign and support charity dedicated to advancing and safeguarding the health and rights of African girls and women, with a particular focus on female genital mutilation (FGM) and forced and child marriage.

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The Federation of the Somali Associations in the Netherlands (FSAN) is a non-profit, non-political organisation founded in the Netherlands in 1994. Fifty-two regional and district organisations in the Netherlands fall under the umbrella of FSAN. One of the main programmes of FSAN is working to eliminate FGM with African community based organizations in the Netherlands and Dutch professional Institutions. FSAN considers FGM as a gender-related violence and as a violation of women's rights as well as the rights of a girl child. Their mission therefore is the abandonment of all forms of FGM.

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West Midlands European Centre based in Brussels is responsible for the dissemination aspects of the project and will help to ensure that the project recommendations are passed to national and European policy makers to help stem the tide of FGM in Europe.

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