

An Evaluation of Community-Based Interventions Used on the Prevention of Female Genital Mutilation in West African Countries

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Abstract

The traditional practice called Female Genital Mutilation has been recorded in several countries in Africa and in other regions around the world. Female Genital Mutilation is regarded as a major Public Health burden due to the extensive health risks associated with the procedure and community-based interventions has been prescribed to eliminate the practice. This paper presents a review of published literature about community-based interventions carried out to prevent Female Genital Mutilation in West Africa between the years 2000-2013. A literature search was conducted for papers published between the years 2000 - 2013. Papers were reviewed if they reported a positive change in knowledge, attitude and behaviour towards FGM. Twenty papers met the inclusion criteria. A total of eight types of methods were identified: Advocacy Campaigns, Health Education, Sensitization Workshops, Community dialogue, Media campaigns (radio, newspaper, film shows, information posters) counselling, role plays and Skills training. This study identified that these interventions utilised health promotion models such as the behaviour change, client-centred/empowerment, social change and most commonly the educational model. None of the interventions were based on the medical model of health promotion. Hence, it seems an incorporation of the medical and educational models of health promotion could result in a greater impact in community-based interventions to prevent FGM.

Keywords: Female Genital Mutilation, Community-Based Interventions, Health Promotion Models

Introduction

Female genital mutilation (FGM), also referred to as Female Circumcision (FC), Female Genital Cutting (FGC), encompasses “*all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for cultural or non-therapeutic reasons*” World Health Organisation (WHO) (2008). The practice has been classified into four major types by the WHO, and there are numerous reports on the extensive health risks associated with the procedure (WHO, 2008). Female genital mutilation has been recognised as a violation of basic human rights (United Nations Population Fund - UNEFPA, 2007) and strongly interwoven into the social fabric of beliefs and culture (WHO, 2008).

According to a WHO report on FGM (WHO, 2008, 2011, 2012) almost 3 million girls are at risk of the procedure every year and a global estimate of prevalence for the practice indicates that about 100 to 140 million girls and women in many societies around the World have undergone the procedure (WHO, 2008 and United Nations Children’s Emergency Fund - UNICEF, 2010). Lax (2000) contends that the “secret veil” underneath which the procedure is carried out makes collecting accurate data impossible. Many practicing communities justify the practice of FGM based on a variety of reasons and long held false beliefs about the benefits associated with the procedure. These include that FGM is a requirement for the moral upbringing of a female child (Herlund, 2003), an initiation into womanhood and necessary for marital discipline or prevention of sexual immoralities (Mackie, 2000). FGM is linked with certain religions which has aggravated the problem especially in highly religious regions such as Africa (Rouzi, 2013). FGM is associated with negative short and long-term health for women and girls (WHO, 2008, UNICEF, 2010). Several authors such as Dorkenoo and Elworthy, (1992), WHO, (2008) and UNICEF, (2010), establish that FGM can lead to obstetric complications, psychological trauma, sexual and reproductive health problems and also physical complications such as bleeding, fracture, shock, infection, severe pain amongst others. In fact, FGM is major public health burden (Toubia, 1994) because the practice has affected the lives of numerous women and girls. It is a threat to the safety of female children and a major contributory factor to maternal and infant morbidity and mortality rates across Africa (WHO, 2008).

The Ottawa Charter (1986) highlights the key areas of action which includes: build capacity for the development of healthy public policy; establish supportive and healthy living environmental conditions; strengthen community action; reorient health service to ensure shared responsibility for health promotion among individuals, communities, health service and government; develop personal skills and health literacy; partnership with governmental, non- governmental and international organisations to create

sustainable actions (WHO,1986); legislate and supervise to ensure high level of protection from harm; and equity in health for and advocacy for health as a basic human right (WHO,1986). In order to promote successful eradication of FGM, there is need to tackle the problem from the grass-root/community level (WHO, 2008). The Ottawa Charter for Health Promotion advocates community empowerment to enable the improvement of quality of life (WHO, 1986). Many girls and women in communities that practice FGM are not empowered and do not possess the necessary will and courage to make decision about whether or not to undergo the procedure. Many victims of the practice are forcefully subjected to the practice, including the ordeals of female infants who have their genitals mutilated due to one reason or the other. Therefore, it is argued that public health and health promotion practitioners have the responsibility to publicise health as a basic human right and encourage a change in the attitudes and behaviour of communities toward female genital mutilation.

Community based interventions are targeted towards individuals in the same geographical region (Klassen et al. 2000). A health promotion community-based intervention *“involves the working with groups of the public in a sustained way which will enable them to increase control over and improve their health”* (Scriven, 2010). Several organisations in and across Africa such as WHO, UNICEF, UNEFPA, emphasise that community-based interventions are important strategies towards the successful prevention and eradication of FGM (WHO, 2008). Likewise, it is established that community-based interventions hold promises to tackle the practice and are an important means of encouraging a positive change in the knowledge, attitudes and behaviours of individuals towards FGM (WHO, 2008).

Accordingly, there are five models of health promotion that can be applied to community-based interventions to prevent the practice of FGM and these includes: the medical, behavioural, educational, client-centred/empowerment and social change models. The medical model of health promotion involves treatment or medical intervention to prevent diseases and illnesses (Scriven, 2010). In other words, the principal aim of this model is to reduce morbidity and prevent premature mortality among a targeted population through an expert-led or top-bottom type of intervention which reinforces the authority of medical professionals because they possess expert knowledge required for the success of the intervention (Naidoo and Wills, 2000). The behaviour change model of health promotion involves an expert-led or top-down approach to health promotion which aim is to change people’s individual attitude and behaviour, in other to enable them adopt a healthier life style (Scriven, 2010). The educational model of health promotion entails the provision of information and knowledge to enable people make an informed decision about matters relating to their health (Naidoo and Wills, 2000). It

involves a two-way communication (discussion) between the health promoter or an educated person and the individual(s), does not persuade change in behaviour but solely dependent upon people's autonomous decision (Scriven, 2010). Client-centred/empowerment model of health promotion characterises of a process by which an individual or a community recognizes and expresses its own needs, considers how best the needs can be met and jointly identifies the priorities for action (Naidoo and Wills, 2000). The model is based on a 'bottom-top' strategy whereby the health promoter plays the role of a facilitator that assists the community to achieve their set agenda (Naidoo and Wills 2000, Scriven 2010). Also, Woodall et al. (2010) added that the application of this model to interventions can contribute to empowering members of the community to enable them to improve their quality of life, health and well-being, as much as possible through their own initiative and required support from the health promoters. The social change model of health promotion involves a top-down strategy that aims at facilitating a change in the physical, social and economic environment that enables the choice of a healthier life style. Naidoo and Wills (2000) summarised the usefulness of the model in a phrase 'to make the healthier choice the easier choice'. In addition, the utilization of this model can lead to changes in legislation, enforcement of new laws, organizational or regulatory changes, and creation of new social or cultural norms which helps to promote health (Naidoo and Wills, 2000).

Despite a number of community-based interventions in West Africa, FGM is still prevalent (UNICEF, 2013). Thus, the aim of this study was to evaluate the community-based interventions carried out to prevent Female Genital Mutilation (FGM) in West Africa between the years 2000 - 2013. This study sought to identify the types of methods that had been implemented and those most frequently used to try to achieve a positive change in knowledge, attitude and behaviour towards FGM in West African communities.

Methods

This study is a narrative literature review that included some elements of a systematic review. Both quantitative data (counting the types of interventions, number of interventions that changed knowledge, attitude and behaviour) and qualitative data (how did the interventions work, not work and why) were evaluated. In order to identify potential studies to include in this review, these data bases were searched: Cumulative Index for Nursing and Allied Health Literature (CINAHL), Intermed, Psych INFO, Medline, PubMed Central, Wiley Online Library, Biomed Central, Science Direct and Sage. Google search was assessed to obtain some relevant articles, reports and reviews. The web sites of specific organisations which were particularly relevant for obtaining information pertaining to the subject area were searched. Websites of organizations such as World Health Organisation

(WHO), United Nations Children’s Fund (UNICEF), United Nations Educational, Scientific and Cultural Organizations (UNESCO) were assessed. In addition, the websites of non-governmental organisations (NGOs) that are involved in FGM eradication programmes were assessed. Examples include; International Planned Parenthood Federation (IPPF), Gambia Committee on Traditional Practices (GAMCOTRAP), Campaign Against Female Genital Mutilation (CAGEM), TOSTAN (Senegalese NGO).

Only primary researches, reports and reviews based on interventions carried out in West African communities and published in English language were selected. The search was limited to cover publication from the year 2000-2013 within the public domain, using the following key words: ‘Female Genital Mutilation’, ‘Female Genital Cutting’, ‘Female Circumcision’, ‘West Africa’, ‘Intervention’, ‘Community based interventions’, ‘Community based programmes’, ‘Community measures’, ‘Awareness’, ‘Knowledge’, ‘Attitude’, and ‘Behaviour’. A total of 20 papers which included primary studies, reports and reviews, formed the final sample for this study.

Table 1. *Twenty papers on community-based interventions preventing FGM in West-Africa*

Author	Aim of the intervention	Sample of participants	Type of method	Health promotion model	Method of evaluation
Amazonian Initiative movement AIM (2007)	To evaluate the effectiveness of a project aimed at improving the livelihood options for women and reducing the practice of FGM	n=80 participants from 13 villages. 15-80 years	Sensitization workshops, educational campaigns in schools, training of women in agriculture and animal husbandry and public discussion of FGM.	Client centred/Empowerment	Focus group
Asekun-Olarinmoye and Amusan (2008)	To disseminate health education messages of FGM and to assess the impact	n=400 respondents 10 years and above	Health education sessions	Behaviour change	questionnaires
Aubel, J (2010)	To promote girls’ development and discourage harmful practices such as FGM	People from rural communities in Senegal. Not clearly specified	Adult education and community dialogue	Client centred/Empowerment	interviews
Babalola, S (2006)	To present evidence of the impact of a programme designed to raise awareness about FGM, increase community dialogue, mobilize communities to abandon the practice and advocate for FGM elimination	n=100 households in three local gov. areas. Age of participants = 18-59 years	Mass media campaigns: radio programs, newspaper articles. Health education and community dialogue	Behaviour change	Group interviews
Diop and Askew (2009)	To empower women through educational and health promoting activities	n=40 villages. Ages 15 years and above	Health education and community dialogue	Educational	Group interviews

Diop et al. (2008)	To assess the impact of village participation in public declaration on the incidence of FGM and early marriage. To assess the impact of the TOSTAN (Senegalese non-governmental organization) programme in villages on their rates of FGM and early marriage	n=12 villages	Community education and dialogue. Qualitative evaluation	Educational	Interviews and observations
Gahn and Finke (2005)	To enable uncircumcised girls, act as peer educators in their communities through education and training	n=20 girls. 8-13 years	Health education, songs and role plays	Educational	interviews
Gambia Committee on Traditional Practices (GAMCOTRAP) (2011)	To sensitize community and women leaders on the impacts of FGM, women and children rights, gender-based violence and clear misconceptions that FGM is a religious obligation	n=6 villages. Ages of participants not specified.	Sensitization workshops	Behaviour change	Focus group
Gambia Committee on Traditional Practices (GAMCOTRAP) (2011)	To provide opportunity for communities to discuss women's right issues, gender-based violence and FGM.	n=25 villages	Training workshops	Educational	Focus group
Herlund, Y. (2009)	To upgrade skills and awareness of participants about the harmful effects of FGM (including HIV/AIDS) and other harmful traditional practices	n=117 communities. Ages not specified. Primary beneficiaries: women and girls. Secondary beneficiaries: circumcisers, traditional birth attendants, women group leaders, religious scholars, village and district chiefs and people living with HIV AIDS.	Training workshop (including video screening in village town halls)	Educational	Interviews, focus group, participatory observation and video documentation
International Planned Parenthood Federation (IPPF) (2013)	To reduce the prevalence of FGM with emphasis on changing attitude at community level	n=20 villages. Ages not specified. Community leaders, FGM practitioners and a local women's NGO	Advocacy campaigns, sensitization and training on FGM	Behaviour change	Focus group
Lankoande and McKaig (2005)	To improve the knowledge of community members through information,	n=2 rural districts (Gnagna and	Health education, counselling and service delivery such as long-	Client centred/Empowerment	Focus group

	education and communication. To contribute to the reduction of negative practices that affects women's health, specifically FGM and other forms gender-based violence. To increase access to and use of reproductive health services.	Koupeoplogo) 12-46 years	term contraceptive		
Monkman et al. (2007)	To qualitatively analyse how an NGO non formal "village empowerment programme" raised consciousness about the harmful practice of FGM.	n=men and women in 6 villages	Non-formal community education	Client centred/Empowerment	Interviews and observations
NAVRONGO Health Research Centre Ghana. Adongo et al. (2005)	To develop a means of accelerating the abandonment of FGM	n=yearly inclusion of adolescent girls aged 12-19 years from 1999-2003. A total of 8,473 participants	Community mass education and livelihood skills	Educational	Focus group and interviews
Norwegian Church Aid (NCA) (2005)	To evaluate the NCA's cross-regional programme on FGM	n=21 projects in nine countries (Mali, Ethiopia, Eritrea, Sudan, Somalia, Kenya, Mauritania, Egypt and Tanzania	Awareness raising, advocacy targeting religious leaders, education on FGM as a human right issue, community forum for information and education training of NCA's staff and partners on FGM.	Behaviour change	Focus group, interviews, key informant interviews, project reports, literature reviews, informal observation, visit to community health centres, informal discussion with men and women
Norwegian Church Aid (NCA) (2009)	To contribute to reducing the prevalence of FGM, to evaluate the progress in achieving specific objectives set forth in the programme (raise awareness for eradication of FGM, early marriage and care of fistula	In partnership with 6 local NGOs in the region of Segou, Mopti, Gao, Timbuktu, Kida and Bamako districts	Development of national framework against the practice and to cover the medical and rehabilitation cost of gender-based violence	Social change	Focus group discussion, direct observation, key informant, interview and literature analysis
Osawu-Darku (2002)	To work in collaboration with two local organizations towards the abandonment of FGM: Muslim Family Counselling Services (MFCS) and Ghana's	n=2 districts. Jesikan districts:60 imams and Muslim chiefs, 20 community nurses and midwives, 16	Sensitization workshops and Health education	Educational	Focus group

	Association of Women's affair (GAWA)	Traditional Birth Attendants, 50 women leaders, 40 community teachers, 30 in-school adolescents, 50 out of school adolescents. Mamprusi districts: 3 communities, 20 community teachers and nurses, 60 LGAs and a village chief			
Ouoba et al. (2004)	To test the effectiveness of replicating the village empowerment programme (VEP) developed by the Senegalese NGO TOSTAN in Burkina Faso, for the eradication of FGM	n=46 villages (23 intervention and 23 control villages)	Community-based education sessions	Educational	Interviews and surveys
Women's Right to Education (WREP) (2006)	To raise awareness of FGM as a violation of women's reproductive rights as well as its negative outcome. To establish counselling centres for women that have undergone FGM	n=3 local areas of Benue state (Van deokya, Kwande and Konshisha). Ages not specified	Sensitization workshops, advocacy campaigns and rallies, counselling meetings, role plays, lectures and projector presentations	Educational	Discussion
United Nations Children's Fund (UNICEF) 2010	To encourage community discussion and abandonment of FGM	n= all members in 41 villages	Out-door educational anti-FGM film show (mobile cinema)	Educational	Interviews

Table 1 shows how each paper was grouped under headings: author, aim of the intervention, sample of participants, types of methods, types of health promotion model used and method of evaluation. Following this, the aims for all the interventions were interpreted to generate the common themes and the most common or fewer common aims were identified. Likewise, the different types of methods were identified and quantified; evaluation methods used in each intervention were also counted and grouped.

Findings

Each of the 20 papers reported between one and eight types of methods. The methods were advocacy campaigns, health education, skills training, sensitization workshops, community dialogue, media campaigns (radio, newspaper, film shows, information posters), counselling and role plays. These interventions took place across 10 countries in west Africa and

these are; Burkina Faso, Cote d’Ivoire, Gambia, Ghana, Guinea, Mali, Mauritania, Nigeria, Senegal and Sierra Leone. Sixty per cent of the interventions took place in Gambia, Mali, Nigeria and Senegal. This study revealed that the most common aim for community-based interventions to prevent FGM in West Africa was to ‘raise awareness’ (n=5), less common aim was to promote girls’ development (n=1). In addition, the study revealed that the most common health promotion model utilised for the interventions was the Educational model (n=10) of health promotion, less common health promotion model was the social change model (n=1) of health promotion as shown in table 1.

Table 1 shows that the target population for these interventions were mainly rural communities/villages. Only seven of the papers included clear information about the ages of the participants with the youngest reported age being 8 years and the oldest was over 80 years. Most (n=18) of the interventions included both men and women in the target population, one intervention carried out in Sierra Leone by the Amazonian Initiative AIM (2007) included only female participants and one intervention carried out in Guinea (Gahn and Finke, 2005) included only young girls between the ages of 8 and 13 years. The intervention with the largest population sample of 117 communities was “Training and Information campaign on the eradication of FGM” (Herlund, 2009) carried out in Gambia but a relatively small sample of participants (20 girls) were involved in an intervention carried out in Guinea.

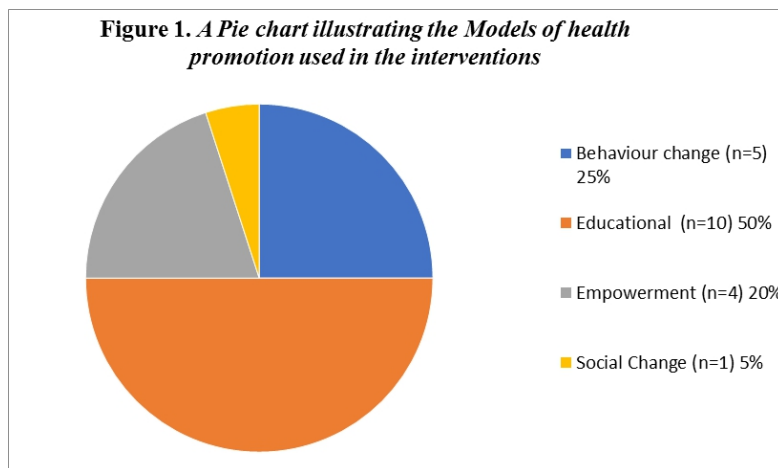
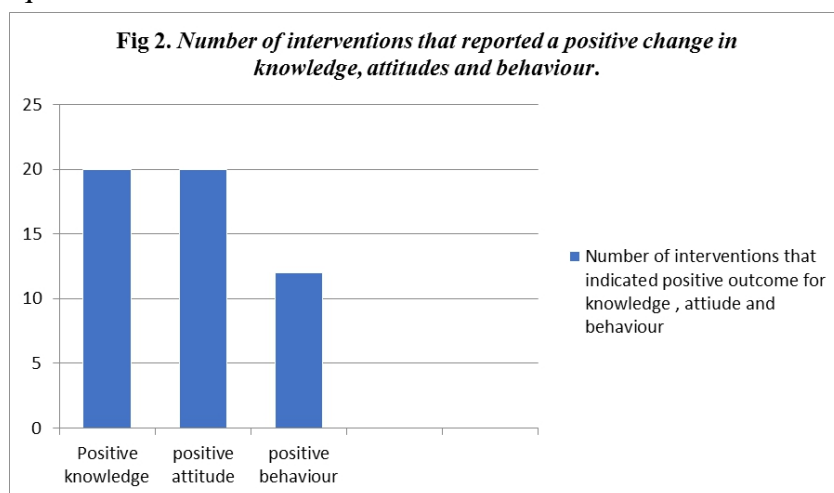


Figure 1 shows that most of the interventions (n=10) were based on the Educational model of health promotion. For example, an education programme carried out in Ghana by NAVRONGO (NGO) Health Research Centre (2005) gave participants health education on FGM. The participants were taught the female reproductive organs, the normal female genitalia and the health implications for FGM. This health education in turn encouraged the

participants to make an informed choice for the abandonment of FGM. Following this, 25% (n= 5) of the interventions utilized the behaviour change model to health promotion, for example, a programme carried out in Nigeria by Asekun-Olarinmoye and Amusan (2008) utilized the persuasion approach to provide health information about the consequences of FGM which in turn resulted in a positive change in the behaviour of the participants towards FGM. A total of twenty percent of the interventions were based on the empowerment model of health promotion. For example, the ‘village empowerment’ programme carried out in Mali (Monkman et al., 2007) invited community members to identify the problems caused by FGM and express their concerns about the practice. Only one intervention reflected the social change model of health promotion and this was implemented in Mali as part of a wider gender-based violence (GBV) programme. It resulted in the provision of free medical care and rehabilitation cost for GBV victims (Norwegian Church Aid, 2009).

The most common type of method was community health education (n=12). This implies that most of the interventions to prevent FGM in West Africa were based on the provision of health education to enable people make an informed choice about their traditional practices. For example, the health education programme carried out in rural areas of southern Senegal by Diop and Askew (2009) which aimed to empower women through educational and health promoting activities. Less common among the methods were role plays (n=3) and counselling (n=2). The only intervention that involved counselling meetings for women and girls that have undergone FGM was carried out in Nigeria by the Women’s Right to Education (WREP, 2006). Most (n=19) of the interventions were evaluated using qualitative approaches (focus groups interviews and discussions). One of the intervention was evaluated through the use of questionnaires.



Interventions that changed knowledge

The results from this study showed that all (n=20) of the interventions reported a positive change in knowledge as seen in figure 2. Most of the interventions that resulted in a positive change in knowledge were carried out in rural villages and were evaluated by using the focus group or interviews. Methods such as advocacy campaigns, health education, sensitization workshops were reported to have resulted in increase in knowledge of participants about FGM. For instance, after the advocacy campaign activities that were conducted by Norwegian Church Aid (2005) in Eastern and West African communities, one participant said: *“Before the intervention project, I did not know that the clitoris was important for the woman”* (Circumciser in Mali (NCA, 2005). Also, the Norwegian Church Aid research in Eritrea discovered that community teachers were able to directly relate FGM pains and school absenteeism among girls (NCA, 2005). In addition, an awareness raising intervention that was carried in Nigeria between Enugu state (intervention) and Ebonyi state (Comparison), reported that there was a 12 percent increase in the level of awareness about FGM among the men in Enugu state as compared to their peers in Ebonyi state (Babalola, 2006).

The most common method (n=12) that resulted in a positive change in the knowledge of participants was health education. The use of the health education activities was carried out in countries such as Burkina Faso, Senegal, Mali and Nigeria. An example was the village empowerment programme that involved an education-based approach was carried out in Senegal by TOSTAN (NGO) which included four modules: human rights, problem-solving process, basic hygiene and women’s health (Diop and Askew, 2009). Diop and Askew reported that immediately after the intervention, there was a marked increase in the percentage of men (11 to 80%) and women (7 to 83%) that could confidently mention at least two of the consequences of FGM. The TOSTAN’s education programmes have also been replicated in Burkina Faso and it contributed to a significant increase in knowledge about human rights, women’s health and FGM, both among men and women (Ouoba et al., 2004). Less common among the methods that resulted in a positive change in knowledge were role plays (n=3) (Gahn and Finke, 2005); NAVRONGO Health Research Centre Ghana, 2005) and Women’s Right to Education WREP, (2006) and counselling (n=2) (Lankoande and Mckaign, 2005 and Women’s Right to Education WREP, 2006).

Common to the interventions that were associated with a positive change in knowledge was the use of interactive discussion and visual displays. The interactive discussions created opportunities for participants to ask questions to clear any misconception and to share their personal experiences and opinions. Visual displays such as pictures and films contributed to

knowledge because they provided pictures of the difference between the normal female genitalia and a mutilated one, and visualise the horrors associated with practice. The most common aims of the interventions that resulted in a positive change in knowledge were: to educate and sensitize/raise awareness of participants about FGM.

Interventions that changed attitudes

It was discovered that 20 of the interventions reported a positive change in the attitude of participants towards FGM. Most of these interventions were carried out in villages. Some of the interventions reported that the sample included specific groups such as village heads, religious leaders, circumcisers or FGM practitioners, women's groups amongst others. Nineteen of the interventions that reported a positive change in the attitude among participants were evaluated through focus group discussions and interviews. Methods such as health education, community dialogue, advocacy campaigns, role plays and mass media were mostly reported to have influenced a positive change in attitude. For example, the Norwegian Church Aid NCA (2005) carried out advocacy campaigns targeting religious leaders as opinion makers to influence decisions, during a cross-regional programme on FGM in nine countries and achieved positive changes in attitude of participants. Drawing from the qualitative aspect of the interventions carried out by NCA, one of the Imams (Islamic leader) said: *“since the beginning of the project, religious leaders changed their speech in our area. They had information and training permitting them to understand that religious arguments do not justify the practice”* (Imam from el Mina) (NCA, 2005).

The most common type of method (n=13) was Health education. For example, Olarinmoye and Amusan (2008) assessed the impact of health education on the attitude of 400 respondents toward FGM. The researchers gave health talks to enable the participants understand the issues associated with FGM; utilised pictures to illustrate the normal female genitalia and conducted question and answer sessions after each talk. The programme resulted in an increase in the number of men who wanted the practice of FGM to be abandoned (Olarinmoye and Amusan, 2008). Five interventions that reported a positive change in attitude involved the use of community dialogue and these were carried out in Ghana (Osuwu-Darku, 2002), Senegal (Aubel, 2010; Diop and Askew, 2009), Sierra Leone (Amazonian Initiative Movement, 2007) and Nigeria (Babalola, 2006). Four involved the use of Advocacy campaigns and the less common was the use of mass media campaigns (n=3) (Adongo et al., 2005; Babalola, 2006 and UNICEF. 2010) and role plays (n=3) (Livesy Abokyi, 2004; Gahn and Finke, 2005 and Women's Right to Education WREP, 2006).

Common factors that were associated to the positive changes in attitude include; the involvement of community leaders such as village chiefs and religious leaders, as they are the decision making body of the communities and are also trusted by their people; the utilization of excircumcisers/practitioners as change agents and peer educators and the linking of FGM programmes to other women's right issues. Common aims of the interventions that achieved a positive change in the attitude of participants were: to health educate participants, to raise awareness about the harmful effects of FGM and to empower women and other community members.

Most of the interventions (n=10) that reported a positive change in attitude were based on the educational model of health promotion. Following this, a total of five interventions were based on the behaviour change model and four of the interventions were on the empowerment/client centre model of health promotion.

Intervention that changed behaviour

Figure 2 also illustrates that 12 of the interventions reported a positive change in behaviour and these were carried out in Cote d'Ivoire (IPPF, 2013), Senegal (Aubel, 2010; Diop and Askew, 2009), Nigeria (Olarinmoye and Amusan, 2008), Sierra Leone (America Refugee Committee-Amazonian Initiative movement, 2007), Mali (Monkman et al., 2007; UNICEF, 2010), Burkina Faso (Ouoba et al., 2004) and Gambia (Herlund, 2009; GAMCOTRAP, 2011). Methods such as health education, community dialogue, advocacy campaigns, and skills training were mostly reported to have influenced a positive change in behaviour. The most common type of method (n=6) was Health education (including both adult education and school-based education programmes). Most of these interventions were evaluated through focus groups and interviews. For example, Ouoba et al (2004) noted that through the implementation of health education programmes in province of Bazega in Burkina Faso, there was a significant increase in the percentages of girls aged 0-10 years who had not been subjected to FGM within a period of two years after the intervention although the exact figure was not stated. Another example can be drawn from the evaluation of the long-term impact of an NGO's educational programme in Senegal (Diop et al., 2009). Diop et al reported that the communities that completed the education programmes had a greater level of awareness of the dangers associated with FGM which prompted the communities to call for public declarations of the practice. A village Imam said;

"FGM has been banished by the people of this village. Tostan conducted awareness –raising activities with discussions about FGM to teach people the harmful effect of the practice. Our village heard about all of these activities and attended several meetings about FGM in Medina Cherif. That is what

motivated us to participate in public declaration” (a village Imam) (Diop et al., 2008).

Three interventions that reported a positive change in behaviour were linked to community dialogue and two of these were carried out in Senegal (Aubel, 2010; Diop and Askew, 2009). Advocacy campaigns were used in 2 of the interventions were carried out in Cote d’Ivoire, and Mali. It is also important to highlight that, most of the advocacy campaigns targeted religious leaders, village chiefs and women’s groups. For example, as result of an advocacy campaign in Mali, a patriarch led his clan in a public declaration not to circumcise their female children (NCA, 2005). In other instances, an advocacy campaign resulted in enhancing change within different religious discourse and adopting of FGM abandonment as an institutional agenda of some religious organisations such as the Evangelical church of Eritrea (NCA, 2005). Less common of the methods used to influence a positive change in behaviour was skills training for women and girls (n=1). For example, the performance of skills training in agriculture and animal husbandry for women and girls was carried out in Senegal, which reported a positive change in behaviour of the participants. One of the women said; *“If someone says we should stop because it is harmful and gives us an alternative, we would stop it straight away”* (comment by the Sowies in a focus group discussion, AIM’s mid-term report) (AIM, 2007). An important common factor among the interventions that resulted in positive change in behaviour was the involvement of men among the target population.

The most common aims mentioned of these interventions were to empower women and other community members (n=4) and to encourage community dialogue (n=3). Out of the 12 interventions that reported a positive change in behaviour, most were based on the educational and empowerment model health promotion (n=5 respectively).

Discussion

This study aimed to evaluate the community-based interventions carried out to prevent Female Genital Mutilation (FGM) in West Africa between the years 2000 - 2013. This study sought to identify the types of methods that had been implemented and those most frequently used to try to achieve a positive change in knowledge, attitude and behaviour towards FGM in West African communities, in order to provide empirical evidence regarding choice of methods for FGM interventions. In this research, it was found that most of the interventions were carried out in rural communities and involved both men and women in the target populations. According to UNICEF (2013) FGM is commonly practiced in many African communities and any intervention aimed at preventing the practice should involve people at the grass-root level. This study found that the interventions to prevent the

practice of FGM were mostly carried out in rural communities where there are high levels of ignorance and lack of knowledge about FGM. The most common aim of these interventions was to create awareness in the communities about the harmful effects of FGM and its practice which is also seen as a violation of human rights. An example can be drawn from the Norwegian Church Aid programme that helped to raise awareness about the normal female genital and importance of the clitoris to women (NCA, 2005). It was discovered in this study that, methods such as advocacy campaigns, health education, sensitization workshops were reported to have resulted in increase in knowledge of participants about FGM. However, majority of the interventions that resulted in a positive change in the knowledge of participants were linked to health education activities.

Dalal et al (2010) highlighted that the attitude of people plays a significant role in the persistence of the practice and an access to information about the negative consequences associated with FGM can result to a less tolerant attitude towards the practice. Heitman (2000) suggested that educationally empowered people are more enlightened about the controversy surrounding the practice of FGM. This is in accordance with the findings of this study that revealed that most of the interventions that resulted in a positive change in attitude were strongly linked to health education and based on the educational model of health promotion. This study found that the interventions that reported a positive change in attitude towards FGM conducted educational programs for the participants in order to increase awareness about the consequences of FGM. For example, the studies conducted in Burkina Faso (Ouoba et al, 2004) and Senegal (Diop et al, 2009) which reported that a positive change in the attitude of the people towards FGM was encouraged through adult health education. Also, the study conducted by Dalal et al (2010) in Egypt reported that educational interventions helped to lower the favourable attitude towards FGM among Egyptian women. Moreover, Barstow (1999) mentioned that interventions that incorporate education into the programme may be more successful in encouraging a positive change in attitude than only legislation against the practice. Therefore, adequate educational campaigns are essential in order to inform the communities about the risks related with the practice.

The WHO (2008) recommended that in order for interventions to be effective in eliciting a positive change in the attitude of people towards FGM, it is essential that key members of the communities be involved in the programmes. This reflects the findings of this study because it reveals that a common factor associated with the interventions that achieved a positive change in attitude was the involvement of the community leaders (such as village chiefs and religious leaders) and the involvement of FGM practitioners as change agents and peer educators. Community leaders are usually seen as

role models by the people in the community, and their judgements are usually emulated thereby enhancing the acceptance of anti-FGM messages given by the experts. Therefore, without the involvement of key members of the community, there is a tendency that health messages would be ignored because community members view the FGM experts as outsiders trying to condemn their traditional beliefs.

As FGM is an integral aspect of traditions and culture, the WHO recommended that intervention programmes should be geared towards changing the behaviour of individuals to adopt healthy behaviours (WHO, 2012). Several authors such as Scriven (2010), Naidoo and Wills (2000), amongst others are of the opinion that an approach that is dependent on people's autonomous decision can help to elicit a positive change in health behaviour. This educational model of health promotion is non-directive in nature but enables individuals to make an informed health decision (Scriven, 2010). Notably, the findings of this study revealed that most interventions that reported a positive change in behaviour were most strongly linked to the educational model of health promotion. The success of this model was recorded in several interventions such the education programmes carried out in Senegal where the programme never directed the people to stop FGM but the community reached the decision to abandon the practice after series of educational sessions (Diop and Askew, 2009). The findings of this study support the point raised by Jones et al (2004) and WHO (2012) that, the decision to stop the practice must be made by people of practicing communities themselves in order for there to be a real and lasting change.

Additionally, it was found in this study that the common methods were; sensitization workshops, advocacy campaigns, health education, media campaigns, skills training and community dialogue. Amongst these separate methods, it was discovered that the most frequently used method was health education based on the educational model of health promotion. This implies that the use of health education has been a key measure towards the successful eradication of FGM in West African communities.

Conclusion

Generally, it was found that these interventions reflected a range of health promotion models such as the behaviour change, client centred/empowerment, social change and commonly the educational model that positively influenced changes in knowledge, attitude and behaviour towards FGM which has helped in reducing the practice in West African communities. None of these interventions were based on the medical model of health promotion. Hence, it seems that an incorporation of the medical and educational models of health promotion could result in a greater impact in community-based interventions to prevent FGM.

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