# The REPLACE Approach: supporting Communities to end FGM in the EU. A Toolkit

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# The REPLACE* Approach: Supporting Communities to end FGM in the EU.

## A Toolkit

**2015**

**\*Researching Female Genital Mutilation Intervention Programmes linked to African Communities in the EU**

REPLACE 2

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# FOREWORD by Neena Gill MEP

I am pleased to be hosting the launch of the REPLACE Toolkit and Community Handbook Launch at the European Parliament on 21st October 2015. Bringing about an end to the practice of Female Genital Mutilation (FGM) is a priority across the European Union and we need to provide the resources to make this possible, while also raising awareness.

I represent the West Midlands constituency in the UK, and the harmful effects of this practice are experienced by thousands of women and girls from across the region.  West Midlands Police have dealt with 70 cases involving FGM in the first seven months of this year. 632 women and girls were treated for complaints linked to FGM at West Midlands' hospitals between last September and the end of March this year, and that's within my region alone. The physical effects of the surgery are undoubtedly of huge concern, as is the psychological impact, and more needs to be done to prevent the practice. That's why I am throwing my support behind the REPLACE team, which has gone from strength to strength since it was first formed in 2009 to bid for European Commission funding through the Daphne III Action Grant Programme.

The REPLACE pilot toolkit (2011) involved team members from Coventry University, FORWARD UK and the FSAN (Netherlands) working with Somali and Sudanese communities. The team grew to include Gabinet d'Estudis (Spain), APF (Portugal) and CESIE (Italy) and communities from Guinea Bissau, Senegal, Gambia, Eritrea and Ethiopia on the most recent Daphne III Action Grant (2013-15). Consequently, the REPLACE Approach has been tried and tested across five different EU member states, and five different migrant populations. It is flexible and tailored, and importantly, makes use of the assets and skills that lie within communities to help them bring about change for themselves.

The REPLACE Toolkit and the accompanying REPLACE Community Handbook provide a 'how to' guide for community members affected by FGM, and community leaders and organisations working with them to bring about an end to FGM in the EU. The Toolkit provides detailed yet easily digestible 'tools', set around a simple five-point 'cyclic framework for social norm transformation' for supporting and empowering communities to bring about change from within. The Community Handbook presents this information in a brief and functional form, to help community members 'pick up and run' with the REPLACE Approach.

The REPLACE Approach addresses many of the criticisms levied at current efforts to bring about an end to FGM in the EU. It does this in an accessible way, by incorporating interdisciplinary strategies and drawing on the strengths of all the partners and communities involved in its development. The team are to be commended on this bold step forward in working together to end FGM in the EU.

**Neena Gill, West Midlands MEP**

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The REPLACE Approach is an innovative and effective approach to ending FGM in the EU. It was conceived in 2009 and has received two Daphne III action grants (REPLACE1: JLS/2008/DAP3/AG/1193-3DCE03118760084; REPLACE2: JUST/2012/DAP/AG/3273). Together with REPLACE partners (FORWARD (UK); FSAN (Netherlands); CESIE (Italy); APF (Portugal); Gabinet d'Estudis Socials (Spain)) and over a period of five years, the REPLACE Approach has been developed, trialled, improved, implemented and evaluated with African FGM affected communities living in the EU including those from: Eritrea, Ethiopia, Gambia, Guinea Bissau, Senegal, Somalia and Sudan. The REPLACE Approach is presented in this Toolkit, with the accompanying REPLACE Community Handbook giving practical guidance on how to implement the REPLACE Approach.

This Toolkit presents the REPLACE Approach which has been developed with the goal of ending FGM in the EU. It is a bottom-up approach that empowers communities and puts them at the centre of social norm transformation using behavioural change theory. It is thus aimed at those within FGM affected communities or those working with these communities, whose goal is to end FGM in the EU. It is also relevant to policy makers who aim to end FGM; since the success of the REPLACE Approach is enhanced by political support.

**Context**

The exact number of women and girls living with FGM in Europe is not known (EIGE, 2013; Leye, *et al,* 2014). However, in 2009 the European Parliament (EP) estimated that up to half a million women living in Europe had been subjected to FGM with a further 180,000 women and girls at risk of being subjected to the practice every year (EP, 2009). 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. The UNHCR (2013) suggests that those EU countries with the highest numbers of girls and women who have survived or are at risk of FGM are: France, Italy, Sweden, the UK, Belgium, Germany and the Netherlands.

The very limited data available on FGM in the EU 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 (UNHCR, 2013). We therefore have no indication of the prevalence or 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 and requires a community-based approach as advocated by REPLACE.

The ending of FGM in the EU (and elsewhere) has proven very difficult. This deep rooted cultural tradition is very resistant to change. Despite campaigns aimed at explaining the adverse health implications of FGM and the criminalisation of the practice in all EU Member States, FGM continues to be performed on EU citizens. If we are going to end FGM then it is imperative that we understand the social norm and enforcement mechanisms used by different communities to continue the practice in the EU. REPLACE recognises that communities are different and have different belief systems supporting the practice of FGM and different social pressures to continue the practice and that it is important to understand these differences if interventions to end FGM are to be successful.

**The REPLACE Approach**

The REPLACE Approach is a new way to tackle FGM in the EU and replaces the dominant methods used to end FGM in the EU 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.

Behaviour change theories combined with community engagement are central to the REPLACE Approach. With its embedded monitoring and evaluation techniques the REPLACE Approach empowers FGM affected communities through community leaders, influential people within the community and community peer group champions to challenge the social norm supporting FGM.

The three pillars of the REPLACE Approach:

i. **Behavioural Change:** REPLACE recognises that the practice of FGM occurs within a wider socio-cultural context and the behaviour and decisions of others are critical in relation to the outcome of whether or not FGM is carried out. REPLACE also recognises that some individuals are in less powerful or influential positions than others, and therefore are unable to implement certain behaviours that will lead to the abandonment of FGM. REPLACE has therefore adopted relevant elements from both individually focussed behaviour change theories and the theories that concentrate on the role of society to tackle the social norm of FGM.

ii.   **Engaging and working with communities**: When implementing activities and interventions based on behaviour change theories it is very important to understand the belief systems and the social norm supporting the behaviour and identify any barriers to 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 affected community as a whole. In addition every community is different, so what might be the case for one community might not be the same for other communities. 'One size does not fit all'. Thus engaging with communities and listening to community members and leaders is important in order to ensure the intervention is appropriate, culturally acceptable and effective. The REPLACE Approach uses Community-based Participatory Action Research (CPAR) to engage with communities and collect information concerning individual and community practices and beliefs regarding FGM and the perceived barriers to ending FGM.

iii.  **Evaluation**: Evaluation underpins the REPLACE Approach and informs each element of the Approach. It is an iterative and empowering process allowing communities and organisations working with communities to end FGM to target, adapt, implement and assess the impact of activities and interventions to ensure effective use of limited resources for maximum impact. In addition it allows interventionists to learn what works and what needs improving or changing (The Health Foundation, 2015), The REPLACE Approach advocates the use of evaluation approaches that can be easily adopted and employed by communities and organisations working with limited budgets, so that they can assess the effectiveness of their work and decide how best to make use of limited funds and resources.

The REPLACE Cyclic Framework for Social Norm Transformation comprises five elements that represent the flow of motivation and behaviour change within a community, stressing the important role played by community leaders, influential people and peer group champions in achieving social norm transformation. The Cyclic Framework is shown in Figure 2.2.

The REPLACE Approach, whilst addressing the issue of FGM using behavioural change theories, does not regard ending FGM as a *behaviour,* but a *goal.* With the achievement of that goal requiring a number of cycles of the Cyclic Framework.

**Figure 2.1    The REPLACE Cyclic Framework for Social Norm Transformation**
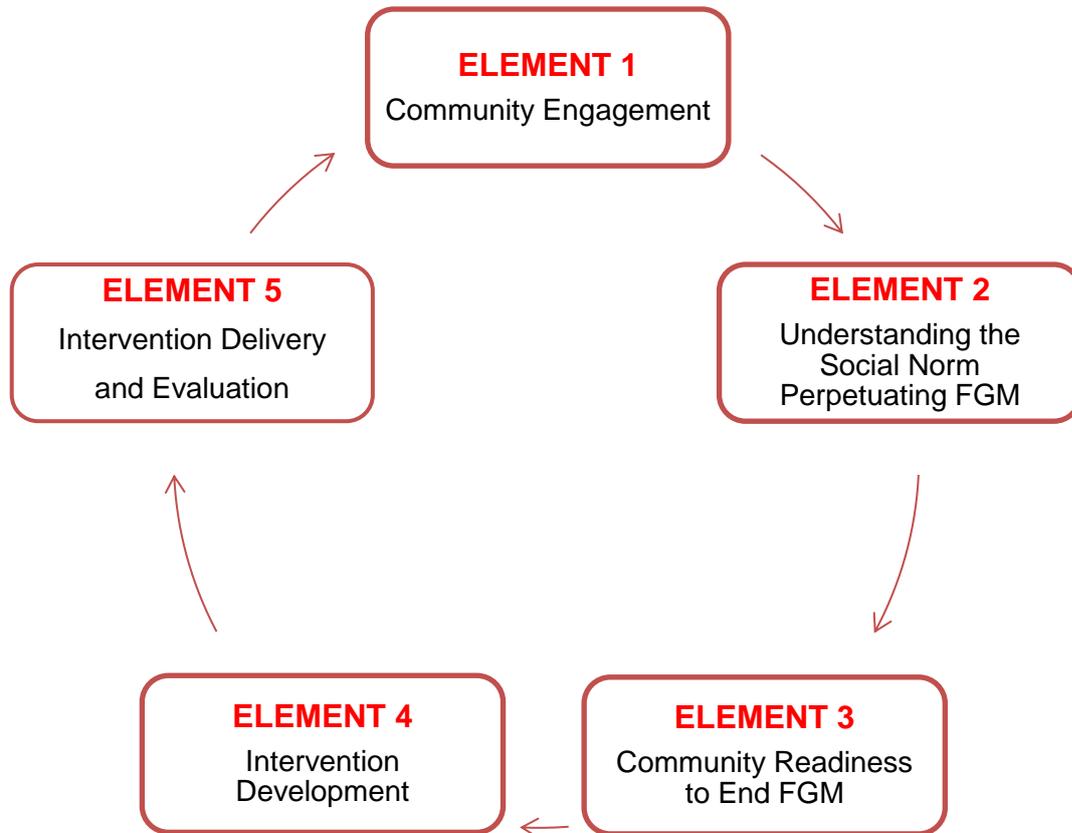


Source: REPLACE

***Element 1: Community Engagement***

Overturning the social norm that perpetuates FGM requires effective community engagement. This is the first element of the REPLACE Approach. Community engagement is based on the assumption that if members of a community support and enforce a social norm, such as FGM, then they could be the key to overturning the norm (Johansen *et al,* 2013). Community engagement does not necessarily represent a separate activity in an intervention project; it is more of an approach for delivering an intervention. It is essentially a mechanism for working with community members and involving them in interventions that deal with issues that affect them.

The REPLACE Approach recognises that communities have a wealth of knowledge and resources that can be harnessed to address issues that affect them. Therefore it emphasises a bottom-up and community-led approach to tackling FGM. This suggests

interventionists should work with community members as collaborators and partners rather than as top-down solution prescribers. Ultimately, REPLACE requires community members to be extensively involved in all aspects of the intervention cycle, including research, design, implementation and evaluation. The community engagement approach of REPLACE is underpinned by four key principles, namely inclusion, respect, effectiveness and transparency.

### *Element 2: Understanding the social norm perpetuating FGM*

The implementation of the REPLACE Approach requires an understanding of the belief systems and social norms that support the continuation of FGM in a community. This is essential to ensure that intervention activities are designed to meet the specific needs of the affected community and are culturally appropriate. REPLACE suggests that Community-based Participatory Action Research (CPAR) should be used to understand the specific belief systems and enforcement mechanisms that support the continuation of FGM in affected communities. CPAR is particularly useful for both research and intervention on FGM because it facilitates an effective engagement with community members and an in-depth exploration of various issues on FGM. The process also empowers and motivates community members to reflect and challenge the belief systems and social norms that support FGM and to take actions to end the practice.

CPAR assists in identifying the range and complexity of the belief systems that are likely to enforce FGM, and which must be confronted by interventions. It should be emphasised that, as much as these belief systems facilitate the practice of FGM they also provide avenues for tackling FGM. A nuanced community-based research approach should provide an effective mechanism for uncovering how the belief systems can be harnessed to bring about change in relation to the social norm perpetuating FGM in the EU.

### *Element 3: Community readiness to end FGM*

Each FGM Affected community in the EU is different and will be at different stages of readiness to challenge and overturn the social norm supporting the continuation of FGM in the EU. Few if any interventions in the EU aimed at ending FGM have taken this into consideration, often using the same intervention for all FGM affected communities. As a result the impact of these interventions has frequently been disappointing, with awareness of FGM being raised but little evidence of behavioural change and the associated abandonment of FGM. Thus the REPLACE Approach incorporates a Community Readiness to End FGM Model based on Stages of Change Models.

REPLACE adapted the Tri-ethnic Centre's Community Readiness model (Plested *et al*, 2006) to the issue of FGM in the EU. REPLACE used the same methodology, namely dimensions of change, to determine a score to match to one of nine stages of readiness to change. These were adjusted to be relevant to the issue of FGM in the EU, and were informed by Elements 1 and 2 of the REPLACE Approach. The REPLACE interpretation of the stages to change range from stage one 'no community awareness of the issues associated with ending FGM' to stage nine 'high level community buy in to end FGM'. These are shown in Figure 5.3.

**Figure 5.2    Community Readiness to End FGM Model**

| DIMENSIONS OF CHANGE | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| LOW (1-3) / MEDIUM (4-6) / HIGH (7-9) | | | | | | | | | |
| A. Community Knowledge Concerning FGM | L | M | M | M | H | H | H | H | H |
| B. Community belief systems and attitudes towards FGM | L | L | M | M | M | H | H | H | H |
| C. Community efforts to ending FGM | L | L | L | M | M | M | M | H | H |
| D. Community Knowledge of the efforts to end FGM | L | L | L | L | L | M | H | H | H |
| E. Community leaders and influential people's attitudes to ending FGM | L | L | L | M | M | H | H | H | H |
| F. Community resources available to support efforts to end FGM | L | L | L | L | L | M | M | M | H |
| Stage number | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| STAGES OF COMMUNITY READINESS TO END FGM | No community awareness | Community Denial/ Resistance | Vague Community Awareness | Preplanning | Preparation | Initiation | Stabilisation | Expansion | Community Ownership |

**FOCUS OF INTERVENTION**

INCREASING KNOWLEDGE OF FGM
- Building community cohesion
- Increase knowledge of health impacts and illegality of FGM
- Challenge belief systems supporting FGM

CHANGING ATTITUDES AND INITIATING BEHAVIOUR CHANGE CONCERNING FGM
- Identify and support community leaders/Peer Group Champions to end FGM
- Support efforts to end FGM by developing appropriate interventions
- Begin to harness community resources to end FGM

SUPPORTING BEHAVIOUR CHANGE NOT TO PERFORM FGM
- Reinforce community efforts to end FGM
- Ensure community and other resources to ensure the abandonment of FGM

**COMMUNITY/INDVIDUAL EMPOWERMENT BALANCE**

Community Empowerment

Individual Empowerment

Community Empowerment

**SOCIAL NORM CHANGE**

| SOCIAL NORM SUPPORTING FGM | SOCIAL NORM TIPPING POINT | SOCIAL NORM ABANDONING FGM |

*Source: REPLACE*

The REPLACE Community Readiness to end FGM Model is easy and affordable to use, and it provides a nuanced tool to inform intervention development, especially when based on community engagement and using Community-based Participatory Action Research methods to understand community dynamics and the social norm perpetuating FGM. It is a tool that can easily be used by communities to determine stage of readiness to end FGM, to help inform the development of appropriate interventions and also when used at regular intervals can monitor a community's progress towards social norm transformation where FGM is no longer acceptable.

### Element 4: Intervention development

The REPLACE  Approach to intervention design and implementation is unique in that it draws on and applies theoretical ideas concerning readiness to change, behaviour change and targeting problem behaviour from both individual and community-based theories of behaviour change intervention development. It does this in collaboration with the community of people where change is desired. When enough people are reached, experience attitude change and as a result alter their behaviour towards FGM the community will be one step nearer achieving the goal of ending FGM.

The REPLACE Approach to intervention development comprises two components:

1. Identifying intervention action(s) with community peer group champions.
2. Undertaking a capability, opportunity, motivation and behavioural assessment (Michie *et al,* 2014) of how to train, resource and support peer group champions to implement intervention action(s).

The result is an intervention action(s) that is matched to the readiness to end FGM stage of the community, employs behaviour change techniques derived from decades of behaviour change research, that is appropriate and culturally sensitive and once delivered will have an impact on those who participate in the intervention, thus moving the community nearer to the goal of ending FGM.

### Element 5: Intervention Delivery and Evaluation

Evaluation is an integral part of the REPLACE Approach and should be planned alongside all stages of intervention development.  Evaluation is an essential part of quality improvement, solving problems and informing decision making (The Health Foundation, 2015). The Health Foundation recommends that 'An evaluation has to be specifically designed to address the questions being asked and the nature of the intervention being

evaluated. This means using different methods, working in different settings, with varied populations and data, under specific constraints of time, expertise and resources, both human and financial.' (The Health Foundation, 2015, 4). Robust evaluation can tell us if an intervention has worked/not worked and how and why, allowing lessons to be learnt for spreading successful interventions and developing new ones.

The REPLACE Approach involves using a combination of qualitative and quantitative methods for evaluating the impact of activities and interventions. The exact focus of evaluation is determined by the nature of the intervention and what has been targeted for change. The REPLACE evaluation strategy includes four core components:

i.   Using the REPLACE Community Readiness to End FGM Model to assess a community's stage of readiness to end FGM at the outset of working with them. This was repeated after intervention delivery and can be repeated again at later dates to continue to assess shifts at the community level.
ii.  Focus groups with community members to gather in depth information concerning their thinking and beliefs. These were carried out before as well as after interventions where possible to get a richer feel for the nature of the changes within communities.
iii. Questionnaires conducted before and after interventions with those who have participated. These included numerical rating scales to assess things like specific beliefs and open-ended qualitative response items to gain valuable information about the nature of any individual behaviour changes.
iv.  Records of the instances of intervention activities, such as the number of community events that are held and the number of people who attended. Over time it might be possible to show increasing engagement and participation in activities designed to end FGM by community members and if this is the case then there is evidence of community development and change.

The REPLACE project aimed to produce a variety of individual and community focussed evaluation techniques that could be picked up and applied by NGOs and communities working to end FGM, to better record and understand the impact of their activities, and feed into better and more effective interventions in the future.

**Conclusion**

The REPLACE Toolkit (and accompanying REPLACE Community Handbook) provides a new framework for working to end FGM in the EU, and to evaluate activities that are undertaken to achieve this goal. The Toolkit demonstrates why traditional approaches typically used to campaign and intervene to end FGM may not be resulting in an end to the practice and argues for a new approach, the REPLACE Approach. The REPLACE Approach combines the latest research into behaviour change with Community-based Participatory Action Research and regular evaluation. The result is a culturally sensitive, community empowering  framework designed to achieve social norm transformation, and bring about an end to FGM in the EU.

# ACKNOWLEDGEMENTS

# GLOSSARY

**Clitoridectomy**: This is a type of FGM; it refers to the partial or total removal of the clitoris (a small, sensitive and erectile part of the female genitals) and/or the prepuce (the fold of skin surrounding the clitoris).

**Community engagement**: This term is used to refer to the process and practice of involving members of FGM affected communities in some form in a programme to end FGM in their community. This includes the process through which community members are informed, consulted, and participate in designing and implementing an intervention to end FGM.

**Community leaders**: This is used to refer to religious leaders, political leaders, cultural leaders and opinion leaders in an FGM affected community.

**Community profiling:** This is an exercise used by REPLACE to try and understand an affected community (target intervention community) better, including the community's history, politics, livelihoods, interest groups, demography, resources and services.

**Community readiness to end FGM:** This is a methodology used by REPLACE to understand the extent to which an affected community is ready to abandon FGM and also determine the specific interventions that are most appropriate for the community.

**Community:** This term is used to refer to a group of people who live in a particular geographical area such as neighbourhood, city or town. It is also used to refer to a group of people who share common interests or characteristics such as ethnicity, religion, or language.

**Community-based Participatory Action Research (CPAR):** This is the approach that REPLACE used to engage members of FGM affected communities to understand the social norm supporting FGM. 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 so that that they can take action to tackle FGM.

**Community-based Researchers (CBR)**: These are selected members of FGM affected communities that REPLACE employed and trained to undertake research in their communities. They included both males and females and mainly undertook information collection and analysis.

**Community Peer Group Champions**: These are people who can champion behavioural change concerning FGM within their peer/gender group. They are respected and are regarded as influential by their peers on sensitive/cultural issues, such as FGM.  They are likely to be some of the first within their community to implement and work with change.

**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 European researcher.  We use the term cultural 'outsider' to refer to the opposite of cultural 'insider'

**Daphne:** This is the funding source at the European Commission that paid for the REPLACE project work.

**Ethno-national Heritage/Group:** This term is used to refer to individuals who share a similar ethnic and national background.

**Excision**: This is a type of FGM; it refers to the partial or total removal of the clitoris and labia minora, with or without excision of the labia majora. The labia are "the lips" that surround the vagina.

**Excisor:** This is term is used to refer to individuals who conduct the procedure of FGM in a traditional setting. They are also called 'cutters'.

**Female Genital Mutilation (FGM):** This is one of many words used to describe the practice of female circumcision or cutting. It is also referred to female genital cutting (FGC).

**Focus Group Discussion (FGD):** This is a method of information collection. It involves a group of people getting together to discuss their thoughts, opinions and beliefs about a particular issue or subject. This is sometimes called a focus group (FG).

**Hadith:** Also spelled Hadīt (Arabic: "news" or "story"). It is the record of the traditions or sayings of the Prophet Mohammed. For more information visit: http://www.britannica.com/EBchecked/topic/251132/Hadith.

**Heterogeneous:** A group of people with different characteristics, i.e. age, gender, marital status, sexuality, beliefs etc.

**Homogenous:** A group of people with similar characteristics i.e. age, gender, marital status, sexuality, beliefs etc.

**In-depth interview:** This way of collecting information involves usually one person taking part in a discussion with a researcher. The researcher prompts the person as they want them to talk freely and at length about the topic being researched.

**Infibulation**: This refers to the practice of FGM Type III, where the woman's external genital is removed and the vaginal opening is sutured to produce a small opening.

**Influential people:** These are respected individuals in affected communities known to be influential on the practice of FGM in their community and can shape public opinion within their community either for or against the practice. They include elders, grandparents and excisors.

**Interventionist:** This term refers to anyone who campaigns against FGM or undertakes an intervention to create some form of a change in relation to ending FGM.

**Medicalisation or clinicalisation of FGM**: This describes the FGM procedure that is performed by a trained medical professional and includes the administration of local anaesthetics, antibiotics, tetanus injections and the use of sterile cutting instruments. It can also mean the bringing of FGM practice under the jurisdiction of qualified medical practitioners (doctors, nurses, pharmacists) in hospitals or family homes.

**Participants/Respondents**: These are people who take part in participatory research.

**Peer group champions**: These are individuals within the family or community who have influence among their peers in relation to the practice of FGM. Anybody in the community can be a peer group champion, whether young or old, male or female.

**Re-infibulation:** This is an FGM procedure that involves the closing of the vaginal opening after childbirth.

**REPLACE Approach:** This is the approach advocated by REPLACE for tackling FGM. The approach is underpinned by community-based participatory action research, community engagement, and evaluation. It is based on empowering and motivating FGM affected communities through community leaders, influential people and peer group champions to challenge the social norm supporting FGM and move via a number of behaviour change cycles towards social norm transformation.

**REPLACE Cyclic Framework for Social Transformation:** This is a cyclic model for tackling FGM based on a combination of individualistic and social-based behaviour change theories. It recognises that in order to end FGM a number of cycles of behaviour change will need to take place within the community, namely community engagement, understanding the social norm perpetuating FGM, community readiness to end FGM, intervention development and evaluation.

**Sample:** This is the term used to describe the people who take part in a research as participants. They represent a sample of the population as a whole. A sample frame refers to the population that is selected for a research project.

**Social Norm:** This is used in this document to refer to the informal regulation within communities that motivate individuals to perform FGM. These regulations are in the form of societal expectations and beliefs and enforced through informal processes of approval and disapproval within families and communities.

**Stakeholder analysis:** This involves the process of identifying individuals, groups, and organisations that are affected by FGM or an intervention on FGM, or have an interest in these. The process also entails seeking an understanding of the individuals or groups identified, especially in respect of their needs and motives.

**Sunna/Sunnah**: This is a term used by some 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. It 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.

**Symbolic Circumcision**: This refers to FGM Type IV which involves other harmful procedures to the female genitalia for non-medical purposes not covered in FGM Types I, II and III e.g. pricking, piercing, incising, scraping and cauterizing the genital area also the introduction of corrosive substances to narrow or tighten the vagina.

**Target community**:  this refers to the community where an intervention to end FGM is carried out.

# ABBREVIATIONS

**APF** – Associacao para o Planeamento da Familia (Portuguese REPLACE Partner)

**BCC** - Behaviour Change Communication

**BCI** - Behaviour Change Interventions

**BCT** - Behaviour Change Techniques

**CBR** - Community-based Researcher

**CESIE** – (Italian REPLACE Partner)

**COM-B** – Capability, Opportunity, Motivation and Behaviour

**CPAR** - Community-based Participatory Action Research

**DoH** - Department of Health (UK)

**EC** – European Commission

**EIGE** - European Institute for Gender Equality

**EP** – European Parliament

**EU** – European Union

**FG** – Focus Group

**FGD** – Focus Group Discussion

**FGM** - Female Genital Mutilation

**FORWARD** - Foundation for Women's Health Research and Development ( UK REPLACE Partner)

**FSAN** - Federation of Somali Associations Netherlands REPLACE Partner)

**GES** – Gabinet d'Estudis Socials (Spanish REPLACE Partner)

**HIV** - Human Immunodeficiency Virus

**IEC** - Information, Education and Communication

**NGO** – Non-governmental Organisation

**PATH** - Programme for Appropriate Technology in Health

**REPLACE** - Researching Female Genital Mutilation Intervention Programmes linked to African Communities in the EU.

**SD** – Standard Deviation

**UK** – United Kingdom

**UNHCR** – High Commissioner for Refugees

**UNICEF** - United Nations International Children's Emergency Fund

**WHO** – World Health Organisation

# Introduction to the REPLACE Approach Toolkit

The REPLACE Approach is an innovative and effective approach to ending FGM in the EU. It was conceived in 2009 and has received two Daphne III action grants (REPLACE1: JLS/2008/DAP3/AG/1193-3DCE03118760084; REPLACE2: JUST/2012/DAP/AG/3273). Together with REPLACE partners and over a period of five years, the REPLACE Approach has been developed, trialled, improved, implemented and evaluated. The REPLACE Approach is presented in this Toolkit, with the accompanying REPLACE Community Handbook giving practical guidance on how to implement the REPLACE Approach.

After working with FGM affected communities on REPLACE1 (2010-11) the REPLACE Team at Coventry University (Barrett *et al*, 2011 and Brown *et al*, 2013) argued that as FGM is a social norm and that each community has different belief systems and enforcement mechanisms supporting its continuation , there was a  need to draw on both individualistic and community focussed theories of behaviour change to fully capture the complexity of the practice of FGM in an approach to end it. The REPLACE Approach achieves this by:

1. Engaging with affected communities and ensuring they are active participants in the development and implementation of an intervention in order to gain their trust and commitment to the project and to identify key people in the community to work with, such as community leaders and peer group champions (Section 3).

2. Understanding the nuances of the social norms that perpetuate FGM amongst FGM affected communities living in the EU and the enforcement mechanisms used by the community to ensure individuals continue the practice. This is achieved using community-based participatory action research methods (Section 4).

3. Drawing on community readiness theory (e.g. Edwards et al., 2000), successfully applied to other community issues including drug abuse and domestic violence, to assess where the whole community sits in relation to addressing FGM (Section 5). This helps to identify intervention actions that can be targeted at the community level by community members to achieve change.

4. Working with communities and in particular with community peer group champions to develop interventions aimed at moving the community towards ending FGM in line with the community's readiness to end FGM assessment. The interventions incorporate recent developments in the science of behaviour change (e.g. Michie *et al*, 2014) to assist communities in developing resources and support to help them address the belief systems perpetuating FGM in their community (Section 6).

5. Monitoring and evaluation is an essential part of the REPLACE Approach. This should include both quantitative and qualitative methods to capture community as well as individual responses to the REPLACE Approach and in particular intervention implementation and outcomes. Evaluation can ensure resources are used effectively, that behaviour change is occurring and informs progression through the REPLACE Cyclic Framework (Section 7).

Each of these five are elements are embedded in the REPLACE Cyclic Framework for Social Norm Transformation (Section 2). Each cycle of the framework should make a change to the attitudes and behaviour of the community and individuals within the community concerning the continuation of FGM. This change might be slow at first but will likely speed up as the community gains the confidence to challenge the social norm perpetuating FGM. It is anticipated that a number of cycles of the Cyclic Framework will be needed to shift the community to overturning the social norm supporting FGM and thus achieving the overall goal of ending FGM.

## How to use the REPLACE Toolkit

This Toolkit presents the REPLACE Approach which has been developed with the goal of ending FGM in the EU.  It is a bottom-up approach that empowers communities and puts them at the centre of social norm transformation using behavioural change theory. It is thus aimed at those within FGM affected communities or those working with these communities (interventionists) whose goal is to end FGM in the EU. It is also relevant to policy makers at community, regional or national levels whose aim is to end FGM, as the success of the REPLACE Approach is enhanced by political support.

The Toolkit comprises seven sections as follows:

**Section 1**: gives some important background and contextual information concerning the practice of FGM in general and within the EU.   It demonstrates that FGM is a social norm that takes on different characteristics in different FGM practising communities in the EU. Traditional approaches to tackling FGM in the EU have had limited success and therefore a new approach, such as the REPLACE Approach, is needed to effectively tackle this issue.

**Section 2**:  the REPLACE Cyclic Framework for Social Norm Transformation is introduced and described. The Cyclic Framework comprises five elements which are discussed in greater detail in the following five sections of the Toolkit.

**Section 3**: Element 1, the need to engage with FGM affected communities is discussed and the importance of community involvement and gaining trust is explained. Identifying a target population and key community members is an important part of the REPLACE Approach. Community engagement cannot be rushed, as it underpins the REPLACE Approach, its sustainability and ultimately its success at ending FGM.

**Section 4**: Element 2, understanding the social norm and enforcement mechanisms supporting the continuation of FGM is essential in order to develop appropriate and culturally sensitive interventions. This is done using community based researchers and community peer group champions to work with their communities and peer groups. They are trained and supported in undertaking community-based participatory action research. The information is analysed and is used to inform Element 6 of the Cyclic Framework.

**Section 5**: Element 3 is assessing the community's readiness to end FGM. The REPLACE Approach recognises that different communities are at different stages of readiness to end FGM and their readiness stage will shift as interventions take place. The assessment involves undertaking interviews with individuals representing different segments of the FGM affected community or undertaking focus group discussions and assessing the community in terms of six dimensions of change. These are then translated into one of nine stages of readiness to end FGM, which ranges from 'no community awareness of FGM' through to 'community ownership of the need to end FGM'. It can also be used as an evaluation tool to assess the impact of interventions on FGM affected communities.

**Section 6**: Element 4 involves intervention development and implementation by the community. This is informed by the results of Elements 2 and 3. Using behavioural change theories such as the COM-B Model, the community is assisted in identifying target intervention action(s) and developing an intervention that will change community and individual attitudes and behaviour concerning FGM, moving the community a step nearer challenging the social norm perpetuating FGM and ending the practice.

**Section 7**: Element 5 concerns monitoring and evaluation which is a central part of the REPLACE Approach and should take place during every element of the Cyclic Framework. It is particularly important to undertake evaluation before and after intervention delivery to assess its effectiveness and success. The REPLACE Approach suggests the use of qualitative and quantitative methods that target both community and individual experiences. The results of the evaluation element will inform the next round of the Cyclic Framework and

progress towards achieving the goal of social norm transformation within the community with the resulting ending of FGM.

## Ethical Considerations

The research associated with, and the implementation of the REPLACE Approach must be done in an ethical manner. Ethical issues must be identified and addressed at each element of the REPLACE Approach. This includes considering the ethical issues associated with:

- Community engagement and identifying the target community
- Recruiting community-based researchers and peer group champions
- Consent, confidentiality and the handling and storage of information
- The development and implementation of the intervention
- Evaluation and de-briefing
- Ensuring participant and researcher safety and emotional well-being
- Processes to follow if a participant discloses intent to practise FGM or a recent case of FGM.

Information and guidance on how to deal with these issues are contained in the REPLACE Community Handbook.

The REPLACE Toolkit is accompanied by a REPLACE Community Handbook which gives practical guidance and examples of how each element of the REPLACE Approach can be implemented.

There is also a REPLACE website that contains more material and examples, as well as help and advice on the REPLACE Approach. This can be accessed on:

www.REPLACE2FGM.eu.

The REPLACE Team look forward to receiving your comments and feedback on the REPLACE Approach

# Section 1: Female Genital Mutilation (FGM): Background and Context

## 1.0    Introduction

Section 1 of this toolkit will give you important contextual information on the practice of Female Genital Mutilation (FGM). FGM is sometimes labelled Female Genital 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.

## 1.1    WHO Definition and Classification of FGM

The WHO defines FGM as "all procedures involving partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons" (WHO, 2008:4).

**FGM Classification**

WHO classifies FGM into four types:

- *Type I:* **Clitoridectomy**: Partial or total removal of the clitoris (a small, sensitive and erectile part of the female genitals) and/or the prepuce (the fold of skin surrounding the clitoris).

- *Type II:* **Excision**: Partial or total removal of the clitoris and labia minora, with or without excision of the labia majora. (the labia are "the lips" that surround the vagina)

- *Type III:* **Infibulation**: Narrowing of the vaginal opening by cutting and bringing together the labia minora and/or the labia majora to create a type of seal, with or without excision of the clitoris.

- *Type IV:* **Symbolic Circumcision**: All other harmful procedures to the female genitalia for non-medical purposes, e.g. pricking, piercing, incising, scraping

and cauterizing the genital area also the introduction of corrosive substances to narrow or tighten the vagina. (UNICEF, 2013: 7)

Types I to III reflect increasing invasiveness of the cutting, whilst Type IV includes unclassified or symbolic genital injuries. EndFGM (2010) estimate that globally, 90% of females who have experienced FGM have been subjected to Types I, II and IV, while 10% have been subjected to the more serious Type III (infibulation) which predominates in Sudan and Somalia. Table 1.1 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 variations between practising ethnic groups as to the type of FGM preferred (UNICEF, 2013).

**Table 1.1    Percentage of Girls who have Undergone FGM, by Type, as Reported by Mothers for Selected Countries**

| Country | Type IV | Types I & II | Type III | FGM Prevalence (15-49 years) |
|---------|---------|--------------|----------|------------------------------|
| Benin | 1 | 98 | 0 | 13 |
| Djibouti | 6 | 25 | 67 | 93 |
| Eritrea | 46 | 4 | 39 | 89 |
| Gambia | 0.1 | 89 | 9 | 76 |
| Guinea Bissau | 0.2 | 84 | 12 | 50 |
| Mali | 14 | 55 | 2 | 89 |
| Nigeria | 8 | 48 | 4 | 27 |
| Senegal | 10 | 53 | 14 | 26 |
| Somalia | 1 | 15 | 79 | 98 |

*Source: UNICEF, 2013*

FGM is usually performed on girls from infancy to 15 years, but in some communities takes place at an older age (UNHCR, 2013; UNICEF, 2013). This depends on local rituals and customs. The practice is usually performed by traditional cutters/excisors who have no formal medical training and perform the operation in non-sterile conditions using a blade or razor, although there is an increasing trend for medicalization (UNICEF, 2013). It is often performed on groups of girls at the same time, thus increasing the risk of cross-infection. Through this ritual, these girls become 'sisters', forming a strong social support network.

The variations in prevalence and types of FGM performed between countries can best be understood by the ethnic composition of the region. FGM derives much of its meaning from

its association with ethnic identity (EIGE, 2015; UNICEF, 2013), so ethnicity might be a better indicator of risk of FGM than nationality within the EU (EIGE, 2015).

## 1.2   Terminology

Recently researchers have been employing terms such as 'female genital surgeries', 'female genital operations' and 'female genital alterations' (Padwell, 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 used by the WHO, the European Commission and many NGOs campaigning against the practice because it is felt that the term 'mutilation' reflects the physical and psychological gravity and severity of the act (EIGE, 2013). Furthermore, it is argued that the use of the term FGM differentiates the practice from male circumcision. Within this toolkit the term FGM is used. However, REPLACE recognised that affected communities in the EU, depending on their national heritage, employ various terms to refer to the practice.

When undertaking interventions with practicing communities it is important to be aware of the terminology used by the community as many practising communities do not believe that the cutting of female genitals is mutilation and many parents wrongly believe they are subjecting their daughters to FGM for their own good.  In all other respects they are good loving parents. Thus REPLACE suggests that interventionists and others working with communities to end FGM should use appropriate traditional or local terms for FGM to prevent alienation and the hostility of the community, in at least the initial stages of community engagement.

## 1.3   Numbers of Females Subjected to FGM

FGM is concentrated in 29 countries in Africa and the Middle East (see Figure 1.1), but FGM has also been documented outside these countries, including India, Indonesia, Iraq, Malaysia, Colombia, and Peru. UNICEF (2013) estimate that more 150 million girls and women worldwide have been cut with over 125 million of these living in the 29 high

prevalence countries located in Africa and the Middle East.   Each year it is estimated that 3 million girls globally are at risk of FGM (Population Reference Bureau, 2010).

The most recent data shows wide variation in FGM prevalence.   The practice is almost universal in Somalia, Guinea, Djibouti and Egypt, with prevalence levels above 90% (UNICEF, 2013). In Cameroon and Uganda on the other hand, prevalence rates are approximately 1%. Figure 1.1 shows the FGM prevalence rates in the 29 most affected countries in Africa and the Middle East.

## Figure 1.1  Prevalence of FGM in Africa and the Middle East
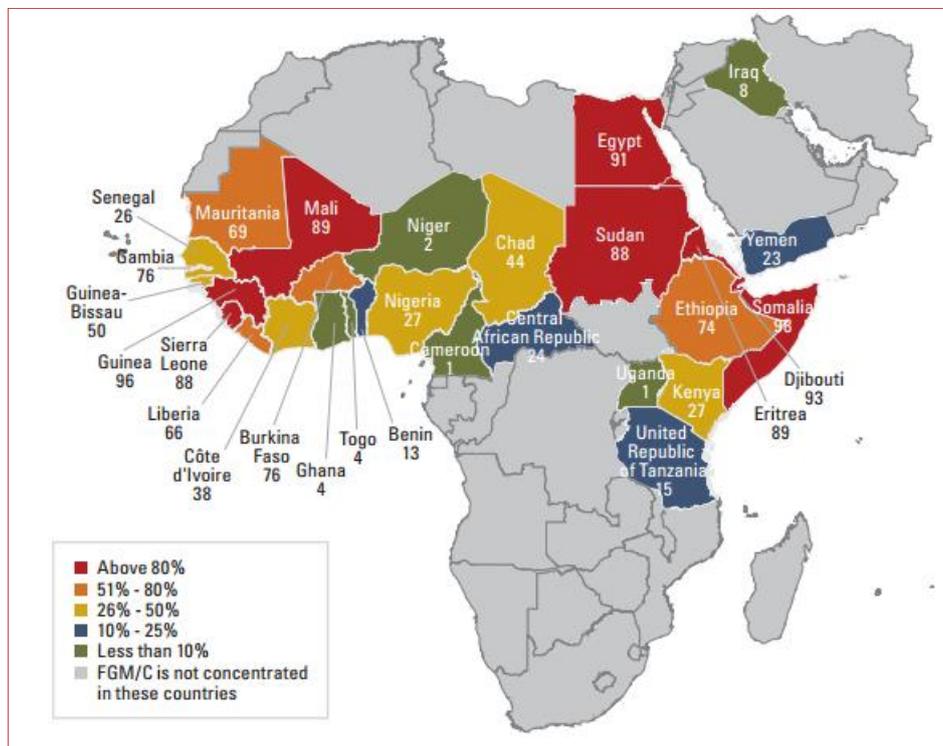


*Source: UNICEF, 2013:26*

With increasing globalisation and many people from FGM practising countries migrating to the EU and other developed regions, the practice of FGM is no longer restricted to the traditional practising countries. There are now substantial populations of girls and women living in the EU who have been subjected to FGM or who are at risk of FGM (EIGE, 2013; UNHCR, 2013; UNICEF, 2013).

The exact number of women and girls living with FGM in Europe is not known (EIGE, 2013; Leye, *et al*, 2014). However, in 2009 the European Parliament (EP) estimated that up to half

a million women living in Europe had been subjected to FGM with a further 180,000 women and girls at risk of being subjected to the practice every year (EP, 2009). 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. However EIGE (2015) claim that FGM is decreasing amongst migrant groups from high prevalence countries living in the EU as migrants change their attitudes and/or behaviour concerning FGM. Factors that may be associated with such changes include  the legal framework in the EU outlawing FGM , the raised awareness of the harmful impact of FGM, reduced social pressure to perform FGM and increased contact with people from cultures that do not practice FGM. The UNHCR (2013) suggests that those EU countries with the highest numbers of girls and women who have survived or are at risk of FGM are: France, Italy, Sweden, the UK, Belgium, Germany and the Netherlands.

The very limited data available on FGM in the EU 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 (UNHCR, 2013). We therefore have no indication of the prevalence or 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 and requires a community-based approach as advocated by REPLACE.

## 1.4   Health Impacts of FGM

There are numerous studies which demonstrate the significant association between FGM and various gynaecological and pregnancy complications (UNICEF, 2013; UK DoH, 2015). 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 several immediate and long-term physical, psychological and sexual consequences (see Figure 1.2). 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. FGM has no health benefits and as Figure 1.2 shows, it harms girls and women in many ways, both physically and psychologically.

All types of FGM have immediate health risks such as excessive bleeding, septicaemia, death and HIV transmission (Cook, 2008; Shell-Duncan, 2001; WHO, 2000; 2006; 2008). There are, however, differing long term health impacts between FGM types (Berg *et al*, 2010b; WHO, 2006); both physical and psychological. 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) (Utz-Billing & Kentenich, 2008).Type III FGM is a significant causal factor in maternal death or obstructed labour if not appropriately treated (Shell-Duncan, 2001). 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 (Morison *et al,* 2001).

After childbirth, women from some FGM practising communities who have been subject to Type III FGM (infibulation), 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.

## Figure 1.2 The Possible Health Impacts of FGM
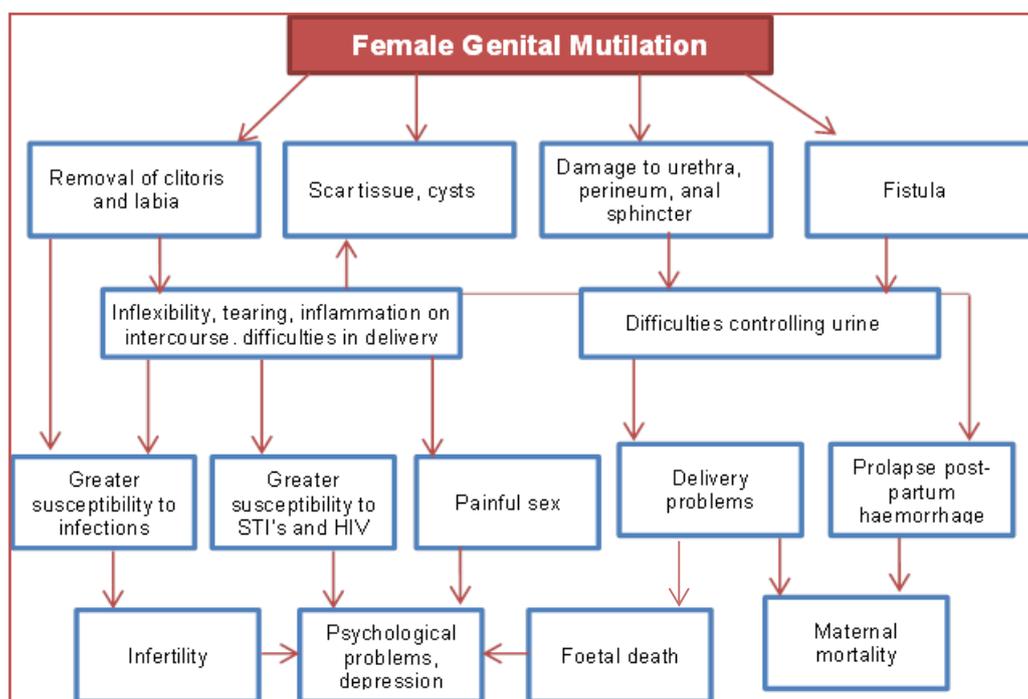


*Source: Adapted from Morison et al., 2001, 645; Cook et al., 2002 and WHO, 2008.*

A systematic review of 17 observational comparative studies (Berg *et al*, 2010a) that compared women who had been subjected to FGM with those who had not, suggested that women who had experienced FGM were more likely to experience psychological disturbances such as suffering from anxiety, somatisation, phobia and low self-esteem than women who had not experienced FGM. Survivors of FGM were also likely to experience increased pain and a reduction in sexual satisfaction and desire which are likely to affect their sexual relationships. Utz-Billing and Kentenich (2008) concluded that FGM causes psychological distress and feelings of humiliation, fear and inferiority. Figure 1.2 shows the possible impacts of FGM on female health, infant and maternal mortality. There is little doubt that FGM (whatever type) has a negative effect on female health.

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. Healthcare professionals in the EU have limited understanding of FGM and its potential complications during pregnancy and childbirth (Capon *et al,* 2014; Leye, *et al,* 2008). Sensitisation of medical staff to FGM is necessary.

Despite the excellent intervention materials available in all EU countries concerning the medical impacts of FGM, the response of many FGM affected communities is to medicalise the procedure and/or perform less physically invasive forms of FGM (UNICEF, 2013).

The medicalisation or clinicalisation of FGM describes a variety of activities related to the FGM procedure. This includes the administration of local anaesthetics, antibiotics, tetanus injections and the use of sterile cutting instruments. It can also mean the bringing of the practice under the jurisdiction of qualified medical practitioners (doctors, nurses, pharmacists) in hospitals or family homes. In 1982 the WHO declared that the medicalisation of FGM was unethical and contravenes the Hippocratic Oath, as the procedure causes harm to the patient. However parents living in the EU do send their daughters to countries where FGM has been medicalised or put pressure for medicalisation within their new home country, as has happened in Australia and the USA recently. Another response by communities to the harmful to health message has been to perform less serious types of FGM on their daughters. For example changing from performing Type III to Type II, or from Type II to Type I or from Type I to Type IV. But all types of FGM are harmful and illegal in the EU.

In 1979 the WHO held its first conference on FGM, which recommended that the practice be totally eliminated. The conference 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 sensitive way to challenge the problem. Whilst a human rights approach has now been introduced to tackle FGM (see Section 1.6) raising awareness of the health impacts of FGM amongst practicing communities continues to be the preferred tool used to end FGM (Johansen *et al,* 2013).

The effectiveness of stressing the health impacts of FGM in order to end the practice in the EU is being questioned by many researchers and interventionists (Johansen *et al*, 2013). REPLACE suggests that the reason that this 'health approach' has had limited success in ending FGM is because it does not treat FGM as a social norm, with different communities having different belief systems and being at different stages of readiness to end the practice. Whilst raising awareness of the health impacts of FGM, the approach does not provide communities and individuals with the necessary tools to challenge the social norm which supports FGM enabling behavioural change to occur.

## 1.5   The FGM Legal Policy Environment

In 1993 at the World Conference on Human Rights held in Vienna, FGM 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 1.3). As a result of this reconceptualization of FGM from a health issue to a human rights violation, legislation became the preferred tool to prevent FGM in many countries including those in the EU.

Progress at both the international and national levels includes revised legal frameworks and growing global political support to end FGM, including specific legislation naming FGM or general laws that could be used to prosecute cases of FGM. Twenty-four countries in Africa, including Ethiopia, Uganda, Ghana, Senegal, Nigeria and Togo, together with Egypt and Djibouti, as well as the 27 EU Member States have specific or general legislation making FGM illegal.

In line with International Conventions the EU frames FGM as violence against women and girls. Violence against women and girls is understood by the EU as a violation of human rights and a form of discrimination against females (EIGE, 2013). The most concrete action taken so far by the EC to combat violence against women is through the EU Strategy on Violence against Women (EC, 2010) which states 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, all 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 covered by general legislation concerning grievous bodily harm or injury. By July 2014 specific criminal provisions had been adopted in 13 EU countries (Austria, Belgium, Croatia, Cyprus, Denmark, Germany, Ireland, Italy, Malta, the Netherlands, Spain, Sweden and UK) with the other EU member states addressing FGM under general criminal law provisions in their penal codes (EIGE, 2013; 2015). Twenty-three EU Member States also have an extra-territoriality clause which makes it illegal for their citizens to travel outside the EU to have FGM performed, for example parents taking their daughter(s) to FGM practising countries to have the procedure undertaken and then returning to the EU (EIGE, 2013). It is worth noting that much of this legislation fails to cover emerging issues such as pricking, nicking or re-infibulation. Furthermore, in some EU countries legislation only applies to those individuals with permanent residency. Therefore, individuals on temporary residency visas, such as students, as well as undocumented migrants and asylum seekers, are not covered by the legislation.

**Table 1.2     Range of Conventions and Charters which Classify FGM as a Violation of Human Rights**

- 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

*Source: Adapted from EndFGM, 2010; EIGE, 2013.*

There have been few FGM related convictions in the EU (Demolin, *et al,* 2010) with EIGE (2013) recording only 41 FGM related court cases in the 27 EU Member States up to January 2012. This involved only six countries, with France recording 29 of these cases and Spain recording six cases. Italy and Finland recorded two cases each, whilst the Netherlands and Denmark recorded one case each.  In the remaining 21 EU Member States there had been no cases brought to court.

This has meant that many FGM practising communities in the EU do not take the legislation 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 (Barrett *et al*, 2011). REPLACE have found, as did UNHCR (2013), 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 standardise FGM legislation across the EU and to ensure harmonisation of the application of the legislation and to work with communities to end the practice.

There has been much debate concerning the role of the law in ending FGM. Mackie (2012:3) summarises this succinctly. Criminalisation 'is not an appropriate response to a structural injustice, in compliance with accepted norms, its harmful consequences unintended by-products, and caused by everyone and no one.' He claims that 'Criminalisation fails where there is no social norm of legal obedience, when a new legal norm is too far from a current social norm, or both.' (Mackie, 2012: 3). REPLACE, in line with Mackie, suggest that without social norm change concerning FGM and a social norm of legal obedience, the law alone cannot end FGM in the EU.

## 1.6    Why is FGM Practiced in the EU?

The origins of FGM are unknown. However, some scholars have suggested that it has been practiced for over 2000 years. For many it pre-dates any of the major monotheistic religions such as Christianity, Islam and Judaism and thus it is not connected to any particular religion, culture, or socio-economic group. FGM takes place in many countries and communities with diverse religious belief systems, including Christian and Muslim. All communities where FGM 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, and 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.

In a systematic review of 25 qualitative studies of the factors promoting and hindering FGM in affected communities living in Western countries (*Berg et al*, 2010b) it was concluded that there is 'an intricate web of cultural, social, religious and medical pretexts for FGM/C' (Berg *et al*, 2010b, 2). They identified six key factors promoting FGM in affected communities living in the West. These are shown in Figure 1.3

.

**Figure 1.1    Conceptual Model of Factors Promoting and Hindering FGM in Western Countries**
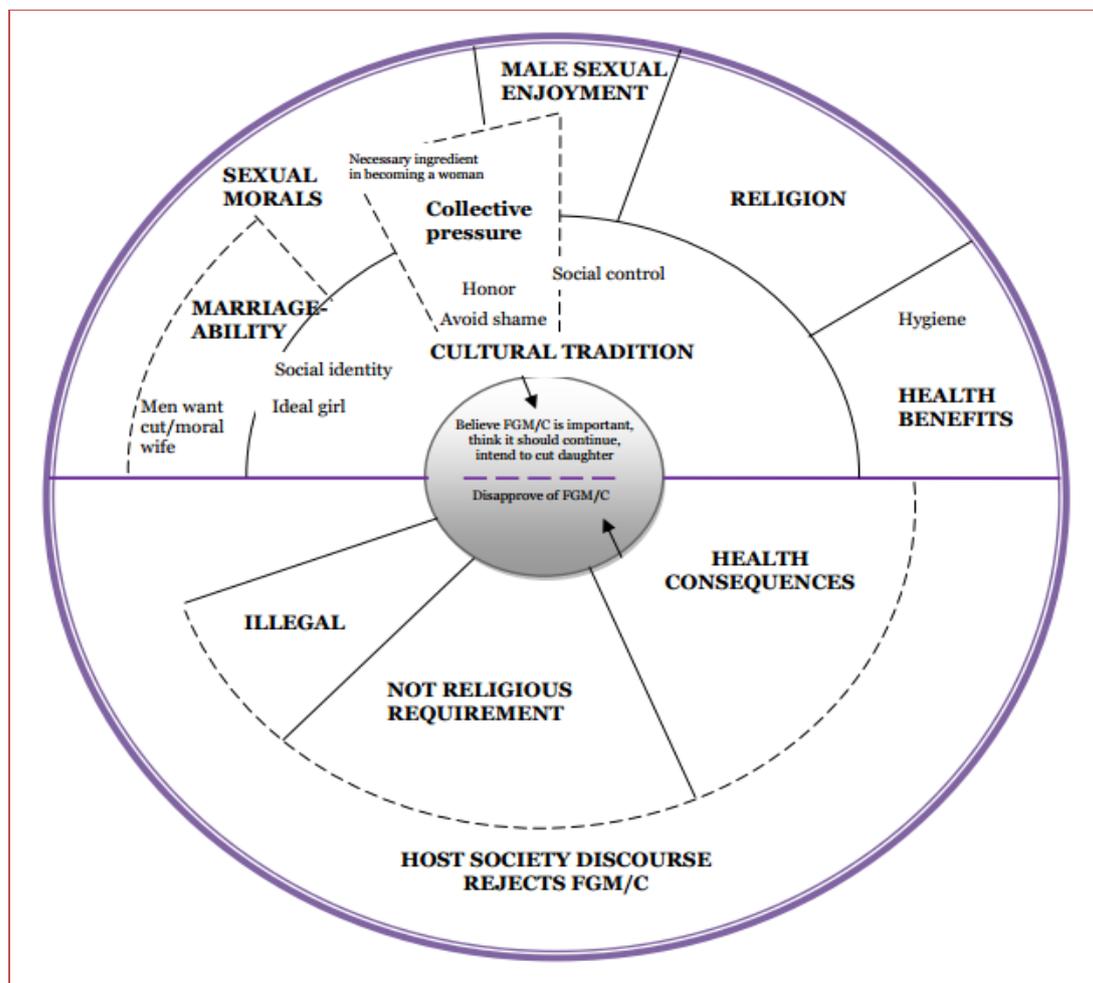


*Source: Berg et al. 2010b.*

The key factors supporting the continuation of FGM are shown in the upper half of Figure 1.3 with 'cultural tradition' the most dominant factor. With sexual morals, marriageability, religion, health benefits and male sexual enjoyment also being important. The authors state 'in almost all studies, the participants considered it [FGM] a meaningful cultural tradition, which functioned as a form of social control as well as a form of identity for women and as a feature of the ideal girl.' (Berg *et al*, 2010b: 45).

These six factors form a set of beliefs perpetuating FGM in the West including the EU. FGM is performed mainly for reasons of cultural conformity that over many centuries have become deeply rooted and entrenched. Gali states 'the practice is embedded in many cultural systems through multiple ties to historical tradition, tribal affiliation, social status, marriageability, and religion.' (cited by Berg *et. al,* 2010a: 48). For many communities FGM has become 'a cornerstone of moral standards' (Berg *et al*, 2010b:5).

Interestingly the Berg *et al.* (2010b) report also identified four factors which hindered the continuation of FGM in the West. These are shown in the bottom half of Figure 1.3 and are: the health consequences of FGM; the fact FGM is not a religious requirement; FGM is illegal; and the host country rejects FGM. It did not discuss how these factors could be used to persuade communities to stop performing FGM and why and how attitudes to FGM had shifted following migration. REPLACE explores the community and individual barriers to ending FGM in the EU by using participatory action methods in order to ensure interventions are targeted at the belief systems of practicing communities, to encourage behavioural change to end FGM in the EU.

## 1.7   FGM is a Social Norm

As we have seen in Section 1.6 'FGM/C is rooted in social conventions within a frame of psycho-sexual and social reasons such as control of women's sexuality and family honour which is enforced by community mechanisms' (Berg *et al*, 2010a: 4). According to UNICEF (2013:14) "FGM/C has been regarded as a customary rule of behaviour and is often referred to as a social norm".

There are many different definitions of a 'social norm'. Mackie (2012a: 71) examined 16 different definitions and concluded that the understanding of social norms tends to converge on three elements:

- **Social Expectations**: A social norm is constructed by an individual's beliefs about what others do, and by the individual's beliefs about what 'others' think they should do.
- **Reference Group**: the relevant 'others' used by an individual to inform beliefs and actions.
- **Social Influence**: a social norm is maintained by social influence using approval, including positive sanctions by the reference group and disapproval, including negative sanctions by the reference group.

Mackie (2012a) also found that most theorists state that Social Norms are distinct and different from Legal or Personal Norms.

- A **Social Norm** is a regulation through informal processes of approval and disapproval of individual beliefs and behaviour by a social reference group (e.g. family, community).
- **Legal Norms** are formal and implemented by States and can be enforced by coercion.
- A **Personal Norm** (Moral Norm) is internally motivated and differs from a Social Norm that is externally motivated.

FGM is clearly a social norm where 'pressure is enforced by their own communities' and 'Today, even in the context of life in exile, FGM/C continues to be valued and has strong social and cultural support'. (Berg *et al*, 2010b: 49). However EIGE (2015) suggests that the prevalence of FGM in the EU is declining as the social norm weakens. The debate will continue until we have accurate and robust prevalence data in the EU. However there is agreement that social norms are important in perpetuating FGM in the EU.

According to Mackie (1996) FGM has become a "belief trap"; a self-enforcing belief where 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 community social norms thus allowing their daughters to have social approval and access to social networks and resources, including marriage partners.

Family honour and social expectations play a powerful role in perpetuating FGM (see Section 4). This makes it very difficult for individuals or families 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 and access to social capital. On the other hand conformity is met 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).

## 1.8   Conclusion

The reasons for performing FGM vary between ethnic groups and communities. It is important that interventions designed to end FGM appreciate that FGM is a Social Norm with different communities having different belief systems, attitudes towards FGM and enforcement mechanisms.  Interventions must recognise this diversity and be tailored to different communities' Social Norms concerning FGM in the EU. This is exactly what the REPLACE Approach sets out to do.

# Section 2: Introducing the REPLACE Approach to working with African Communities to end FGM in the EU

## 2.0 Introduction

The previous section has demonstrated that FGM is a problem in the EU despite being illegal. Whilst many women arrive in the EU as asylum seekers or migrants having had FGM performed in their home countries, it is estimated that 180,000 girls and women who currently live in the EU, most of whom are EU citizens, are at risk of FGM. This is a breach of their human rights and effective action needs to be taken to protect them. It is clear that health messages and the fear of prosecution are having little impact. The most effective way to end the practice is to overturn the Social Norm that supports the continuation of FGM within affected communities.

The REPLACE Approach has been developed, trialled, improved, implemented and evaluated. This Section provides an introduction to the REPLACE Approach and its main underpinnings.

## 2.1 The Need for a New Approach

Despite decades of campaigning and activity in the EU targeted at bringing about an end to the practice of FGM, the data suggests that many thousands of young women and girls continue to be at risk of the practice each year, demonstrating that efforts to bring about a reduction and end to FGM in the EU have had a limited impact to date (see Section 1). REPLACE aimed to investigate why this was the case and to suggest a new methodology or approach to tackling FGM in the EU.

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, 1999). 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 is 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" (1999: 2).

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 2.1).

The authors of the review 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 is to be achieved and FGM to be ended.

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 fifteen years 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 of a lack of long term resources and the fact that 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. In addition to our own previous work (Barrett et al., 2011; Brown et al., 2013), an exception is work published by Shell-Duncan *et al.* (2010) which looked 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).

**Figure 2.1    FGM 'Mental Map'**
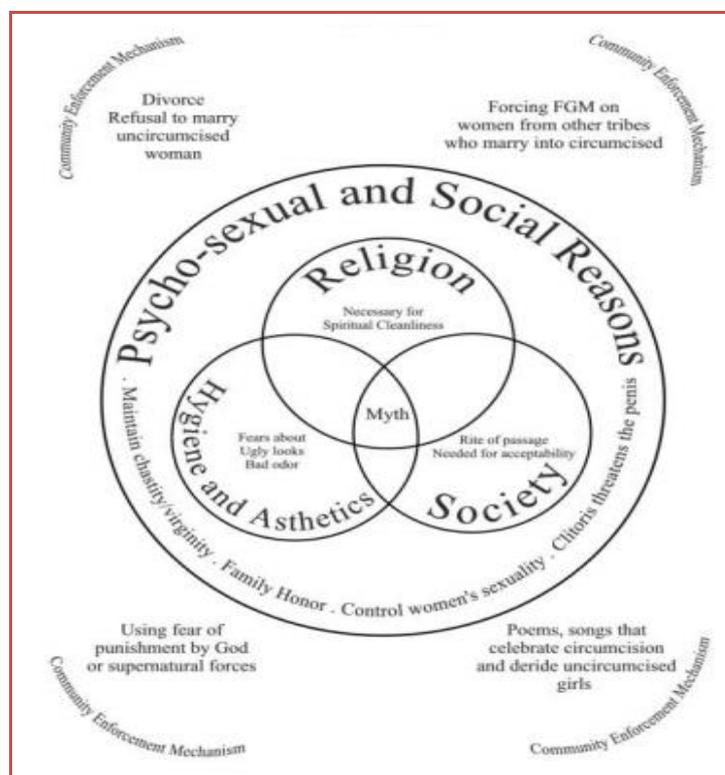


*Source: WHO, 1999*

REPLACE set out to remedy this situation and to show how both individualistic and community based behavioural change theories can be incorporated into activities and interventions designed to end FGM. It accepts that awareness raising is an important part of working with communities to end FGM, but suggests that communities need to be empowered, through behaviour change techniques to challenge and overturn the social norm supporting FGM. It recognises the important role played by community leaders,

influential people and peer group champions in mobilising communities to end FGM by employing community-based participatory action methods.

## 2.2    What is the REPLACE Approach?

The REPLACE Approach is a new way to end FGM in the EU. This approach replaces the dominant methods used to tackle 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.

Behaviour change theories combined with Community-based Participatory Action Research are central to the REPLACE Approach. With its embedded monitoring and evaluation techniques the REPLACE Approach empowers FGM affected communities through community leaders, influential people and peer group champions to challenge the social norm supporting FGM and move via a number of behaviour change cycles towards social norm transformation.

The REPLACE Approach has been developed, implemented and evaluated over five years with different FGM affected communities living in five EU countries.  These are shown in Table 2.1. The results have been very positive with evidence of behavioural change occurring as a result of the implementation of the REPLACE Cyclic Framework for Social Norm Transformation.

**Table 2.1    Country of residence, FGM affected communities and Facilitating Partner of REPLACE**

| Country/City | FGM Affected Community | Facilitating Partner |
|---|---|---|
| Italy, Palermo | Eritrean and Ethiopian | CESIE |
| Netherlands,    Amsterdam and Rotterdam | Somali | FSAN |
| Portugal, Lisbon | Guinea Bissauan | APF |
| Spain, Banyoles | Gambian and Senegalese | GES |
| UK, Bristol and London | Sudanese | FORWARD |

*Source: REPLACE*

## 2.3    The Three Pillars of the REPLACE Approach

### 1.  Behavioural Change

A review of the application of behavioural change approaches to FGM in Africa and Europe was undertaken by Leye in 2005. This showed the limited application of behavioural 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 behaviour change approaches broadly fall into two groups:

- Behavioural change theories which focus on the individual e.g. Stages of Change Model (Shell-Duncan *et al*, 2010)
- Behavioural change theories which concentrate of the role of society and communities e.g. Social Convention Theory (Melching, 2004; Mackie and LeJeune, 2009), Diffusion of Innovation Theory (Rodgers, 1995)

FGM does not neatly fit into either of these groupings, as FGM is performed on an individual within the confines of family and community beliefs and social norms. Yet communities comprise individuals and social norms can be overturned if enough individuals question and challenge the norms and adopt a different behaviour, which in turn will become the norm.

REPLACE recognises that the practice of FGM occurs within a wider socio-cultural context and the behaviour and decisions of others are critical in relation to the outcome of whether or not FGM is carried out.   REPLACE also recognises that some individuals are in less powerful or influential positions than others, therefore are unable to implement certain behaviours that will lead to the abandonment of FGM. REPLACE has therefore adopted relevant elements from both individually focussed behaviour change theories and the theories that concentrate on the role of society to tackle the social norm of FGM.

The REPLACE Approach, whilst addressing the issue of FGM using behavioural change theories, does not regard ending FGM as a *behaviour,* but a *goal.* Existing theorising and research in this field tends to treat FGM as a behaviour that requires changing, and this is problematic because it is not a single behaviour.  In a community where people are already aware of anti-FGM messages, whether or not to carry out FGM on any given individual is the consequence of a whole series of behaviours, which themselves are the consequences of many beliefs and decisions, by many people and influenced by the social norm. The REPLACE Approach gets to grips with this reality.

The REPLACE Cyclic Framework for Social Norm Transformation described below is a cyclic model based on a combination of individualistic and societal-based behaviour change theories, which can be used to explain how a community is influenced by the behaviour change of community leaders, influential people and peer group champions. 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, that gradually engage more and more of the affected population will need to take place within the community.

## 2. Engaging and working with Communities

When implementing activities and interventions based on behaviour change theories it is very important to understand the belief systems and the social norm supporting the behaviour and identify any barriers to 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 affected community as a whole. In addition every community is different, so what might be the case for one community might not be the same for other communities. 'One size does not fit all'.  Thus engaging with communities and listening to community members and leaders is important in order to ensure the intervention is appropriate, culturally acceptable and effective.

The REPLACE Approach employs Community-based Participatory Action Research (CPAR) to engage with communities and collect information concerning individual and community practices and beliefs regarding FGM and the perceived barriers to ending FGM. CPAR was selected as it 'involves the study of a particular issue or phenomena with the full engagement of those affected by it. Its most distinguishing features are a commitment to the democratisation and demystification of research, and the utilisation of results to improve the lives of community collaborators'. (Clifford and Valentine, 2005: 162).

Community-based Participatory Action Research (CPAR) which is part of the Participatory Action Research family is defined as follows:

'CPAR is a collaborative research approach that is designed to ensure and establish structures for participation by communities affected by the issue being studied, representatives of organisations, and researchers in all aspects of the research process to improve health and well-being through taking action, including social change.' (Hacker, 2013, 1)

Hacker (2013) identifies nine important principles of community-based participatory action research. These are as follows:

Community-based Participatory Action Research

- Acknowledges community as a unit of identity
- Builds upon strengths and resources within the community
- Facilitates a collaborative, equitable partnership in all phases of research involving an empowering and power-sharing process that attends to social inequalities
- Fosters co-learning and capacity building among all partners
- Integrates and achieves a balance between knowledge generation and intervention for the mutual benefit of all partners
- Focuses on the local relevance of public health problems and on ecological perspectives that attend to the multiple determinants of health
- Involves systems development using a cyclical and iterative process
- Disseminates results to all partners and involves them in wider dissemination of results
- Involves a long term process and commitment to sustainability.

(Hacker, 2013: 10-14).

Community-based Participatory Action Research is therefore ideal in combination with behaviour change theories to work with FGM affected communities towards the goal of ending FGM.

## 3. Evaluation

Few assessments of the effectiveness of campaigns and intervention activity aimed at ending FGM have been undertaken, particularly in the EU. More careful consideration of what works and why it is needed so that we do not continue to invest in ineffective activities or fail to identify effective strategies. Not only is this a waste of resources, but it puts many girls and women at risk of FGM. There is also the danger that ineffective interventions may backfire and reinforce belief systems and social norms supporting FGM. Evaluation should be an essential part of any FGM intervention and a monitoring and evaluation strategy put in place at the beginning of any campaign and intervention designed to end FGM.

Two recent systematic reviews by Berg, Denison and colleagues have identified a total of just eight evaluations of interventions that included before and after assessments and a control or comparator group (Berg *et al.*, 2009; Berg & Denison, 2013). None of these evaluations assessed interventions delivered in a European context. Whilst the evidence

from the evaluation data suggested that some interventions have had small positive effects, the methodological designs were judged to be weak, so findings should be treated cautiously. Denison *et al.* (2009) called for further research to involve randomised controlled trial methodologies, engaging in longer-term follow-up, and including objective assessment of prevalence, including the issues of self-declared FGM status (EIGE, 2013) as well as measures of behaviours and intentions relevant to carrying out FGM.

It is clear that more robust evaluations and assessments are needed in this field in order to try to determine what works, and why, in different contexts and with different communities (WHO, 1999). When this evidence is produced those who produce it need to work to ensure that the knowledge is translated and mobilised for action by those working in and with FGM affected communities (see Wallace, Brown and Hilton, 2013; 2015). The REPLACE team suggest that what is also needed is the development of evaluation approaches that can more easily be adopted and employed by communities and organisations such as NGOs working on limited budgets so that they can assess the effectiveness and impact of their FGM related activities in order to decide how to make use of limited funds and resources. In addition, evaluation of this type needs to be specific to identified sub-goals of such activities and interventions; such as changing beliefs at an individual level, engaging more people in taking action against FGM and changing the social norm that supports the continuation of FGM.

Evaluation underpins the REPLACE Approach and informs each element of the Approach.  It is an iterative and empowering process allowing communities and organisations working with communities to end FGM to target, adapt, implement and assess the impact of activities and interventions to ensure effective use of limited resources for maximum impact. In addition it allows interventionists to learn what works and what needs improving or changing (The Health Foundation, 2015), and as communities move closer to ending FGM it allows assessment of progress, so that interventions can be  tailored to the stage of readiness to end FGM of the specific community.

## 2.4   The REPLACE Cyclic Framework for Social Norm Transformation

The REPLACE Cyclic Framework for Social Norm Transformation comprises five elements that represent the flow of motivation and behaviour change within a community, stressing the important role played by community leaders, influential people and peer group champions in achieving social norm transformation. The Cyclic Framework is shown in Figure 2.2.

**Figure 2.2   The REPLACE Cyclic Framework for Social Norm Transformation**
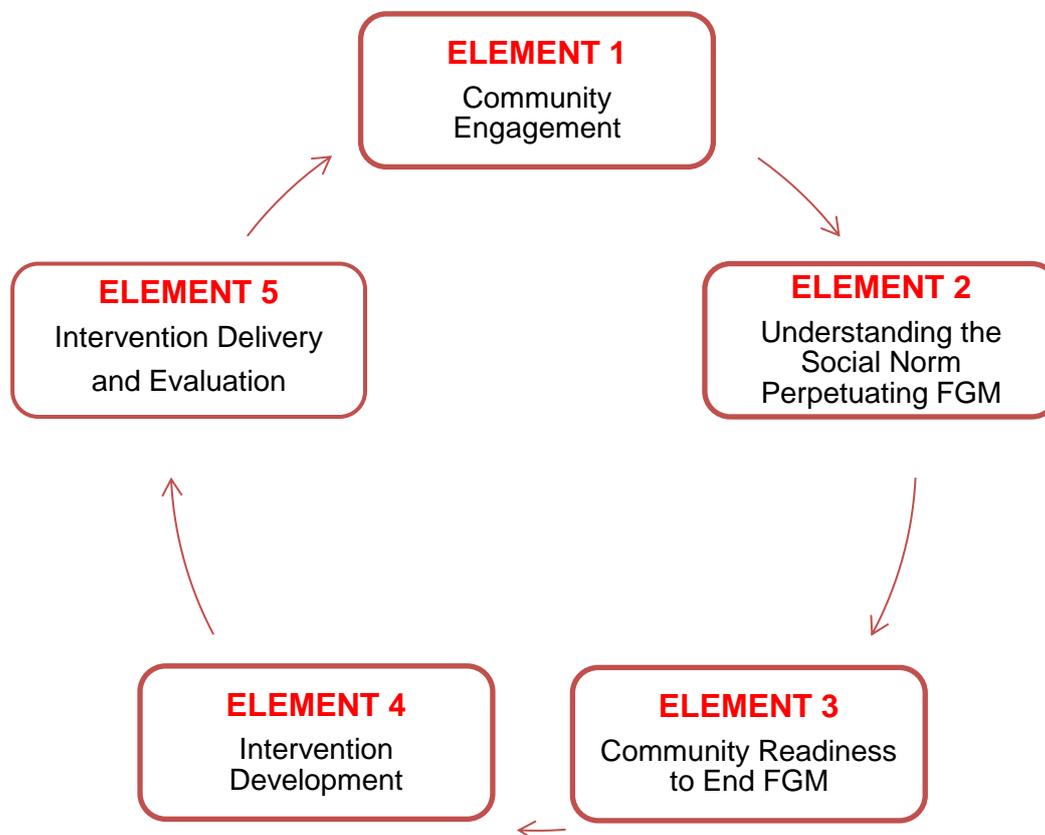


*Source: REPLACE*

*Element 1*:   **Community Engagement**

This element involves engaging with the FGM affected community in order to gain their trust and involvement in the project. In this element community leaders, influential people and community peer group champions are identified and motivated to begin to challenge the social norm supporting FGM in their communities. Community-based researchers are appointed and trained.

*Element 2:*   **Understanding the Social Norm Perpetuating FGM**

In this element Community-based Participatory Action Research (CPAR) is used to identify the belief systems and enforcement mechanisms that perpetuate FGM in the community and to identify the barriers to behaviour change and ending FGM.

**Element 3:** **Community Readiness to End FGM**

This element involves understanding the community's level of readiness to end FGM by applying the REPLACE Community Readiness to End FGM Model.

**Element 4:** **Intervention Development**

Using the information gained in Elements 1, 2 and the stage of readiness to end FGM assessment, the community-based researchers and community peer group champions suggest an appropriate target intervention activity. Using capability, opportunity, motivation and behaviour (COM-B Model) assessments (see Section 6 for more information) the community peer group champions are trained and supported in developing and implementing the target intervention activity.

**Element 5:** **Evaluation**

In this element the intervention strategy is implemented, and both quantitative and qualitative evaluation methods are used before and after intervention implementation. This is used to monitor attitudinal and behavioural change and progress towards social norm transformation. The results inform future action, with the REPLACE Cyclic Framework for Social Norm Transformation continuing, engaging more and more community members, until the goal of ending FGM is achieved.

## 2.5   Conclusion

The REPLACE Approach combines relevant aspects of both individualistic and community-based behaviour change theories to present a new methodology that can be used to help FGM affected communities and organisations working with these communities to overturn the social norm perpetuating FGM. It is a cyclic framework which recognises that ending FGM is a goal that will require many different behaviours to be changed.

The Approach is simple and generalised, as it must be, to ensure that it can be used with FGM affected communities that are very different. It is predicated on working with FGM affected communities using Community-based Participatory Action Research, which put communities at the centre of the Approach and which gives communities the confidence and tools to challenge existing social norms. It also ensures the sustainability of the activities and interventions towards realising the goal of ending FGM.

In order to establish whether behaviour change is occurring in an FGM affected community and to assess if the activities and target interventions are having the desired effect, it is important to engage in monitoring and evaluation. Thus monitoring and evaluation is embedded in each element of the REPLACE Approach.

The following sections describe and discuss the REPLACE Approach whilst the accompanying Community Handbook gives practical information about how to apply the REPLACE Approach.

# Section 3: The REPLACE Approach
# Element 1: Community Engagement

**The REPLACE Cyclic Framework for Social Norm Transformation: Element 1**
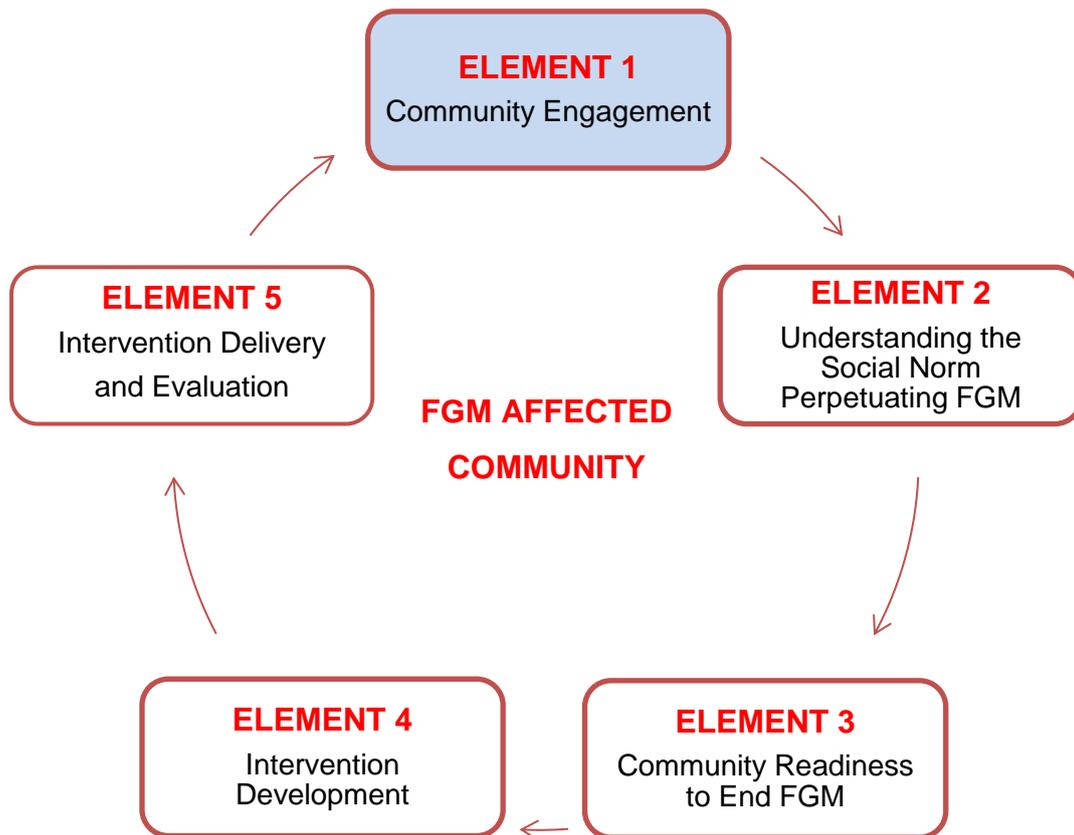


Source: REPLACE

## 3.0 Introduction

Overturning the social norm that perpetuates FGM requires effective community engagement. This is the first element of the REPLACE Approach. Community engagement is based on the assumption that if members of a community support and enforce a social norm, such as FGM, then they could be the key to overturning the norm (Johansen *et al*, 2013). Community engagement does not necessarily represent a separate activity in an intervention project; it is more of an approach for developing and delivering an intervention. It is essentially a mechanism for working *with* community members and involving them in interventions that deal with issues that affect them.

Thus, given that FGM is driven by social norms (see Section 4), the REPLACE Approach is modelled around extensive community engagement, with each Element of the REPLACE Approach involving community engagement. This Section discusses the process that REPLACE used to engage with communities to end FGM.

## 3.1   Why Community Engagement is Important

Recent findings on the influence of social norms on the continuation of FGM have led to an increased emphasis on 'community-led' approaches for tackling FGM (Mackie, 2000; UNICEF, 2010). Proponents argue such an approach is needed to create a sustainable change in the abandonment of FGM (Newell-Jones *et al.*, 2011). In addition, REPLACE discovered several other benefits that can be derived from community engagement. These include the fact that community engagement:

- Allows for community knowledge and resources to be brought to bear on an intervention in order to enhance effectiveness.
- Creates a sense of ownership over the intervention by community members and enables them to work together with the interventionist to determine the most appropriate way to address the problem.
- Increases the take up of intervention programmes. There is greater possibility for an intervention to be adopted by community members if they are involved in devising and implementing it.
- Reduces community resistance towards the intervention programmes.
- Enhances the long-term sustainability of an intervention project. By actively participating in an intervention, community members learn new skills with which they can use to continue the intervention beyond the lifetime of the project.
- Provides avenues for developing rapport and trust with community members.

A lack of community engagement is likely to create community resentment and resistance towards intervention efforts.

## 3.4   The REPLACE Community Engagement Approach

Community engagement means different things to different people. However, it is used here to refer to the process and practice in which individuals of a particular community participate

in an intervention programme in order to achieve a common goal. By this definition, community engagement is essentially a tool for facilitating the process of an intervention programme and for achieving specific intervention objectives. It provides a means through which community members are informed, consulted and involved in the design and implementation of intervention programmes that affect them.

REPLACE recognises that communities have a wealth of knowledge and resources that can be harnessed to address issues that affect them. Therefore it emphasises a bottom-up and community-led approach to tackling FGM. This suggests interventionists should work with community members as collaborators and partners rather than as top-down solution prescribers. Ultimately, REPLACE requires community members to be extensively involved in all aspects of the intervention cycle, including research, design, implementation and evaluation. The community engagement approach of REPLACE is underpinned by four key principles, namely inclusion, respect, effectiveness and transparency (See Table 3.1).

**Table 3.1     Principles of Community Engagement**

| Engagement Principles | Description |
|---|---|
| **Inclusion** | The involvement of different individuals or groups affected by the FGM-related issue being tackled regardless of their position in society. This suggests building an ethno-cultural, gender and inter-generational diversity in the engagement process. It also means the need to eliminate physical, psychological and socio-economic barriers to participation by all groups. |
| **Respect** | Recognising the autonomy of community members over decisions that affect them and their ability to bring about change over issues that affect them. This also means recognising the knowledge and resources of community members and the need to take their views and inputs seriously. Respect for community members also suggests that adapting community engagement to the needs of the community. |

| | |
|---|---|
| **Empowerment** | Adequate measures are taken to ensure that community members are adequately empowered through information and education and the provision of resources needed to enable them engage effectively in the project. |
| **Transparency** | The need for community members to be adequately informed about the intervention project, including the purpose and limitations of the project as well as the nature of their involvement. |

*Source: REPLACE*

REPLACE used three broad processes to engage with communities; these are: knowing the target community; engaging with the community; and monitoring and evaluation of the engagement process. These processes are discussed in detail below.

3.4.1   Knowing the Target Community

Effective community engagement depends on identifying and engaging with the 'right' community. Thus it is important to consider from the outset who is the target community of the intervention, the nature and characteristics of the community, and how to mobilise members of the community.

### 1.  Determining the Target Community

A target community could include a range of different social groupings. In terms of FGM interventions, a target community mostly refers to a group of people who live in a specific geographical area (e.g. town, neighbourhood) or share a common interest, characteristic (e.g. gender), experience, or belief. REPLACE found that the key characteristics of a community that need to be considered when determining which community to engage with include the following:

> i. Membership of a community is not mutually exclusive. Individuals often belong to different communities simultaneously and as a result their experiences, opinions and interests are shaped by these communities. Thus when individuals engage in an intervention programme they tend to bring to bear their experiences from all the communities that they belong to even if those communities were not the target of the intervention. Nonetheless, such an inclusive membership enriches the wealth of experience that community members are likely to bring to interventions and can also

facilitate the diffusion of new ideas, belief systems and social norm transformation concerning FGM to the other communities they are members of.

ii. Membership of a community may not always be explicit. Individuals may sometimes not realise that they are members of a particular community. For example, an FGM survivor may not be aware that they have been cut and belong to the community of FGM survivors. As a result such individuals are unlikely to come forward when FGM survivors are called upon to participate in an intervention. Therefore, clarity about the target community and their demographics and defining features are important for reaching and recruiting target members for the intervention.

iii. Communities are usually internally diverse. Even though members of a particular community share certain common characteristics, there are often internal differences which need to be recognised when recruiting for community engagement. There may be differences in terms of social class, age, gender and views of the social norm. For example, the African diaspora groups that REPLACE worked with were internally heterogeneous. Some members were conservative and resistant to change in relation to FGM while there were others who wanted to see an end to the practice. Recognising such internal differences is crucial to ensuring that members of different segments of the community are represented in the intervention.

## 2. Choosing the Target Community

In many cases the identification of a target community is quite straight forward because it would have been pre-defined in the broader project. But where the target community is not predefined the aim of the intervention should naturally point interventionists to the right target community. The latter process may sometimes be complex because of the need to include participants from a diverse range of sub-communities. This may require the interventionist to undertake a *stakeholder analysis*, as was done in REPLACE. Stakeholder analysis basically involves working through the question *"who are the stakeholders of the FGM issue being tackled?"* A stakeholder is any person or group who affects or is affected by a particular issue. Thus, in the case of FGM, this generally includes all individuals and groups who contribute to the continuation of the practice (the reference group) or are affected by it either directly or indirectly (see Table 3.2). Box 3.1 provides a list of questions that REPLACE used to identify the target community and participants for the intervention to end FGM.

**Box 3.1     Questions Used by REPLACE to Identify a Target Community**

1. *Whose wellbeing is adversely affected by FGM?*
2. *Who are the members of the reference group supporting the social norm of FGM?*
3. *Who enforces compliance to the social norm supporting FGM?*
4. *Who has the expertise (unique knowledge or skills) to bring to the intervention to ensure its effectiveness and can act as Peer Group Champions?*
5. *Who are the power brokers or influential individuals/groups on FGM?*
6. *Who are likely to contribute to the development and delivery of the intervention?*

*Source: REPLACE*

**Table 3.2     Key Communities/Stakeholders on FGM Identified by REPLACE**

| **FGM Affected** | **Beneficiaries & perpetrators of FGM** |
|---|---|
| ▪ Girls who have had FGM<br>▪ Women who have had FGM<br>▪ Husbands of FGM affected women | ▪ Excisors<br>▪ Parents<br>▪ Grandmothers/grandfathers<br>▪ Aunties and uncles<br>▪ Peers |
| **Influential persons on FGM** | **Service providers and safe guarders on FGM** |
| ▪ Religious leaders<br>▪ Traditional leaders<br>▪ Opinion leaders<br>▪ Elderly people<br>▪ Parents<br>▪ Grandparents | ▪ Health service providers<br>▪ Social workers<br>▪ NGOs<br>▪ Law enforcement authorities |

*Source: REPLACE*

Owing to the need for greater inclusion, REPLACE adopted a multi-stage approach to identify and recruit target communities and participants for the intervention programme. The approach begins with an identification of the broader target community of the intervention (a country, town), followed by groups (sub-communities) and individuals in the community that are particularly relevant to the intervention. The selection of participants at each stage of the process is shaped by the aim of the intervention activity. Box 3.2 describes the multi-stage approach used by REPLACE.

**Box 3.2       Multi-stage Approach Used by REPLACE to Identify Target Community**

The communities that participated in REPLACE were identified based on their high FGM prevalence. To do this, first, an analysis was conducted on secondary data to find out which countries in the EU had the highest prevalence rate of FGM. This was difficult due to a lack of accurate FGM prevalence data; however, EU research data was used to determine five countries with some of the highest rates of FGM in the EU to be included in the project. These included Italy, Portugal, Netherlands, Spain and the UK.

Once the project countries had been identified five community-based organisations (partner organisations) were selected from each of the countries to lead the project in-country. The partner organisations were then tasked to identify specific communities in their countries where FGM practice was widespread. In doing this the partners were also challenged by the lack of FGM prevalence data in their countries. What they then did was to use the prevalence rates from African countries and projected this onto diaspora communities that were based in their countries. Based on this, eight communities were chosen:

Italy -  Eritrean and Ethiopian communities

- Portugal - Guinea Bissauan community
- Netherlands – Somali and Sudanese communities
- Spain – Gambian and Senegalese communities
- UK - Somali and Sudanese communities.

The next stage was to determine which specific community of the diaspora groups to engage. This was done based on the city/town where nationals of the countries identified were most concentrated.  This resulted in choosing Palermo (in Italy), Lisbon (in Portugal), Amsterdam and Rotterdam (in the Netherlands), Banyoles (in Spain), and Bristol and London (in the UK).

In the last stage, individuals were selected from the communities to participate in the project. This was mostly done by community-based researchers. All the partners recognised the diversity of groups in their communities and therefore ensured that participants were selected to represent different genders, generations, and length of stay in the EU as these characteristics were deemed to be likely to influence people's perception and attitude towards FGM. The actual number of participants and approach used to select them depended on the purpose of the engagement activity.  In most cases, a purposive sampling technique was used to select participants for the community-based research and the development, implementation and evaluation of the intervention.

*Source: REPLACE*

### 3. Knowing the Target Community

The next step after identifying the target community is to try to understand it. This may require undertaking a community profiling exercise. REPLACE used such an exercise to understand the target communities better, including the history, politics, livelihood options of the communities as well as the various interest groups and their characteristics. Also, community profiling was use to understand the resources of the community and how they can be harnessed for the intervention. Information about a target community may be obtained from secondary sources such as census data and local authority documents or from primary sources such as key informant interviews. In REPLACE preliminary information about the target communities was obtained through interviews with community-based researchers and key influential individuals in the communities. See REPLACE Community Handbook for more information on how to achieve this.

### 4. Community Mobilisation

One of the key challenges of community engagement is related to the accessibility of the target community. This therefore requires devising a strategy to mobilise community members for the programme. The community mobilisation process can be long and difficult especially for organisations that have no previous community engagement experience in the target community, as was the case with some of the REPLACE partners. For example, the Dutch and the UK partners had previously worked on FGM in their respective communities and as a result did not face particular difficulties in mobilising community members for the project. But this was different for other partners who did not have substantial community engagement experience with FGM affected communities and therefore had to first nurture a relationship of trust and good rapport with the communities.

REPLACE used community-based researchers (CBR) to support engagement with communities and to help mobilise community members. The CBRs were selected from the target communities and facilitated an initial understanding of the communities and developed a good relationship with community members. They were also primarily responsible for conducting community-based participatory action research on FGM with the target communities. With their deep local knowledge and understanding of the cultural heritage of their communities, the CBRs helped the project officers to overcome some of the barriers which cultural 'outsiders' often face when working on culturally sensitive issues such as FGM.

There is no specific approach for recruiting CBRs. However, one of the methods successfully used by REPLACE was to conduct a series of community meetings and focus groups to discuss FGM and recruited participants who displayed high levels of enthusiasm and knowledge about the community and FGM. Others approached existing community based organisations for suggestions on potential CBRs for recruitment (see Box 3.3). In selecting CBRs it is recommended to aim at individuals who hail from the target community and have substantial community knowledge and social skills. Also, knowledge and interest in FGM and previous experience in qualitative research will be an added advantage. Depending on the target community, CBRs of different gender, age and ethnicity may be needed to facilitate effective engagement with different members of the community. However, it may be counterproductive to recruit individuals who are known by the community to be engaged in anti-FGM campaigns.

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**Box 3.3       APF's (REPLACE Portuguese partner) Experience of Recruiting CBRs**

*"The main challenge APF faced on the REPLACE project was difficulty in engaging with the Guinean Bissauan community that we worked with. It was just difficult to get things started with them at the beginning. This was because we had not previously worked with the community prior to REPLACE. So it was very difficult to know who to speak to, how to win their trust, and how to get them to work with us. Because the intervention development was preceded by the community based research, what we did was to recruit community based researchers for the research. And to do this, we contacted organisations who were already working with the Guinea Bissauan community in Lisbon on other social issues. They recommended a few people to us based on criteria we had given them. After a series of informal conversations and formal interviews four CBRs were chosen and engaged to conduct the research. They were the ones who later introduced the REPLACE project to the community, conducted the research, and recruited members for the intervention activities. APF were very lucky indeed to have the CBRs involved in the project!"*

---

*Source: APF REPLACE project report*

It is one thing to identify a target community and another to engage its members in a project. Certain community members are often unable to participate in a programme that they are primary stakeholders in. Therefore where resources permit interventionists need to find practical ways of identifying and addressing barriers that are likely to hinder the effective participation of identified community members. In some cases the identified community members may simply be unwilling to participate in the project. Experience from REPLACE

shows that such an attitude is often due to a lack of interest in the intervention issue or scepticism arising from previous negative experiences with similar projects. Moreover, some target community members may want to derail the intervention because they benefit from the continuation of the problem (e.g. FGM). Therefore, it is important to understand the target community properly and stimulate their interest through intensive information dissemination. Participation cannot be forced on community members; interventionists need to provide the target community with honest information about the project and allow members to decide whether to participate or not.

### 3.4.2  Engaging with the Target Community

REPLACE used a range of different mechanisms to engage with communities. These are broadly categorised into information dissemination, consultation/research, and active participation. Although these mechanisms represent separate approaches for achieving specific intervention objectives, they can form part of a broader community engagement process to achieve a single project goal. Thus, community engagement can be perceived as consisting of a continuum of activities with an increasing level of community influence from passive recipients of information dissemination, and involvement in consultation and research, to active participation and leadership  (see Figure 3.1). The starting point is usually informing community members about the project, with iterations of engagement activities leading to consultation and/or involvement in research, and subsequent active participation in the project. In some cases an ultimate aim is to achieve community leadership. REPLACE has this far managed to reach the active participation of community members in the process and we propose the framework is capable of supporting projects targeted at ending FGM to ultimately achieve community leadership on the issue.

**Figure 3.1    Approaches and Continuum of Community Engagement**



*Increasing level of community influence and participation*
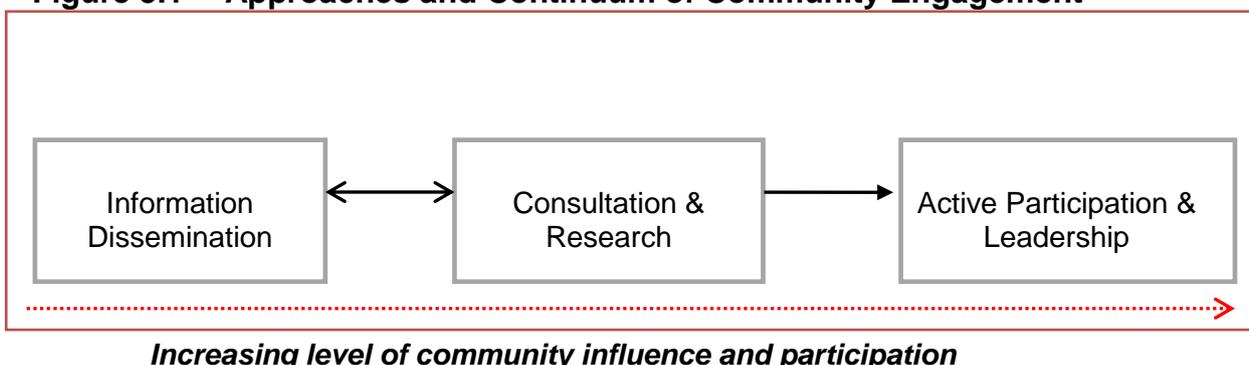
*Source: Adapted from Queensland Department of Communities (2005)*

### 1. Information Dissemination

Information dissemination is an essential element of effective community engagement. It provides the means through which community members are informed about a particular intervention programme and can act as a first stage in changing attitudes and behaviours on an issue.

Information dissemination is based on three processes of communication, these are:

- Communication from the interventionist to community members,
- Communication among community members,
- Communication from community members to the interventionist.

At the initial stages of a community engagement process it is assumed few people will be interested in the issue of FGM. Therefore, there is a need for intensive communication between project officers and community members using both face-to-face and other information dissemination tools to inform and garner interest in the programme. During REPLACE, as the project became known to community members the issue of FGM became interesting to some community members; those members began to talk to other community members, and interest snowballed. Subsequently, those who participated in the information dissemination events and processes provided feedback to inform other information dissemination activities and engagement began progression to consultation and research.

### Tools and Techniques for Disseminating Information

A range of different tools were employed in REPLACE to disseminate information, this depended on the purpose and target audience of the dissemination. The dissemination techniques involved active and passive processes. This means that a piece of information can be made available in a particular medium such as website or newsletter and community members are required to access it themselves. Alternatively, information can be disseminated through awareness raising events and workshops where project officers have direct interaction with community members to pass on information to them. Both active and passive information dissemination techniques were used in REPLACE. Table 3.3 provides a range of information dissemination tools that were used at various stages of the REPLACE project.

**Table 3.3    Information Dissemination Tools Used in REPLACE and their Strengths and Weaknesses**

| Dissemination tools and techniques | Purpose and skills required | Strengths | Weaknesses |
|---|---|---|---|
| **Person-to-person interaction** | This technique was mostly used at the beginning of the project by project officers to inform community members about the project and also to recruit them for participation. Requires interpersonal skills | Particularly useful when intervention is still new and also when the issue is novel and requires community members to be persuaded to participate. | Labour intensive and provides limited coverage of community members. |
| **Workshops and community meetings** | These were mainly used to sensitise community members about FGM. Skills required include organisation skills, public speaking and communication skills and facilitation skills. | Able to reach large numbers of people; mostly readily accessible by community members; particularly useful when all the target population is not known. | Tends to attract 'elite' community members and likely to exclude people who have less interest in FGM or oppose it; can be expensive to organise; may be less accessible to people with severe physical and visual and auditory disabilities. |
| **Websites** | Information about the REPLACE project was put up on a project website to inform the general public, including members of affected communities Information technology skills required to manage websites. | Able to reach large numbers of people; addresses distance barriers. | Tends to exclude disadvantage groups as they often have limited access to and knowledge of computers; access is limited to people with formal education and those who already have an interest in FGM; websites maybe expensive to manage. |
| **Newspaper articles** | Articles were used intermittently to respond to current developments on FGM in the community and also to generate public interest in FGM issues. Skills required include | Can reach very large audiences and increase the profile of the project. | Potentially exclusionary of illiterate populations and people with less interest in FGM; high risk of message being skewed to the interest of the media |

| | writing and editing, media skills. | | organisation publishing the article. Stigmatisation of FGM affected communities by the media. |
|---|---|---|---|
| **Newsletters** | This was produced on a quarterly basis to inform stakeholders about new developments and milestones reached in the REPLACE project. Requires writing, editing and design skills. | Particularly useful for keeping community members informed about an intervention and to ensure transparency and sustainability of interest in the project. | May not be accessible to people with low literacy |
| **Dissemination in public places and events such as mosques, churches, weddings and christening events.** | These were used mostly to inform community members both about the REPLACE project and FGM. Also used as a tool for recruiting community members for the project. | Can be very accessible and inclusive of people in various socio-economic groups if appropriate events and places are used. | May restrict accessibility by certain individuals if the information is disseminated in an event or place that they do not use. |

*Source: REPLACE*

Judgement over which dissemination tool to use depends on the purpose, context, and target audience of the intervention as well as the skillset of the intervention team. It also depends on how much knowledge community members already have about the issue being addressed. Where there is little community interest in the social issue and/or the intervention is new or novel, a more pro-active approach may be needed for information dissemination, especially at the beginning of community engagement. Similarly, where many members of a community lack formal education and access and skills to use computers, an active dissemination tool may be needed.

## Designing an Effective Information Dissemination Strategy

REPLACE found that the effectiveness of information dissemination depends not only on the tools and the resources available but also the information transmitted. Therefore particular attention needs to be paid to key elements of the information that defines its quality, these include the aim, content and accessibility. As the community engagement process moves from information dissemination towards consultation and research (see below) the feedback

and input from the community can help to refine the aim, content and accessibility of your strategy.

*Aim*: Information dissemination needs to have an aim to provide it with a focus. The aim may be action oriented, such as to engage the community and to recruit community based researchers and community peer group champions.  Also, the aim needs to clear and specific and determine the target audience of the dissemination.

*Content:* This refers to the nature of the information being transmitted, the effectiveness of which depends on the extent of its clarity and relevance. Thus, information needs to be clear both in nature and style of presentation. As a general rule keep language simple and straightforward. FGM affected communities often have cultural and traditional terminologies that they use to describe the practice (see Section 1.2). It is important that interventionists identify these terminologies and incorporate them in their messaging. The avoidance of acronyms or abbreviations (e.g. FGM) is likely  to enhance the clarity of a message. Although pictures may sometimes be useful for presenting certain kinds of information care must be taken not to use explicit pictures unnecessarily as this may be counterproductive. It is usually a good idea to  ask permission to show pictures of the cut or uncut  female genitalia if it is felt this may be necessary to make a particular point and educate the audience (or reassure people that is not going to happen if you do not feel it is necessary). Also the wording of the information needs to be culturally appropriate so that it does not incite the displeasure of community leaders. But at the same time the information should not be wrapped up too much to lose its meaning.

Moreover, the subject matter of the message needs to be made relevant to the target audience in order to gain their attention and facilitate uptake. In some cases the subject matter of the message may not be directly relevant to the target audience and therefore the interventionist has to couch the message in a way that connects with the target audience.

*Accessibility*: The medium through which the information is communicated needs to be accessible to the target audience. In communities where many older people are illiterate a text-based communication may prove less effective than an audio-based one. REPLACE found that some migrants living in the EU have limited access to and knowledge of the internet; as a result information delivered through the internet may have low take-up in those communities. Not only should the medium of communication be appropriate to the target audience, it should also be user friendly. In REPLACE, the use of mobile phone apps was found to be more effective for disseminating information among young and middle-aged

participants, but less effective among older people. A consideration needs to be given to individuals with visual or auditory impairment and an appropriate tool chosen to ensure that they are able to access project information. Accessibility is also related to the style in which the message is presented. The volume and content of the information need to be right in terms of the amount of detail presented. Also the appropriate language should be used. In a multi-lingua community it may be crucial that the information is presented in a lingua franca or translated into languages that are commonly used by most members of the community.

## 2. Consultation and Research

This approach represents phase two of the community engagement continuum and relates to the act of seeking the advice and views of community members on an intervention project. It involves a two way process of sharing ideas between the interventionist and community members. REPLACE used this mainly after information dissemination to seek ways that community members could contribute to the intervention process as well as to understand the belief systems that supported the practice of FGM in affected communities (see section 4).

REPLACE used a range of different tools to undertake consultation and research with the project communities, these included face-to-face interviews, focus group discussions, and community workshops. Other tools such as open house and workshops have proved to work effectively in an FGM context even though these were not extensively used on REPLACE. The choice of a tool for consultation and research depends on the nature of the participants as well as the purpose of the activity. For example if the aim of an  activity is to understand the barriers and facilitators to ending FGM then a focus group discussion or  an individual interview may be a preferred option,  compared with simply wanting to examine ways of involving community members in a project. Here more informal community workshops may be most appropriate.

In terms of research, REPLACE recommends the use of Community-based Participatory Action Research (CPAR) as a means to understand the belief systems that underpin the practice of FGM in affected communities (see Section 2.3). One of the key advantages derived from community consultation and research during the REPLACE project was that it allowed for the interventions to be informed by the knowledge and expectations of the communities which increases the likely effectiveness of the intervention. It also allowed for the development of trust and confidence between project officers and community members. During this phase some community members became interested in active participation and

contributing the project development. Table 3.4 provides an outline of the consultation and research tools used in REPLACE.

**Table 3.4     Consultation/Research Tools Used in REPLACE**

| Consultation tools | Description and Purpose | Strength | Weakness |
|---|---|---|---|
| **Face-to-face interviews** | Involves direct communication with individuals to elicit their views on a particular issue. This was used for research purpose to understand the belief systems that drive FGM in the project communities (see Section 4). | Allows interventionist to obtain detailed information from community members. Allows for an interaction between the interventionist and interviewee in order to build rapport and trust. | It is resource intensive particularly if translation from a local language is required. |
| **Community workshops** | Typically involves participants gathering in a single space, followed by the interventionist providing them with information about the topic to be discussed. This is then followed by question and answer sessions and expression of views by participants. This was used at the beginning of the intervention to understand how identified community members could be involved in the intervention | Facilitates an interactive process between project officers and community members and also among community members; useful for recruiting people to engage in a longer-term intervention. | Could lead to the under-representation of marginalised groups due to meetings potentially being hijacked by powerful interest groups in the community and language barriers. May result in polarised views of community members on an issue because it has no built-in consensus building mechanisms. |
| **Focus group discussions** | This is a group interactive session, mostly to explore and deliberate on a particular issue. Unlike community workshops they mostly involve a relatively small number of people and are more focussed on a particular issue. Typically, the group discussion has a leader (typically the CBR) who facilitates the discussion process. Was used to understand community views on the belief systems that support FGM. | It allows for intensive interaction between people to brainstorm on an issue.  It is effective for understanding difference and agreement on an issue in a community and also for building consensus. Useful for brainstorming on the design and execution of an intervention. | Not useful for engaging with community members on confidential issues. May sometimes limit the representation of marginalised groups because discussions are often hijacked by influential members of the community. |

*Source: REPLACE*

## 3.  Active Participation

Participation refers to the act of taking part in an intervention project, in whatever form. The extent to which community members participate in a project can range from passive through

to active. Both information dissemination and consultation involve lower levels of participation as community members typically  consume information or provide their views on an issue and engage in discussion and debate. Active participation involves more substantial participation of community members in the development, design, implementation and evaluation of an intervention programme. It involves supporting community members to take responsibility for the issue they wish to tackle and designing and executing solutions to address the issues. Thus active participation requires the interventionist to delegate power and responsibility to community members to steer the intervention as they deem fit. It is about a shift in power and control from the interventionist to the community. It may ultimately lead to handing over leadership altogether.

In order for community members to reach this third phase of engagement process, they need to be fully involved in the programme and the issues that it addresses. Hence part of the information dissemination and consultation as well as the research phases should be directed at fulfilling this objective. This will enable community members to direct their efforts and resources to bring about behavioural change and challenge the social norm that supports the continuation of FGM in their communities. As people move towards active participation they feel increasingly committed, have ownership of the process and a vested interest in the outcomes of the intervention.

REPLACE used a number of techniques and tools to encourage and facilitate active participation, including workshops, steering committees, and working groups. The ultimate goal of community engagement in REPLACE was to get community members to actively engage in devising and implementing an intervention to change behaviour concerning FGM and move towards ending FGM in their communities. Through the information dissemination and consultation processes, community members were motivated and supported to identify a behaviour that could contribute to challenging the social norm perpetuating FGM in their communities and to devise and implement an intervention to facilitate the behaviour.

### 3.4.3  Monitoring and Evaluation of Community Engagement

REPLACE demonstrates there is a need for community engagement interventions to be continuously monitored and evaluated to ensure that the aims and objectives of the intervention are being achieved. Monitoring is carried out during the course of the intervention to keep track of progress and to see if adjustments are needed. Evaluation, on the other hand, focuses on the impact and long term outcomes of the intervention and is

mostly conducted before and after the intervention has been implemented. Monitoring and evaluation require continuous data collection and decision making. Thus, it is important that data is collected:

- Before the start of the engagement intervention process as baseline data for comparison.
- During the course of the intervention to monitor the extent to which outputs and immediate outcomes of the intervention is being met or not met.
- Shortly after the intervention has finished exploring the short-term outcomes of the intervention.
- A while after the intervention has ended to assess the impact and sustainability of the changes that may have resulted from the intervention.

REPLACE was designed in a way that allowed for feedback from monitoring and evaluation to be implemented to improve the project. It is important the monitoring and evaluation strategy of the programme is determined at the very beginning of the project, including the indicators of impact and measurement tools. Details of the REPLACE monitoring and evaluation tools are discussed in Section 7.

## 3.5 Conflict Management in Community Engagement

As FGM is a somewhat controversial issue, it is possible that conflicts will occur during the community engagement process. Such conflicts are mostly associated with negative outcomes and are may derail the community engagement process when they occur. However as experienced by REPLACE, conflicts can sometimes be a force for good. As community members are engaged on the topic of FGM they develop new perspectives which are likely to be different and challenge the social norm supporting FGM in the community. Such disagreements often trigger deliberation and debates that bring about positive adjustments in community beliefs and may support behavioural change.

REPLACE found three types of conflict that are likely to occur during community engagement concerning FGM. These include conflicts:

- Between individuals directly involved in the project (e.g. project participants, project officers) and individuals not directly involved in the project (e.g. community members).

- Among community members.  This could be conflict between different groups of the community such as those who support FGM and those who oppose it; or between different generations in the same community.
- Among project participants/staff. These are mostly caused by differences in views on the intervention.

### 3.5.1  Conflict Management

The idea of community engagement and the emphasis on stakeholder participation is based on the need prevent disruptive conflicts in an intervention. However, conflicts are sometimes inevitable and therefore there is the need for the interventionist to anticipate them and devise a strategy to address them when they occur. There are several approaches that can be used to manage conflicts during community engagement, these include, force, withdrawal, compromise and consensus building (Warner, 2000). Table 3.5 provides an outline of these strategies and how they were used in REPLACE to address conflicts.

**Table 3.5     REPLACE Recommended Conflict Management Strategies**

| Conflict management strategy | Description and used in REPLACE |
| --- | --- |
| **Withdrawal** | This refers to the situation where a party withdraws from the activities or issues causing the conflict.  This technique is mostly used in order to avoid confrontation between the opposing parties. Again the approach could be used by both interventionists and community members. For example in REPLACE, project officers sometimes avoided certain trouble spots or individuals in the community who were fanatical in their support for FGM. |
| **Accommodation** | This refers to the situation where one party concedes to all or most of the demands of the opposing party in order to foster good relationship with them. This is mostly necessary when such a relationship or their participation in an intervention is needed in order to pursue other intervention objectives effectively. In REPLACE there were cases where project officers had to be sympathetic to the idea of 'sunna' (clitoridectomy) as a substitute for infibulation in order to pacify religious leaders and gain their participation in the project. |
| **Compromise** | Compromise refers to the situation where one of the parties forgoes part or all of the demands that was the cause of the conflict. This is similar to accommodation except that the party making the compromise anticipates no gains to be made from their action. This is likely to happen when a party finally realises that they are on the wrong side of the argument or the evidence is |

| | |
|---|---|
| | stacked against them.  In REPLACE, there were several situations where individuals who initially supported FGM and were in conflict with project officers later embraced the project narrative about the need to end FGM. This mostly came about after intensive engagement with such individuals and sensitisation about the harmful effects and myths surrounding FGM. |
| **Consensus Building** | This approach often seeks to build the capacity of the parties that are involved in the conflict situation so that they can develop dialogue and an understanding of each other's demands.  This was the approach mostly used by REPLACE which was aimed at generating a win-win outcome with fewer compromises. The approach is mostly centred on getting the parties to focus more closely on their underlying needs and demands and to think about other options and solutions to the problem. One of the tools that was commonly used by REPLACE to facilitate effective consensus building during intervention workshops and focus groups was role-play - where parties are ask to act out the roles of others in order to appreciate their interest and concerns.  Another was to organise a focused meeting where the parties were able to discuss the issue exhaustively and gain a better understanding of the issue. Due to the win-win outcomes, the process mostly led to more sustainable outcomes. |

*Source: REPLACE*

In every community there are people who possess skills or hold key positions that can be leveraged to deal with conflict situations. These include professionals such as facilitators, counsellors, negotiators, mediators, arbitrators and religious leaders. It is important that the community profiling exercise makes an effort to identify such individuals at the outset of the programme and incorporate them into the intervention programme.

## 3.6   Conclusion

Engaging with communities to end FGM can be extremely challenging especially for interventionists that have no prior engagement experience with the intervention community. The success of an intervention programme largely depends on how well project officers are able to engage with the target community, and thus it is imperative to invest in this activity. The REPLACE community engagement approach discussed above is not meant to be prescriptive, but provides a guide that can be adapted for different contexts. Interventionists need to be aware of the heterogeneity of FGM affected communities and thus adapt community engagement approaches to the needs and characteristics of target communities.

# Section 4: The REPLACE Approach

# Element 2: Understanding the Social Norm perpetuating FGM

**The REPLACE Cyclic Framework for Social Norm Transformation: Element 2**
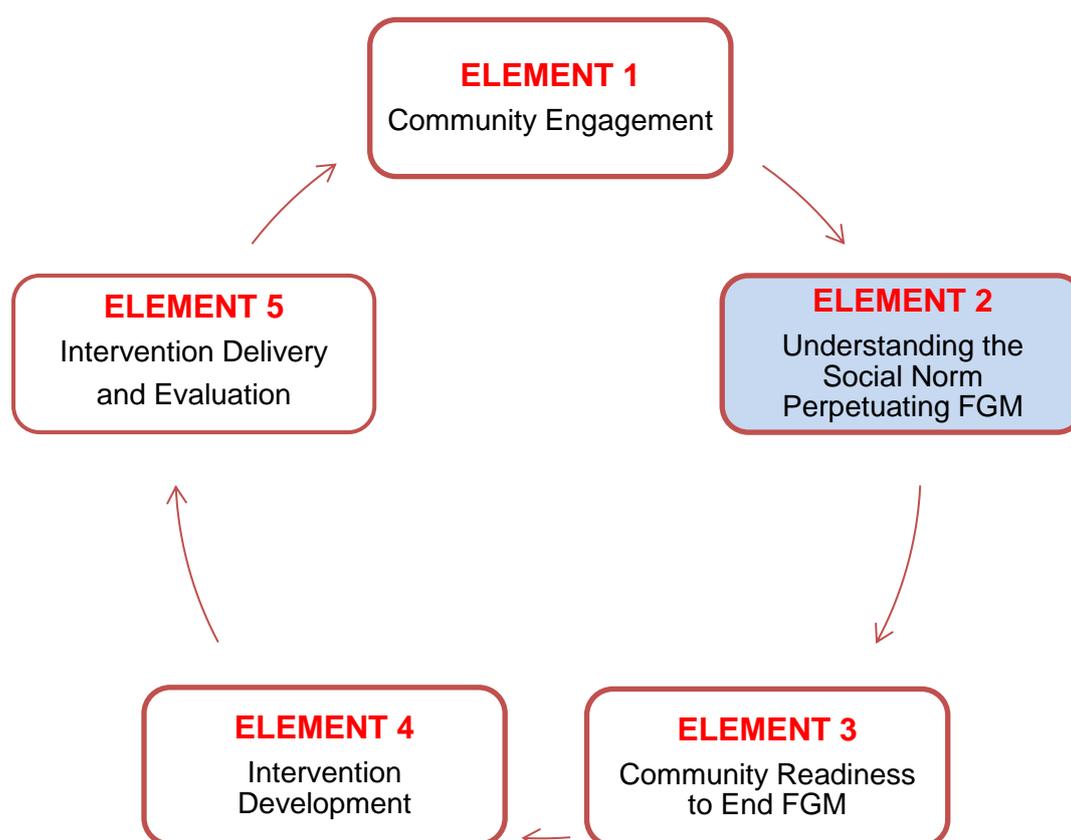


*Source: REPLACE*

## 4.0   Introduction

The implementation of the REPLACE Approach requires an understanding of the belief systems and social norms that support the continuation of FGM in a community. This is essential to ensure that intervention activities are designed to the specific needs of the affected community and are culturally appropriate. Thus as part of the REPLACE project, Community-based Participatory Action Research was conducted in the five African migrant communities where the REPLACE Approach was implemented and evaluated to understand

the specific belief systems and enforcement mechanisms that support the continuation of FGM in those communities. The research was conducted as part of the community engagement process (see Section 3) and provided useful information to shape the design and implementation of specific intervention activities for the communities.

## 4.1 The Need for an Understanding of the Belief Systems and Social Norms Supporting FGM

Studies have shown that the effectiveness of an intervention aimed at ending FGM depends largely on the extent to which it is evidence-based (Gruenbaum, 2005). The increasing realisation of the strong influence of social norms and beliefs in FGM practice has led to recent calls for particular focus on these factors when designing interventions to end FGM. A review by the WHO (1999) demonstrates how beliefs around religion, hygiene and aesthetics and social acceptance combine to influence individual decision making in favour of undertaking FGM in various countries in Africa and the Middle East. The influence of modernisation on traditional beliefs and practices has often led to the assumption that FGM will diminish with increased migration of people from high prevalence countries to Western societies. However, a recent review by Berg, Denison and others (2010b) suggests that not only is FGM practiced by such migrants, it is driven by belief systems prevalent in the home countries. The authors underscored the importance of traditional beliefs related to women's sexuality, marriage, religion, and health to be particularly influential in promoting the continuation of FGM in Western societies (see Section 1.6). They further emphasised that FGM often developed social significance in contexts where it is practiced, and that these are particularly influential for its continuation.

What is clear from reviews of various literature on FGM is that belief systems and social norms are extremely important in the continuation of FGM in the EU, Africa and the Middle East. It also suggests that belief systems that support FGM vary across different contexts, even where they are similar the nuances and relative strength of each one differ, from one context to another. Thus it cannot be assumed that beliefs that perpetuate FGM in one community will be the same in another and therefore can be used as a basis for intervention development. This suggests the need for new research to be conducted to understand the nature and dynamics of the belief systems that support FGM practice in a particular community before interventions are developed to end FGM in that community. Information provided by such research will be useful for the design and implementation of effective and culturally appropriate interventions.

## 4.2 The REPLACE Approach to Understanding the Social Norm Concerning FGM

Owing to the complex and culturally specific nature of the social norms and belief systems that motivate and enforce FGM, REPLACE recommends the use of Community-based Participatory Action Research (CPAR) to understand community beliefs and practices regarding FGM. CPAR is particularly useful for both research and intervention on FGM because it facilitates an effective engagement with community members and an in-depth exploration of various issues on FGM. The process also empowers and motivates community members to reflect and challenge the belief systems that support FGM and to take actions to end the practice. The accompanying REPLACE Community Handbook gives information on conducting CPAR in the context of FGM.

REPLACE adopted CPAR methodology to understand the belief systems and social norms that underpinned FGM practice in the affected communities of the project. Box 4.1 provides an outline of the specific methodological approach used in the research.

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**Box 4.1    CPAR Methodology used by REPLACE to Understand the Belief Systems and Social Norms Perpetuating FGM in the EU**

### *Research aim*

To understand the belief systems and enforcement mechanisms supporting the practice of FGM in African diaspora affected communities in the EU.

### *Methods*

In line with the CPAR approach, a combination of focus group discussions (FGDs) and in-depth narrative interviews were employed to collect information. FGDs were used to enable research participants to openly debate and possibly challenge the cultural beliefs that underpin FGM in their communities. The in-depth narrative interviews were used as a complementary method of information collection due to the sensitive nature of FGM, so that people who wanted to express their views in confidence could do so. A total of 40 FGDs and 90 in-depth narrative interviews were conducted across the five communities. Each community undertook at least eight FGDs and twenty in-depth interviews.

### *Sampling*

The research was conducted in all the five FGM affected communities of the REPLACE project. These included the Eritrean and Ethiopian community in Palermo, Italy; the Guinea

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Bissauan community in Lisbon, Portugal; the Gambian and Senegalese communities in Banyoles, Spain; the Somali communities in Amsterdam and Rotterdam, Netherlands; and the Sudanese community in Bristol and London, UK.  Participants for the research were purposively selected from each community to reflect differences in gender, age and length of stay in the EU. These characteristics were deemed have an influence on a migrant's perception concerning FGM. Only adult (individuals aged 18 years and above) members of the communities were involved in the research due to ethical reasons. A saturation approach was used to determine the number of participants for the research. Thus, participants were recruited until a point where no new information was obtained from an additional participant recruited (Glaser and Strauss, 2009).

***Analysis***

Information was analysed using Nvivo software, and was informed by a grounded analytic approach. Each country partner analysed their own data separately to identify preliminary key themes. These findings were then compared with a parallel analysis of all the data by the Coventry University REPLACE team for triangulation purposes.

*Source: REPLACE*

## 4.3   Findings on Belief Systems that Perpetuate FGM

The CPAR found that FGM is supported by a range of belief systems similar to those reported by Berg, Denison and others (2010b) and the WHO (1999). These include beliefs that are associated with religion, sexuality, marriage, communication, and socialisation. The latter beliefs (socialisation and communication) have not been emphasised in previous studies, which further underscores the diversity of beliefs that perpetuate the practice of FGM in various affected communities. The findings also reveal the relative importance of the various belief systems influencing the continuation of FGM, and therefore the notion that a one-size-fits-all approach is not an appropriate strategy for ending FGM.

It should be emphasised that as with any piece of qualitative research, the findings presented in this Section are based on interpretations, views and perceptions as revealed during the FGDs and in-depth interviews. These may have been expressions of individual personal beliefs or community-wide beliefs. It was generally difficult to differentiate between individual and community beliefs. Nonetheless, understanding both beliefs is fundamental to the effective implementation of the REPLACE Approach to ending FGM.

### 4.3.1 Terminology as a Barrier to Ending FGM

REPLACE found that terminologies that are used to describe FGM have considerable implications for the continuation and eradication of the practice. Meaning associated with particular terminology, appears to be important in the continuation of FGM across the affected communities. Table 4.1 demonstrates the various terminologies utilised by the Eritrean, Ethiopian, Gambian, Guinean Bissauan, Senegalese, Somali and Sudanese communities who participated in REPLACE.

**Table 4.1   Traditional and Local Terms Used for FGM by REPLACE Participants from Ethiopia, Eritrea, Gambia, Guinea Bissau, Senegal, Somalia and Sudan**

| Country of origin | Term used for FGM | Meaning of term |
|---|---|---|
| Ethiopia | Megrez | Circumcision/cutting |
| | Absum | Name giving ritual |
| Ethiopia | Mekhnishab | Circumcision/cutting |
| Gambia | Niaka | Cut/weed clean |
| | Kuyango | The 'affair' also name for the shed built for initiates |
| | Musolula | The women's side/that which concerns women |
| Guinea Bissau | Fanadu | Circumcision of girls |
| Senegal | Londindeh | Circumcision |
| | sunnadeh | Circumcision |
| Somalia | Gudinin | Circumcision. Used for male and female circumcision |
| | Halalays | Sanctioned, implying purity. |
| | Qodiin | Stitching/tightening/sewing. Refers to Type III infibulation |
| Sudan | Khifad | To lower. Presumably sexual desire. |
| | Tahoor | To purify. |
| All communities | Sunna | Religious tradition/obligation for Muslims. Usually referring to Types I and II |
| | Pharonic or Big/heavy Sunna | Refers to Type III infibulation |

*Source: REPLACE; Department of Health UK, 2015.*

An important observation across the communities was the use of similar terminologies to describe both male and female circumcision. The word 'circumcision' was used as a 'catch-all' term to refer to male and female circumcision. Even though a few communities

sometimes qualified the term circumcision with 'female', in most communities 'circumcision' was used for both male and female circumcision. Not surprisingly individuals often conflated male and female circumcision and the beliefs associated with them.  As a result many community members did not reflect and question the values that were attributed to FGM because they automatically assumed them to be the same as for male circumcision. For example, it was common for participants to apply the health benefits and the religious requirement of male circumcision to justify their support and practice of FGM.

Similarly, most communities used terminologies that portrayed FGM as benign. Terminologies that reveal the harmful effects were often discouraged as being culturally inappropriate. For example, among the Gambian/Senegalese community the terms *londineh* or *sunnandeh* were preferred over '*salindeh'* for describing FGM because the latter was deemed to portray the practice as 'harsh'.  Most Guinea Bissauan participants reported a preference for using the term *fanadu* to describe FGM because it showed that the practice is a positive educational ritual. As a result, many parents did not perceive FGM as a form of physical abuse, but as an educational ritual.

> "When *I hear 'fanadu' I don't see it as mutilation. What I understand is that it is a ritual that helps girls to learn. Because of that it does not shock me [I don't see it as a terrifying practice] when I hear of it. I see it as a good thing that helps children to learn about their culture.*" (Female participant, Guinea Bissau community, Lisbon)

In relation to the term FGM, there were a few participants who supported the use of the term because they believed that it gave an accurate representation of what the practice does to women's bodies. However, the majority of community members did not use the term FGM because they perceived it to have negative connotations, and preferred to use their local terminologies.   They often described the term FGM as 'scary', 'horrific', 'aggressive', 'barbaric', and culturally insensitive. Other participants disapproved of the term because they thought it evoked horrific images and psychological distress'. Also, many did not perceive FGM Types I and II as 'mutilation' and some participants believed that FGM Type III was aesthetically pleasing and therefore not mutilation (see Box 4.2).

> **Box 4.2    What REPLACE Respondents Said About the Term 'FGM'**
>
> '*We cannot call it mutilation as our loved families did this out of culture not hate.*' (Somali)
>
> '*It is the correct definition, but can't be used because of the word mutilation.*' (Somali)
>
> "*Even though I agree with your term [FGM], emotionally I cannot use it*'. (Sudanese)
>
> "*Mutilation and cutting are too strong words so I hate the word FGM. I am a very visual person, I start to shake when I hear of [the phrase] female genital mutilation.*" (Guinea Bissauan )

*Source: REPLACE*

The implications of these terminologies is that members of the communities did not  make a clear mental connection between the FGM practices that they subjected their daughters to and the negative effects attributed it. It also suggests that terminologies that are used in interventions could affect the take up and impact of the message. Therefore REPLACE project officers and CBRs used local FGM terminologies during the intervention activities to ensure that the message was as clear as possible. They constantly qualified the local terminologies with 'female' to differentiate FGM from male circumcision and to underscore the negative consequences of the former. Also efforts were made to refrain from using the term FGM due to fears that it could alienate certain community members from the intervention. This approach reduced ambiguities and enhanced the effectiveness of communication about FGM during REPLACE intervention activities.

### *4.3.2  Belief Systems that Support FGM Practice*

Several beliefs were found to underpin the practice of FGM in affected communities. These included beliefs associated with religion, socialisation, marriage and sexuality, culture, tradition and identity, social pressure and communication. The significance of each of these beliefs in driving FGM varies from one community to another (see Table 4.2). Also within each of the beliefs lie the barriers and facilitators to change in relation to ending FGM in affected communities. This provided useful information for the design of specific interventions for the communities engaged with REPLACE.

**Table 4.2    Belief Systems and their Level of Importance\*\*\* in the FGM Affected Communities Engaged with REPLACE**

| FGM AFFECTED COMMUNITY | BELIEF SYSTEMS THAT SUPPORT FGM | | | | | |
|---|---|---|---|---|---|---|
| | Religion | Socialisation & Discipline | Marriage & Sexuality | Culture, tradition & Identity | Social stigma | communication |
| Eritrean/Ethiopian Community (Italy) | ✔ | ✔✔ | ✔ | ✔✔ | ✔ | ✔✔ |
| Guinea Bissauan Community (Portugal) | ✔✔✔ | ✔✔✔ | ✔ | ✔ | ✔✔ | ✔ |
| Gambian/Senegalese Communities (Spain) | ✔✔✔ | ✔✔✔ | ✔ | ✔ | ✔✔ | ✔ |
| Somali Community (Netherlands) | ✔✔✔ | ✔✔ | ✔✔✔ | ✔ | ✔ | ✔ |
| Somali/Sudanese Communities (UK) | ✔✔✔ | ✔✔ | ✔✔✔ | ✔ | ✔ | ✔ |
| **Key** <br> ✔✔✔ = Very important <br> ✔✔ = Quite important <br> ✔ = Less important <br><br> **\*\*\*** *Rating is based on the frequency of times that the beliefs were mentioned during the FGDs and in-depth narrative interviews in the affected communities.* | | | | | | |

*Source:  REPLACE*

## Religion

The strong influence of religious beliefs in the continuation of FGM has been widely noted in the literature (Berg *et al*, 2010b). Not surprisingly such beliefs were found to be pervasive across the affected communities engaged in the REPLACE Project. The religious beliefs were mostly related to Islam, even though a few respondents whose faiths were Christianity and Judaism were also found to support FGM for religious reasons. This suggests that FGM cuts across religions, and is not related to any specific religious group. Despite the widespread belief that FGM is an Islamic practice, REPLACE found no actual proof that the practice is a religious requirement in any of the monotheistic religions. There is no clear authentic religious text that supports the practice. Rather, FGM is largely a cultural practice. It emerged that religious beliefs may have been conflated with cultural ones resulting in FGM being seen as a religious practice.

Many Muslim respondents said they supported FGM because it is 'Sunna' (an approved practice of Prophet Mohammed) and therefore a good deed for Muslims. The source of this

belief was attributed to a *hadith* (the sayings and preaching of Prophet Mohammed) in which Prophet Mohammed is purported to have asked a woman (an excisor) "to cut [a girl] slightly, but not to overdo it." In Islam most Sunna practices are not obligatory because they are not directly cited in the Koran, yet Muslims are often encouraged to practice them because they are a source of gaining 'extra' divine reward. Thus even though most people were found to be aware that FGM is not an obligatory practice (because it is not mentioned in the Koran), they still practiced it as a way of earning such 'extra' rewards.

> *"If a girl is submitted to fanadu it is "Sunna" which means that she complies with the orders of the Prophet.  It is not compulsory, and whoever does not submit their daughters to fanadu it is not something bad in Islam. But you will be rewarded if you did it."* (Male participant, Guinea Bissauan community, Lisbon, Portugal)

> *"It [FGM] is Sunna, so there are no obligations, which means you can do it or avoid it."* (Male respondent, Sudanese/Somali community, Bristol, UK)

> "*Some people believe that [it is obligatory], 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.  But I think it is still good that Muslim women do it"* (Female respondent, Somali community, Amsterdam, Netherlands)

Among the Eritrean/Ethiopian community, FGM was reported to be practiced by Muslims, Christians, and the Falashas (Jews). The Christian and Falasha respondents perceived FGM as a religious ritual that ensured women's sexual purity, even though they often could not tell the specific religious text that prescribed it. They appeared to be persuaded more by the instrumental value of FGM rather than the religious beliefs associated with it.

> *"In my country everyone does it [FGM], whether Muslim, Christian or Jews we all do it especially in the villages…. Now it is better. In my religion [Judaism] once a baby is born whether boy or girl, the religion expects that they are circumcised …. You have to do it before baptism.  They say it is a tradition of our religion, I don't know if this is true or not. But it [FGM] is good because it protects the girl." (*Male respondent, Eritrea/Ethiopia community, Palermo, Italy*)*

Among the participants who practiced Traditional African Religions, such as animism or ancestral worship, the belief that FGM is required by ancestral spirits was widely reported.

They believed that a person could be punished by the ancestral spirits if they failed to perform or subject their daughter to FGM:

> *"Our ancestors did it and they expect us to do it in their absence. They are always watching over us. If you disobey them, it does not matter where you are they can send the punishment to you."* (Female participant, Senegalese/Gambian community, Banyoles, Spain*)*

Across the affected communities FGM was categorised into two types: excision/clitoridectomy (little/big *sunna*) and infibulation (*pharaonic*). Some Muslim participants were of the view that not all types of FGM are Islamic. Most respondents generally believed that infibulation is *haram* (forbidden and sinful). As a result, there were a substantial number of Muslims who opposed FGM on religious grounds, mostly citing the lack of authentic religious texts to support the practice. Many respondents also asserted that FGM is overturned by a higher injunction in the Koran which abrogates all practices regarded as harmful to humans.

> *"Most people in this community think that the Prophet wants us to cut our daughters. But this is not true. That hadith is weak. Allah says in the Koran that we should not do anything that harms us."* (Male participant, Guinea Bissauan community, Lisbon, Portugal*)*

> "*FGM is different from Sunna. As mentioned in our religion; men should be circumcised but for women nothing is said about them in the Koran. So anybody who does it is haram."* (Male respondent, Somali community, Rotterdam, Netherlands)

Another common religious belief was that FGM is required for Muslim women to cleanse themselves for the performance of the Muslim prayer (*salat*). As a result, FGM was commonly seen as a virtue that strengthened women's faith and brought them closer to God. Women who were cut were generally perceived to be more religious and respected.

> "*So if a woman accepts it [FGM] it shows that she's more...religious, she's a practicing Muslim, she's not fake… I see women who have done it to have higher faith than those who haven't done it.*" (Male respondent, Somali community, Rotterdam, Netherlands)

*"The thing about cleanliness is that even when you rinse the thing [clitoris] it is still dirty. So it [clitoris] has to be removed so that we will be cleaned. So if a woman is not circumcised her prayer will not be accepted…."* (Female participant, Gambian/Senegalese community, Banyoles, Spain)

An important lesson from these findings which fed into REPLACE's intervention development work was the recognition that religion could be a powerful tool for tackling FGM. Consequently, some of intervention activities were built around using religious leaders and narratives to persuade people to abandon the practice (see Section 6). The religious narrative was based not just on the assertion that FGM is not a religious requirement, but also the fact that it is actually banned by a higher injunction in the Koran which invokes a do-no-harm principle. This appeared to have resonated well with many community members. Engaging with religious leaders was particularly useful because they are held in a high esteem and regarded as a credible source of information on FGM in the communities. However, it was sometimes difficult to gain the involvement of religious leaders in the intervention activities because many of them still strongly believed that FGM is an important religious practice and thus supported the social norm that perpetuates FGM.

## Socialisation and Discipline

It was widely believed among respondents in the Guinea Bissauan and Gambian/Senegalese communities that FGM is an important initiation practice that educates girls about good cultural values and prepares them for adulthood. The education rituals associated with FGM in these cultures were regarded very highly by members of these communities and who often perceived FGM to be synonymous with social education. Through FGM girls were expected to learn about rules of etiquette and culturally acceptable inter-gender and intergenerational relationships. Some perceived that the physical pain of FGM helps to train girls to become stronger to withstand the difficult challenges of life, especially the pains of child birth. Some participants mentioned that within the traditional set up it is through FGM that women are accorded with the privileges of womanhood; therefore they did not want their daughters to miss out on those privileges when they go back to their home country.

*"In Guinea, we know fanadu as a practice of emancipation, and a transition from one level to another, from child to adult, and a way to learn all the skills you need to become a good woman."* (Male FGD participant, Guinea Bissauan community, Lisbon, Portugal)

*"If she is not circumcised nobody will respect her when she goes back home. They will always see her as a small girl and she cannot do things that other women do. May be it will pain her now when she is cut, but she would not forgive me if she is not cut and in future nobody respects her"* (Female participant, Gambian/Senegalese community, Banyoles, Spain)

The cultural training associated with FGM, particularly that associated with being a good wife and mother, was deemed to be particularly relevant within the European context because it enabled parents to pass on and preserve their culture in their daughters. It was also seen as a way of countering the influence of western culture on girls which was seen as a source of moral decadence and indiscipline. Some parents believed that the main cause of disobedience in young girls was excessive sexual drive, and therefore FGM was needed to curb such drive and instil discipline. Consequently, it was common practice in the communities for a person to recommend to a parent to send their daughter home to Africa to be "taught a lesson" if she was deemed to be deviating from the cultural norm expected of girls.

*"…circumcision of girls is very good. Uncircumcised girls are very disrespectful. When you have high feelings for men you cannot be respectful…. if you have a girl and you don't want her to be naughty you have to send her home to be cut."* (Male participant, Gambian/Senegalese community, Banyoles, Spain)

However, in some of the communities, especially among the Eritrean and Ethiopian, a substantial number of participants expressed scepticism about the effectiveness of FGM for instilling cultural values in children, given the young age at which girls were submitted to the practice, even though they also believed that FGM enabled girls to become disciplined through the reduction of their sexual pleasure.

"*I think there is no benefit to it [to FGM]…. the best way to educate children is at home and not to send them to be cut. If a child is cut when she is only a few weeks old what will she learn? Nothing! For our people it is not about the learning but because the sexual drive is reduced."* (Female participant, Eritrean/Ethiopian community, Palermo, Italy)

This finding supports the point made by Berg, Denison and others (2010) about the role of social significance in the perpetuation of FGM by migrants to Western countries. This

suggests that interventionists may have to look beyond the belief systems that are traditionally associated with the practice of FGM and to also focus on the current social functions that FGM perform within migrant affected communities in order to effectively deal with it.

## Marriage and Sexuality

The belief that FGM enhances the marriageability of a woman was also common in the affected communities, even though this was not as widespread as religion and socialisation. The perceived role of FGM in enhancing marriageability is related to other beliefs around chastity, decency and sexual pleasure.

FGM was widely believed to reduce women's sexual drive, and therefore to be an effective tool for preventing girls from engaging in premarital sexual activities and committing adultery when married which were deemed to be sinful and shameful. Women and girls were commonly perceived to be too weak and unable to resist sexual temptations and therefore needed to be protected through FGM. Most participants believed that FGM was necessary to prevent their daughters from becoming prostitutes.

> *"We do it to reduce the sexual obsession of our girls, and not to maltreat them. You know we women are very weak so if we don't protect out daughters they will not be able to resist the temptations and they will become prostitutes"* (Female participant, Gambian/Senegalese community, Banyoles, Spain)

> "*We the parents don't want to stop circumcision so that our daughters will not go astray and become prostitutes."*(Female participant, Gambian/Senegalese community, Banyoles, Spain)

Some participants perceived sexual curtailment through FGM as a means to enable women to become decent and enhance their marriageability. Across the communities participants mentioned that proof of virginity was not a prerequisite of marriage for women within the European context, even though it was noted to enhance marriageability as it was seen as a marker of decency and chastity. In many of the communities when a man wanted to marry, he enquired about the 'decency' of the girl, which was based on public perception about her sex life. Women who were subjected to FGM were perceived to be 'decent' because they were less likely to be promiscuous. Most middle-aged men expressed a preference for

circumcised women for marriage because they perceived them to be faithful. They were likely to travel to their home countries in order to find a circumcised woman to marry:

> *"When I am ready for marriage I will like to go back to my village and find a wife. Here it is difficult to find a good wife. They are not cut so they are not pure…. Women who are cut are faithful to their husbands* (Male respondent, Guinea Bissauan community, Lisbon, Portugal)

While there was a lack of consensus over the effects of FGM on women's sexuality, most men thought the curtailment of sexual drive in women was necessary for them to be able to satisfy their wives and prevent infidelity. Uncircumcised women were perceived to be too sexually sensitive and likely to be unfaithful to their husbands. Men who had left their wives behind in their home country perceived that FGM was necessary to ensure that their wives did not commit adultery. Among the Eritrean and Ethiopian community, uncircumcised women were perceived as promiscuous.

> "*If you see a girl who is restless that is because she's not circumcised. An Eritrean girl, if she has several relationships, even if people don't know if she's circumcised or not, they automatically assume that she is not circumcised. It becomes difficult for her to find a man to marry at home."* (Male participant, Eritrean/Ethiopian community, Palermo, Italy)

> *"An uncircumcised woman is more sexually obsessed. If an uncircumcised woman is married to a man who is not strong, she might end up committing adultery. Just by touching herself, she becomes horny. The one who is circumcised has her sexual obsession reduced and will not commit adultery. They are good for marriage"* (Female participant, Gambian/Senegalese community, Lisbon, Portugal)

Some women were of the view that FGM was necessary to sustain marriage. Among the Guinean Bissauan and Gambian/Senegalese communities it was believed that the clitoris physically blocks male penetration and therefore its removal makes it easier for men to make love and to achieve sexual satisfaction. This was perceived to bring happiness in marriage.

> *"A circumcised woman makes a happy marriage home because they are able to satisfy their husband. If you are not circumcised you always face a lot of problems in your marriage. Nobody respects you…."* (Female participant, Gambian/Senegalese community, Banyoles, Spain)

Conversely, there were a few women who mentioned that FGM was a source of friction in marriage because it affected the sexual life of couples. Some participants cited numerous cases where marriages have been dissolved as result of the adverse effects of FGM on the wife's sexuality. Also, there were a few men, mostly youth, who reported a preference for uncircumcised women because they perceived them to be more sexually attractive than those who have been subjected to FGM.

Thus within the EU it appears there is a shift in the perception about the role of FGM as a requirement for virginity and marriage. People in affected communities seemed to be less driven by the marriageability function of FGM. Also, many people seemed to be beginning to question claims that FGM prevents promiscuity in women and were increasingly concerned about its adverse health effects, often citing practical examples to support their scepticism. This scepticism and practical examples provided REPLACE with a useful resource to encourage community members to end FGM.

**Culture, Tradition and Identity**

Across all the communities, one of the most commonly cited reasons for practicing FGM was related to culture, tradition and identity. Beliefs associated with culture and tradition were very common among the older generation who mostly perceived themselves as custodians of cultural tradition. People did not often have any particular reason to justify why such a tradition should be continued other than that they needed to preserve what their ancestors had passed on to them. These people often seemed to be open to change if compelling evidence was provided against FGM, especially on the adverse health effects. Most youth, especially those who had lived in the host country for most of their lives were less persuaded by the tradition-argument in support of FGM.

> *"The people who gave birth to us did it before we were born. So we cannot just say that it is wrong because they did it for an important reason. Until there is concrete evidence to show that it is wrong we cannot condemn it."* (Male participant, Guinea Bissau community, Lisbon, Portugal)

For some of the older generation the abandonment of a particular cultural practice was believed to incur the displeasure of the ancestors or seen as shirking their responsibility for preserving cultural tradition which their reputation partly depended upon.

> *"The elders in this community are well respected. They are those who protect our culture. They have a lot of experience and we respect them. So when they recommend that you subject your daughter to FGM you have to respect that."* (Male respondent, Guinea Bissau community, Lisbon, Portugal)

However, for some people the need to continue FGM was due to the fear of being labelled as a cultural traitor. Thus some people thought that keeping their cultural tradition was an important way of identifying themselves with their ethnic heritage and enabled them to fit into their migrant society. This was particularly important within the diaspora context where interdependence and friendship networks were crucial for daily living.

Related to the above point is the fact that some participants perceived FGM as a marker of both cultural and religious identity. A substantial number of the members of the Guinean Bissauan and Gambian/Senegalese communities perceived that FGM defined the identity of a Muslim woman:

> *"If she is circumcised nobody will mistake her for a non-Muslim. We are Muslims and circumcision is good because that is what all Muslims do. Wherever we are we have to make our identity known."* (Female participant, Gambian/Senegalese community, Banyoles, Spain)

Among the Ethiopians and Eritreans, infibulation was generally associated with Islam and clitoridectomy and excision with Christians and Jews.

> *"Infibulation is not our type. It is only the Muslims who do it. For us it is just a small cut of the clitoris"* (Female narrative interview respondent, Eritrean/Ethiopian community, Palermo, Italy)

Many participants accused anti-FGM campaigners of being insensitive to their culture. As a result it was particularly difficult for individuals from the affected communities to be openly critical of FGM. Such individuals were often accused of being 'bought' by Europeans and labelled as traitors. Some participants also perceived the campaign against FGM as a conspiracy to obliterate Islamic practices.

The cultural underpinnings of FGM make it difficult for interventionists to tackle the practice. Cultural 'outsiders' fear being accused of ethnocentrism while community-based campaigners risk being labelled as traitors. However, experience from REPLACE shows that

armed with strong myth-busting evidence and culturally sensitive community engagement techniques, interventionists can make substantial impact in persuading people out of their cultural beliefs on FGM.

## Social Pressure

Across the communities there were certain common beliefs that stigmatised women that were not subjected to FGM. For example, among the Gambian/Senegalese communality uncircumcised women were labelled *solima*, meaning 'rude', 'ignorant', 'immature' and 'uncivilized'. The Guinean Bissauans called such women *blufo*, which means 'stupid' or 'promiscuous'. The Eritreans and Ethiopians commonly believed that an uncircumcised woman is a prostitute. Such labels not only caused emotional distress among uncircumcised women, but also deprived them of certain privileges such as participation in important family and community events and decisions.

> *"I was born in Guinea Bissau and I know that if you don't go to fanadu you are insulted, you are blufo, you can't eat together with others that have been submitted to fanadu, and you cannot get together with those who are submitted to fanadu. You feel ashamed that they call you that. Even here some people still use those words on people who are not circumcised."* (Female participant, Guinea Bissauan community, Lisbon, Portugal)

> *"In our culture if you are not circumcised you are nobody. You are treated like a small girl, nobody respects you and you are not consulted on anything"* (Female participant Guinea Bissauan community, Lisbon, Portugal)

> *"In our culture a woman who is not circumcised is called a prostitute. They say her feelings are too high and so she goes after men…. here in Italy when a woman is promiscuous our people say it is because she has not been cut."* (Female participant, Eritrean/Ethiopian community, Palermo, Italy)

It is not just uncircumcised girls who were affected by such stigma, but their parents and family too. Participants in the Guinean Bissauan community reported that in the home country parents were respected and honoured if they submitted their daughters to FGM. But they were rejected and accused of under-valuing their culture if they failed to submit their daughters to FGM.

*"I have four daughters and all of them have been submitted to fanadu. I really wanted them to go to fanadu because when you have a daughter there is nothing more important than the day she is going to be submitted to fanadu. Everyone respects you when you daughter has gone to fanadu."* (Male participant, Guinea Bissauan community, Lisbon, Portugal)

*"In our country, in order for us to be happy and have peace we have to submit our girls to fanadu."* (Female participant, Guinea Bissauan community, Lisbon, Portugal)

Although the stigma of non-practice of FGM was greatest in the home country, it was also common amongst the diaspora communities. Some parents feared that even if their daughters managed to escape such stigma in the host country they are still likely to face stigma when they visit relatives in their home country.

*"If you don't do it [FGM] she will not be respected when she goes back home. They will treat her like a minor. Her colleagues will harass and poke fun at her."* (Female participant, Gambian/Senegalese community, Banyoles, Spain)

Among the Somali and Sudanese participants there was evidence to suggest that older women tended to influence one another to subject their daughters and granddaughters to FGM. Also young women who were circumcised were reported to persuade their peers to undergo the practice. This underscores the importance of the use of peer group champions in achieving social norm transformation.

**Communication**

Discussion about FGM was generally limited in the affected communities due to the belief that such discussion is a taboo. It was considered inappropriate for mothers to discuss FGM or issues of a 'sexual' nature with their sons. Likewise, fathers were 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. Also 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.

*"It is known in Somalia that girls and boys are subject to khitan without discussing the issue with them. 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"* (Female participant, Somali community, Bristol, UK ).

*"In my community FGM is hardly talked about, actually it is a taboo"* (Female participant, Somali community, Rotterdam, Netherlands)

However, REPLACE found that both men and women did occasionally discuss the issue of FGM with their same sex friends and extended family relatives. This suggested that peer networks can be an effective way of getting messages out amongst people. Thus, peer-to-peer and intergenerational communications were used in REPLACE to tackle FGM practice in the affected communities.

## 4.4   Conclusion

The factors discussed in this Section highlight some of the most important barriers to change and enforcement mechanisms present in data we collected for REPLACE. As we publish more detailed analysis of the data we will provide information about this on the REPLACE website (see   www.replacefgm2.eu). It is possible other belief systems that enforce FGM were missed by the research, however, we are confident that the most important belief systems that facilitated FGM practice in the affected communities were captured by the nuanced methodology (CPAR) adopted and large numbers of participants in the REPLACE Project.

The findings of the research underscore the range and complexity of beliefs that enforce FGM, and which REPLACE interventions had to grapple with. It should be emphasised that as much as these beliefs facilitate the practice of FGM they also provided avenues for tackling FGM. A nuanced community-based research approach should provide an effective mechanism for uncovering how the belief systems can be harnessed to bring about change in relation to the social norm perpetuating FGM in the EU.

. Even though it may not be possible to tackle all the beliefs that are identified in a particular community, REPLACE found that belief systems that enforce FGM tend to overlap and reinforce one another and therefore by carefully planning an intervention a number of beliefs can be addressed in a single programme. Due to resource scarcity it is useful to focus on the most important beliefs in the community, even though these may be amongst the most challenging to address.

# Section 5: The REPLACE Approach

# Element 3: The REPLACE Community Readiness to End FGM Model

**The REPLACE Cyclic Framework for Social Norm Transformation: Element 3**
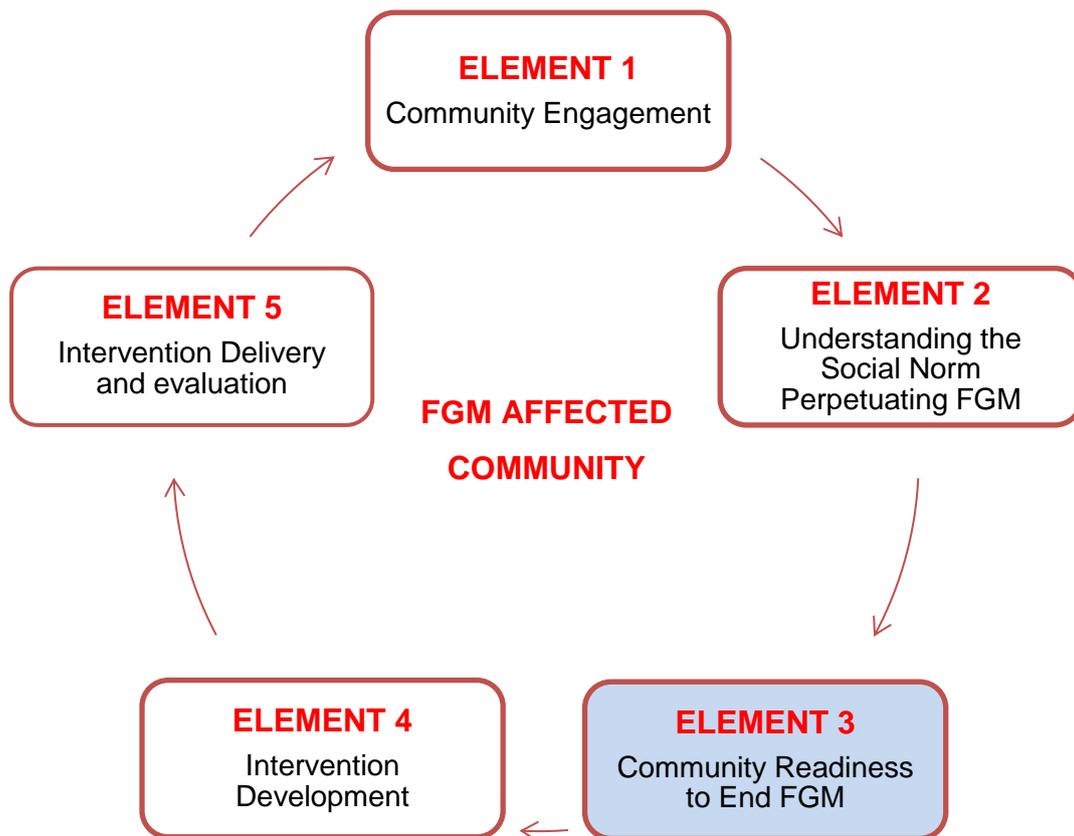


*Source : REPLACE*

## 5.0 Introduction

As we have seen, African communities living in the EU that practice FGM have different belief systems, social norms and community enforcement mechanisms that perpetuate the practice. So each community is different. This may be based on their ethnic heritage, the EU country in which they live and the length of time they have lived in the EU. Age, gender and social class may also be important factors. Communities are complex evolving entities

and whilst they may continue the practices of their heritage country the reasons for doing so might be different in the host country.

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, even if from the same ethnic group or country of origin. Furthermore, we should not assume that all individuals who identify as members of a practising community wish to continue the practice. Indeed, Johnsdotter (2007) suggested that Somalis living in Sweden may find it a relief that they do not have to circumcise their daughters, though more recent findings suggest women having immigrated to Sweden from an FGM-practicing country were more ambivalent to the practice – having recognised its negative health consequences but acknowledging the importance of the practice within their culture (Isman *et al.,* 2013). 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.

Thus each community is different and will be at different stages of readiness to challenge and overturn the social norm supporting the continuation of FGM in the EU. Few if any interventions in the EU aimed at ending FGM have taken this into consideration, often using the same intervention for all FGM affected communities.  As a result the impact of these interventions has frequently been disappointing, with awareness of FGM being raised but little evidence of behavioural change and the associated abandonment of FGM.  REPLACE suggest this is mainly because interventions do not contain behavioural change elements, but also because they do not take into account the internal dynamics of FGM affected communities and the fact that some communities are more responsive to messages of change than others. Thus the REPLACE Approach incorporates a Community Readiness to End FGM Model based on Stages of Change Models.

## 5.2 Stages of Change Models and Behaviour Change

Two types of theory have tended to dominate when considering 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 behavioural change in steps. One such stage 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).[1]

The Stages of Change Model was originally developed to explain smoking cessation (Prochaske and DiClemente, 1983) and focussed on the behaviour of individuals. It proposes that individuals go through five distinct stages on their journey from not performing to consistently performing a health-relevant behaviour such as giving up smoking. These are:

1　Pre-contemplation: the person is not yet thinking about changing their behaviour.
2　Contemplation: the person has become aware of and has begun to think about behaviour change.
3　Preparation: the person is getting ready to change their behaviour.
4　Action: the person has begun to change but has been doing so for a short time period (often cited as less than 6 months).
5　Maintenance: the person has been performing the new behaviour successfully for a substantial time period (often cited as over 6 months).

The model also contains a 'relapse' element to account for the fact that people may go backwards as well as forwards in the journey to permanent behaviour change. The Model suggests that people weigh up the positive and negative aspects of behavioural change and will perceive greater negatives and fewer positives in the early stages compared to more positives and fewer negatives in the later stages (known as decisional-balance). Self-efficacy (a person's confidence in their ability to do something) is also believed to increase as people advance through the stages and as temptation decreases.

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. As a result they include two additional dimensions: preference and actual behaviour in their

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[1] We provide supplementary material for the interested reader on other models of behaviour change on the REPLACE website www.replacefgm2.eu

analysis. The five categories of readiness to change behaviour relating to FGM identified by Shell-Duncan *et al* (2010) are illustrated in Figure 5.1.

## Figure 5 1 Five Categories of Readiness to Change Behaviour Relating to FGM in the Senegambia Region of West Africa

| Behaviour | Attitudes Towards the Practice | | |
|---|---|---|---|
| | Thinks FGM/C should continue | Undecided | Thinks FGM/C should stop |
| Adherent of FGM/C | Willing adherent | | Reluctant adherent |
| Undecided | | Contemplator | |
| Abandons FGM/C | Reluctant abandoner | | Willing abandoner |

*Source: UNICEF, 2013.*

The two dimensions of preference and actual behaviour illustrate the fact that decision making and behaviour relating to FGM in the Senegambian context are rarely under individual control. FGM is a social norm and enforced by the community, thus whilst some people might have a preference to abandon FGM, they feel compelled to continue the practice due to community pressure. They are the Reluctant Practitioners of FGM.  Shell-Duncan *et al* (2010) have identified this interface between individual preference and community enforcement of social norms as problematic when applying the Stages of Change Models to the issue of FGM.

Shell-Duncan *et al* (2010) conclude that whilst the Stages of Change Model has much to commend it when working to end FGM in the Senegambia region, it did not take enough account of social norms and community pressure to conform. They found that FGM in this region was maintained by intergenerational peer pressure to which people conformed. 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 older generation of women were respected in decisions as to whether to perform FGM on their granddaughters. Shell-Duncan *et al* (2010) research shows the complex nature of ending FGM, due to the complex links between individuals, families and the wider

community. It clearly demonstrates that individual motivations to change behaviour are affected by social norms and community beliefs and that people balance the benefits and costs of performing any change in behaviour, including abandoning FGM.

As Edwards *et al* (2000: 294) state; a major difficulty with Stages of Change Models (and this is demonstrated by the Shell-Duncan *et al* (2010) study), is that 'communities are not individuals, they are groups. Group processes and conditions do not readily translate into the five stages of individual readiness. For example, leadership has no place in individual stages of readiness but it is an essential element of community readiness.' In short, Stages of Change Models do not adequately characterise the multidimensional nature of communities and social norms.

## 5.3 Community Readiness Models

In response to calls for Stages of Change Models to incorporate more community elements a number of Community Readiness Models have been developed combining community and individual-level readiness models. These have been used to understand and analyse the success of various prevention programmes such as drug use (Donnermeyer *et al*, 1997; Edwards *et al*, 2000), domestic violence, alcohol abuse as well as bicycle helmet use (Kakefuda *et al*, 2011). One of the first attempts to systematically study a community's readiness level was undertaken by Miller (1990) who assessed the readiness of a community to accept a public education programme on wastewater treatment alternatives. He distinguished between three types of readiness: individual, group and community. Miller concluded that the inclusion of community into the analysis of readiness requires an appreciation of community values and norms and the level of participation by individuals in community affairs. Miller defined Community Readiness as 'the relative level of acceptance of a program, action or other form of decision-making activity that is locality-based' (Miller, 1990 cited by Donnermeyer *et al*, 1997:68).

Donnermeyer *et al* (1997) developed these ideas further and produced a nine stage model of community readiness for prevention programmes. The stages ranged from : community tolerance of the problem behaviour; denial that anything can be done about the problem behaviour; vague awareness that there is a problem but little understanding of the extent or nature of the problem behaviour; preplanning where communities recognise that there is a behavioural problem; preparation when a group of community leaders are actively developing a plan of action to tackle the problem; initiation when the plan is put into action; institutionalisation, the programme is well established and running; confirmation/expansion where the programme receives widespread support from the community; and

professionalisation   where the programme has developed into a highly professionalised service with positive support from the community. An anchor rating technique was adopted using the following five dimensions:

1    The prevention programme itself

2    Knowledge about prevention programming

3    Leadership and community involvement

4    Information about the problem locally

5    Funding/support for the prevention programming

The Tri-ethnic Centre for Prevention Research at Colorado University, USA, combined Donnermeyer *et al.'s* (1997) work on community responses to drug abuse with Prochaska and DiClemente's (1983) conceptualisation of individual cessation of  smoking to produce a new Community Readiness Model (Edwards *et al*, 2000) which they thoroughly tested. The result was a Community Readiness Model with six 'dimensions of readiness' which are key factors that influence a community's preparedness to take action on an issue. They are as follows:

A.  Community Actions: What are the current actions, programmes and policies designed to address the issue?

B.  Community Knowledge of Actions: What do community members know about local actions and their effectiveness and are these accessible to all members of the community?

C.  Leadership: Do community leaders and other influential community members support the issue?

D.  Community Climate: What is the prevailing attitude of the community toward the issue? Is it one of helplessness or responsibility and empowerment?

E.  Community Knowledge about the issue: What do community members know about the problem, its consequences and how it impacts their community?

F.  Resources related to the Issue: What local resources, people, time, money, space etc are available to support actions?

(Plested *et al.*, 2006)

Each of these Dimensions of Readiness are scored by 4-6 individuals representing different segments of the community. The combined score determines the Stage of Community Readiness. There are nine stages of community readiness as follows:

1. No awareness: Issue is not generally recognised by the community or leaders as a problem

2. Denial/resistance: At least some community members recognise that it is a concern, but there is little recognition that it might be occurring locally

3. Vague awareness: Most members of the community feel there is a local concern, but there is no motivation to do anything about it.

4. Preplanning: There is clear recognition that something must be done, and there may even be a group addressing it. However efforts are not focussed or detailed.

5. Preparation: Active community leaders begin planning in earnest. Community offers modest support to efforts

6. Initiation: Enough information is available to justify efforts. Activities/interventions are underway.

7. Stabilisation: Activities are supported by administrators or community decision makers. Staff are trained and experienced.

8. Confirmation/expansion: Efforts/interventions are in place. Community members feel comfortable using services and they support expansion.

9. High level of Community Ownership: Detailed and sophisticated knowledge exists about the problem, its prevalence, causes and consequences. Effective evaluation guides new directions. Model is applied to other issues.

(Plested *et al.*, 2006)

The view of the Tri-ethnic Centre for Prevention Research is that 'Efforts by *local* people are likely to have the greatest and most sustainable impact in solving *local* problems and in setting *local* norms.' (Edwards *et al,* 2000, 292). Therefore assessing a community's readiness to change is an important part of social norm transformation.

This Community Readiness Model has been successfully used with American communities experiencing problems with: drug abuse, alcohol abuse, intimate partner abuse, child abuse, head injury, environmental trauma, transportation issues, animal control issues; and suicide. It has not been used with communities experiencing FGM.

## 5.4 REPLACE Community Readiness to End FGM Model
REPLACE adapted the Tri-ethnic Centre's Community Readiness model to the problem of FGM in the EU. REPLACE used the same methodology, namely dimensions of change, to determine a score to match to one of nine stages of readiness to change. These were adjusted to be relevant to the issue of FGM in the EU, and was informed by Elements 1 and

2 of the REPLACE Approach. The REPLACE interpretation of the stages to change range from stage one 'no community awareness of the issues associated with ending FGM' to stage nine 'high level community buy in to end FGM'. These are shown in Figure 5.2.

The Model was used by all five REPLACE participating communities. For details of the implementation of the Model see the REPLACE Community Handbook. Some used interviews of those representing the community, others used focus group discussions and others a combination of these two methods to score the community's readiness to end FGM. These were all valid procedures. What emerged was the need to ensure that all segments of the community were represented in the scoring and that there was consensus. For this reason REPLACE suggest that focus groups might be the best method, as the dimensions of change can be discussed, agreed and scored by the whole group, thus representing the social norm in place at the time. Community scores were then totalled and a community placed in a stage of readiness to end FGM.

**Figure 5.2    REPLACE Community Readiness to End FGM Model: Dimensions of Change and Stages of Readiness to Change**
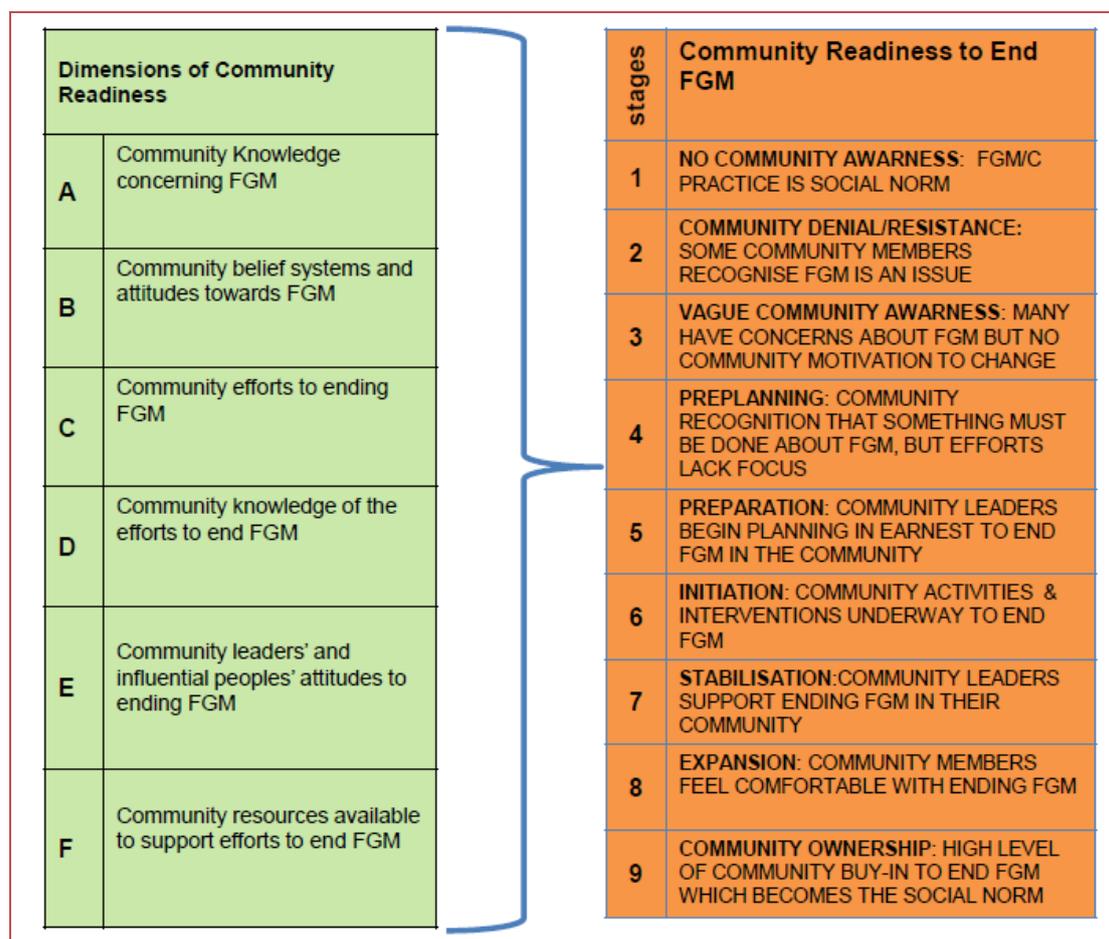


*Source: REPLACE*

The typical scoring of the dimensions to change and the corresponding readiness to change stages are shown in Figure 5.3. This shows that there must be a logical and step-by-step attention to each of the dimensions of change.  It suggests that increasing a community's awareness and knowledge of health effects and illegality of the practice in the EU must be achieved before belief systems supporting FGM can be challenged and community efforts to end FGM be mobilised. The role of community leaders and peer group champions is essential in both challenging the social norm supporting the continuation of FGM and developing and implementing interventions to change behaviour. In order for sustainability and the abandonment of FGM, leadership as well as community and outside resources are necessary.

**Figure 5.3    Community Readiness to End FGM Model**

| DIMENSIONS OF CHANGE | LOW (1-3) / MEDIUM (4-6) / HIGH (7-9) | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| A. Community Knowledge Concerning FGM | L | M | M | M | H | H | H | H | H |
| B. Community belief systems and attitudes towards FGM | L | L | M | M | M | H | H | H | H |
| C. Community efforts to ending FGM | L | L | L | M | M | M | M | H | H |
| D. Community Knowledge of the efforts to end FGM | L | L | L | L | L | M | H | H | H |
| E. Community leaders and influential people's attitudes to ending FGM | L | L | L | M | M | H | H | H | H |
| F. Community resources available to support efforts to end FGM | L | L | L | L | L | M | M | M | H |
| | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| STAGES OF COMMUNITY READINESS TO END FGM | No community awareness | Community Denial/ Resistance | Vague Community Awareness | Preplanning | Preparation | Initiation | Stabilisation | Expansion | Community Ownership |
| FOCUS OF INTERVENTION | INCREASING KNOWLEDGE OF FGM | | | CHANGING ATTITUDES AND INITIATING BEHAVIOUR CHANGE CONCERNING FGM | | | SUPPORTING BEHAVIOUR CHANGE NOT TO PERFORM FGM | | |
| | - Building community cohesion<br>- Increase knowledge of health impacts and illegality of FGM<br>- Challenge belief systems supporting FGM | | | - Identify and support community leaders/Peer Group Champions to end FGM<br>- Support efforts to end FGM by developing appropriate interventions<br>- Begin to harness community resources to end FGM | | | - Reinforce community efforts to end FGM<br>- Ensure community and other resources to ensure the abandonment of FGM | | |
| COMMUNITY/INDIVIDUAL EMPOWERMENT BALANCE | Community Empowerment | | | Individual Empowerment | | | Community Empowerment | | |
| SOCIAL NORM CHANGE | SOCIAL NORM SUPPORTING FGM | | | SOCIAL NORM TIPPING POINT | | | SOCIAL NORM ABANDONING FGM | | |

*Source: REPLACE*

The resultant scores of the five communities participating in REPLACE indicated a range of stages of readiness to end FGM as shown in Table 5.1. These range from stage 1- 2 (no community awareness -community denial/resistance) through to stage 4 (pre-planning).

**Table 5.1    Stages of Community Readiness to end FGM of REPLACE Participating Communities**

| FGM Affected Community | Stage of Readiness to End FGM | Community Assessment of the Situation |
|---|---|---|
| Eritrean/Ethiopian Community living in Italy | 1-2  No community awareness of FGM mixed with denial and resistance | FGM 'is a concern, but there is little recognition it might be occurring locally' |
| Gambian/Senegalese Community living in Spain | 2  Community denial and resistance  that FGM is an issue | 'Their main concern was that if girls were not circumcised they will be subjected to distain and insults.' |
| Guinea Bissauan Community living in Portugal | 3  Vague awareness concerning FGM but no community motivation to tackle the issue | 'There is local concern, there's not an immediate motivation to do anything about it' |
| Sudanese Community living in UK | 3  Vague awareness concerning FGM but no community motivation to tackle the issue | 'They started to do some awareness about FGM when they started to come to the UK (a bit – not too much – a little) and they turned to address other issues which were more pressing to them.' |
| Somali Community living in Netherlands | 3-4  Between vague awareness (as above) and Preplanning: there is community recognition that something must be done to end FGM, but efforts lack focus. | 'The biggest worry is that many women within the community do not count the lightest form (sometimes called sunna) as a type of circumcision.' 'Religion is still a problem, women know female circumcision is culture, but there is no Imam in the Netherlands originally from Somalia, who dares to speak out and state that female circumcision is not necessary to do and that there is no need for sunna.' |

*Source: REPLACE*

The Eritrean and Ethiopian communities living in Italy proved extremely challenging, as this is a group of migrants who were highly transient, wishing to leave Italy and settle elsewhere in the EU as soon as they had their papers. Thus community cohesion was weak with people having few opportunities to meet as a community and having no recognised leadership. Amongst the Gambian/Senegalese communities in Spain and Guinea Bissauan community in Portugal the issue was the reference back to social norms in the home country and perceived sanctions from extended family if they did not conform. This meant that the Legal Norm in the EU which has made FGM illegal was not accepted, with the Social Norm of continuing FGM taking precedence. Amongst the Sudanese community in the UK there were comments that anti-FGM messages were not aimed specifically at them (rather the Somali Community) and did not differentiate members of the community who had resided in the UK for a long time and those who had recently arrived fleeing political upheaval. In the Netherlands the Somali community were concerned about 'moral breakdown' within their communities and were confused concerning FGM, which was a sign of being a 'good woman' in Somalia, yet in the Netherlands was regarded as mutilation and was illegal. They asked for help in speaking about FGM in their families and giving sexual health advice to their children and on how to deal with the 'social confusion' concerning FGM.

The fact that communities are not homogeneous and readiness to change may vary by age, gender and length of residence living in the host country, might suggest that the REPLACE Community Readiness to End FGM Model could be applied to different segments of the community, with interventions being tailored to these groups. However if a social norm is to be challenged and overturned all segments of the community must be involved.

## 5.5   Linking REPLACE Community Readiness to End FGM Model to Intervention Development

Clearly the strategies and interventions associated with ending FGM will be different for each of the community readiness to change stages (Figure 5.3). In addition whilst communities may be placed in the same stage of readiness to change, their scores may differ across the dimensions of change.  This provides a good guide to the dimensions of change that require attention and intervention and can ensure that an action with appropriate input is implemented and matched to the dimension needs and stages of readiness of the community.

In general the application of the REPLACE Community Readiness to End FGM Model indicated that if a community was placed in:

- Stages 1-3, then interventions need to focus on building community cohesion, increase awareness and knowledge of the health implications of FGM and that fact that it is an illegal practice in the EU and begin to challenge the belief systems supporting the continuation of FGM.

- Stages 4-6, then interventions need to initiate behaviour change through identifying and supporting community leaders, developing appropriate interventions and harnessing community resources to end FGM. These are crucial stages in social norm change, as during these stages the tipping point in Social Norm change will occur and individual self efficacy and empowerment will begin to challenge the Social Norm supporting FGM.

- Stages 7-9, then interventions need to support behavioural change as well as embed and strengthen social norm change in abandoning FGM.

Section 6 gives more information on intervention development that is informed by the REPLACE Community Readiness to End FGM Model.

## 5.6 The REPLACE Community Readiness to End FGM Model as an Evaluation Tool

Whilst the REPLACE Community Readiness to End FGM Model is an excellent technique to assess the stage of readiness of communities to change so that interventions can be appropriately targeted to achieve maximum effectiveness, it can also be used as an evaluation tool. When used before and after interventions it can indicate the success of the intervention and when used at regular intervals can suggest what interventions are now needed to achieve social norm change as well as monitor the progress of a community towards ending FGM.

## 5.7 Conclusion

The REPLACE Community Readiness to end FGM Model is easy and affordable to use, and it provides a nuanced tool to inform intervention development, especially when based on community engagement and using Community-based Participatory Action Research methods to understand community dynamics and the social norm perpetuating FGM. It is a tool that can easily be used by communities to determine stage of readiness to end FGM, to help inform the development of appropriate interventions and also when used at regular

intervals can monitor a community's progress towards social norm transformation where FGM is no longer acceptable.

# Section 6:  The REPLACE Approach
# Element 4: Intervention Development

**The REPLACE Cyclic Framework for Social Norm Transformation: Element 4**
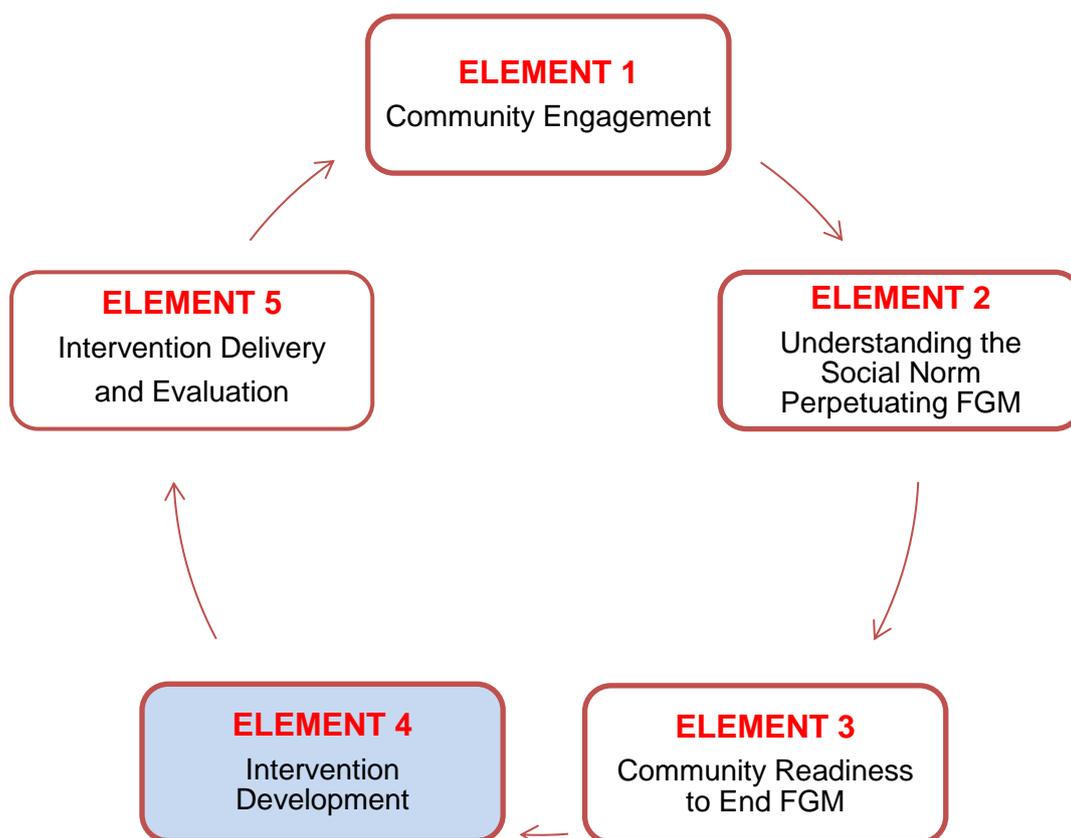


*Source:  REPLACE*

## 6.0   Introduction

Intervention development begins after Elements 1, 2 and 3 of the REPLACE Approach have been completed. Engaging with the FGM affected community and understanding the specific drivers, belief systems and enforcement mechanisms of FGM within the community is important for defining the focus of intervention actions (Elements 1 and 2). A community readiness to change assessment (Element 3) needs to have been carried out with the FGM affected community before intervention development can begin. This is important as identification of the community's stage of readiness to change informs the intervention development process. Re-assessment at later time-points can also contribute to evaluation and ensure a focussed and effective intervention.

The REPLACE Approach to intervention design and implementation is unique in that it draws on and applies theoretical ideas concerning readiness to change, behaviour change and targeting problem behaviour from both individual and community-based theories of behaviour change intervention development. It does this in collaboration with the community of people where change is desired. When enough people are reached, experience attitude change and as a result alter their behaviour towards FGM the community will be one step nearer achieving the goal of ending FGM.

Interventions are 'behavioural change steps' towards the goal of ending FGM and in order to be effective must incorporate behaviour change elements and be tailored to the stage of readiness to end FGM of the community. It is possible that communities will go through a number of cycles of intervention development and implementation before a shift in social norms will begin to be detectable and gains momentum.

## 6.1   Intervention Development Using the REPLACE Approach

The REPLACE Approach to intervention development comprises two components.

**Intervention development (i): Identify a target intervention action (or actions) with community peer group champions.**

Intervention development began by drawing on the readiness to change stage that has been identified through the REPLACE Community Readiness to End FGM Model to identify a target intervention action. Aligning type of intervention action with stage of readiness maximises the likelihood that engaging in that action will move the community forward to the next stage of behaviour change and towards social norm rejection and replacement. In general, as Figure 5.3 shows that where a community is in stages 1-3 of readiness to end FGM interventions need to focus on increasing community cohesiveness and knowledge of FGM within the community, including raising awareness of the health implications of FGM and its illegality in the EU.  In addition interventions may begin to challenge the belief systems supporting the continuation of FGM within the community. Where a community is in stages 4-6 of readiness to end FGM then interventions should pay attention to changing attitudes and initiate behaviour change concerning FGM. By stages 7-9 behaviour change concerning FGM will be established and interventions need to reinforce and support behaviour change and social norm transformation.

Table 6.1 provides suggested target intervention actions aligned to each stage from the REPLACE Community Readiness to End FGM Model. Because none of the REPLACE communities were deemed to have moved beyond stage 4, the focus of REPLACE's intervention actions were based on organising community events and opportunities to discuss FGM and present information and persuasive arguments about ending FGM. Suggested actions for the later stages are based on the work of Edwards *et al.* (2000) and Plested *et al.* (2006) as well as discussions with REPLACE partner organisations and Community Peer Group Champions.

**Table 6.1    The REPLACE Community Readiness to End FGM Model with Exemplar Intervention Actions Implemented by REPLACE (stages 1-4) and Suggested Interventions for Stages 5-9**

| Stage number | Stage name | Suggested intervention actions |
|---|---|---|
| 1 | **No Community Awareness**<br><br>Community members not conscious FGM is a problem and accepts it as the way things are.<br>FGM is the social norm | ▪ Initiate community engagement.<br>▪ Discussions with community leaders and members about FGM.<br>▪ Visit existing and established small groups to inform them of the issue.<br>▪ Raising the issue with friends/peers and potential supporters. |
| 2 | **Community Denial/Resistance**<br><br>Some awareness FGM viewed as problematic but no motivation to act or belief anything can be done to change things | ▪ Continue visits and discussions and encourage those you've talked with to assist.<br>▪ Gain understanding of the belief systems and enforcement mechanisms supporting the continuation of FGM<br>▪ Discuss local anecdotal evidence of harms of FGM<br>▪ Approach and engage local safeguarding/education/health outreach programmes and interested NGOs to assist efforts<br>▪ Present information to community groups. |
| 3 | **Vague Community Awareness**<br><br>Some community members communicate in general terms about FGM; poor | ▪ Present information at local community events and to unrelated community groups, with community leaders if possible.<br>▪ Begin to initiate events (e.g. community women's health events etc.) to present information on the issue.<br>▪ Provide 'safe' opportunities to allow people to  talk openly about FGM e.g. at specially organised events |

| | | |
|---|---|---|
| | understanding of the issues and no community motivation to change things | |
| 4 | **Preplanning**<br><br>Clear recognition of the problem of FGM; community leaders are willing to take action; no clear understanding of what action to take | ▪ Introduce more formal information about FGM through presentations at community events and through social media.<br>▪ Develop support from community leaders and peer group champions.<br>▪ Review existing efforts in the community to determine next steps.<br>▪ Begin to change attitudes towards FGM |
| 5 | **Preparation**<br><br>Planning begins to take on focus and detail; data may be collected to aid planning and decisions are made about what to do; resources are gathered and put to use and there is some community support | ▪ Conduct surveys with FGM prevalence and type questions.<br>▪ Conduct community surveys.<br>▪ Present in-depth local information concerning belief systems.<br>▪ Determine and publicise the costs of the problem to the community.<br>▪ Conduct public forums to develop strategies.<br>▪ Utilise key leaders and influential people to speak to groups and to participate in<br>   o local radio and television shows in order to introduce behavioural change concerning FGM. |
| 6 | **Initiation**<br><br>Activity or action to end FGM may have started but is perceived as novel; leaders enthusiastic; community support | ▪ Plan publicity efforts associated with start-up of intervention or activity.<br>▪ Attend meetings to provide updates on progress of the intervention.<br>▪ Conduct community information gathering to identify service gaps and improve existing services.<br>▪ Begin library or internet search for resources and/or funding.<br>▪ Support community members wishing to end FGM |
| 7 | **Stabilisation**<br><br>General support remains; Community leaders support ending FGM; some prevalence tracking going on supported by an organised and experienced administration; on-going evaluation likely and building motivation for | ▪ Plan community events to maintain support for ending FGM.<br>▪ Conduct training for influential people and Community Peer group Champions.<br>▪ Conduct training for community members.<br>▪ Introduce programme evaluation through training and newspaper articles.<br>▪ Conduct quarterly meetings to review progress and modify strategies.<br>▪ Hold special recognition events for local supporters or volunteers.<br>▪ Prepare and submit newspaper articles detailing progress and future plans.<br>▪ Strengthen networking between service providers and the community. |

| | | |
|---|---|---|
| | change/progression | |
| **8** | **Expansion**<br><br>Support has grown to end FGM and most community members are comfortable with ending FGM; some evaluation has happened and new efforts being made to access more of the more resistant FGM affected community | ▪ Publish a localised Programme Services Directory concerning FGM services and help.<br>▪ Develop a local speakers network.<br>▪ Begin to initiate policy change through cooperation with local city officials.<br>▪ Conduct media outreach on specific data and trends related to FGM.<br>▪ Embed behaviour change in the community |
| **9** | **Community Ownership**<br><br>Knowledge and understanding of problem sophisticated; community involvement is high and on-going evaluation and adaptation is typical. Social Norm is not to perform FGM | ▪ Engage local business, community and solicit financial support from them to support interventions.<br>▪ Continue re-assessment of the issue and progress made.<br>▪ Utilise external evaluation and use feedback for programme modification.<br>▪ Celebrate the end of FGM within the community.<br>▪ Engage and support other communities on their journey to end FGM. |

*Source: REPLACE; Edwards et al, 2000; Plested et al., 2006.*

Table 6.2 below shows the selected intervention actions and content focus chosen by members of the FGM affected communities who were involved in the REPLACE project; along with their stage of community readiness to end FGM at the outset of the project in 2013.

**Table 6.2 REPLACE Intervention Actions and Content Focus Identified by Participating Communities, Listed by REPLACE Community Readiness to End FGM Assessment**

| FGM affected community | Intervention action | Focus of main messages based on evidence about FGM perpetuation in each community | Stage of community readiness to change at outset of REPLACE2 |
|---|---|---|---|
| **Dutch Somali** | Koranic school teachers delivering a Koranic school lesson focussing on challenging the belief that FGM required by Islam | 'Little Sunna' or FGM is not a requirement of Islam. | 3 – Vague community awareness but approaching 4 - Preplanning |
| **British Sudanese** | Organisation of a community event to present sessions on health consequences of FGM Types I and II and challenge the belief FGM is required by Islam. Break-out discussions in three languages | 'Little Sunna' or FGM is not a requirement of Islam. Women with FGM Type 1 and 2 are four times more likely to have health problems than women who have not be subjected to FGM | 3 – Vague community awareness |
| **Spanish Gambian and Senegalese** | Organisation of a set of community sessions focussing on attitudes towards European culture and FGM including health, religion, the law, and gender equality. Opportunity for discussion. | Link between gender inequality and economic development; and between gender inequality and FGM  Development of capabilities and opportunities for intergenerational communication concerning FGM | 2 – Community Denial/Resistance |
| **Portuguese Guinea Bissauan** | Organisation of a set of community sessions focussing on attitudes towards European culture and FGM including health, religion, the law, and gender equality. Opportunity for discussion | Link between gender inequality and economic development; and between gender inequality and FGM  Development of capabilities and opportunities for intergenerational communication concerning FGM | 3 – Vague Community Awareness |
| **Italian** | Organisation of a | Providing people with a | 1 - No community |

| Eritrean and Ethiopian (Habesha) | set of community sessions to bring community members together | greater sense of community and belonging to help them better understand Western values. A transient community not ready to address FGM | awareness to 2 – Community Denial/Resistance |
|---|---|---|---|

*Source: REPLACE*

**Intervention development (ii): COM-B assessment of how to train, resource and support peer group champions to perform intervention actions**

Having identified a target intervention action or actions, the next part of the intervention development process involves understanding the psychological, social and 'environmental' factors that may specifically be influencing the community and potentially preventing them from successfully engaging in the identified intervention activities. For this REPLACE proposes the application of the COM-B model (Michie *et al.*, 2011; 2014) to the target intervention action or actions. (We explain how to do this in detail in the accompanying REPLACE Community Handbook.) The COM-B model is shown in Figure 6.1.

## Figure 6.1  The COM-B Model
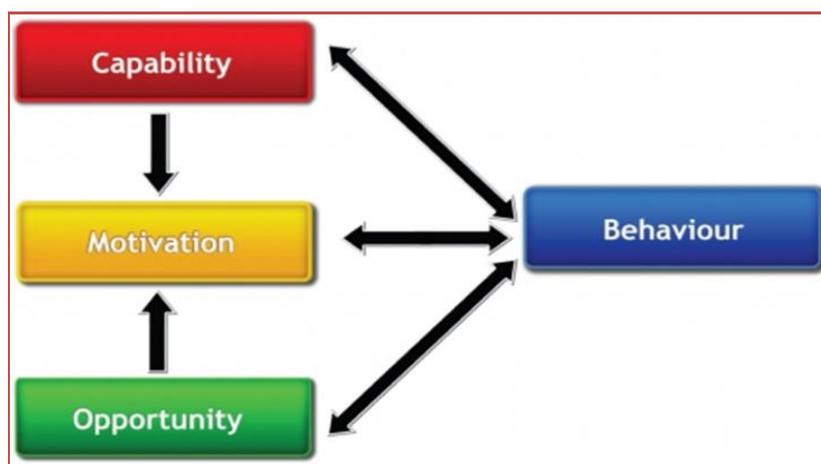


*Source: Michie et al., 2011; 2014*

This model has been developed to incorporate all of the factors that research has found to be important in the understanding of behaviour and behaviour change (Michie et al., 2014). In basic terms, the model proposes that for any behaviour (or target intervention action) to

be enacted by an individual, the three components on the left hand side of Figure 6.1 must be present. An individual must be capable of performing the behaviour, they must be motivated (or want) to perform the behaviour, and they must have the opportunity to perform the behaviour.

These three components are further subdivided as follows:

**Capability**
- o Psychological capability – includes knowledge, skills, aptitude, understanding, ability to self-regulate behaviour
- o Physical capability – includes physical ability to carry out the behaviour

**Motivation**
- o Automatic (passive) motivation – includes wanting to do something out of habit or because it makes you feel good without using effortful thought
- o Reflective (active) motivation – includes positive evaluations of performing the behaviour through effortful thought

**Opportunity**
- o Social opportunity – includes opportunities created by the interaction of peers, family, and other networks and the influence of social norms including culture and subculture to support the behaviour
- o Environmental opportunity – includes opportunities created by the physical environment; objects, services, resources and locations that promote the behaviour

Whilst the COM-B Model is aimed at changing individual behaviour it is also highly relevant to community behaviour change and associated intervention actions. In order for community members to engage effectively in the intervention actions (or behaviour) identified, it is important to work with them to identify which COM-B factors they may be lacking in, and to work together, and potentially with other experts, to improve one or all of their capabilities, motivation and opportunities to act.

There is no single one way to assess where the community members may need support or resources to enact the target intervention action. In REPLACE we brought community members together as a group, or spoke to people one-to-one or in pairs or small groups to ask questions about their capability, opportunities and motivation. Guideline questions are

provided in the REPLACE Community Handbook. After following the guidance in the REPLACE Community Handbook it should be much clearer as to what type of support community members or community peer group champions need in order to carry out the target intervention action or actions effectively.

The REPLACE Community Handbook provides detailed guidance on the type of behaviour change techniques (BCTs) intervention developers and community peer champions might then draw upon in order to support bringing about changes in capability, motivation and opportunity to take action. The BCTs are aligned to the COM-B components, although there is considerable overlap in the way they can be used.

To provide a flavour of the way COM-B components were targeted in REPLACE interventions with BCTs, examples are provided in Boxes 6.1, 6.2 and 6.3. The BCTs are presented in bold in the text. For more detail about selection of BCTs based on identified COM-B components please refer to the accompanying REPLACE Community Handbook.

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**Box 6.1      Example from REPLACE: Dutch Somali Intervention Addressing Capability**

Capability was identified as the main component of the COM-B Model where the Dutch Somali Koranic School teachers needed support in order to be able to deliver lessons in Koranic Schools concerning the myth that 'little sunna' was a requirement in Islam.

Through training and group discussions the community women, who included Koranic School teachers and lay women who had helped recruit the Koranic School teachers to the project, were provided with training. This covered what constitutes FGM (including the fact that what is referred to as 'little sunna' is still FGM), **information about the health consequences** (including **information about psychological and emotional consequences of FGM**), and **information about the legal (environmental) consequences** of activity relating to carrying out FGM in the Netherlands. In addition, the group arranged for an Islamic scholar, Prof Dr Hidir, from the Islamic University of Rotterdam to come and talk to them and **present clear arguments based in evidence from the Koran and the Hadiths that FGM/Sunna is not a requirement and not even approved of in Islam**.

Through their coming together and engagement in the REPLACE project these Dutch

Somali women received **social support** and **information about others' approval** of taking action to end FGM including approval from those within their own community.

Working with the REPLACE team the group devised a lesson plan to support delivery of the Koranic School session, so that the Koranic School teachers had a **clear guide about what content to deliver, in what order and in what ways**. The group **delivered pilot lessons** and **watched each other do this** and **provided feedback** and **praise** to one another. Whilst **social reward** actually targets motivation rather than capability it was a useful addition to help maintain motivation of the group to improve their capabilities.

The delivery of the lesson in several Koranic Schools in Rotterdam was an important outcome of the REPLACE project. Evaluation activities to determine the impact of the lesson as well as the impact on the Dutch Somali women and the teachers were carried out (see section 7). Critically however, any target intervention activity that is successfully carried out, is intended to influence the motivation of others to become involved in the fight against FGM (or at least to come to view FGM as wrong, question the social norm perpetuating FGM and thus favour the abandonment of FGM). The lesson plan that was developed therefore also included activities and content containing relevant BCTs. See a copy of the lesson plan (an example of **adding an object to the environment** to support behaviour change) in the REPLACE Community Handbook.

**Box 6.2     Example from REPLACE: Supporting Opportunity to Take Action with the Spanish and Portuguese Partner Communities**

On the REPLACE project the Gambian/Senegalese and Guinean Bissauan communities in Spain and Portugal experienced difficulties with discussing FGM openly with family, friends and community members. This was predominantly an issue with social opportunity but one that was addressed through organising events for community members to attend (**social support (practical)**), engaging those who attended in **problem-solving to identify other barriers and solutions to getting people to come and talk about the issue of FGM** and **through exposure** to talking about FGM which led to a greater acceptance of discussing the issue. This was done during the intervention sessions which were held over a period of around 6 weeks between February and April of 2015.

**Box 6.3     Example from REPLACE: Supporting Motivation with the British Sudanese Community**

Even though many community members working with REPLACE were already motivated to take action to bring about change in their communities in relation to FGM, maintaining motivation was still important. The British Sudanese community members used regular group meetings and communicating via a free SMS messaging service called 'Whatsapp?' to provide **social support** to one another. FORWARD UK would provide **material rewards or incentives** in the form of money to re-coup costs of attendance and a free lunch at group meetings. The women used group meetings to report to one another on successful target activities to end FGM that they had engaged in individually and provided each other with **congratulations and praise on such successes**). In addition, similar to the Dutch Somali community, the REPLACE team worked with community members to **provide discussion topic guidance** for a major community event they organised. The purpose of this was to provide guidance on how to structure arguments and discussion that included persuasive communication about the fact that FGM is not a requirement of Islam and the evidence that even FGM Types I and II can have severe health consequences for women.

## 6.2   Conclusion

The REPLACE Approach to intervention development as outlined in this section, ensures that:

i)      Voices from within the FGM affected community are listened to and are included in the intervention design, implementation and evaluation, enabling change to be a bottom-up process, and thus more sustainable.

ii)     The most appropriate target intervention activity has been implemented, matched to Community Readiness to End FGM stage of the community and is thus likely to support moving the community as a whole forward towards social norm transformation.

iii)    Important areas where community members may need support in order to carry out target intervention actions are identified and addressed.

iv)     Effective intervention strategies, that employ behaviour change techniques derived from decades of behaviour change research, are developed, implemented and evaluated.

v) That once delivered, interventions will have an impact on those who participate in the intervention, such that they change their understanding, beliefs and motivations in relation to FGM and may become motivated to also take action in their community to end FGM, thus moving the community nearer to ending FGM.

Continued monitoring and evaluation of intervention activities, the people they reach, and the impact they have is critical however, in order to understand whether what is done (e.g. messages delivered) is effective, or needs changing or adapting in some way based on what is found.

# Section 7: The REPLACE Approach
# Element 5: Intervention Delivery and Evaluation

**The REPLACE Cyclic Framework for Social Norm Transformation: Element 5**
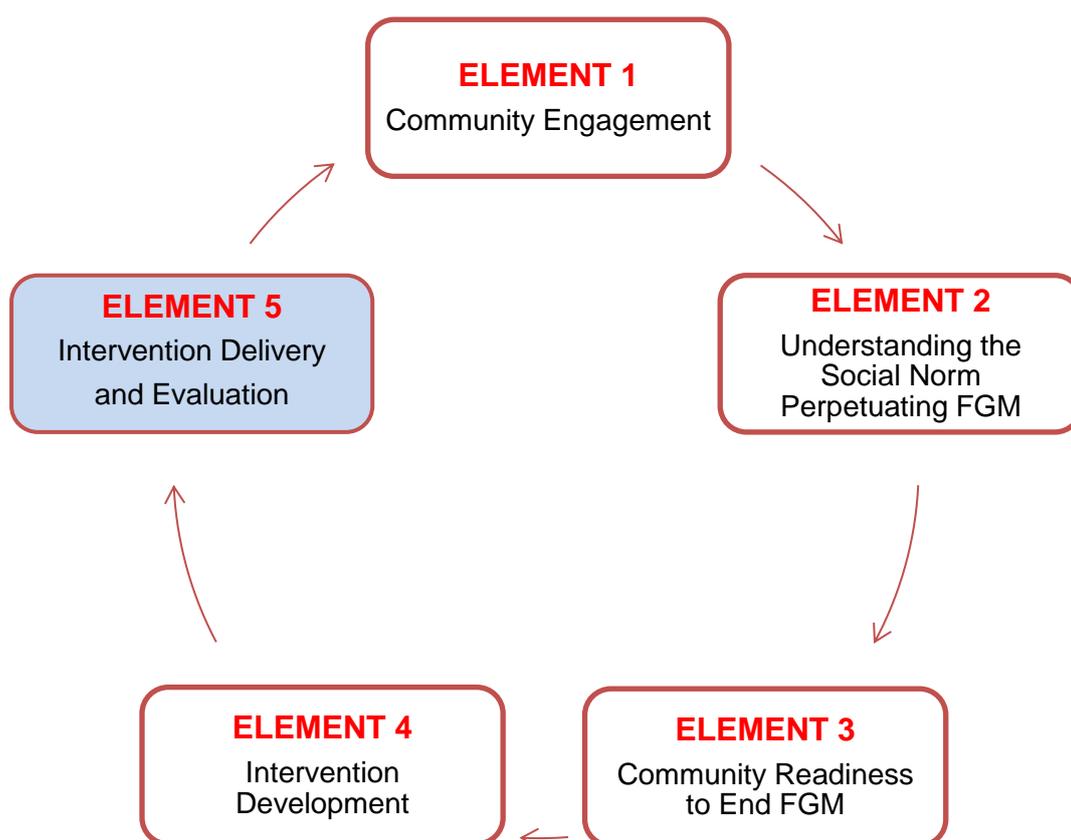


*Source: REPLACE*

## 7.0   Introduction

Evaluation, set around intervention delivery, is an essential part of quality improvement, solving problems and informing decision making (The Health Foundation, 2015). The Health Foundation recommend that 'An evaluation has to be specifically designed to address the questions being asked and the nature of the intervention being evaluated.  This means using different methods, working in different settings, with varied populations and data, under specific constraints of time, expertise and resources, both human and financial.' (The Health Foundation, 2015, 4). Robust evaluation can tell us if an intervention has worked/not worked

and how and why, allowing lessons to be learnt for spreading successful interventions and developing new ones (The Health Foundation, 2015).

The term 'evaluation' can mean different things to different individuals, groups and organisations. Approaches to evaluation and activities carried out as part of evaluation can vary greatly depending on the purpose of the evaluation. However, when thinking about evaluation, it can be useful to keep in mind the following….

*'Does it achieve what it sets out to achieve?'*

….where 'it' is the activity, action, communication, intervention or promotion being done in order to have an impact on or affect a particular desired outcome(s).

With regards to the REPLACE Approach; 'it' is both the activities delivered to support community members to achieve the target intervention action, and the target intervention action itself.  The desired outcome is delivery of the target intervention action and the impact that the target intervention has on a range of things including; preventing FGM, but also sub-goals (see below) such as increasing awareness amongst community members that FGM is illegal in the EU, or changing attitudes towards FGM amongst members of an affected community. In short what we want to know is:

i.      Does the support provided to community members result in them being able to deliver identified target intervention actions?

AND

ii.      What effect do target intervention actions have on those who receive or experience the intervention?

One, or ideally both of these things should be assessed in some way as part of the evaluation.

## 7.1    The REPLACE Approach to Evaluation

Evaluation is an integral part of the REPLACE Approach and should be planned alongside all stages of intervention development (Section 6) (The Health Foundation, 2015).  So if, for example, community members need support around capability and motivation in order to carry out their identified target intervention action (Section 6); evaluation relating to this

might assess whether improvements in capability and motivation were achieved and the extent to which community members actually carried out the target intervention action. Similarly, the content of communications and messages delivered during target intervention actions will have an intended effect or impact, for example, persuading people that FGM is harmful to health. Evaluation relating to this might assess the extent to which people who receive the intervention change their beliefs about the effects of FGM on health outcomes for women.

Whilst the ultimate goal of any campaign or intervention work targeting FGM is to bring about an end to the practice, there are a potentially infinite number of sub-goals that may be addressed by an intervention and can be assessed as part of evaluation. These sub-goals will be specific to the particular intervention activity, but there are many common sub-goals and they can be broadly categorised as follows:

1. Changes to individual level knowledge, beliefs, perceptions, skills and attitudes (could be community members including community leaders, other influential people, peer group champions or the community members they go on to communicate with).
2. Changes to social and cultural norms (these are less tangible and more difficult to assess but still an important sub-goal for change; see REPLACE Community Readiness to End FGM Model (Section 5).
3. Changes in observable actions and behaviour including the way people talk about FGM, the things they say and to whom they say them (could be community members including community leaders, other influential people, peer group champions or the community members they go on to communicate with).

Changes to any of these sub-goals are not easy to assess, but Box 7.1 presents some examples from the REPLACE Project.

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**Box 7.1     Examples of Sub-goals Aligned to REPLACE Intervention Activity**

A group of women from an FGM affected community who are motivated to take action to bring about an end to FGM have been getting together over a number of months to receive training and support from a local NGO. Data collected within their community through focus groups has revealed amongst other things, that the majority of men never talk about FGM and have very limited understanding of what it physically involves, there is subsequently little if any understanding of why the

practice might create health problems for their wives and daughters, but they demonstrate concern about the wellbeing of the women they care about and wanted to know more.

The women have identified a small number of men who are willing to work with them and the NGO to receive training and support to go out into the community at appropriate events and locations to talk with men on this subject. They decide that the important sub-goals of their specific activities are:

i. An improvement in the skills, knowledge, confidence and competence of the small number of men who are willing to work with them in talking to other men on this subject.

ii. A change in the knowledge, beliefs and perceptions of the men who are present at community sessions and events such that they understand what FGM involves, the link between damaging the flesh of the female genitalia and things like subsequent psycho-sexual, and gynaecological and obstetric problems.

iii. An increase in the amount of communication about FGM within the community (an outcome we might expect as a result of the men successfully engaging in the target intervention action and because of the content of their message).

iv. An increase in the number of men willing to work with them to communicate with other men (an outcome we might expect as a result of the men successfully going out and communicating the message content).

Once sub-goals such as these are clearly identified for a specific intervention activity, thought can be given to how they can be measured or assessed in some way. Suggestions and exemplars for measures and ways to assess change are provided below in relation to the interventions and evaluations carried out for the REPLACE Project.

*Source: REPLACE*

## 7.2   REPLACE Approach for Evaluating Change

The REPLACE Approach involves using a combination of qualitative and quantitative methods for evaluating the impact of activities and interventions. The exact focus of

evaluation is determined by the nature of the intervention and what has been targeted for change. The REPLACE evaluation strategy includes four core components as outlined below:

1. REPLACE Community Readiness to End FGM Model was used to assess a community's stage of readiness to end FGM at the outset of working with them. The Community Readiness to End FGM assessment was repeated after intervention delivery (and potentially repeated again at later dates to continue to assess shifts at the community level). This involved conducting qualitative interviews or focus groups based on dimensions of change which then translate to a stage of community readiness to change in relation to FGM (Section 5). This evaluation method assesses community level change.

2. Focus groups with community members to gather in depth data about their thinking and beliefs. These were carried out before and after interventions to get a richer feel for the nature of the changes but it is particularly important to carry them out afterwards so that the some understanding of how people experienced the intervention activities, what they liked and didn't like, and so on. The information can provide real insight into why something was effective or not effective. This evaluation method assesses change at an individual level, but it is important to note that it involves relying on people reporting on their perceptions of what has changed, so the purpose is not to achieve objective certainty, but rich and in-depth information about the perceptions of those who are part of the community and involved in creating change. It is also important to note that data collected as part of focus groups will be influenced by the group composition and dynamics to at least some extent; some individual perceptions may be lost. This can be mitigated by including a mix of one-to-one interviews.

3. Questionnaires conducted before and after interventions with those who have participated. These included numerical rating scales to assess things like specific beliefs and open-ended (qualitative) response items to gain richer information about the nature of any changes. This evaluation method assesses individual level change, and using numeric rating scales means it is possible to assess whether on average individuals shift their thinking and beliefs.

4. Records of the instances of intervention activities, such as the number of community events that are held and the number of people who attended, or the number of people a community member has reached with their one-to-one or small group activities. This method assesses both individual and community level change, since every individual instance of someone attending an event or engaging in discussion

about FGM that they would not have done before the intervention, represents some sort of change. Over time it might be possible to show increasing engagement and participation in anti-FGM activities by community members if this is the case then there is evidence of community development and change.

A 'how to' guide relating to each of these evaluation activities is provided in the REPLACE Community Handbook. Templates are also provided in the Handbook as starting points for producing evaluation materials. Below are examples of the evaluation carried out as part of the REPLACE project, including an overview of the methods and the evaluation of results.

Two examples of the evaluation of REPLACE interventions follow.  The evaluation of the first, the Dutch Somali community's intervention shows change in targeted beliefs of individuals, evidence of developed skills and knowledge of communicating about FGM  and a move in the community's readiness to end FGM.  The second example, which is of the Spanish Gambian/Senegalese community's intervention suggests shifts in motivation and capability to communicate about FGM did not occur (based on questionnaire data), but qualitative focus group data provides evidence that interventions were welcomed, and changes in knowledge and attitudes experienced. They also highlighted why such shifts did not translate to the potential for engaging in further activities beyond the intervention.  Whilst the intervention did not appear to change behaviour in that example, the community's readiness to end FGM did shift. Both examples show the value of undertaking different types of evaluation.

## 7.3   Example of the REPLACE Approach to Evaluation as Applied to the Dutch Somali Community's Intervention

### 7.3.1  Background

The FSAN in the Netherlands worked with twelve Somali women who had been trained as health advocates in their communities to select a target intervention action. They drew on findings from the community engagement elements of the REPLACE Approach (Elements 1 and 2). This demonstrated that FGM, often referred to as 'sunna' by the local Somali community, is strongly believed to be a requirement of Islam, and was a major factor associated with its continuation for this community. Local evidence suggests that the community may have moved from performing the most severe forms of genital cutting (FGM Type III) , to the less severe FGM Type I in response to campaigns promoting messages

about the severe health consequences of FGM. Many in the community do not view 'sunna' as FGM, and consequently traditional campaigns containing messages about the health consequences of FGM (which usually refer to FGM Types II or III) are likely to be having little, if any, effect on moving the community closer to FGM abandonment.

The target behaviour selected by the Dutch Somali community women was; Koranic School teachers to deliver a lesson to their pupils on the issue of FGM that specifically addresses and argues that FGM is not a requirement of Islam.

### 7.3.2  Intervention Development

In brief, the community women engaged in REPLACE recruited eight and retained four Koranic School teachers to receive training and support in delivering a Koranic School lesson in four different schools in Rotterdam. Although the intervention was directly targeted at young people attending Koranic School, traditionally Koranic School is part of wider community activities held in that location and therefore discussion of the lesson content was expected to influence the wider community including the parents of the pupils.

### 7.3.3  Methods

*A REPLACE Community Readiness to End FGM* assessment was carried out   using standard community readiness assessment questions (Section 5). Discussions were held with key informants from the community about the issue of FGM at the outset of the REPLACE project and towards the end, after delivery of all the Koranic School lessons. Data from these discussions were used by two independent REPLACE team scorers to rate each dimension of community readiness and establish an average rating for overall community readiness to address the issue of FGM.

*Focus groups before and after intervention delivery with community members:* focus groups were conducted with community members before and a short while after the intervention was delivered in Koranic Schools to establish whether there were changes in the types of responses and the content of what people were saying pre versus post intervention delivery.

*Quantitative questionnaire data:* a questionnaire was used to assess the core belief that was targeted by the intervention and the perception community members held about the status of FGM in their community. Adults present in the Koranic School environment before

and after intervention delivery were recruited to complete this. Three Likert scale measures with seven possible response options were used to assess whether:

1. The belief that FGM or 'sunna' is a requirement of Islam changed post intervention compared with pre intervention (scaled 7 - not a requirement at all to 1 – Islam absolutely requires it).
2. The perception that people in the community in general are in favour of FGM/'sunna' (scaled 7 - everyone thinks it should be done to 1 – no-one thinks it should be done).
3. The perception that people known well to them are in favour of FGM/'sunna' (scaled 7 - everyone thinks it should be done to 1 – no-one thinks it should be done).

More detail regarding measures and focus group schedules are provided in the REPLACE Community Handbook accompanying this toolkit.

### 7.3.4  Findings

**Community Readiness**

The community readiness to end FGM assessment at the outset of REPLACE identified an average community readiness stage of 3.75. This meant that The Dutch Somali community were placed between stage 3 of readiness to change (Vague Community Awareness) and stage 4 (Preplanning).

Re-assessment of community readiness towards the end of the project has placed the community at an average community readiness to end FGM as stage of 4.5. This means they are now placed at between stage 4 (Pre-planning) and stage 5 (Preparation).

**Focus Groups**

Qualitative data that had been collected from community members both before and after intervention delivery focussing on awareness of anti-FGM related activities in their community and perceptions about shifts and changes in attitude in the community with regard to FGM revealed interesting evidence of changes amongst participants. These are illustrated in Tables 7.1 and 7.2 as two major themes. There was evidence of a shift in their experience of the focus of interventions as illustrated in Table 7.1.

**Table 7.1 Shifts in Experience of the Focus of Interventions by REPLACE Somali Participants in the Netherlands**

| Before REPLACE Intervention | After REPLACE Intervention |
|---|---|
| The content of community members' comments before the intervention were themed around 'information-giving' events.<br><br>For example, 'I heard about FGM via an information session'<br>And, 'via FSAN and others the community in Rotterdam has been informed about the bad aspects of FGM' | Data collected after the intervention work had been delivered illustrated the impact of normative influences on community members.<br><br>For example, one community member said 'It was interesting to see that some of the women (female Koranic School teachers) were pro FGM and changed so much that they now are active against it. That is a great thing.'<br><br>There was consistent evidence that the messages about the fact that Islam did not require FGM to be informed had got through. Ten different people made comments about this. For example, 'I liked that they told us about Islam and FGM. They showed clearly that it is not an Islamic practice.' |

*Source: REPLACE*

There was also evidence that the participants were engaging more with the reasons why FGM is a human rights violation and not a religious requirement. They also demonstrated an interest in tackling these as can be seen with differences in comments about perceived changes in the community on the issue of FGM before, compared with after, intervention delivery.

**Table 7.2    Evidence of Development of Thinking on the Issue of FGM**

| Before REPLACE Intervention | After REPLACE Intervention |
|---|---|
| Examples of the types of comments people made about the community's position on FGM before the interventions included,<br><br>'Yes I noticed people more often think FGM should be stopped, still there are people who think it should be done.'<br><br>'Many people realise it is a bad thing for the whole Somali community, still I think there is more need for education and campaigning.'<br><br>They summarised the views held using general terms and often commented that some were in favour of continuation and some were against. | The type of language used to talk about this issue after the intervention delivery illustrated greater elaboration of the arguments and a greater depth of thought on the community's position.<br><br>For example, 'People are more open about it; they are not ashamed to say they don't circumcise their girls.'<br><br>'Here in the Netherlands yes, first of all it is not allowed. And people do not want to lose their children and go to jail. I wonder if they would think the same if they were in Somalia. There they have the opportunity to do it, so maybe then they don't think it is wrong. I don't know how many have really changed their mind.'<br><br>There was commentary specifically on what more could be done rather than a simple call for more education or campaigning.<br><br>For example, 'I think they should lecture the men about this topic, that it is not an Islamic practice. Often the men are head of the house, especially when it comes to religion. If he convinces his wife or sisters or mother that it is not something from our religion, I think they would stop believing it is a good thing.' |

*Source: REPLACE*

**Questionnaire Data**

The mean and standard deviations of scores on the three Likert scale items from before and after intervention delivery are shown in Table 7.3.

**Table 7.3     Means and (standard deviations) for Likert Items Measures**

| Likert scale measure | Means and (SDs) pre-intervention | Means and SDs post-intervention |
|---|---|---|
| Belief that FGM is required by Islam (Increase is positive for this item) | 4.24 (2.59) | 5.2 (2.55) |
| Perception that FGM is approved of by the community in general (Decrease is positive for this item) | 2.47 (1.66) | 2.4 (1.59) |
| Perception that FGM is approved of by people known well to them (Decrease is positive for this item) | 2.14 (1.61) | 1.87 (1.45) |

*Source: REPLACE*

Although participants who completed questionnaires were asked to provide a person-generated code to match data over time points, participants did not do this and so analysis can only consider overall means and standard deviations from the un-matched data rather than run a within subjects analysis comparing means over time.

The means and standard deviations suggest, however, that there has been a reasonable improvement in the belief that FGM is not a requirement of Islam. People are typically responding 'It is a good thing if it is NOT done' after intervention delivery compared with a typical response of 'It doesn't matter one way or another' before intervention delivery. There are very slight decreases in mean scores for the other two items relating to perceptions about FGM approval by the community in general and by people known well to the respondent. These should be considered items on which there has been no change.

## 7.4 Example of the REPLACE Approach to Evaluation as Applied to the Spanish Gambian/Senegalese Community's Intervention

### 7.4.1 Background

GES worked with a group of four community based researchers (CBRs) who they identified during a period of community engagement with the Gambian/Senegalese communities in Banyoles in Spain. The CBRs led initial focus groups with community members, producing some of the first data collected regarding FGM and the belief systems of this particular migrant African community. The data provided rich and in-depth information about the factors contributing to the continuation of FGM within this community, but in particular the community members who participated identified the fact that there are barriers associated with simply communicating about FGM within the community that they felt they needed to address. Specifically, they decided that there needed to be a focus in their intervention on helping mothers and daughters to communicate about FGM and assist husbands and wives communicate about FGM.

The target behaviour selected by the Spanish Gambian/Senegalese community was: community members communicate effectively and as often as they can about ending FGM in their community.

It is important to note that there is a key difference between the Dutch and Spanish communities whose work is used as examples of the REPLACE Approach in practice. FSAN and Dutch migrant communities have had two decades or more of experience working to end FGM in the Netherlands. In comparison, migrant Gambian/Senegalese communities in Spain are relatively new and the NGOs supporting them have limited experience in this field of work. Therefore the focus of the intervention development work in Spain was on developing resources with GES and their CBRs, and providing training and support to community members in preparing to communicate more effectively and more often about FGM.

### 7.4.2 Intervention Development

As with the Dutch intervention work, more detail on the development can be found in the accompanying REPLACE Community Handbook including the materials used. In brief, GES' CBRs recruited eight core community members (5 female and 3 males) to participate in the

intervention work. GES staff, the CBRs and Coventry University team members worked collaboratively to develop ideas for training content based on information collected from focus groups about beliefs associated FGM, attitudes towards the European context they now live in and incorporating development of communication skills. These were developed iteratively with a focus on improving the capability and motivation of those who attended, to communicate about FGM and wanting it to end. Formal session plans were created and these were used along with identified additional session resources by the CBRs, Community Peer Group Champions and Gabinet staff to facilitate sessions with community members.

### 7.4.3  Methods

A *REPLACE Community Readiness to End FGM assessment* was carried out using standard community readiness assessment questions (Section 5). Discussions were held with key informants from the community about the issue of FGM at the outset of the REPLACE project and towards the end, after delivery of all the community sessions. Data from these discussions were used by two independent REPLACE team scorers to rate each dimension of community readiness and establish an average rating for overall community readiness to address the issue of FGM.

*Focus groups following intervention delivery with community members:* focus groups were conducted with community members a short while after all intervention sessions had been delivered to establish perceptions about the impact the intervention had had on participants.

*Quantitative questionnaire data:* A questionnaire was used to assess changes amongst participants on their own capability and motivation to communicate about FGM, their perceptions about community views on FGM and community motivation to talk about FGM. Eight Likert scale measures with seven possible response options were used to assess:

1. Perception of current state of beliefs on FGM in the general community (scaled 7 – everyone thinks it should be done to 1 – no-one thinks it should be done).
2. Perception of current state of beliefs on FGM amongst those known well to the participant (scaled 7 – everyone thinks it should be done to 1 – no-one thinks it should be done).
3. Confidence in ability to talk to people in the community about FGM (scaled 7 – very able to 1 – not at all able).

4. Confidence in ability to talk to people known well to the participant about FGM (scaled 7 – very able to 1 – not at all able).

5. Motivation to talk to people in the community about FGM (scaled 7 – very much to 1 – not at all).

6. Motivation to talk to people known well to the participant about FGM (scaled 7 – very much to 1 – not at all).

7. Perception of motivation of community in general to talk about FGM (scaled 7 – very much to 1 – not at all).

8. Perception of motivation amongst people known well to the participant to talk about FGM (scaled 7 – very much to 1 – not at all).

More detail regarding measures and focus group schedules are provided in the REPLACE Community Handbook.

### 7.4.4  Findings

**Community Readiness to Change**

The community readiness to end FGM assessment at the outset of the REPLACE intervention identified an average community readiness stage of 2.25. This meant that the Spanish Gambian/Senegalese community were placed at stage 2 of readiness to end FGM (Community Denial/Resistance).

Re-assessment of community readiness to end FGM was undertaken towards the end of the project and placed the community at an average community readiness stage of exactly 3. This means they are now placed at stage 3 (Vague Community Awareness).

**Focus Groups**

Availability of time and resources for the Spanish partner (GES) meant that evaluation focus groups were only conducted after intervention delivery. The purpose was to gather rich data from participants about the perceived impact of the intervention. Twelve people took part in the focus group (10 females and 2 males); two participants were community based researchers (1 female and 1 male) and the remainder had participated in intervention workshops as part of the REPLACE project. The findings have been organised into three

main themes which summarise the content of the discussions the group had over a three-hour period. These are described and illustrated with excerpts from the discussions below.

**Opportunity to speak and be heard**

Participants talked about the experience of the intervention very positively. It was identified as the first time a project or intervention had ever involved members of the affected communities. For example one person explained,

> "*before the project only professionals had been involved, that both in Banyoles and in Catalonia at large conferences and meetings… these had only been attended by professionals but never by community members. This was a subject that did not reach the community directly. Conferences and lectures have been held but without any interest in knowing what the community thought about it*"

> "*They have worked for the Africans but without the Africans*"

The REPLACE project was therefore highly regarded for its inclusivity and demonstration of respect for the community. The greatest achievement of the project was recorded by one person as,

> "*Having addressed people in a respectful way to know what they think about this issue, without judging them. This has allowed the generation of trust and that people has talked.*"

Others agreed that the project had been a great opportunity to talk about this issue. Saying for example that they valued having,

> "*…had the opportunity to talk about this topic, which was a taboo so far.*"

They were clear that for men it was a particular opportunity since,

> "*…this was an issue they did not talk among them.*"

**Evidence of Change in Knowledge and Attitudes**

There was clear evidence from the focus group data that participants had experienced a change in knowledge and attitudes in relation to FGM. Messages about the health consequences for women had had some of the greatest impact,

> *"…it came as a surprise to discover that the consequence of this practice were very severe, particularly types II and III. We saw in an explicit way [with drawings and photos they had asked the doctor who had conducted the session to see] and understood the harm that this practice can bring about. For us, the health problems provoked by the FGM are enough reason to abandon it."*

> *"I have learnt that the FGM is not harmless as it has negative effects for women, above all as regards health…this is one of the most important lessons I have learnt and also that this practice does not provide any benefits for women."*

There was also commentary relating to messages about religion, including evidence that the session looking at FGM and Islam had inspired one women to do her own research,

> *"It is indeed true that FGM is not a requirement of Islam as we were told…I have consulted on it, and answered that the 'Hadith' that was said to state that cutting a little is OK, is false."*

Others also commented saying, for example,

> *"…religion does not make this practice mandatory: although mostly we have known it in advance, the information and the data they have provided with, has confirmed our views."*

**Limits to Impact on Behaviour and Need for Influencers**

Although there was evidence that things had changed in terms of knowledge and attitude towards FGM for the participants, there was an acknowledgement that there may be limits to what had been achieved in terms of behaviour and the continuation of FGM. The participants themselves suggested they were now against this practice. For example one of the men stated,

*"…prior to participation in the activities I had practically never heard about this issue and that anyway I considered that the FGM was a 'normal' issue and that it should be carried out. But now, knowing what I now know about this issue, particularly regarding the consequences of the FGM on the women's health, I am not in favour of carrying it out."*

It was acknowledged however that decisions about the practice were not made by one individual in isolation:

*"Nevertheless, this [whether to have FGM done to a daughter] is something to be decided and agreed by two persons, husband and wife."*

And participants felt reticent about taking further action against FGM voluntarily:

*"…in principle we are not going to be involved in this subject on a voluntary basis. There is a lack of a job, which does not allow us to 'devote' ourselves to this issue unless there is some sort of payment, even if modest."*

A CBR added that:

*"This is still a delicate matter and showing themselves openly contrary to this practice and publicise this position within the community puts these women in an uncomfortable situation. I have even been insulted on these grounds."*

With which, all the other participants made noises of agreement and spontaneously applauded the CBR.

It was suggested that the power of influential people was crucial to bringing the community to a place where an end to FGM would be reached. According to one of the male participants:

*"It is possible to end this practice. In order to end it definitely, it would be essential to persuade and enlist three key persons: the 'tagué', the Imam and a grown up woman who is respected by the community. Once these key persons are convinced and agree that this practice must be abandoned, they will have to make it known to the members of the community in the mosque or in other community places. This way,*

*the community, which respects and relies on these influential persons, will automatically stop the practice both here and in Africa."*

There were high levels of agreement that this would support bringing about an end to FGM.

## Questionnaire Data

The means and standard deviations for scores on the eight Likert scale items are shown in Table 7.4.

**Table 7.4    Means and (standard deviations) for pre and post Likert Measures Taken from Spanish Gambian/Senegalese Intervention Participants**

| Likert scale measure | Means and (SDs) pre-intervention | Means and SDs post-intervention |
|---|---|---|
| 1. Perception of current state of beliefs on FGM in the general community (Decrease is positive for this item) | 4.38 (1.15) | 4.33 (1.12) |
| 2. Perception of current state of beliefs on FGM amongst those known well to the participant (Decrease is positive for this item) | 4.5 (2.01) | 4.8 (1.19) |
| 3. Confidence in ability to talk to people in the community about FGM (Increase is positive for this item) | 5.6 (2.07) | 5.5 (1.03) |
| 4. Confidence in ability to talk to people known well to the participant about FGM (Increase is positive for this item) | 5.7 (1.95) | 5.0 (0.94) |
| 5. Motivation to talk to people in the community about FGM (Increase is positive for this item) | 5.78 (1.31) | 5.5 (1.31) |
| 6. Motivation to talk to people known well to the participant about FGM (Increase is positive for this item) | 6.25 (0.62) | 5.17 (1.10) |
| 7. Perception of motivation of community in general to talk about FGM (Increase is positive for this item) | 4.88 (1.29) | 5.33 (1.22) |
| 8. Perception of motivation amongst people known well to the participant to talk about FGM (Increase is positive for this item) | 5.0 (1.25) | 5.33 (0.38) |

*Source: REPLACE*

Consideration of the means and standard deviations suggest that on most measures there is little change in scores post intervention compared with before. Exceptions may be for items 6 and 7. On item 6 it appears as though there may be a decrease in motivation to talk to people known well to the participant about FGM after the intervention, and there may be a slight increase in the perception that the community wants to talk about FGM.

Paired samples t-tests revealed that the only statistically significant difference was for measure 6. Participants reported feeling less motivated to talk to people they knew well about FGM after the intervention compared with before (t=2.998, df=9, p=.015). The same result was identified after running bootstrapping analysis to address issues with non-normally distributed data with 95% confidence intervals ranging from .334 to 1.767. This was disappointing and resulted in community and partner deliberations as to why the target behaviour change had not been achieved. Without evaluation such analysis would not have taken place.

## 7.5   Discussion

The changes identified in REPLACE Community Readiness to End FGM stages suggests that there has been a positive shift in community readiness to end FGM since the REPLACE project began amongst the Dutch Somali community in the Netherlands and the Gambian/Senegalese community in Spain. The REPLACE Community Readiness to End FGM Model takes account of changes on the dimensions of community efforts and knowledge about community efforts, knowledge about the issue of FGM, activities and motivation amongst community leaders, community climate and resources available to support action (Section 5). The REPLACE project sought to deliver activities that would have an impact on these dimensions of potential change. The data collected from community informants after the interventions had been delivered provided evidence that these changes were genuinely perceived and experienced by those in the community.

Focus group information from the Dutch Somali community shows evidence that the content of the intervention engaged the community; it is noticeable that the message content (re: FGM not being a requirement of Islam) had been picked up and the sources of that message had been influential in attitudinal change. In addition, the fact that the language and the type of commentary people were providing about the community's perceptions of FGM showed a new level of engagement from those who participated on this issue. This is a very positive outcome. It suggests that the REPLACE Intervention Approach is more engaging and

persuasive to those who receive it than previous programmes. This conclusion is a cautious one because there may be a recent effect at play, i.e. because our intervention was the one participants experienced most recently, they may be remembering key messages and demonstrating greater engagement post-intervention because it is relatively fresh in their minds.

Focus group data from the Spanish Gambian/Senegalese community also showed a positive impact the intervention had had on participants. It was valued as the first real opportunity for members of this community to be involved in discussion and debate on the issue of FGM, and to have their voices listened to and respected as part of international dialogue. There was evidence that participants' knowledge and in many cases, attitudes towards FGM had changed as a result of the discussions and messages they had engaged with, with many affirming they felt the practice should be abandoned by their community. Despite these individual changes, it was acknowledged that decisions made about FGM were rarely made by one person in isolation, and it was expressed that real change across the community as a whole would be dependent on a powerful trio of voices from the respected Tagué people, Imams and female community elders. If these powerful and influential groups were united in speaking out against FGM then it was felt highly likely abandonment could be achieved.

It was also clear from the Spanish Gambian/Senegalese focus group information that despite the change in attitudes amongst many who had participated, no-one felt motivated enough by the intervention to continue to communicate and take action within their community about FGM. Greater priorities in their lives, such as the need to find work, earn money and provide for their families was understandably viewed as taking precedence. The issue of other priorities as a barrier to bringing about change in relation to FGM has been identified before (Barrett *et al.,* 2011), and funded initiatives aiming to work towards the goal of ending FGM need to address some of these priority issues for FGM affected communities if future efforts are to be successful.

The pre-post questionnaire data from the Dutch Somali community reflect the findings in their qualitative data. First, both data sets show evidence that people have taken on board the key message relating to FGM not being a requirement of Islam. Although we could not test for significant differences on this in the questionnaire data, there does appear to be an increase in participants reporting that FGM is not a requirement of Islam. Second, although the qualitative information shows evidence of greater engagement with the issues and arguments around FGM amongst participants, there are similar beliefs being expressed about the extent to which the community approves of FGM before compared with after

intervention delivery, just as the questionnaire data suggest (i.e. no change on these metrics). This is what may be expected given the relatively short timescales involved in follow-up here (immediately after intervention delivery for the questionnaire and within weeks for the focus groups). Effects on those involved in receiving the intervention is clear and has been positive, but the participants were aware of effects on the wider community and their views will take longer and require more intensive effort.

Similarly, the pre-post questionnaire data collected from Spanish Gambian/Senegalese participants reflects the findings in the focus group data, in that evaluation in both cases suggests that people are not particularly willing to go on to take action in their community. There was no significant change in any of the questionnaire measures except a negative shift in motivation to talk to people known well to the participant, which is disappointing.

Taken together, the data suggests that the Spanish Gambian/Senegalese intervention was not effective in addressing the motivation or capability of those who participated, to talk more often about the issue of FGM in their community. However, the focus group data and the shift in community readiness that was detected suggest that there have been some important influences on knowledge and attitude (which were not assessed by the questionnaire as they were not the principle target for change). In addition, when the project provided people with the opportunity to talk about FGM, whether in focus groups or during intervention sessions, they demonstrated that they were both motivated and capable of doing this, and suggested that with appropriate resources (i.e. modest payment for their efforts), they would absolutely consider taking further action. In future it is recommended that standard measures of knowledge and beliefs/attitude regarding FGM are included in questionnaire based elements of the evaluation and that funded initiatives consider remuneration for community members to become activists or community peer group champions on this issue.

## 7.6   Conclusions

In this section the REPLACE Approach to evaluation of FGM intervention work has been explained. REPLACE recommend that evaluation be planned for, carefully, from the outset of a project/intervention and aligned with the targets for change. The combination of applying individual level and community level evaluation methods is important for getting a rounded picture of the impact of the intervention work. In particular, combining qualitative and quantitative methods is important for understanding why things have or have not changed in the way that might be expected or desired. For example, the focus group data from the

Spanish Gambian/Senegalese community shed real light on the apparent lack of motivation to go on and communicate about FGM highlighted by the questionnaire data, and provides insight into what may need to be done in the future to bring about behavioural change not achieved on this occasion.

No evaluation is ever perfect and there are always ways in which methodologies and measures can be improved. The REPLACE project aimed to develop and test a particular approach that could be picked up and applied by NGOs and communities working to end FGM, to better record and understand the impact of their activities, and feed into better and more effective interventions in the future. We provide a clear 'how to' guide for evaluation in the accompanying REPLACE Community Handbook and employ the learning from the REPLACE evaluations to date in our recommendations.

# Section 8: The REPLACE Approach: Conclusion

The REPLACE Toolkit (and accompanying REPLACE Community Handbook) provides a new framework for working to end FGM in the EU, and to evaluate activities that are undertaken to achieve this goal. The Toolkit demonstrates why traditional approaches typically used to campaign and intervene to end FGM may not be resulting in an end to the practice and argues for a new approach, the REPLACE Approach. The REPLACE Approach combines the latest research into behaviour change with Community-based Participatory Action Research and regular evaluation. The result is a culturally sensitive, community empowering framework designed to achieve social norm transformation, and thus end FGM in the EU.

The REPLACE Approach recognises that FGM is a social norm and each community is different, having different belief systems and enforcement mechanisms which support the continuation of the practice. Thus the REPLACE Approach involves engaging with FGM affected communities and working with them, identifying community insiders to lead the way and researching the factors associated with the continuation of the practice for a given community.

The Approach recommends formally assessing community readiness to end FGM and identifying aligned target intervention actions with motivated community members or peer group champions. Training and support for community peer group champions should be devised around the planned target intervention actions and specifically designed to overcome the particular barriers they face in going out into their community to take action. Behaviour change techniques are incorporated into that training and support given according to whether peer group champions need to become more capable, more motivated or have greater opportunities to take action (or all three). In addition, behaviour change techniques are embedded into the planned communication peer group champions have within their communities, with message content being based on what is known about the belief systems that perpetuate FGM within that community.

At the heart of the REPLACE approach is the requirement for evaluation and monitoring to ensure the success of interventions and the effective use of scarce resources. The REPLACE Community Handbook provides templates and strategies that allow assessment of whether the intervention achieved what it set out to, and if not, why. The REPLACE

Approach uses a variety of standard techniques including both qualitative as well as quantitative methods to monitor and evaluate progress.  It also requires spending time reflecting on the process and the experience for the REPLACE team, REPLACE partners and the FGM affected communities involved in the project.

The REPLACE team implemented the REPLACE Approach in five EU countries with a range of migrant African communities over three years, and learnt a lot about the challenges of engaging on this issue and of implementing the Approach. Although it was known at the outset how important it is to engage with affected communities in a genuine and honest way; the amount of time and resources needed to do this cannot be underestimated. REPLACE partners with greater experience of engaging with FGM affected communities in the UK and the Netherlands (FORWARD and FSAN) were in a much stronger position to move quickly on engagement because of their long histories of working in the field. It was more challenging for the Southern European partners (APF, CESIE and GES) who were working with newer migrant communities and who as organisations had only recently begun working with them on the issue of FGM. All REPLACE partners did an excellent job engaging and working with FGM affected communities, but REPLACE recommend that plenty of time is built into projects applying the REPLACE Approach for this critical early work and for trust to be formed with the target communities. The REPLACE project also found that time to develop intervention content and materials is absolutely critical to getting the process right, and so plenty of time and resources need to be built into projects for this element of the work.

 It is really useful to understand how other organisations and communities are getting to grips with the challenge of using the REPLACE Approach, and so it is suggested that those implementing the REPLACE Approach identify themselves as part of the REPLACE Approach community so that they can be known to one another and can provide opportunities (e.g. through an online forum on the REPLACE website) to share learning and challenges. Other aspects of REPLACE learning relate to the absolute importance and value there is in placing FGM affected communities in the EU at the heart of tackling the issue of bringing the practice to an end. REPLACE viewed this as highly important, but through the delivery of the REPLACE project have truly understood how critical this is. In Southern European communities in particular, this was the first time these communities had been consulted directly on the issue, and the power of providing the community with their own voice is immense. It is itself a highly motivating part of the REPLACE activities that communities could talk openly and honestly about their views concerning FGM without being judged.

Finally, the REPLACE team have learnt that the optimum context for applying the REPLACE Approach is alongside other activities that are designed to address the needs of FGM affected communities. One of the reasons why communities in the UK and the Netherlands are typically a little further along the stages of community readiness to end FGM is because they have fewer broader social and economic issues to contend with and therefore greater capacity to engage on the issue of FGM. Ultimately a sustainable, long-term end to the practice of FGM lies in the hands and minds of FGM affected communities. This REPLACE Toolkit and accompanying REPLACE Community Handbook can provide effective support to communities, NGOs and other stakeholders in taking action to end FGM in the EU.

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