

# Prevention Programs





## PREVENTION PROGRAMS

<b>Prevention programs in Africa and destination countries.....</b>	<b>61</b>
<b>Frameworks for female genital mutilation/cutting prevention.....</b>	<b>62</b>
Health education and promotion .....	62
Human rights, women’s and children’s rights and the law.....	64
<b>Indonesia: Where laws condone the practice.....</b>	<b>65</b>
<b>Processes of community and cultural engagement for change .....</b>	<b>68</b>
<b>Examples from Africa.....</b>	<b>70</b>
Senegal: TOSTAN.....	70
Sierra Leone, Uganda, Ghana, Ethiopia and Tanzania: Alternatives to female genital mutilation/cutting .....	71
Egypt: A ‘positive deviance’ approach.....	72
<b>Examples of effective program responses in non-practising countries of settlement .....</b>	<b>73</b>
Sweden’s legal and social alert system.....	73
The UK: FORWARD and the African women’s clinics .....	74
The US: Community-based research.....	75
Canada: Winnipeg.....	75
Australia.....	76
<b>Summary and discussion.....</b>	<b>79</b>
<b>Bibliography.....</b>	<b>80</b>



## Prevention programs in Africa and destination countries \_/

This report presents research on female genital mutilation/cutting (FGM/C) prevention programs in countries where FGM/C is practised, and in non-practising countries that host migrants and refugees from FGM/C practising countries (host countries).

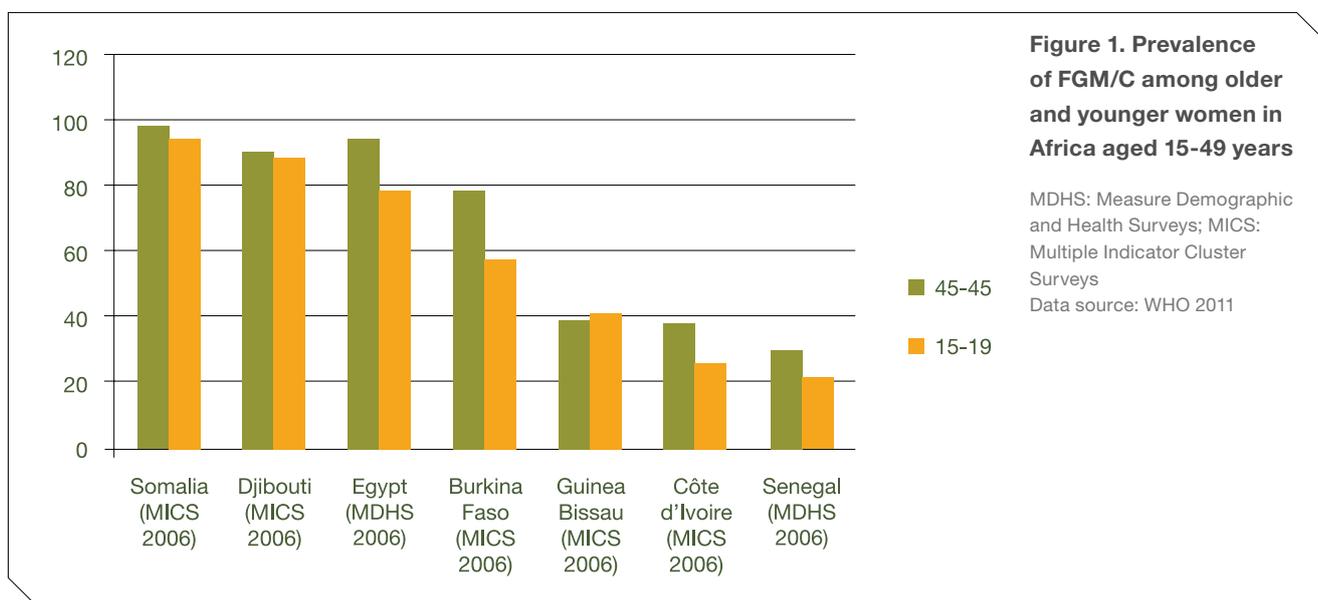
There have been several waves of attempts to prevent FGM/C. When missionaries in Kenya first encouraged the abandonment of FGM/C practices in the 1930s, local communities saw this as a colonialist attack on their traditional custom aimed at hastening their ‘Europeanisation’ (UNICEF 2010, p. 45). A cultural relativist stance prevailed internationally until the later decades of the twentieth century (Caldwell, Orubuloye & Caldwell 2000) when human rights, child rights and particularly women’s rights, were promoted. FGM/C and other harmful traditional practices were understood internationally as not only very harmful to the health and wellbeing of women and girls, but also as an abuse of their human rights and a form of violence.

In the 1970s and 1980s, delivering health messages about the harmful consequences of FGM/C for women and girls became the dominant conceptual approach in combating its occurrence in African countries. By the 1990s, all major relevant international bodies

and most governments had committed themselves to the eradication of FGM/C, and the human rights stance had been integrated into a health promotion approach. At the community level, human rights and responsibilities are still constantly being negotiated and these complex processes form an important part of community development and health promotion work on the ground level.

The practice of FGM/C in Africa is showing some encouraging signs of declining. One key indicator is that in African countries, younger women aged 15-19 years are less likely to have been subjected to FGM/C than are women in older age groups, as illustrated in Figure 1 below (WHO 2011, p. 1).

Nevertheless, ‘in many countries the reduction in prevalence is not as substantial as hoped for, and in a few no decline can be noted’ (WHO 2011, p. 4). This is despite significant efforts by international bodies, non-government organisations and governments to eradicate the practice. In 2008, the World Health Assembly passed a resolution on the elimination of FGM/C, emphasising the need for concerted action in all sectors, namely health, education, finance, justice and women’s affairs.



The World Health Organization's (WHO) efforts to eliminate FGM/C currently focus on:

- › advocacy: developing publications and advocacy tools for international, regional and local efforts to end FGM [female genital mutilation] within a generation;
- › research: generating knowledge about the causes and consequences of the practice, how to eliminate it, and how to care for those who have experienced FGM;
- › guidance for health systems: developing training materials and guidelines for health professionals to help them treat and counsel women who have undergone procedures.

The WHO is particularly concerned about the increasing trend for medically trained personnel to perform FGM/C and strongly urges health professionals not to perform such procedures (WHO 2012).

The research literature reviewed below reflects a range of interconnecting and overlapping approaches to the eradication of FGM/C practices that have been adopted in various communities around the world.

## Frameworks for female genital mutilation/cutting prevention

The key frameworks used for the prevention of female genital mutilation/cutting (FGM/C) are health education and promotion, legal and human rights, including women's and children's rights, and changes in the social dynamics of FGM/C through community engagement.

### Health education and promotion

Health education involves informing people about female genital mutilation/cutting (FGM/C) and its harmful effects (Banks 2006; Knight et al. 1999; Mathews 2011). Three distinct but interconnecting levels of health education and promotion are addressed here as strategies in the campaign for abandoning FGM/C. The first is the migrant or settling community of people; the second, professionals interacting with practising communities in a multitude of ways; and the third, the societal level, a 'whole of population' approach.

For migrants arriving in new countries, there are many opportunities for change, with education playing a significant role. Particular examples described later in this report highlight, in part, the roles of immigration, settlement and other relevant

workers engaging with and informing new arrivals about their new country's health, housing, employment and services, as well as providing information about laws relating to compulsory schooling, visas, child protection, domestic violence and gender relations. Professionals can raise awareness at the time of arrival, or later when people are more settled, about sexual and reproductive health and FGM/C and its harmful effects on girls and women. Many of the people arriving may never have discussed FGM/C (Steele 1995) and may have inadequate knowledge of their bodies and biological facts.

As such, health-related problems are well placed among the psychosocial issues discussed in settlement programs with new migrants (Knight et al. 1999). Educators can invite religious leaders to inform people of

the mis-association of FGM/C with religion, and the laws against and consequences of performing the practice in the new country (Ierodiaconou 1996; UNICEF 2010). Further, support and counselling should be available. Founder of the non-government UK organisation FORWARD, Efua Dorkenoo, declared that 'when genitally mutilated women, en masse, understand what has been stolen from them, there will likely be a period when they will need every possible psychological support' (cited in Steele 1995, p. 122).

Migrants who have experienced FGM/C programs in Africa are well placed to contribute to educating others for whom it has been a taboo or unquestioned topic. Women and men of African backgrounds who are activists against FGM/C are seldom given credit for their attempts to promote human rights (Khaja et al. 2009) and are often excluded from leadership, decision-making or policy making roles. This is because they have been depicted as being unqualified to comment about their traditional practices (Johnsdotter & Essen 2010).

The way in which education about FGM/C occurs is important. Adults are more likely to consider new ideas, attitudes and behaviours when they are part of a group that provides opportunities for safe discussion; respects and appreciates cultures, values and aspirations; draws on common experiences; and establishes agreement about change. The more supportive, accepting and caring the learning environment, the freer people feel to experiment with new attitudes and ideas. Adults retain and act on knowledge that they discover themselves more so than knowledge that is presented by others (Vella 2002). Educational approaches that use these principles can engage and empower people to make their own decisions to abandon FGM/C (Daniel et al. 2011).

Adult learners appreciate opportunities for debate (Vella 2002). Facilitators can invite religious and other leaders from the communities concerned, as well as health and community professionals, to discuss the

conflicting constructions of FGM/C. Being of the culture, community and religious leaders can be ambassadors of new ways, working with community members to frame problems and solutions in the context of religion and culture, using metaphors, idioms of distress, and proverbs that are familiar and accessible (Al-Krenawi & Graham 2001, p. 677) to inform people of the mis-association of FGM/C with religion and the laws and consequences against the practice in the new country (Ierodiaconou 1996; UNICEF 2010).

The participation of migrants in higher education is likely to create openness to re-thinking cultural assumptions and practices. For example, exposure to international education and discourse on human rights has been seen to influence young men in Muslim communities in Southern Thailand. On their return home, these men opposed FGM/C, in contrast to local people who want FGM/C to remain part of their traditions (Merli 2010).

For health, welfare and legal workers, it is important to undertake training in FGM/C and its consequences, including the barriers to effective and responsive health care. Systematic training is needed for professional groups who may deal with women affected by FGM/C, including immigration officers, settlement and health workers, lawyers and English language and other teachers. Training should be targeted at programs that will assist women who have undergone FGM/C and support them in seeking assistance for gynaecological or psychosexual help or counselling (Ierodiaconou 1996). If health professionals are not informed about the physiology and cultural bases of FGM/C, they may not know how to establish rapport with women who have experienced the practice when they present at medical settings. With culturally appropriate education and the use of interpreters (Knight et al. 1999), health professionals can provide a thorough assessment at first presentation. Counselling and further management can then be arranged if necessary.

At the whole of population level, technology and media can be used as a powerful

force for health promotion, mass education and influence (World Health Organization 1986). Radio and television talk shows, documentaries, films and educational programs reach large segments of the population and can provide the basis for discussion and debate. Through the media, positive news about public abandonments can be widely disseminated. Media attention can expose illegal FGM/C procedures performed secretly, incidents of failed attempts to cut girls and the physical and emotional repercussions of the practice (UNICEF 2010).

The use of films such as *Moolaadé* (2005) by Senegalese director Ousmane Sembène, and Alice Walker and Pratibhar Parmar's *Warrior marks* (1996) can sensitively inform people about FGM/C and its devastating consequences (Steele 1995). Documentaries extend the reach of abandonment movements across geographical borders and explain how and why communities made the decision to abandon FGM/C. Such films have been screened across Africa to stimulate reflection and discussion in practising villages. When movies about FGM/C practices were shown in Senegal to men and women, an open discussion forum followed. Women said they learnt that other women in the world were not cut and did not suffer the pain and complications during childbirth that they did. The men in the community said they were previously unaware that their daughters and wives were being subjected to such practices. The new insights and ensuing discussion contributed to the significant changes in FGM/C practices in Senegal (Wellerstein

1999). Similarly, movies and books such as Alice Walker's *Possessing the secret of joy* (1992) and Waris Dirie and Cathleen Miller's *Desert flower* (2009) are useful in raising awareness of FGM/C in migrant settler communities (Steele 1995).

Public exposure of FGM/C must take into consideration the impact it has on the affected communities. Swedes of African backgrounds expressed ambivalence about mass media coverage of the FGM/C issue because they felt it depicted all Africans as the same in relation to FGM/C, despite the differences that exist between them regarding practices (Johnsdotter et al. 2009). In the 1994 public health campaign about FGM/C in Victoria, Australia, which followed the introduction of FGM/C specific laws in Victoria, African communities resented public discussion of their private parts and the subsequent adverse responses from health and community professionals (Allotey, Manderson & Grover 2001). Johnsdotter (2004, p. 38) advocates the Danish strategy of promoting evidence of abandonment in the press as a means of swelling the numbers towards a critical mass of people who openly declare resistance to the traditional practices.

For women in countries of settlement, FGM/C remains an intensely private and sensitive subject and public discussions are considered disrespectful and embarrassing (Patrick & Markiewicz 2000, p. 16). Due to the veil of silence and secrecy surrounding the practice, it is difficult for women to speak up in their communities. As such, great sensitivity is required in any health education or health promotion campaign relating to FGM/C.

## Human rights, women's and children's rights and the law \_\_\_\_\_/

In response to the Maputo Protocol, the governments of twenty African nations have introduced legislation against female genital mutilation/cutting (FGM/C). These countries include Benin, Burkina Faso, Central African Republic, Chad, Côte d'Ivoire, Djibouti, Egypt, Eritrea, Ethiopia, Ghana, Guinea, Kenya, Mali, Mauritania, Niger, Senegal, South Africa, Tanzania Togo and Uganda (CRR 2006). Eighteen countries that host refugees and

migrants from FGM/C practising countries have laws criminalising the practice. These countries are Australia, Belgium, Canada, Cyprus, Denmark, Finland, Greece, Italy, Luxembourg, Portugal, the Netherlands, New Zealand, Norway, South Ireland, Spain, Sweden, the UK and the US. Other countries such as France and Switzerland rely on existing criminal legislation to prosecute practitioners of FGM/C and parents procuring

the service for their daughters (Rahman & Toubia 2000). The role of legal sanctions varies between countries, with some placing greater emphasis on criminal proceedings and others prioritising other prevention strategies such as community support and education (CRR 2006; Leye et al. 2007).

There have been a few FGM/C cases prosecuted in Italian and Swedish courts, but France is the only country where the systematic criminal prosecution of FGM/C practices takes place. France, in the absence of specific FGM/C legislation, relies on existing criminal legislation. Between 1979 and 2006, 40 cases were heard in the French court involving 120 children and 99 parents. Parents, mainly mothers, were charged and given (mainly suspended) prison sentences for subjecting their daughters to the practice (Leye et al. 2007; Poldermans 2006; Rahman & Toubia 2000). While criminal proceedings may be seen to do justice in individual cases (Poldermans 2006), their greater function is social marketing, raising public awareness through the publicity they evoke. Prohibitive legislation against FGM/C provides

disincentives, sanctions and penalties (Steele 1995) and serves as a warning signal to the families and communities concerned.

While there are several organisations that are responsive to the needs of FGM/C affected African communities in France, there are few policy initiatives and little coordination for community education or health promotion (Poldermans 2006). In contrast, the UK's specific FGM/C legislation, which involves penalties of five to 14 years imprisonment for performing or assisting genital surgery, focuses on child protection and child rights with an obligation to report to social services rather than to police (Guine & Fuentes 2007). By 2008, there had been no prosecution of parents and only two doctors had been expelled from the UK medical council (Dustin & Phillips 2008). In contrast to France, the UK locates its legislation within a well-integrated educational, human rights and local and international policy and research approach (Guine & Fuentes 2007).

## Indonesia: Where laws condone the practice \_\_\_\_\_ /

The law in relation to female genital mutilation/cutting (FGM/C) type IV in Indonesia is interesting in its condoning of medically conducted 'circumcision'. A large-scale country-wide research project in 2003, funded by USAID, concluded that 92% of the 1,694 families interviewed expressed support for the continuation of FGM/C for their girls and future grandchildren (Budiharsana et al. 2003). The research reported that the practice of FGM/C in Indonesia violated the rights of the child under the Convention on the Rights of the Child, which Indonesia ratified in 1990. Under international pressure, the Indonesian government committed to a campaign of zero tolerance of FGM/C, but the government's response was 'relaxed' (Newland 2006, p. 396). Despite Budiharsana and colleagues' (2003) recommendation that Indonesia's Ministry of Health take firm action to prevent the medicalisation of FGM/C,

subsequent Indonesian laws specify how the symbolic and small-cut incisions of the clitoris should be performed (Kesehatan 2010). These laws condone the practice, as long as it is conducted by a qualified paramedic, preferably a woman, not a traditional healer. The legislation stipulates that the paramedic must wash her hands for 10 minutes before beginning, wear gloves, wipe the vulva with iodine before starting and register and monitor the procedure when finished. Only the hood of the clitoris should be touched. It is prohibited to scratch or cut the clitoris or labia. The procedure is to be conducted in a clean room with good lighting, running water, gloves and sterilised equipment (Menteri Kesehatan 2010; Pendak 2011). The girl should sign a letter of request and agreement and be warned of possible infection. This legislation directly contradicts the World Health Organization's (WHO) guidelines

stipulating that under no circumstances should FGM/C be performed by health professionals or in health establishments.

Amnesty International notes the following:

- In 2007, the Committee on the Elimination of Discrimination Against Women (CEDAW) recommended that Indonesia develop a plan of action to eliminate the practice of FGM/C, including implementing public awareness-raising campaigns to change the cultural perceptions connected to it and provide education regarding the practice as a violation of the human rights of women and girls that has no basis in religion.
- In 2008, the United Nations (UN) Committee against Torture (CAT) recommended that Indonesia adopt all adequate measures to eradicate the persistent practice of FGM/C, including through awareness-raising campaigns in cooperation with civil society organisations (Amnesty International 2011).
- Amnesty International has called on the Indonesian authorities as state party to CEDAW and CAT, to:
  - repeal the Regulation of the Minister of Health No. 1636/MENKES/PER/XI/2010 concerning female circumcision
  - enact specific legislation with appropriate penalties prohibiting FGM/C
  - implement public awareness-raising campaigns to change the cultural perceptions associated with FGM/C (Amnesty International 2011).

## Australia

In 2010, a debate within the Australian medical profession about women who wanted to be re-infibulated (re-sewn after childbirth) resulted in a recommitment not to conduct female genital mutilation/cutting (FGM/C) practices (Mathews 2011). Australian law prohibits the performance of any type of FGM/C, with six out of eight states and territories (NSW, SA, ACT, NT, Victoria and Queensland) having legislated specifically against the practice. Western Australia uses its existing laws (Spencer 2002) and Tasmania has legislation planned, but not implemented. There is no coordinated legislation at the federal level, but FGM/C is prohibited nationally by the policy of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (Mathews 2011). Moeed and Grover's 2012 survey indicates that Australian obstetricians and gynaecologists adhere to these directives.

**The relevant laws in Victoria are as follows:**

*The Children Youth and Families Act 2005* mandates certain professional groups (doctors, nurses, teachers, school principals

and police) to report concerns if they form a belief on reasonable grounds that a child is in need of protection from physical or sexual abuse, including FGM/C (AFMW 2009).

*The Crimes (Female Genital Mutilation) Act 1996* makes it illegal to circumcise a woman, young girl or any child under the age of 18 years. It is illegal to remove or cut off any part of the female genital area (excision), including any part of the clitoris or labia, stitch up the female genital area (infibulation), conduct any procedure to narrow or close the vaginal opening or damage or mutilate the genital area. Even if someone requests or agrees to have any of the above surgery or their parents have provided permission, it is still illegal. It is illegal to perform, help or find someone to perform or take a person out of Victoria to another state or country to have any of the above practices. The punishment is a prison sentence of up to 15 years.

Surgical procedures on the female genital area can be performed by a medical doctor when the procedure is necessary for the health or to relieve physical symptoms of a person and only performed by a doctor, when

it is deemed medically necessary during labour or immediately after the birth and is performed by a doctor or midwife in hospital, or is a sexual reassignment procedure (a sex change) performed by a medical practitioner (The Women's 2010).

There appears to be no legislation against cosmetic genital surgery, piercing or tattooing of the genitalia. In 2010, 1400 women made Medicare claims for labioplasty operations (Stark 2010), with some aspects of sexual reassignment qualifying for Medicare health insurance cover (SMH 2010).

Practice guidelines for reporting a belief that a child may be or has been subjected to FGM/C in Victoria are found on the websites of the Royal Women's Hospital (The Women's 2010), the Australian Federation of Medical Women (AFMW 2009) and the Office of the Child Safety Commissioner (OCSC 2009). Each of these sites refers to the Victorian Family and Reproductive Rights Education Program (FARREP). The discovery in Victoria in 1993 of two Eritrean girls who had been infibulated led to Victoria's amendment of the Crimes Act in 1996 to prohibit FGM/C (Rogers 2009; Ierodiaconou 1996; Swensen 1995). In the 1993 case, it emerged that the girls had undergone FGM/C prior to their arrival in Australia. Prosecution of the parents resulted in the family feeling persecuted for doing what they believed was in the children's best interests (FARREP worker 2010). In a subsequent case in the north of Melbourne, a school reported to police and Department of Human Services Child Protection their suspicion that a family was planning to take their daughter overseas to undergo FGM/C. This again resulted in the family's culturally condoned intentions being depicted as criminal, causing great distress to the family with no decisive outcome (FARREP worker 2011). In September 2012 in Sydney, Australia, The Sydney Morning Herald (Bibby 2012) reported that a sheikh, a nurse and two parents were charged with the genital mutilation of two girls aged 6 and 7 years.

FGM/C is unlike other forms of abuse that are known to harm such as rape or domestic

violence. The practice is usually committed in the misguided belief that it is in the child's best interests. Accordingly, information should be made available to parents about the harmful consequences of FGM/C and, when it is thought probable that a child is to be subjected to FGM/C, strong legal intervention is required (Ierodiaconou 1996). A young girl is not able to give consent because she cannot be cognisant of the physical, psychological, sexual and social ramifications. A child protection response, however, must be sensitive and culturally informed. In the case of FGM/C occurring, a child may need medical assessment and care, as well as counselling about the possible trauma she experienced. Further, the provision of family counselling is important to ensure the family understands the reasons for the state response (Patrick and Markiewicz 2000).

In conclusion, legal measures that are solely punitive and criminalise FGM/C can stigmatise affected communities, reinforce traditional beliefs and drive the practice underground. As it is difficult to detect FGM/C, legislation cannot be well monitored without taking steps that could be perceived as racist and intrusive. While legislation may act as a disincentive, its importance lies in underpinning an integrated, holistic framework for culturally affirming, engaging interventions that involve communities and health professionals, promote child protection and are based on human rights. As Mathews (2011, p. 141) said:

'Australia has strong and clear prohibitions of FGM [female genital mutilation] in both law and medical policy, and possesses a generally enviable record of gender equality and health provision. With a small population and a small but growing number of residents born in nations where FGM is customary, the current context may offer a chance to contribute to new ways of investigating FGM, reducing its incidence and altering its motivating attitudes'.

## Processes of community and cultural engagement for change

We have noted that legislation, health promotion and human rights work that focuses on delivering health and human rights messages to communities that practise female genital mutilation/cutting (FGM/C) do not, on their own, bring about the desired attitude or cultural and behavioural changes. Experience across the world, some of which is described later in this report, has shown that a community engagement or community development approach to consciousness raising, health and human rights education and research is more effective in bringing about this change.

Implementing a community approach involves:

- the creation of trust and safe spaces for people to think and discuss at a deep level the harm and human rights abuses of FGM/C and to explore these within wider political, social and cultural contexts, examining complexities and contradictions (i.e. consciousness raising processes)
- culturally respectful public discussion of issues around FGM/C
- cooperation between government and non-government agencies, religious leaders, societal opinion leaders and health experts in dialogue and education of the public
- the involvement of men and community leaders in educational and awareness-raising efforts, including facilitating conversations between men and women who have undergone FGM/C
- education of girls concerning their bodies and their human rights, similar to the Protective Behaviours Program (PBA 2012)
- the promotion of awareness of key human rights instruments (Mathews 2011, p. 141).

These approaches are integral to programs that work towards the abandonment of FGM/C in Egypt, Ethiopia, Kenya, Senegal and Sudan. In these countries, abandonment is achieved through challenging gender relations and negative assumptions and stereotypes. Rather than fighting against local cultures with a negative view of their traditional behaviours, effective programs have promoted significant questioning and attitude change, thus changing the social dynamics of FGM/C (UNICEF 2010).

The United Nation Children's Fund Innocenti Research Centre (UNICEF 2010) explores the process that mobilises communities to publicly abandon FGM/C in FGM/C practising countries. Abandonment initiatives take into account the complex social dynamics surrounding FGM/C, tapping into the same factors that motivate parents to decide to have their daughters undergo the practice (UNICEF 2010, p. viii). Mackie and Le Jeune (2009) draw on Shelling's (1960) social convention theory to examine the reasons why harmful conventions endure for generations and how families, individuals and communities can be persuaded to abandon them. They emphasise the importance of discussion and deliberation about social sanctions, moral judgements and human rights (UNICEF 2010, p. viii).

Where a social convention or norm is in place, decision-making is an inter-dependent process whereby a choice made by one is affected by and affects the choices made by others. This is a result of reciprocal expectations. The social convention theory offers an explanation as to why communities continue to choose FGM/C and why it is so difficult for individual girls or families to abandon the practice on their own. The convention assumes that girls are cut as a pre-requisite for marriage. Parents make the decision to cut their own daughters to ensure they are prepared for adulthood, a proper marriage and their social and

economic security. Failure to conform leads to social exclusion, ostracism, disapproval, rebuke or even violence. Conformity to FGM/C expectations meets with approval, respect, admiration and maintains social standing for a girl and her family in the community. Daughters of families that break the convention find it difficult if not impossible to marry and may become social outcasts. Where FGM/C is universal within the marrying community, girls themselves want to be cut to ensure their marriageability. Compliance with the norm seems to be in the best interests of everyone concerned (UNICEF 2010; Mackie & Le Jeune 2009).

In the social convention theory, the opposite also applies whereby if a sufficient number of families in a community choose not to have their daughters cut, cutting loses its power as a pre-requisite for marriage. Families will abandon the practice only when they believe that most or all others will make the same choice at the same time. The challenge is to garner enough abandoning families through community discussion, decision and public commitment. Conventional practices are only abandoned when there is a coordinated act undertaken by a large enough proportion of the group concerned to ensure that the shift is effective and stable. Families will not abandon FGM/C on their own. They will only act when they believe that social expectations have changed and that most or all others in their community will make the same decision (UNICEF 2010).

The process of community change begins with an initial core group of individuals who set in motion a dynamic of change. As this group becomes ready to abandon FGM/C, they seek to convince others to also abandon the practice. This is done through spreading the knowledge of their intention to abandon FGM/C through social networks until there is a large enough portion of the affected community ready to abandon. If this tipping point is reached and there is sufficient trust in the intention of others, new expectations not to cut their daughters emerge. Public declaration of the new attitudes and willingness to change indicates

the community's commitment to abandon the practice. As news of the community resolve spreads, social sanctioning shifts onto those who continue the practice (UNICEF 2010).

The United Nations Children's Fund Innocenti Research Centre's (UNICEF 2010) research into prevention programs that have achieved community attitude and behavioural change in relation to FGM/C identified the following key elements operating in coordinated and comprehensive strategies:

1. Interdependent decision-making and readiness for change
2. Communities feel that change is in their best interests
3. Positive aspects of local cultures are reinforced
4. Human rights education is linked to values and aspirations
5. Engagement of the media to promote social change
6. Engagement of influential social networks and institutions at the local and national level
7. Interconnection between the national and local levels
8. Legislative reform as part of a broader transformative process
9. Links developed beyond national borders (UNICEF 2010)

The following section provides examples of programs, policies and processes that have been effective in preventing FGM/C in practising African countries and in countries of migration.

## Examples from Africa

Successful initiatives leading to the abandonment of female genital mutilation/cutting (FGM/C) lie within a broader framework of human rights, social justice and community development. The United Nations Children's Fund Innocenti Research Centre (UNICEF 2010) provides examples of education programs in Kenya and Sudan, community dialogue and conversation in Ethiopia, human rights and democracy in Senegal and a sociocultural approach in Egypt. These programs examine practical concerns relating to daily life, associating

human rights principles with local values and using familiar language and images. Programs 'play an instrumental role in changing social expectations surrounding FGM/C [female genital mutilation/cutting] because they provide men, and women, girls and boys with tools to deal critically with the reality surrounding them. Experiences confirm that human rights deliberations are more transformative if they challenge established gender relationships and existing assumptions and stereotypes' (UNICEF 2010, p. 47).

## Senegal: TOSTAN

The female genital mutilation/cutting (FGM/C) eradication program in Senegal began in 1997 when a US educator, Molly Melching, and a political theorist, Gerry Mackie, worked with a revered imam from a Senegalese village. The imam said that the only way to change deeply rooted traditions was to persuade villagers whose young people intermarried to abandon the practice simultaneously. This became the defining idea for TOSTAN, meaning 'breakthrough' in the Wolof language. Seventy-seven year old imam Mr Diawar visited the 10 intermarrying villages of his extended family. He won over the village chiefs and convinced imams that there was no religious requirement for cutting. He was tactful, never using the term 'female genital mutilation', but he did explain its consequences. The villages agreed to give up the tradition and in 1998, held what is believed to have been Africa's first collective abandonment (Dugger 2011). The principles established in this process inspired Melching and Mackie to develop the TOSTAN strategy of intervention (UNICEF 2005; Diop & Askew 2009). They contended that, unlike rape or other forms of violence against women, FGM/C was a convention that parents followed out of love and care for their children, similar to the foot binding of Chinese girls over centuries. Eradication would require a collective commitment and pledge to stop the practice (Dugger 2011).

Village women engaged in dialogue about human rights and the harmful health consequences of FGM/C and began to conduct public discussions in their villages to extend and reinforce the goal of ending the practices. They used a non-formal, educational, integrated approach embracing national languages, life and sociopolitical skills, as well as innovative pedagogical approaches influenced by African traditions and local knowledge. The program built on positive traditional practices such as breastfeeding and challenged others such as FGM/C and forced marriage, and was underpinned by a strong human rights component. It was a fairly typical community development approach that involved village development committees, trained health facilitators and participants and used peer education and 'adopt a friend' approaches based on traditional ways of sharing. Women and men were involved. Diop and Askew (2009) evaluated the project using pre and post evaluation and a comparison group design. Overall, 'the prevalence of FGM/C [female genital mutilation/cutting] among daughters aged ten years and younger decreased significantly over time as reported by women who were directly or indirectly exposed to the program' (Diop & Askew 2009, p. 307).

The TOSTAN behaviour change model highlights the 'cultural embeddedness'

of FGM/C and the consequent need for communities to make shifts in their cultural practices and beliefs to enable behavioural change. The TOSTAN village empowerment programs extended into other regions in Senegal and have been replicated in eight other African countries. The following factors were important to the successes of this work:

- A strong government position (legislative and policy)
- An integrated (education, dialogue, consciousness raising and health care), holistic (focus on women's issues, not on a single health issue) approach at the local level focusing on both health and human rights

- Deliberate examination of traditional and cultural practices, reinforcing some (e.g. breastfeeding) and challenging others (e.g. FGM/C), and adopting traditional processes and ways of sharing information (e.g. stories, drama, 'adopt a friend')
- A broad community development approach, bringing villages together for sharing, awareness-raising and collective action
- Public declaration to abandon FGM/C, which was most significant and powerful

(UNICEF 2010)

## Sierra Leone, Uganda, Ghana, Ethiopia and Tanzania: Alternatives to FGM/C

Because female genital mutilation/cutting (FGM/C) is deeply rooted in culture and tradition as 'a rite of passage for all virtuous women', it needs to be replaced with an alternative rite of passage (Steele 1995, p. 135). An effective strategy is that of encouraging communities to find healthy alternatives to FGM/C without giving up its social and ritual aspects. Examples include the Kenema Project in Sierra Leone that worked with opinion leaders of the secret circumcision societies to educate them about the harmful effects of FGM/C and to encourage adolescents to go through the ceremonies without the harmful operations. This project encouraged young men to pledge that they would not insist on marrying only circumcised women and young women to pledge that they would not circumcise their daughters (Kiragu 1995).

Past prevention programs in Uganda involved girls in health and human rights education and discussion, from which they were able to make their own decisions about abandoning the FGM/C aspect of the rituals, with the support of the program. The practice was

replaced with 'Circumcision Through Words', a coming of age ritual of celebration for girls (UNICEF 2010; Wellerstein 1999).

In Tanzania, women elders said they maintained their practice of cutting girls because they had no other form of income to support their extended families. Health Integrated Multisectoral Services (HIMS 2010) set up a cleansing ceremony to replace FGM/C. The Maasai elders gave up the tools that they had used to cut young women for many years and pledged to give up their trade of female circumcision. With the support of HIMS, they trained in other skills areas, such as beauty therapy and shopkeeping, so that they could continue to financially support their families. The ceremony took place in a public space to encourage the community to support the women in their choice to end the tradition (Miles 2012).

A project in Ghana worked to reduce opposition from practitioners by giving them alternative employment as traditional birth attendants. Another project in Ethiopia trains traditional circumcisers in sandal making and bread baking (Kiragu 1995).

## Egypt: A 'positive deviance' approach

The Centre for Development and Population Activities (CEDPA) identified that most programs in Egypt prior to 1999 had previously focused on the root causes of female genital mutilation/cutting (FGM/C). In contrast, a 'positive deviance' approach was initiated in 1999 to understand the factors that led to some families ceasing to have their daughters undergo FGM/C. CEDPA partnered with four key organisations and communities in Egypt, involving both women and men. It organised training for staff about FGM/C practices and their associated harm and conducted in-depth interviews to sensitively identify 'positive deviants'. Positive deviants are individuals, 'who have "deviated" from conventional societal expectations and explored – perhaps not openly – successful alternatives to cultural norms, beliefs, or perceptions in their communities' (CEDPA 1999, p. 1). Their responses about how and why they had changed their opinions were analysed to discover how best to work with communities.

The research process described above enhanced awareness of FGM/C and led to open conversations where there was usually secrecy. The interviews revealed that the emotional and psychological trauma associated with FGM/C is the most influential factor leading to the rejection of the practice. By understanding the reasons why people resisted FGM/C, more effective ways of combating the practice in communities were able to be developed. The CEDPA project exceeded expectations and led to awareness-raising and education campaigns. Key community members in decision-making roles were targeted, including young men, doctors, religious leaders and elder women. The principle that 'solutions already exist in the communities' was emphasised. The project strengthened the relationship between the communities and non-government organisations to one of equal partnership and trust, respect and reciprocity, re-affirming principles of sustainability and ownership (CEDPA 1999).

In order to be open to ideas that challenge long-held beliefs and traditions, families want to be confident that the new information will benefit their communities, improve their lives and be widely accepted. The most successful programs in Africa engaged respected community members to promote change, including religious and local leaders, representatives of local women's and youth associations and others, rather than bringing in outsiders to initiate discussions on FGM/C. When the information came from their own credible sources and there were opportunities to reflect, discuss and act, communities considered and were able to choose viable alternatives. Trust was built through community development projects that addressed local needs identified by the communities themselves. The introduction of health centres, education programs, microcredit schemes and other development projects provided communities with tangible, credible evidence that the new information and ideas could improve their lives (UNICEF 2010). Similar life improving responses to migrants' needs for housing, work and acceptance in Australia evoke a similar sense of goodwill, creating a platform for change.

## Examples of effective program responses in non-practising countries of settlement \_\_\_\_\_/

Berg, Denison and Fretheim (2010) identified factors perpetuating female genital mutilation/cutting (FGM/C) in non-practising countries of settlement. The factors that promote FGM/C exist at multiple levels, namely intrapersonal (e.g. health consequences), interpersonal (e.g. the enhancement of male sexual enjoyment), meso (e.g. cultural tradition) and macro (e.g. religion or legislation). More information on these findings can be found in part one of *A Tradition in Transition - female genital, mutilation/cutting*. These dimensions need to be understood in their connectedness rather than as discrete aspects. The factors enabling discontinuance can be seen largely as a negated reflection of the factors

supporting continuance, reinforcing the United Nations Children's Fund Innocenti Research Centre's statement that the 'social dynamics that perpetuate FGM/C can also help to drive its abandonment' (UNICEF 2010, p. 6). Johnsdotter and colleagues state that it is 'highly significant that these traditional practices, once a sign of conformity to social norms, are viewed in the opposite light in the new cultural context' (Johnsdotter et al. 2009, p. 117).

This section provides examples of FGM/C prevention programs in countries of settlement.

## Sweden's legal and social alert system \_\_\_\_\_/

Johnsdotter and colleagues have been researching female genital mutilation/cutting (FGM/C) in Sweden since 2000. They have described the situation for migrants from Ethiopia and Eritrea who came to Sweden in the 1980s for labour reasons at a time of economic prosperity and, as such, were able to integrate into Swedish society quickly. The researchers confidently conclude that they abandoned FGM/C within a decade of arriving in Sweden (Johnsdotter et al. 2009). On the other hand, people from Somalia came later in the 1990s and 2000s, fleeing civil war and arriving in Sweden at a time of economic downturn and unemployment. This made their active participation and integration in Swedish society more difficult. Johnsdotter and colleagues do not have the same level of confidence that Somali Swedes have fully abandoned FGM/C, with the prevailing socio-economic conditions seen as the key explanatory factor (Johnsdotter et al. 2009).

The strength of Sweden's effective prevention approach is its strong child protection response to FGM/C that includes:

- educational programs about FGM/C for community groups, including internal debate within exiled African communities and interaction with other exiled Muslims who do not practise FGM/C (e.g. people from Arabic countries), giving rise to debates on Islam and FGM/C
- several long running state prevention programs, including cooperative networks that involve authorities and other relevant agencies
- mass media campaigns to raise awareness of FGM/C, then to promote its abandonment
- a Child Protection Alert system that prohibits
  - all forms of FGM/C
  - performances of, participation in, facilitation of, attempts at, or procurement of FGM/C for another person or child

- » failure to report information about performed or future FGM/C
- » gives citizens, teachers, children's day care, health care and social services staff and police the duty to report knowledge of performed or suspicion of future FGM/C to social authorities who may report to police
- » enables a genital medical examination by a physician of a child who is believed to have had FGM/C performed or where there is a suspicion of future FGM/C, even if the child's parents object to it (Johnsdotter 2004).

The alert system has a strong emphasis on prevention and searching activities. Professionals are well informed about FGM/C and the laws against the practice and alert to signs that may indicate intention or that it has occurred. There are clear guidelines or

routines for dealing with cases of suspected FGM/C in schools and through social authorities. The person suspecting FGM/C is not expected to investigate or 'know for sure' before reporting it to social authorities who make the decision when cases are reported. There are cooperative networks between police, social authorities, school staff and health and social services. Only two cases in Sweden have reached court, with people receiving custodial sentences (Johnsdotter 2009). Both cases involved similar negative impacts on prosecuted children's families that occur in other legal systems that criminalise FGM/C (Johnsdotter 2004).

## The UK: FORWARD and the African women's clinics \_\_\_\_\_/

FORWARD (Foundation for [African] Women's Health Research and Development) is a UK registered African women-led charity that is dedicated to advancing and safeguarding the sexual and reproductive health and rights of African girls and women. The foundation works in the UK, Europe and Africa to help change practices and policies that affect access, dignity and wellbeing, focusing on female genital mutilation/cutting (FGM/C), child marriage and related rights of girls and young women (FORWARD 2012, p. 1).

Specific clinics in the UK offer empowerment programs for women from affected communities (Ball 2008; Dustin & Phillips 2008; Poldermans 2006). Culturally trained maternal and child health nurses and midwives develop trust, carry out de-infibulation procedures and refer women to gynaecologists where necessary. Midwives document the intact genitalia of newborn girls as grounds for legal proceedings if FGM/C is then suspected to have been performed. In Birmingham, midwifery and obstetric staff are informed and aware of cultural practices

to watch for as warning signs that a child may be at risk. They engage the parent/s through discussion, education and support programs in order to protect those at-risk children (Ball 2008).

Criticisms of the British response included a lack of inclusion of the affected communities in discussions and decision-making and gaps in programmatic responses, including the lack of interagency cooperation and inadequate community education for relevant communities and professionals (Guine & Fuentes 2007).

FORWARD has built strong connections between research, aid and advocacy in FGM/C affected countries and awareness-raising, training and education of medical professionals in the UK.

## The US: Community-based research /

A community-based research approach was used in the US in 2005 to assess the health care needs of Somali women living there. A participatory research network involved the Somali refugee community, health professionals, representatives from community-based organisations, refugee resettlement agencies and immigration law experts. The network explored migrant women's traditional health beliefs to determine how sociocultural norms and values influenced their perception of health. They examined the role of acculturation in influencing adaptation to health-related cultural norms upon migration to a non-practising context. They considered the interplay of host country's cultural norms with migrants' previous experiences with health

care providers, with an emphasis on health beliefs, health-seeking behaviours, health care utilisation, motivation to follow-up with ongoing care and willingness to participate in research studies (Johnson, Ali & Shipp 2009). The partnership involved the Somali community in all stages of the process. Educational focus groups and interviews were conducted in women's homes using an illustrated anatomical guide to female anatomy. A sense of privacy and security created an atmosphere where 'women felt comfortable and unabashed in viewing the diagrams and asking intimate questions'. The inclusive study led to improved, culturally competent health care (Johnson, Ali & Shipp 2009, p. 235).

## Canada: Winnipeg /

Daniel and colleagues (2011) described the activities and outcomes of a community-based education program addressing female genital mutilation/cutting (FGM/C) with newly arrived refugee and migrant African women in Winnipeg, Canada. Participants had, on average, been living in Winnipeg for nine months. The program comprised ten weeks of educational, health and sociocultural support sessions to discuss, compare and share stories about models of health care, reproductive health, gender analysis, culture, values, sexuality laws, marriage and intimacy in Africa and Canada.

The project team developed a manual of materials designed for services to use with migrant and refugee women in relation to sexual and reproductive health and FGM/C information and prevention. Community-based researchers, including men and youth from practising communities, were trained in community-based education and facilitation. They ran three hour workshops for service providers on FGM/C, constantly reviewing and updating the content and processes, and a FORWARD funded symposium on FGM/C.

The program aims to respond to newly arrived communities within their first nine months of arrival (Daniel et al. 2011).

Four strong elements in this program are that, first, it has an incremental effect where knowledge and practice evolve through experience, honest reflection and review; second, the program addresses a wide range of women's health and reproductive health issues, as well as transition issues for refugees coming to live in Canada; and third, there is a strong connection with and involvement of community participants from a range of ages and countries of birth, including men, women and young people. Finally, the program is strongly connected with key community organisations, including the Society of Obstetricians and Gynaecologists and other local and international networks.

Longitudinal evaluation of the impact of the Winnipeg program (Daniel et al. 2011) is not available. The immediate outcomes, however, indicate changes in understanding, attitude, behaviours and intentions. 'Many felt that by virtue of living in a new culture, the decision

not to circumcise daughters was easier' (Daniel et al. 2011, p. 28). The qualitative feedback from the refugee women conveys rich information about how change occurs. For example:

**'Back home - they want change but don't educate women. Here (Winnipeg) we're talking and learning about it. We go home and tell our family and friends ... this is how the change happens'** (cited in Daniel et al. 2011, p. 27).

This program appears well resourced and transferrable to the Australian context.

Ahlberg and colleagues (2004) argued that Swedish anti-FGM/C interventions should take greater heed of the values, meanings, organisation and contexts of FGM/C, including the dynamics within which migrants negotiate their identities. For example, one of the dilemmas Somali migrants in Sweden identified was their fear of bringing up an uncircumcised daughter in the context of the sexually liberal mores of Sweden. Honouring the community's moral imperatives that underpin the practices of FGM/C is important in engaging practising communities in change (Ahlberg et al. 2004).

## Australia

### New South Wales Education Program on Female Genital Mutilation

Since 1997, the New South Wales Education Program on Female Genital Mutilation (NSW EPFGM 2012) has been addressing the eradication of female genital mutilation/cutting (FGM/C) through an integrated community engagement approach. It incorporates legislative (*Crimes (Female Genital Mutilation) Amendment Act 1994*), educational, health and human and child rights. With funding from the federal government and the NSW Department of Health, the NSW EPFGM is a statewide program under the auspices of Sydney West Health Service. FGM/C is specifically identified as child abuse under the NSW *Children and Young Persons (Care and Protection) Act 1998*.

The program has a strong educational approach targeted at service providers and communities at risk. Four staff (2.5 full time positions) work with 14 contracted bi-lingual community workers, a Program Advisory Group and a Men's Advisory Group to provide professional education for service providers on the effects of FGM/C on women's health and on culturally appropriate services for affected women. The program provides education sessions to raise awareness of general health issues where specific information is provided on the local and

global occurrence of FGM/C. Programs held around the state are facilitated by bi-lingual community workers with shared cultural and language backgrounds. The program aims to respect cultural diversity and create safe community spaces for women to discuss and explore the harm of FGM/C to women and girls. It also celebrates events such as Children's Rights Days, holds men's seminars, conferences, forums and camps, and in the global context, contributes to national and international advocacy work (NSW EPFGM 2012).

The NSW EPFGM is evaluated through a research partnership with Diversity Health Institute, a collaborative group of state and federally funded programs that focuses on people from culturally and linguistically diverse backgrounds (NSW EPFGM 2012). Data from the Australian Bureau of Statistics (ABS) and the Department of Immigration and Citizenship (DIAC) inform their target groups and comprehensive strategic plan and their annual report specifies and reports on targets and key performance indicators. Detailed evaluations of these programs and events are available on their website (NSW EPFGM 2012).

## Victoria: The Office of the Child Safety Commissioner \_\_\_\_\_ /

The Office of the Child Safety Commissioner (OCSC) established a Working Group in October 2007 'to facilitate intervention to prevent the occurrence of FGM [female genital mutilation] in children and ensure access to appropriate health care where required' (OCSC 2008). With representation across government and from community groups, including the Department of Human Services, Centre for African-Australian Women's Issues, Victoria Police, the Department of Education and Early Childhood Development, the Association of Independent Schools and CASA (Centres Against Sexual Assault) Forum, the group is well placed to work towards a coordinated response to female genital mutilation/cutting (FGM/C). The current status of this group is unclear. One of its 2007 goals was to seek clarification from the Department of Immigration and Citizenship (DIAC) regarding the information on FGM/C that migrants receive before arrival and upon settlement in Australia (OCSC 2008).

Their report, *In our own words: African Australians report* (OCSC 2010), indicated that community members want information on the child protection system, the Children's Court, family law processes and Centrelink payment procedures, the role of the OCSC and the Working with Children Check, management of family violence, educational policies for children attending school and policies about racial discrimination. Members of African communities believe that workers could benefit from an improved understanding of African collectivist cultures and traditional child rearing practices in areas such as gender roles, views about sex before marriage and supervision of children (OCSC 2010).

## Victoria: The Family and Reproductive Rights Education Program \_\_\_\_\_ /

The Family and Reproductive Rights Education Program (FARREP) has been involved in raising awareness to prevent female genital mutilation/cutting (FGM/C) since 1997 (Neophytou & Adam 2011; Adam et al. 1994). Workers facilitate aspects of the approaches that appear to be effective elsewhere and have sound views about effective ways forward.

'We need a strategy or program to support parents, support people from affected communities which has nothing to do with the word FGM [female genital mutilation]. Legislation has forbidden FGM, in doing so something has been taken away from people who are traditional practice FGM. We need to recognize they are going through some difficulties there, broaden support for parenting issues, support to empower people to practise their culture as long as it is not harmful; perhaps some community funding to assist them [to] address health issues' (FARREP worker 2010).

Formal partnerships with the Department of Immigration and Citizenship (DIAC), Red Cross, refugee and migrants' rights advocates and settlement services create opportunities for experienced workers to raise awareness of Australian legal, general and maternal and child health, education and social systems, as well as FGM/C, through discussion and debate with communities as they arrive.

## Engaging community and religious leaders, men and boys \_\_\_\_\_ /

Effective programs use a 'whole of community' approach, working with women-only or men-only groups as required by the community's culture or the personal and sensitive nature of discussions. Engaging boys, men and community leaders, male and female, breaks the myth that female genital mutilation/cutting (FGM/C) and its eradication is only 'women's business'. It enlists men as allies rather than spectators in the stance against FGM/C and addresses the fact that pressure for continuing FGM/C is likely to come from men as well as women. There is a need for discussion and debates between African Muslims and non-African Muslims whose interpretations of Islam differ in relation to FGM/C.

Timing of programs is significant, with arguments for both early and later intervention. The research of Johnsdotter and colleagues (2009) demonstrated that in Sweden, new arrivals, older generations and people less acculturated are more likely to hold on to traditional views. Over time, with opportunities for integration, migrants feel less social pressure from their extended family and community because of the distance from home. They begin to perceive themselves as belonging to a new society where girls do not undergo FGM/C. At that time, migrants can question traditional practices in light of their new cultural context (Johnsdotter et al. 2009). This perspective promotes an approach that waits until people have settled and are not in the early crisis of post refugee flight and struggles. The programs of Daniel and colleagues (2011) in Canada, on the other hand, engage new arrivals from FGM/C practising countries in education and awareness within their first year of living in their new country, assisting them with settlement and integration

processes. Both programs are successful in the connections made between FGM/C education and awareness and community participation and settlement.

Community participation is an important aspect in mobilising prevention in countries of settlement, where key figures from affected communities play important roles facilitating dialogue between all parties concerned. Migrants who hold prestigious positions in their communities of origin and pay remittances to family members in their home communities may wield considerable influence (Hussein & Manthorpe 2012). Change is likely to be greater in scale and endure over time when influential people are part of the growing social consensus (UNICEF 2010).

## Summary and discussion

With 7,000 women and girls worldwide subjected to female genital mutilation/cutting (FGM/C) each day, there is an urgent need to maximise opportunities for change to stop the practice when migrants and refugees come to non-practising countries. This research has reported efforts in Africa and countries of settlement in order to find effective program responses that may be transferrable to the Victorian and Australian context.

The World Health Organization (WHO), the United Nations Children's Fund (UNICEF) and other international researchers use the social convention theory to explain the processes of abandoning FGM/C in Africa. The social convention theory says that when enough people in a community commit to a new set of beliefs and practices, the balance of beliefs tips towards the new norms, replacing the old ways. Once there are sufficient numbers, a community pledge is a significant step in a community's decision not to have their daughters undergo FGM/C. There is strong evidence of abandonment of FGM/C practices in some parts of Africa, although it continues elsewhere in the continent.

Migrants arriving from FGM/C affected countries are likely to be influenced by the values of the new community. Traditional leaders, imams and influential activist women and men who have changed their views and practices are well placed to facilitate dialogue with new arrivals who may never have discussed the practice before. This includes men, who can benefit from being informed of the legal and financial costs and consequences of participating in any way in the practice of FGM/C in Australia.

The main strategies for eradication are health education and promotion, legal and human rights, including women's and children's rights, and culturally sensitive community engagement and research with cross-sectorial links between systems.

Legislation is an essential aspect, as it provides disincentives, sanctions and penalties. However, on its own, legislation does not stop FGM/C and can send the practice underground if introduced without other strategies.

FGM/C is a child protection issue that warrants a public health response. Australia's legal, medical and welfare systems are robust and, with increased awareness of FGM/C practices, trends, indicators and effective prevention approaches, health, legal and welfare professionals are well placed to work in collaboration with newly arrived and settled communities in their efforts to stop the practice.

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