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Behaviour change towards female genital mutilation: lessons learned from Africa and Europe

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1. Information, Education and Communication to raise awareness on FGM in Africa, and the gap between knowledge, attitudes and practices

The first programme for the prevention of female genital mutilation (FGM), which started in the mid 1970s focussed on promoting, informing, motivating and teaching on the adverse health effects of FGM, in order to break the taboo surrounding this harmful traditional practice. Therefore, efforts to stop the practice of FGM, used information, education and communication (IEC) materials, such as leaflets, booklets, training manuals and guidebooks for professionals. These IEC activities were often conducted with a focus on awareness raising rather than behaviour change and thus focused on short time results, since behaviour change takes time. Moreover, these messages were neither research-based nor adapted for a specific context. The messages of the IEC tools were often developed without the involvement of the target population and messages were seen as imposing (e.g. "Stop Excising"), demoralizing (e.g. "Plan your family or you will be poor") or were hard to understand (World Health Organisation, 1999).

A survey by the World Health Organisation (WHO) examined information on the content of the messages various organisations in Africa convey in their IEC and public information activities for stopping FGM (WHO, 1999). The messages used listed in order of frequency (from most used to least used) were:

- FGM has negative consequences on the health of women and children
- FGM is a harmful traditional practice
- The performance of FGM with the same instrument may facilitate the spread of HIV/AIDS infections
- FGM violates the rights of women and children
- FGM is not required by Islam
- 'Unexcised' women are marriageable
- FGM does not prevent promiscuity
- FGM reduces a woman's enjoyment of sex
- FGM is not required by Christianity
- Since girls are being 'excised' at a younger age, 'excision' as a rite of passage has lost its significance
- FGM curtails chances of girls furthering their education

Research showed that whilst IEC activities are essential steps for reaching behaviour change in FGM, these activities (by themselves) did not stop the practice of FGM, which was the desired behaviour change (WHO, 1999).

In communities where IEC activities took place, there was a gap between what people knew and what people did, the so-called KAP[1]-gap: there was a greater awareness (knowledge) of the adverse effects of FGM among the FGM practising communities and people changed their attitudes towards FGM (e.g. "I am not going to circumcise my daughter"), but only a minority of the people actually changed their behaviour, i.e. abandoned the practice of FGM (Potrow et al, 1997).

1 KAP means knowledge, attitudes and practice

IEC (WHO, 1999)

- *Project implementers often conduct IEC activities, with a focus on awareness raising rather than behaviour change.*
- *IEC materials are often not research based or pretested, the production of material becomes an end by itself.*
- *Messages of the IEC materials are often developed without involvement of target audiences, messages are imposing, demoralizing, or hard to understand.*
- *Well-designed IEC material can raise awareness and change attitudes but are not sufficient for behaviour change.*

2. Behaviour change: the theories

Although IEC activities remain an important and crucial first step in the process of behaviour change, a shift was made in the early 1990s from traditional IEC strategies, which informed people and tried to raise awareness, to communication strategies that aimed at changing behaviour.

Individual and community behaviour change

Changing behaviour to FGM (or any other undesired practice such as smoking or the practice of unsafe sex which might lead to HIV infection) requires a particular approach. To better understand this process of behaviour change, several theories have been developed that explain individual or community behaviour change.

a. The 'stages of change' behaviour change model

The **stages of change** theory was developed by Prochaska and Diclemente in 1982. It is based on a comparative analysis of major systems of therapy, and was initially applied in a study of smoking cessation, but has also been used to study alcohol abuse, contraceptive use and psychological distress. Izett and Toubia have adopted this theory and developed a model which can be used to bring about behaviour change to FGM (Izett and Toubia, 1999, pp. 20-25). This model proposes 5 stages a person needs to pass through in order to make and sustain a behaviour change regarding FGM (Izett and Toubia, 1999, p. 19).

One of the limitations of an individual behaviour change model such as the 'stages of change' model is that the focus is on changing the behaviour of the individual. For stopping FGM, the behaviour of **the entire community needs to be addressed**. FGM is a socio-cultural practice and therefore requires that the wider range of values, beliefs and interaction within the community is addressed.

b. Diffusion of Innovation – Rogers (1962)

This behaviour change theory gives more insight into community behaviour change. It states that new ideas and behaviours are not adopted by all persons at a single point in time, but rather are adopted first by **innovators**. The diffusion occurs gradually within a community until a **critical mass** of adopters has been reached, at which point the diffusion may accelerate. This model has been further adapted to recognise that interventions implemented in a participatory way are likely to lead to more rapid diffusion of behaviour changes.

c. Convention Theory – Mackie (2000)

This behaviour change theory describes the social processes that create, sustain, and potentially end practices such as female foot binding in China and FGM in Africa.

The Convention Theory predicts that FGM can be terminated through explanation of the physiological dangers of the practice, international condemnation of the practice, and most importantly the existence of groups of parents who refuse to subject their daughters to the practice and refuse to marry their sons to victims of the practice.

5 stages of individual behaviour change, by Izett and Toubia (1999)

- **Stage 1:** *Pre-contemplation (Existing knowledge, beliefs and attitudes): the individual is not thinking about FGM and has no intention of changing; social conditioning and existing views guide his or her beliefs, attitudes and decisions on FGM.*

- **Stage 2:** *Contemplation (Growing awareness of interest; questioning knowledge and beliefs): the individual recognises the problem and is seriously thinking about changing behaviour; the individual may have more awareness and looks for more information at this stage. Events might trigger this contemplation on FGM, such as a direct experience with a child suffering from bleeding, exposure to new information e.g. a media campaign on women's rights; or societal changes might have an impact on the decision not to excise a girl, e.g. moving to Europe.*

- **Stage 3:** *Preparation for action (changing attitudes; deciding to act): the individual recognizes the problem and intends to change the behaviour; the attitude towards FGM is changed and the individual does not want to perform FGM anymore, she might seek support for her decision from others at this stage. Barriers to actually move towards an action, might include strong social pressure to abandon the decision (e.g. during a trip back home).*

- **Stage 4:** *Action: the individual has decided to act and not perform FGM, and might approach others involved in the decision-making, with her or his own decision, e.g. through a public statement, or to choose an alternative rite-of-passage.*

- **Stage 5:** *Maintenance (handling reactions; challenging opposition): the individual maintains new behaviour for six months or more. A person's decision not to perform FGM might trigger strong reactions that have a positive (others in a community speak out against FGM) or negative effect (others overruling the decision and taking the girl for FGM) on maintaining the decision not to perform FGM on the long-term.*

If there is a critical mass of individuals[2] within a group of people whose children marry one another, and they decide to abandon FGM (change in attitude), a public pledge among these groups of people would end FGM for them and encourage the remainder of the intermarrying population to join in the pledge and abandon FGM as well.

Mackie has used the Convention Theory to describe the ending of foot binding in China and the ending of FGM in Senegal.

Behaviour change communication

The stages the individual or community go through and the ways in which the change occurs are equally important elements to take into account when developing an FGM elimination intervention. Another important element is the way in which this change is encouraged, i.e. communication for behaviour change. Behaviour change communication (BCC) is an interactive process with communities instead of a one-way communication process. A variety of communication channels are used to develop tailored approaches and messages.

BCC is also used to promote, sustain and maintain individual, community and societal behaviour change (Family Health International, 2002).

Behaviour change communication recognises that skill building might be needed in order to sustain the change in behaviour, for example on how to resist pressure, and how to establish community support.

Recent developments in communication recognise the need to move beyond top-down communication towards **horizontal and participatory approaches**. Such approaches incorporate the concept of **enabling environments** (e.g. breaking the taboo/silence) and **contextual factors** (e.g. pressure of grandmother to excise a girl) and are framed by the concept of **communication for social change** (Parker, 2004). Elements of the framework of 'communication for change' include:

- moving away from people as objects of change, towards **people and communities as agents of change**;
- moving away from delivering messages, towards **supporting dialogue and debate on key issues**;
- moving away from a focus on individual behaviour, towards a **focus on social norms, policies, culture and supportive environments**;
- moving away from persuasion, towards **negotiation and partnership**; and
- moving away from external technical expertise, towards **integrating communities in assessing issues of concern at local level**.

Behaviour change communication (WHO, 1999)

- *IEC develops the correct message for a general audience, while behaviour change communication (BCC) develops tailored messages using a variety of communication channels.*
- *BCC is an interactive process with communities.*

2 The critical mass of individual does not need to be a majority and possibly the more influential this mass is, the fewer the individuals are needed.

3. How to reach behaviour change: the practice of changing FGM behaviour in Africa

This chapter presents frequently used approaches in the prevention of FGM in Africa, and describes best practices and essential elements of community based interventions that have been successful.

Frequently used approaches in Africa

This section is an overview of most commonly used approaches which have been documented in the publications of the World Health Organization (1999), the Population Reference Bureau (PRB, 2001), Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ, 2001) and Toubia and Sharief (2003).

A description of the approaches and an overview/summary of its strengths and weaknesses will be given.

a. Human rights approach

As a result of the International Conference on Population and Development of Cairo (ICPD) in 1994, FGM is seen internationally as a violation of women's rights (GTZ, 2001). Most programmes link the issue of human rights to FGM and use international conventions as lobbying and advocacy tools.

The Tostan education programme in Senegal has included teaching on human rights as an important topic in its integrated learning programmes in order to reinforce the abandonment of FGM (GTZ, 2001).

Human rights were integrated as part of a larger package of information on health, hygiene and other topics which was used in the women's classes. The material was adapted and delivered in a sensitive and culturally acceptable manner (GTZ, 2001).

When human rights is used as a central and isolated focus of discussion, such efforts usually show little effect and may present a concept far too abstract for many people involved, if not 'translated to fit their realities' (GTZ, 2001). In the TOSTAN programme, the rest of the community did not oppose the use of the human rights approach.

b. Legal approach

Many African and European countries have passed laws declaring FGM illegal. The advantages of FGM legislation are that it provides an official legal platform for project activities; it offers legal protection for women; and it discourages excisors and families fearing prosecution (GTZ, 2001).

Disadvantages associated with FGM legislation are that the laws do not motivate communities and families to stop the practice. It is believed that the criminal laws lead to the performance of FGM in an illegal setting, where any complications are not taken to health services for fear of prosecution (WHO, 1999 and GTZ, 2001). The practice goes underground thus becoming both illicit and unsafe.

A recent study on the implementation of FGM laws in Europe revealed that specific criminal laws on FGM are not more successful in abandoning FGM than general criminal laws, and argues that

more attention need to paid to child protection measures. It also stressed the importance of providing sufficient time, means and commitment in order to implement existing laws successfully (Leye and Deblonde, 2004).

c. Health (risk) approach

The health (risk) approach has been the most widely used motivator in efforts to eliminate FGM for the past 20 years (Toubia and Sharief, 2003). Interventions using the health strategy emphasise the harmful health effects for women, including haemorrhage, infection, pain, fever, difficulty in urinating, and shock. Health professionals deliver health messages about the physical complications of FGM, such as bleeding and infection, and the risk to both mother and child during delivery.

An important aspect of this approach is that it breaks the silence in the social and political environment. It becomes acceptable to talk about FGM in public in situations where it had been previously taboo.

One disadvantage of this approach is that it has led to greater medicalisation of the practice: non-traditional practitioners such as doctors, nurses and trained midwives, perform FGM; milder forms of FGM performed by medically trained personnel have emerged and/or have been promoted (GTZ, 2001).

d. Religious approach

According to GTZ, the Kikuyu people in Kenya who once had a traditionally high FGM prevalence have almost abandoned the practice mainly due to numerous sermons and interventions by priests at the community level. The main messages are **God has made us complete** or **We have no right to destroy or change our God-given body** (GTZ, 2001).

In areas where the population is predominantly Muslim, religion is one of the strongest reasons given by parents for continuing the practice of FGM (GTZ, 2001). As the Koran does not require FGM, it is essential to inform and involve Islamic religious leaders in any strategies for changing the community's FGM behaviour. In many African Muslim countries, religious leaders have supported the campaign against this harmful traditional practice (GTZ, 2001).

e. Training health workers as change agents

Health workers are important stakeholders for sensitising and training communities on FGM due to the significant role they often play in addressing the health consequences of the practice (GTZ, 2001).

GTZ has described the various ways in which health workers are confronted with the issue of FGM. Health professionals:

- have a unique relationship with the community;
- play an important role in medicalisation and may be asked to re-infibulate women after delivery;
- have to deal with the complications of FGM;
- play an important role in counselling women and couples;
- are opinion leaders.

Because of their involvement and their role in handling the issue of FGM, GTZ stresses the importance of training and sensitising health workers on the issue of FGM.

f. Reconversion of excisors

This approach, in which traditional excisors are educated about the health risks of FGM and/or alternative sources of income are provided for them, has been tried in many countries (GTZ, 2001). This approach includes usually 3 phases:

- Identifying excisors and informing them about various issues related to FGM;
- Training excisors as change agents and motivating them to inform the community and families that request FGM about its harmful effects;
- Orienting them towards alternative sources of income and giving them resources, equipment and skills with which to earn a living (GT2, 2001).

Toubia and Sharief state that this strategy was successful in that excisors temporarily or permanently stopped. They also recognised that this approach affects only the supply side of the practice, the demands by parents to excise their girls continues unabated (Toubia and Sharief, 2003). Additionally, the low social status of excisors and the community recognition and payment they receive makes it difficult for excisors to abandon FGM (PRB, 2001).

The success of this approach has been questioned. GTZ is of the opinion that the approach has a number of negative effects:

- it does not deal with the demand and, where such strategies are not accompanied by extensive awareness campaigns addressing the community as a whole, families seek other providers;
- traditional excisors return to cutting within a short period of time, as excision is a lucrative business;
- in Ethiopia, income-generating projects for excisors attracted women who later said they had never excised girls;
- focusing on the excisors sometimes actually boosts their importance instead of exposing the profession as one that is harmful and needs to be stopped (GTZ, 2001).

g. Alternative rites of passage / coming of age programmes

The Population Reference Bureau (PRB) describes this approach as **'developing alternative rituals to substitute for the traditional cutting ceremonies'**. The aim of this approach is that community-based NGOs consult with family and community members, such as tribal and religious leaders, to create coming-of-age celebrations that exclude cutting but embrace other aspects of the ritual including seclusion, information sharing, and celebration (PRB, 2001). The PRB as well as Toubia and Sharief believe that this approach is only applicable when there is a culturally meaningful coming of age ceremony/ritual.

The success of this approach lies in its involvement of family and community members in designing the project. The progress is initially slow, but raising public awareness may have a snowballing effect that increases over time.

The alternative programme has been successful when implemented in close collaboration with the communities concerned and because they are part of a larger strategy: it provides an entry point to promote dialogue among family members about family, life education and sexuality issues (GTZ, 2001, PRB, 2001).

Initial evidence indicates that alternative ceremonies are well received and reduce the number of girls in their adolescent years that are cut as part of initiation. Evaluation of what types of rituals work best and their sustainability over time is needed (GTZ, 2001).

h. Integrated or comprehensive social development approach

FGM requires a comprehensive approach addressing aspects of gender and development, as well as the social, political, legal, health and economic development of a community (GTZ, 2001).

The 'Integrated learning' approach is such a comprehensive approach and integrates the issue of FGM into a wider learning package.

The Tostan programme in Senegal for example, which targets mainly women, includes modules on problem identification and problem-solving skills, women's empowerment, hygiene, health and other subjects, which are relevant to the community.

A similar approach is used in Kenya by Maendeleo Ya Wanawake (an alternative rites of passage approach). Although this approach is very promising, the success of such an intervention requires a large input of human resources as well as concise and systematic monitoring and evaluation. The results need to be quantified in terms of population numbers or number of girls protected rather than number of villages. Long-term follow up is essential to ensure public declarations are followed by a widespread and sustainable stop to FGM (GTZ, 2001).

i. Positive deviance approach

This approach identifies individuals who oppose FGM in communities and promotes them as role models in the community, the so-called 'positive deviants'. Role models may include families, teachers, religious leaders, and others who have opposed the practice, urged others to reject it, or publicly declared their opposition to it. The strategy's effectiveness is enhanced by efforts to document the stories of individuals who rejected FGM and how they dealt with confusion, opposition, and taking a stand against the majority. These individuals then recount their experiences at community forums (PRB, 2001).

As Toubia and Sharief (2003) found no reliable descriptive or analytical reports on this approach, it was difficult to conduct an in-depth analysis of its effect.

j. Research based approach

Programmes have sometimes failed because their approach was perceived as being imported or top-down, or they were criticised because they do not have monitoring and evaluation as key elements in their activities (GTZ, 2001).

This approach encourages the design of an intervention or activity based on a thorough understanding of the local context. The activity needs to also have monitoring and evaluation as key elements in its design (GTZ, 2001).

GTZ has identified four essential elements for a successful programme:

- conduct baseline research (quantitative and qualitative) to gain an understanding of the local context;
- build on monitoring of the implementation process;
- use operations research to add new information;
- conduct proper evaluation based on baseline indicators (GTZ, 2001).

Community based interventions: best practices

Currently, many actors in the anti-FGM campaign are questioning the effectiveness of their information campaigns in changing behaviour. Information campaigns have increased knowledge among the target groups, but they have not changed deeply rooted behaviours in the communities.

In recent years, valuable examples of behaviour change interventions that use the above-mentioned approaches have been implemented in a variety of communities throughout Africa. The following is a compilation[3] of interventions of using behaviour as a tool to bring about the abandonment of FGM.

a. The Intergenerational Dialogue, GTZ, Guinea-Conakry (Bah et al, 2003)

The **listening and dialogue** method creates a two-way dialogue between the community and the actors. It encourages discussion on the ambivalences and dilemmas which accompany the process of adapting attitudes and behaviours.

The intergenerational dialogue, which was originally presented as a listening and dialogue method, was introduced in Guinea as an innovative and most promising approach. Young and old women participated in a guided dialogue on themes such as gender roles, sexuality, traditional values and practices.

In a mutually enriching process of dialogue incorporating playful and interactive aspects, participants learned that communication is possible and understanding is necessary in order to cope successfully with changing views of gender roles, sexuality, traditional values and practices.

In 2000, an association of non-governmental organisations (NGOs) in Guinea launched the 'listening and dialogue' approach among their target groups. They organised **discussion days**, separating age groups and sexes.

They carefully selected trained moderators who were from the same community as the participants to facilitate discussions and encourage exchange.

The aim of the approach was not to educate and inform the target groups, but to ask questions

3 This anthology is based on research performed by ICRH in the framework of the project 'Contributing to the global efforts towards the abandonment of the practice of FGM', implemented by WHO and ICRH.

for which there were no right or wrong answers, to listen, and to facilitate frank discussions based on mutual respect.

The enthusiastic response of the participants, the active involvement during the 'discussion days', the frank discussions and the honest testimonies surprised NGOs representatives and the co-ordination team.

The most important lesson learned was that the **persistence of the practice of FGM is not due to a lack of information**. It was discovered that the target groups were well informed about the harmful effects of the practice and aware of the various implications of a change of behaviour. They had weighed the advantages against the disadvantages of stopping the practice. They were in two minds, they were faced with dilemmas, and they observed the behaviour and comments of others before altering their own ideas and actions.

As a result of discussions, the **intergenerational dialogue** was born.

In several regions, young women who had benefited from the frank and sincere atmosphere of the discussion days, asked the NGO's to organise similar discussions between themselves, their mothers and their grandmothers.

During this intergenerational dialogue, both young and old women reflected on their own values, traditions and aspirations, and decided in their own time under what conditions and in what manner changes should take place.

The intergenerational dialogue method is based on a narrative philosophy of personal and cultural development. According to this philosophy, people understand themselves within their own world through their collective and personal history. Their actions depart from these histories. In order to make both personal and cultural development possible, it is essential that these histories be respected and that any projected changes are tailored to fit into their scheme of things.

It is crucial that personal and cultural narratives are listened to in the intergenerational dialogues that participants see that these narratives are taken seriously and that the rationale behind their values, fears and hopes may be understood and considered in the forging of new agreements.

The dialogues create spaces for reflection, for listening and for an exchange. This process ensures a balanced and open perspective on conflicts and requires that both parties treat each other with mutual respect and appreciation.

To ensure the effectiveness of this approach and that no one group is disadvantaged during the workshops, a number of aspects must be prepared well in advance of the workshops:

- the local language selected;
- the type of language used;
- the age and sex of the moderators;
- the aids utilised;
- the venues and atmosphere.

This process of 'listening and dialogue', in a large group, small group or in pairs, according to GTZ, encourages participants to recognise and point to the links between the personal, cultural and political levels.

Often a new understanding emerges between the members of different groups and unexpected projects are initiated. The generative capacity of the approach is important. The meeting of two generations to discuss topical themes in their own way according to their own priorities allows participants to quickly arrive at the heart of the matter. This method provides important information about the knowledge, attitudes and behaviours of a community.

b. Monitoring of Girls at Risk by Positive Deviants, CEDPA, Egypt (CEDPA, 2004)

What started as an experiment turned out to be a very helpful method in changing behaviour towards the practice of FGM. In 1998-1999, CEDPA-Egypt initiated a project to understand why some families do not excise their daughters.

The project is based on the Positive Deviance Approach (PDA), a methodology that focuses on individuals who have 'deviated' from conventional societal expectations and adopted – though perhaps not openly – successful alternatives to cultural norms, beliefs or perceptions in their communities.

The strengths of this approach lie in understanding that solutions to problems already exist within communities and that, by taking part in a process of self-discovery, community members have the capacity to identify and implement them.

The central approach used for awareness raising in the CEDPA project is community mobilization. **Community mobilization** uses participatory processes to involve local institutions, local leaders, community groups, and members of the community to organise a collective action towards a common purpose. Using the tools of community mobilisation, the project works through local individuals who have decided they are against FGM and refuse to practise the custom, the so-called **positive deviants**.

The program itself consists of three workshops each separated by a period of activity within the community.

The first workshop is designed to provide the local NGO representatives with an introduction to the programme, important information about FGM, and the tools to identify the first group of positive deviants. Before the second workshop, positive deviants are identified, interviewed, and several are selected to participate in the second workshop.

During the second workshop, all participants are provided with comprehensive information on FGM, trained to analyse interviews, and plan the mobilisation activities for the first six months of the program. An action plan is developed and provides a roadmap for all activities and an informed dialogue in the community on the issue is opened. The focus of these community mobilization activities is outreach to community members through small private group activities and larger public meetings.

After three months a one-day check-in workshop assembles teams from several communities. This workshop encourages communities to recognise their accomplishments and challenges of the last three months together and revise their action plan for the final three months of the community mobilization activities. This workshop also provides an opportunity to inform active positive deviants about the next parallel phase of the project, the **Girls at Risk (GAR)** phase.

In the GAR phase, the positive deviants list girls at risk of FGM and a 'Girls at risk' workshop is organised. The GAR workshop focuses on outreach, monitoring, and tracking of girls at risk and their families. After the GAR workshop, active positive deviants begin an outreach programme to families

of girls at risk. All families with girls are visited, but priority is given to girls of excision age.

The intention of families not to excise their girls is noted and the local NGOs should monitor the circumcision status of the girls 'indefinitely' (CEDPA, 2004, pp. 33).

c. Village Education Programme, Tostan Senegal (PRB, 2001; Melching, 2004)

Tostan is an international, educational NGO established in 1991 and based in Senegal. Tostan, which means **breakthrough** in the Senegalese language of Wolof, empowers people through education and knowledge to enhance their personal and community development.

This **basic education program** consists of four modules: hygiene, problem solving, women's health, and human rights. Through these four themes, emphasis is placed on enabling participants, who were mostly women, to analyse their own situation more effectively and find the best solutions for themselves.

Tostan's approach is based on peaceful social change through a basic community education programme and a process of social mobilization. The programme has been implemented in 90 villages in the Kolda Region.

After learning about the negative health consequences of FGM, in 1996 women in the village of Malicounda Bambara gradually began to discuss the practice openly with their husbands, the male village chief, and the imam, a recognized leader or a religious leader. After one year, the women decided and declared that they would end the practice. The village chief supported this decision and no FGM ceremonies were held that year.

As a result of the activities of this community, neighbouring villages also began to speak out against FGM. The imam from the Bambara village of Keur Simbara, who was highly committed to ending FGM, visited all of the Bambara villages over a three-month period. His efforts and the consensus of religious, health, and government representatives culminated in the Diabougou Declaration, which pledged the Bambara community's commitment to end the practice of FGM.

Since 1997, 1,367 communities in Senegal have abandoned FGM through 17 Public Declarations, representing 28% of the 5,000 communities that practiced FGM in 1997. The public declarations are joyful, peaceful and memorable events uniting all communities in a common commitment to health and human rights. It reaches thousands in the country through extensive and positive media coverage and it leads to the beginning of a change in **social convention** on a large scale. This social convention states that non-excised daughters are not respected and not marriageable. People are 'trapped' in this social convention so that not a single person or single family can abandon the practice alone because it will endanger the future marriage prospects of their daughters.

This explains why many people change attitudes but do not change behaviour and stop the practice of FGM. The abandonment of FGM can only occur when people decide together to change the social convention so that no person or family is marginalised. As intra-marrying groups declare abandonment, a momentum is built, influencing others in the ethnic group, in the country and in other neighbouring countries. Mass abandonment occurs as a 'critical mass' is formed and the social convention changes. Abandonment then becomes rapid and universal.

Diffusion occurs through participants sharing information with others through an **Adopt a Friend Strategy**: friend, relative, husband, and village leader. Classes are organised to give participants time to assimilate new information, and to share and discuss ideas and thoughts.

Participants share information with others in the village through use of theater, role-play, song, illustrations, games, poetry and flip charts. Other community meetings (religious and traditional leaders, youth groups) are organised by participants to share new information, gain support and make decisions. Inter-village meetings are held to share with family, neighbours and other members of the same ethnic group. Issues adopted on a regional level lead to public declaration and larger social movements on a regional level.

The effect and the impact of the programme were evaluated in 20 villages in 2003.

The Tostan process has been evaluated as successful because it has provided: basic education, which is vital for empowering villagers; a forum for villagers to meet with each other to discuss the practice of FGM; and the involvement of village leaders (especially religious leaders) who can address people's concerns about Islam's position on the practice.

Furthermore, the Tostan process has also made people aware of alternatives (i.e., not everyone excises their daughters); provides information about the health benefits of not performing FGM; and enables people to agree collectively to halt the practice so that no single family stands out or no person becomes socially stigmatised and thus unmarriageable. Publicity and press coverage have aided the movement in encouraging dialogue on FGM and helped in the dissemination of anti-FGM messages beyond the initial villages.

d. Alternative rites of passage, Maendaleo Ya Wanawake, Kenya (Kittony, 2004)

As a result of a national seminar organized by Maendeleo Ya Wanawake (MYWO) and the Programme for Appropriate Technology in Health (PATH) in 1995, MYWO and PATH in consultation with women leaders, from families who had decided to stop excising their girls, developed an alternative ritual activity in 1996.

The idea to develop an **alternative rite of passage (ARP)** rose because parents who made the decision not to excise their girls were faced with the dilemma of what to do about the traditional ritual. The cultural significance associated with the practice of FGM makes it a very sensitive subject to address and families and communities that are simply not ready to confront age-old tradition opt to continue with the practice even if they understand that it is harmful. The alternative rite of passage was designed to retain the best cultural practices, and discard the 'cut'.

The main objectives of ARP were to:

- To create awareness in the community of the negative effects of FGM with emphasis on the respect for cultural practices and ARP without jeopardizing culture;
- To provide counselling services and referral to girls, parents and couples with FGM concerns;
- To integrate FGM into other MYWO programmes;
- To collaborate and network with the government, other NGOs and community based organisations (CBOs), religious groups, media and donors in the fight against FGM; and
- To advocate and lobby for legislative change against harmful traditional practices.

The project staff and peer educators received training in communication for change as well as counselling skills. The training prepared staff for their critical role of recruiting mothers and girls for the ARP programmes, which involved two stages:

- **Stage 1: Week of seclusion for initiates**
  - During this week girls are trained on self esteem, personal hygiene, relationships with parents, peers, elders, opposite sex and on decision making.
  - Excisors and health personnel also share ideas on different ways of excision and its effects on the health of the girl or woman at this time. This is done using the pelvic module and other IEC materials, such as flip charts, pamphlets, video tapes.
- **Stage 2: Celebration**
  - After a week of training and counselling, a graduation ceremony is held which includes feasting, dancing, singing and the presentation of graduation certificates. The girls receive gifts from their parents, friends, and close relatives.

The first ARP ceremony was celebrated in 1996 in Tharaka Nithi District, where 28 girls were initiated into adulthood. Based on the success of the first ceremony, MYWO replicated the ceremony in the other nine districts of Samburu, Narok, Kajiado, Kisii, Meru, Nyamira, Gucha, Trans Mara and Nandi. Since then, over ten thousand girls have been initiated through the alternative rite of passage. Other organisations have also replicated the MYWO alternative rite of passage.

Essential elements of successful community based interventions in Africa

Over the last five years, in-depth reviews and evaluations have been conducted to ascertain the effectiveness of FGM programmes and approaches[4].

A summary of the conclusions of the various reports and articles on these reviews are that: Community-based abandonment programmes/approaches that have been recently used are effective: the alternative rite-of-passage (e.g. MYWO in Kenya); the community education and consensus building (e.g. Tostan in Senegal); the comprehensive approach (e.g. CEDPA in Egypt) and the positive deviance approach (e.g. CEDPA in Egypt).

The foundation for the abandonment of FGM has been laid in several countries. There are examples of successful programming at community level, and committed groups are working in a coordinated and dedicated manner. The interventions identified as successful are all designed and implemented in close relationship with the community and they have more than one outreach component.

The conducted reviews also show that:

- Most of the intervention programmes which aim to bring about FGM abandonment have been **pilot in nature**, thus **reaching small numbers of at-risk communities**. These programmes have not been tested in settings other than the ones they were initiated and have not been scaled-up (Frontiers in Reproductive Health and Population Council, 2002);
- Most of these programmes have **not been properly monitored, evaluated and documented** and have not been sustainable over a long period of time (WHO, 1999); and
- The FGM interventions have **not been designed with reference to a theoretical model** (Frontiers in Reproductive Health and the Population Council, 2002) but were developed in respond to a particular situation, a specific setting (e.g. uncut girls needing an alternative ritual), programmatic experience (a functional literacy programme) or simply intuition (converting traditional practitioners).

4 a) in 1999, WHO reviewed and evaluated different interventions aiming at behaviour change (WHO, 1999); b) in 2000, Masterson and Swanson published the results from the evaluation of the 'Promoting Women in Development' (PROWID) grants programme; c) in 2001, the Population Reference Bureau published a report presenting an overview and recent statistics about the practice of FGM, a summary of FGM abandonment approaches, and a brief discussion of projects in four countries identified as promising by the WHO and PATH; d) in 2003, Toubia and Sharief published: 'Have we made progress?', an article that assessed progress in FGM interventions, using reviews, secondary reports and evaluation studies from various sources.

A consultative meeting on **'Determinants of successful community based interventions on FGM'**, was organised in Bamako, Mali, November 30-December 3, 2004, by the World Health Organisation in collaboration with the International Centre for Reproductive Health (ICRH).

A result of this meeting was that a framework on determinants of community based best-practices on behaviour change of FGM has been developed (Bauwens et al, 2005).

The following key elements of the design, implementation, monitoring and evaluation of such an intervention were identified by the participants.

a. Design

1. *Assess the **level of intervention** planned: community level; national level and/or international level.*
   - Recognise that both the national and international levels are important levels to be taken into consideration.
   - Consideration of the international level can facilitate the process of exchanging experiences, in guiding your fieldwork, and in building partnerships.
   - Targeting the national level can provide necessary political and collaborative support and might be valuable to legitimise the need for an intervention.
   - Work at the community level is critical in order to reach sustainable behaviour change.
2. *Perform a **situation analysis** to assess the socio-cultural context.*
   The results of this analysis will provide information on community needs, decision making powers in the community, power structures in communities; available resources; FGM situation; possibilities to enter the communities. The intervention will be better planned, implemented and monitored as a result.
3. *Determine the suitable **approach** after conducting a situation analysis.*
   An integrated approach within a broader programme of community empowerment (for example a sexual and reproductive health programme), is likely to be more successful, since it improves the sustainability of the intervention. The benefits for the community are broader using an integrated approach and makes FGM as an issue easier to address within the framework of human rights, gender, and health.
4. *Determine the most suitable **theoretical framework** to provide legitimacy to the used approach/methodology.*
   A theoretical framework helps in assessing the stages of behaviour change, clarifies the methodology, optimises the chances of success of the intervention strategy and facilitates communications/discussions with peer group. It also serves research purposes and may open doors to obtain funds since it can give the intervention credibility.
5. *Address all community members, yet identify primary, secondary and other **target groups** according to the objectives of the intervention, capabilities of the implementing NGO, timeline and available funds.*

b. Implementation

1. *Introduce the issue of FGM as **part of a broader context**. Important elements of this context are to be determined by the situation analysis, in which the social needs of the community are assessed.*
2. *Pay careful attention to **strategies to enter the communities**: identify stakeholders and community leaders at community level to ensure a successful and an effective way in approaching the community(ies), and to seek their support for the intervention. Public meetings and/or door-to-door approach can be used to introduce the intervention to the whole community.*
3. *Consider **social mobilization** as a key activity. This includes an awareness raising phase in which the correct information on FGM is provided and the possibility is given to the communities to reflect on this information. Channels used include: public meetings, family visits, intercommunity meetings, ...*
4. *Select **appropriate personnel/facilitators** and provide good training, which is vital for a successful intervention. Selection criteria for the facilitators include: persons who are visible and respected by the community; persons who are members of the communities; persons with an open attitude, who are supportive of the intervention and who clearly oppose FGM.*

c. Monitoring

1. *Include **capacity building** on monitoring in the design and budget of the intervention, as this will enhance the results.*
2. *Differentiate between monitoring the activities of the programme and monitoring behaviour change at a long term. Using **input indicators** can monitor activities of the intervention.*
3. *Create **monitoring bodies** at community level to ensure community ownership and maintain sustainability (for example community management committees) and provide training on how to monitor programme activities.*

d. Evaluation

1. *Conduct a **baseline survey** and/or ethnographic studies prior to the implementation of the intervention.*
2. *If possible, include a budget for **external evaluation.***
3. *Select a set of **indicators** according to the type of intervention.*
4. ***Disseminate** the outcomes of the evaluation to the communities.*

4. Prevention of FGM: experiences from Europe

Achievements to date

Non governmental and community based organisations

A number of NGOs and community based organisations (CBOs) emerged in the early 80s which worked for the eradication of FGM in Europe. Notably amongst these were Terre Des Femmes in Germany (founded in 1981) and the 'Groupement pour l'Abolition des Mutilations Sexuelles' in France (founded in 1982). These NGOs and CBOs have focused their work either solely on FGM or have adopted a holistic approach by incorporating FGM in their work on women's issues, health issues, or migrant/refugee issues (Leye, 2005).

The activities of the NGOs and CBOs are devoted to prevention work, lobbying and advocacy. They provide information regarding FGM for practicing communities and for particular European stake-holders, especially, but not exclusively, for those who interact with communities that practice FGM.

NGOs have also produced training programmes for professionals, developed educational material, and conducted awareness raising campaigns aimed at different target groups, such as practicing communities, health professionals, the educational system, the police, and the media.

Some NGOs (such as AIDOS in Italy and FORWARD in the UK) and community based organisations also conduct research and support organisations in Africa (Leye, 2005).

Other actors

Within the former 15 EU Member States, particularly in Denmark, Germany, Italy, the Netherlands, Sweden, and the United Kingdom, a wide range of actors work at different levels of society to prevent FGM: for example the health sector, the police, the media and schools.

The Daphne Programme

The Daphne programme of the European Commission has been established to combat violence against women and children in Europe.

Between 1997 and 2004, the Daphne programme has conducted eleven projects on FGM in Europe, some of which are still running[5]. These projects have used a wide variety of strategies. Some of these strategies are the production of IEC material to raise awareness; conducting research on the topic of FGM; developing and implementing community based interventions and the creation of a European-wide network of NGOs and CBOs working with practicing communities on FGM and related issues.

Within these Daphne projects, a variety of IEC tools have been (or are still in the process of being) produced, some of which include:

5 A review of these projects can be found at the Daphne Toolkit website (http://www.daphne-toolkit.org).

IEC material produced in Daphne projects

- **Research reports and workshop reports:** *These reports focus on recommendations for developing a European wide strategy to deal with FGM; on research priorities with regard to FGM in Europe; on frameworks for health professionals on training and service provision; and relevant topics regarding community based organisations' preventive work;*
- **Information booklets:** *These books review existing legislation used to prohibit FGM in 15 Member States of the European Union and provide an analysis of the implementation of the law in Belgium, France, Spain, Sweden and the UK;*
- **Comics:** *comic for youngsters;*
- **Manuals:** *Guide for professionals and manuals for health providers;*
- **Leaflets, TV Spots, websites, bags, T-shirts, posters** *with information on FGM;*
- **FGM teaching kit** *for the prevention and elimination of FGM in the EU, teaching methodology and training of trainers materials.*

Most of these materials have been produced by projects between 1998 and 2004.

The Daphne project entitled 'Strengthening the European Network for the Prevention of FGM by building on experiences and results from the past', discussed the need for and possibilities to develop new IEC material to prevent FGM in Europe. The first workshop of the project, which was conducted in Brussels, Belgium (June 2004), examined the quantity and quality of existing educational material developed by former Daphne projects and what the effectiveness of these materials has been.

Workshop participants were from organisations working on FGM in Europe, the majority of who were also members of the European Network for the Prevention of FGM. Most NGOs and community-based organisations were represented.

The second workshop, held in Ghent Belgium on May 18-19 2005, focused on community-based dimensions of the Daphne FGM projects. Presentations and discussions analysed the extent to which behaviour change had been factored into the design of these projects.

Participants in both workshops acknowledged that as the focus of activities had been awareness raising and advocacy in previous Daphne projects, resources (human, time and financial) had been spent on producing IEC materials.

Participants concluded that these materials have increased the knowledge base of FGM in Europe significantly, and have also helped to underpin actions to fight FGM in Europe. Activities have succeeded in raising awareness regarding FGM.

Some of the Daphne projects that have produced IEC material are:

THE IDIL project

This project, entitled 'Instruments to Develop the Integrity of Lasses', (the IDIL project), was implemented by the Centro Piemontese di Studi Africani in Italy, in collaboration with several partners in Denmark, Germany, Italy, the Netherlands, Spain and Sweden.

This project was for two years (2002-2003) and aimed to define and test strategies to prevent FGM among practicing families/communities in the participating countries.

The project consisted of three essential elements:

- *The production of demographic (data) information which mapped communities in Italy and Spain;*
- *The adaptation and production of materials produced in earlier Daphne projects for use in awareness-raising and information work (including the creation of a website);*
- *The preparation of information/training kits for sectors working in these communities.*

(Source: www.daphne-toolkit.org, accessed November 2003)

FGM Training Kit for the Prevention and Elimination of FGM among Immigrants in Europe

This project, entitled 'Development and production of a FGM teaching kit and the training of community/religious leaders, women and other communicators on its use', was co-ordinated by the African Women's Organisation in Vienna, Austria (2003-2004), in collaboration with partners in the Netherlands and Sweden.

The objective was to provide FGM prevention workers with appropriate and effective tools to address the problems of FGM. The outcome of the project was a training kit in two parts.

The first part consists of information on various aspects of FGM, including the cultural, traditional, religious, health, violence and human rights aspects. This information is intended for a variety of stakeholders who work directly with practicing communities. There are three modules to this first part aimed at community leaders, communicators and religious leaders. Each module's sessions and steps are organised in a logical sequence which gradually builds up information with the intention of raising awareness of FGM and its socio-cultural implications as well as providing accurate and consistent facts about the practice, particularly as it is manifested in Europe.

Resource materials are suggested; laws for the prohibition of the practice in Europe; and experiences and good examples of prevention and elimination of the practice within communities in Africa are also included.

The second part presents a methodology for delivering the first part of the teaching kit in a systematic, trainee-friendly way. It is a teaching guide intended for trainers, teachers and anyone else responsible for delivering training.

(Source: Hadis E, 2005)

Evaluating the impact of existing legislation in Europe with regard to FGM

This Daphne project was coordinated by the International Centre for Reproductive Health in Ghent, Belgium (2003-2004), in collaboration with partners in France, Spain, Sweden and the UK.

The project examined European legislative measures as tools to fight FGM in Europe.

The specific or general legislation for FGM in 15 EU Member states was analysed and reported. In a more detailed analysis, the difficulties of implementation of legislation in 5 EU Member States (Belgium, France, Sweden, Spain and the UK) were discussed in detail, and presented with recommendations for an effective EU strategy to legislate against FGM.

This project produced a number of research reports on legislative measures, the implementation of legislation and recommendations for an effective legislative strategy, which can be used for raising awareness and increasing knowledge on FGM in Europe.

The reports have been published in English, French, Swedish and Spanish.

(Source: www.daphne-toolkit.org, accessed November 2003)

The way forward for Europe

Participants of both workshops made two main conclusions about activities currently being implemented in Europe to prohibit or stop the practice.

The first conclusion was that there is a sufficient amount of IEC material available in Europe. However, there is a need to consolidate what has been produced (Leye, 2004). The following recommendations, which have been summarised below, were made:

Consolidating the achievements regarding IEC material in Europe

- *Existing IEC material needs to be assembled, pre-tested, evaluated, translated and disseminated. It will be necessary to build the capacities of NGOs to perform such pre-tests and evaluations. Criteria should also be developed to select IEC material for translation. More efforts need to be made to ensure effective dissemination of IEC materials amongst various stakeholders and across European countries.*
- *More information regarding issues other than FGM, for example, access to the health and education systems in host countries, needs to be provided.*
- *Research reports need to be 'translated'. There is a need to present the results of research so that findings can be understood, interpreted and adapted by people working with and for practising communities, and not least, by the communities themselves in Europe.*
- *Specific communication tools to reach men need to be developed.*
- *A focal point is needed to centralise all existing IEC material.*

The topic of behaviour change and how it can be achieved was discussed at length during the first workshop. Participants reported a lack of knowledge and understanding of behaviour change communication and how it might be useful in stopping FGM in Europe amongst practising communities.

Community-based organisations, as well as other NGO's wanted information about the use and effectiveness of behaviour change communication as well as knowledge about best practices of this method of communication in Europe.

Given that communication for behaviour change is an interactive process (see chapter 2), oral communication channels are considered to be more reliable in terms of such an interaction. The effectiveness of oral communication channels have not yet been fully explored by Daphne projects, where the focus has been the production of material for raising awareness, educating or training and teaching.

The second conclusion from the workshops was that it is necessary to move from raising awareness on FGM towards developing activities designed to bring about sustainable behaviour change in Europe and that using behaviour change communication interventions could be instrumental in bringing about such change.

Participants therefore suggested a number of issues that could facilitate behaviour change interventions amongst communities in Europe:

Suggestions for behaviour change communication in Europe

- *A **participatory and multidisciplinary approach** is paramount: activities should always be developed in collaboration with communities and with professionals from various backgrounds.*
- ***'Outreach'** is an important tool in BCC in Europe, as it is used for collecting information from the community and if used successfully, can build networks within these communities. Outreach and networks are processes and channels for building trust within the communities.*
- *As the quality and extent of community and interpersonal interventions are critical factors in behaviour change, it is important to work with, listen to and train **influential and respected women and men** in the communities who can then be used as trainers, facilitators and outreach workers. The opinions and attitudes of this key community member's method can reinforce anti-FGM messages and build trust amongst community members.*
- *A **continuous dialogue** with and support of the communities is vital.*
- ***Children, young women and men** are important target groups to address in Europe.*
- ***New communication channels** are emerging, such as 'chat rooms' in Finland; 'peer groups for exchanging views and emotions' in France; and 'young girls committees' in Denmark. These are important developments which need to be taken into consideration and explored when designing new interventions that will bring about behaviour change.*

In order to develop and implement effective IEC activities and behaviour change interventions, needs assessments should be performed. These assessments should originate and involve members from practising communities and should be done in cooperation with multi-disciplinary teams prior to developing new activities.

5. References and further readings

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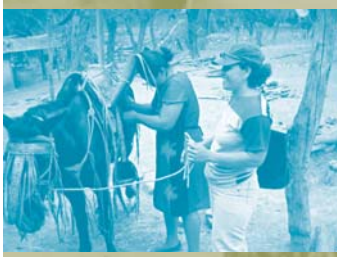

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