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Community-driven strategies to prevent FGM/C in the African context

A review of good practices to support ISF programme in East Africa

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Promoting women's livelihood resilience and bodily integrity

Contents

Ziporah and Miriam Ndiege were cut at a young age. Now as 14-year-old teenagers they are survivors of FGM/C and have a desire to be educated and successful. Their mother advocates against FGM/C in their community. Photo: Nyasha Kadandara

Abbreviations

CMC	community management committee
CSO	civil society organization
FGM/C	female genital mutilation/cutting
GBV	gender-based violence
IDP	internally displaced people
ISF	International Solidarity Foundation
NGO	non-governmental organization
SGBV	sexual and gender-based violence
VAWG	violence against women and girls

1. Introduction

Female Genital Mutilation/Cutting (FGM/C)[1] is a tradition rooted in culture and involves the procedures that intentionally alter or cause injury to the female genital organs for non-medical reasons. FGM/C comprises diverse and multiple practices. Their significance and the motives justifying the practices vary from one community to another.

It is estimated that at least 200 million girls and women alive today have been subjected to the practice. Over the past 40 years interest in curtailing the practice has intensified, and new solutions have been put in place. Efforts to influence behaviour change have employed a variety of approaches, including those based on human rights frameworks, a health risk approach, training health workers as change agents, and the use of comprehensive social development approaches. (Mwendwa et al., 2020.)

FGM/C is occurring primarily in societies where religious, social and cultural climates have worked together for centuries to maintain gender inequalities. Eradicating this behaviour therefore requires intensified efforts at all levels, including **individual level** interventions such as education, healthcare, relationship and communication training; **group level** programs such as sexuality education and advocacy training; and **community -level** interventions such as empowerment activities, capacity building and mass media campaigns. Challenging FGM/C also requires using social influences including family support, social network influences, organizational practices, and public policy. Because individual behaviour is strongly reinforced by social norms, recruiting the larger community and key opinion leaders is critical. (Denison et al., 2009, pp. 57–58.)

Another way of grouping the interventions against FGM/C is to divide them into local, regional, national and international levels. **Local and regional** interventions may for example focus on increasing awareness and/or changing the belief system from which the practice arises. At the **national** level, anti-FGM legislation may act as a legal deterrent to perform the practice. Examples of **international** interventions include enhancing advocacy and capacity skills of national NGOs, enabling them to gain funding from governments and thereby implement their desired interventions. (WHO, 2011.)

A single and unique solution to end FGM/C, effective in every community, doesn't exist. The type of intervention must be in accordance with the social, economic and political context in which they are developed and implemented. **Six key elements** for abandoning FGM/C have become well accepted by NGOs and government bodies as good practice (WHO, 2008):

- a non-coercive, non-judgmental human rights approach
- community awareness raising of the harmfulness of the practice
- the decision to abandon needs to be collective
- requirement of community public affirmation of abandonment
- intercommunity diffusion of the decision
- a supportive, change-enabling environment

Similarly, a report issued by *UNICEF's Innocenti Research Centre* (UNICEF, 2010) summarizes the results of a multiyear research project designed to systematize what has been learned from two decades of effort to discourage the practice in Ethiopia, Egypt, Kenya, Senegal and Sudan. Early efforts that focused largely on criminalizing the practice or educating about health risks were largely unsuccessful. They merely drove the practice underground, shifted the practice from informal providers to doctors or encouraged earlier cutting. Programs began to succeed when they started focusing on the **social dynamics** of abandonment and adopted strategies consistent with social norms theory and **local ownership** of the change process. Programs built on the **universal concern of all parents for the wellbeing of one's children** (a moral norm) while recognizing that collective injunctive norms about what makes young girls "pure", "marriageable" or "socially acceptable" strongly influence what is perceived as in a child's best interest. Likewise, *WHO* (2011) states that interventions which only supply information, education and campaigns (IEC) to increase FGM awareness with messages such as "FGM has negative health consequences" are not suffice alone. This is because IECs do not attempt to change the social belief models from which FGM has been developed from.

1. While the term female genital mutilation (FGM)—increasingly used by researchers, activists, and in policy documents in Western countries—is thought to imply excessive judgment by outsiders and insensitivity toward individuals who have undergone the practice, the less value-laden and less stigmatising terms, female genital cutting (FGC) or female circumcision (FC), have been criticised for not sufficiently acknowledging the harmfulness of the practice. This review follows the strategy to use a hybrid term, female genital mutilation/cutting (FGM/C), unless when directly quoting text that employs different terms.

According to the Innocenti report (UNICEF, 2010), the most successful programs to end FGM/C engaged **respected community members**, including religious and local leaders, to help reframe views of the practice. To reduce the social costs of behaviour change (in terms of future prospects for marriage), they encouraged communities and marriage networks to abandon the practice en masse, and supported those families willing to make public commitments to not cut their daughters. Most importantly, successful programs cultivated critical reflection and deliberation through linking human rights and social justice principles to local values, using familiar language and images. To summarize, elements of successful programs to encourage abandoning of harmful practices are:

- Programs must encourage **community deliberation, collective reflection** and changes in social attitudes and norms. Efforts that focus only on "at risk" girls—such as alternative rites of passage or shelters—have had limited impact. The social stigma of being uncut remained, as did the pressure for girls to be cut.
- Successful programs have built on insights from **social convention and norm theory**.
- Appeals for change must be "value centred". All successful programs have involved some process of consciousness raising and **deliberation on values, rights and gender-based discrimination**. Successful approaches have built on local traditions, songs and values and have introduced rights-based concepts, without necessarily using human rights language.
- Programs must **address the downside of non-compliance** with social norms and find ways, such as collective abandonment pledges, to limit the costs to individual families.
- Successful programs engage **locally respected leaders** to challenge associated beliefs that sustain the practice. These interconnected beliefs must be individually and holistically rethought. First the vision of an alternative must be cultivated (girls remain uncut in other communities); next, false beliefs need to be challenged (e.g., Islam requires genital cutting).

Aligned with the above listed points and the long-term priorities of *International Solidarity Foundation* (ISF), the approaches selected into this review are **community-driven** and **bottom-up** (not government-driven and top-down) and focus on **primary prevention**, that is, they aim to change the underlying attitudes and norms upholding the practice. The review thereby excludes victim support services and strategies to prevent the immediate possibility of FGM/C (such as safe houses), and only briefly discusses national level interventions such as criminalization. Moreover, the review only discusses approaches piloted or relevant for efforts to prevent FGM/C in the **African context** thereby leaving out approaches that may have proven effective in the context of migration to Europe, for example. Priority is given to approaches that have been externally evaluated and/or academically studied. Risks and weaknesses related to each presented approach are pointed out together with their strengths and opportunities.

The main sources of inspiration for this review include reports and studies by *UNFPA* and *UNICEF Joint Programme on the Elimination of FGM* (such as *Seventeen Ways to End FGM/C [2017], Ending child marriage and female genital mutilation in Eastern and Southern Africa: Case studies of promising practices from across the region [2021])* and the *Community of Practice on Female Genital Mutilation (CoP FGM)*[2], as well as academic studies exploring various approaches to ending FGM/C. They, together with other references listed at the end of the review are highly recommended reading along this review.

Additionally, the review includes glimpses of the best practices identified by ISF, which is a Finnish development organization founded in 1970, that promotes women's bodily integrity and livelihood resilience in East Africa. ISF has been involved in FGM/C prevention in Somaliland since 2000, in Kisii and Nyamira counties in Kenya since 2015, and is currently entering the Somali region in Ethiopia and the Puntland State of Somalia. ISF sensitizes of moral duty bearers (such as religious, traditional, and cultural leaders) on human rights and negative consequences of FGM/C. They are encouraged to challenge patriarchal interpretations of culture or religion and raise their voice against FGM/C. ISF also sensitizes judicial duty bearers (political decisionmakers and public officials) about the prevalence, preventability, seriousness, and unacceptability of FGM/C, and supports them to establish coordination mechanisms, laws, policies, and action plans to mitigate FGM/C. Moreover, ISF sensitizes women and girls about bodily integrity and encourages them to collectively mobilize and claim for their rights. Finally, men and boys are engaged in discussions about the rigid gender norms and violence against women and girls.

ISF's programme consists primarily of long-term development projects that are implemented by local partners who have the primary responsibility to plan, implement, and monitor the projects. Partners are local civil society actors such as civil

2. The Community of Practice on Female Genital Mutilation is part of the Building Bridges between Africa and Europe to tackle FGM project, supported by the UNFPA-UNICEF Joint Programme on the Elimination of FGM (see https://copfgm.org/about)

Eradicating FGM/C requires intensified efforts at all levels, including community-level interventions such as empowerment activities.
Photo: Open Hand Studios

society organizations (CSOs) community-based organizations (CBOs), and women's businesses (e.g., cooperatives and other commercial networks). ISF selects partners that have their own important function and role in their local societies. The partners are capacitated according to their needs and supported to become experts in their respective fields.

The main purpose of this review is to support ISF and its implementing partners in piloting and developing new strategies to eradicate FGM/C. Hopefully, other actors involved in ending FGM/C also find it useful. **Chapter 2** briefly presents social norms theorizing as applied to FGM/C—the theoretical frameworks guiding this review and ISF work to prevent FGM/C. **Chapter 3** discusses different community-based approaches to eradicate FGM/C. Finally, **Chapter 4** takes a closer look at the roles of different actors or "change agents" in such initiatives.

2. Theoretical framework

Women's belief that men support FGM/C can be an important motivating factor regarding the cutting of their daughters
Photo: Open Hand Studios

Following, for instance, *UNICEF* (see, for example 2010, 2013), the framework guiding this review and many of the practical approaches presented in the text build on social norms theorizing and social convention theory (see Bicchieri, 2006; Mackie, 1996; Mackie & LeJeune, 2009). These frameworks are briefly presented in sub-chapters 2.1-2.2, while the sub-chapter 2.3 illuminates the interconnectedness of FGM/C and gender.

2.1 FGM/C as a social convention and a social norm

The social convention theory provides an explanation for the continuation of FGM/C, and why it is so difficult for individual families to abandon FGM/C:

> In a community where nearly all girls are cut as a prerequisite for marriage, families believe that girls must be cut as a condition of marriage. They will therefore choose to cut their own daughters to ensure they are prepared for adulthood and can have a 'proper' marriage, which is often essential for a girl's economic and social security. If, on the other hand, families break with social expectations, their daughters will find it more difficult, if not impossible, to marry, and they may be socially outcast. Under these conditions, FGM/C is therefore perceived as the best choice to ensure their daughters have a 'good' future. When FGM/C is universal within the intramarrying group, girls themselves may want to be cut because it will make them marriageable. In this way, FGM/C is a social convention – a social rule that members of a community follow based on the expectation that others have done the same and that others will follow suit. Compliance is in everyone's own best interests. (Mackie & LeJeune, 2009; cited in UNICEF, 2010)

On one hand, the social convention theory illustrates that in communities where FGM/C is widely practised, no single family has an incentive to deviate from the social expectation of cutting because it would affect the marriageability of its daughters. On the other hand, if all families in a community chose not to have their daughters undergo FGM/C, cutting would not be a prerequisite for marriage anymore. The underlying assumption is that parents love their children and want to do what is best

for them. The challenge is for families to move together from an equilibrium in which all girls are cut to one in which no girls are cut. Abandonment is possible, but only by coordinating a collective abandonment within the intramarrying community. Families will abandon FGM/C only when they believe that most or all others will make the same choice at the same time. (UNICEF, 2010, pp. 6–9.)

Apart from being a social (marriageability) convention within intramarrying communities, FGM/C is also a **social norm**: In the case of FGM/C, people's behavior is conditioned by a variety of factors such as beliefs or knowledge that it causes harm (a correct belief) or that it is mandated by religion (an incorrect belief), or that parents know best which risks their daughters confront and that the tried and tested customary practice is the most effective means of protection (Boyden et al., 2012; UNICEF, 2013). A social norms perspective draws attention to individuals' beliefs about others: Bicchieri (2006) argues that two different expectations influence our choice to obey a norm: what we expect others to do (**empirical expectations**) and what we believe others think we ought to do (**normative expectations**). FGM/C can be considered a social norm in a particular context if it meets the following conditions:

> First, individuals are aware of the rule of behaviour regarding the cutting of girls and know that it applies to them. Second, individuals prefer to conform to this rule because: a) they expect that a sufficiently large segment of their social group will cut their daughters, and b) they believe that a sufficiently large segment of their social group thinks that they ought to cut their daughters and may sanction them if they do not. (Bicchieri, 2006; cited in UNICEF, 2013 p. 7.)

This is illustrated in the figure below, applied from UNICEF (2013, Figure 3.1) and complemented with some examples of anti-FGM/C interventions together with arrows showing what "parcels" of the social norm such interventions might address:

Figure 1 FGM/C as a social norm (applied from UNICEF, 2013, Figure 3.1)

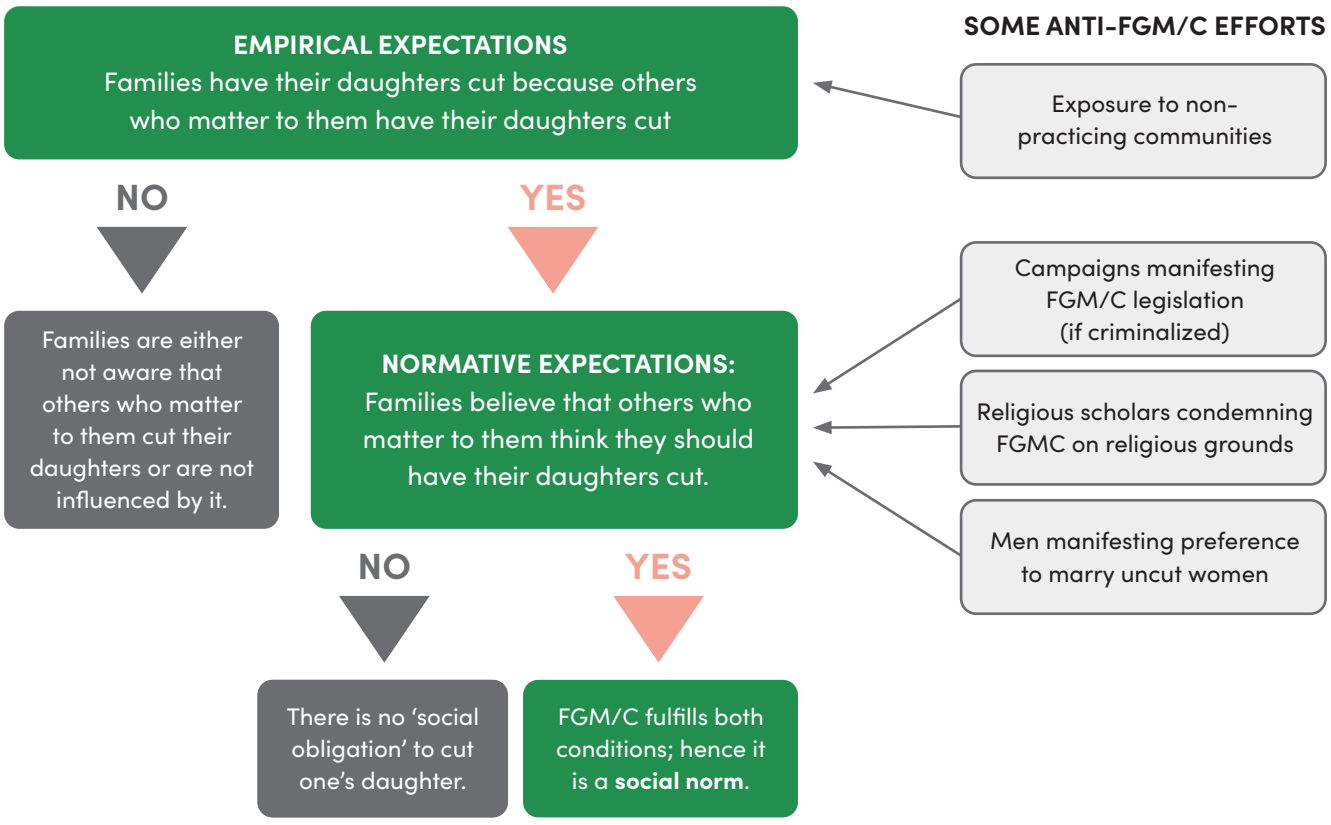


Table 1 Social, legal and moral norms impact individual behaviour (applied from UNICEF, 2013, Table 3.1)

	Legal norms (enacted by the State)	Social norms (enacted by social groups)	Moral norms (evoked by internalized values of right and wrong)
Motivations and rewards for conformityw	Respect for the law	Social acceptance	Self-gratification, "good conscience"
Sanctions for non-conformity	Legal sanctions spanning from citations to fines and imprisonment	Social disapproval manifested by ridicule, shame, stigma and exclusion	Guilt, "bad conscience"

Newell-Jones's (2017) investigation in Somaliland reflects the decision-making dilemma that women confront vis-à-vis FGM/C. The vast majority (94%) correctly listed the complications resulting from pharaonic cutting, yet pharaonic cutting persists as the dominant type in Somaliland. This suggests that a lack of knowledge is unlikely to persist as the primary reason for continued cutting. Also, 83% of women in Newell-Jones' (2017) study hope for some abandonment of the practice (59% want to abandon only pharaonic cutting, 20% pharaonic and the intermediate type, and 4% all types of cutting).

Changing individual attitudes towards FGM/C will not bring about large-scale abandonment. Families need to be convinced that enough other people will support ending the practice. However, the attitudes of individual families are often kept in the private sphere and are not known by most other families in the community. Hence, many families may, in fact, prefer not to cut their daughters. But since they see others continuing the practice, they assume that others support it and will cut their own daughters to avoid social disapproval. This phenomenon is referred to as **"pluralistic ignorance"** and is perpetuated by a **lack of communication** among members of a social group about their private beliefs, attitudes and preferences. (UNICEF, 2013, pp. 16–20.)

For some, recognizing others' normative expectations combined with the empirical expectations is enough to induce conformity, while others require further inducements such as the threat of **negative sanctions**. Absent formal sanctions, and negative emotions such as shame and guilt are also effective enforcers of social norms. (Bicchieri, 2006.) Simultaneously, there are often **positive sanctions** for complying with the social norm, such as acceptance, esteem, and approval (Mackie & LeJeune, 2009). As summarized in Table 1, in addition to social norms, people's behavior is also regulated by **legal norms**, which may prohibit the practice, and **moral norms**, such as doing what is best for one's daughter. These norms may act in harmony or be at odds. For example, where the social norm of FGM/C is in place, the fear of social exclusion for not conforming to the norm may be stronger than the fear of fines and imprisonment (if FGM/C is legally banned). If individuals continue to see others cutting their daughters and continue to believe that others expect them to cut their own daughters, the law seldom serves as a strong enough deterrent to stop the practice. Conversely, legislation can strengthen the legitimacy of their actions and as an argument for convincing others for those groups that have abandoned FGM/C. (UNICEF, 2013.)

According to Bicchieri and Xiao (2009), when normative and empirical expectations are inconsistent, people often do what they think others would do (i.e. follow empirical expectations) even when they believe doing so is not met with approval. One reason is that punishment is often imposed on those whose behavior differs from the majority, instead of those who act against normative expectations. Even when it is formally disapproved (e.g. legally banned), a behavior may be only weakly or not at all punished if it remains common.

According to Lien and Schultz (2013), the social convention theory does not deal with how people internalize information on FGM/C that can contradict cherished norms and values. They claim that **internalization models** are equally important in order to understand social change when new information is internalized by adults. Through analyzing the way in which persons socialized in a cultural context where FGM/C is highly valued receive and process information that contradicts the meaningful norms and traditions they have internalized as children, they argue that it is only when a package of knowledge reaches the higher "levels of conviction"[3] (Spiro, 1997) and becomes motivationally saturated that a paradigmatic change of attitude will be made.

New knowledge that challenges old knowledge which has been taken for granted for generations is often painful and is not easily internalized. When it comes to eradication of social and cultural practices, the new information often comes from another system of thought, from people with another cultural background, who may not be recognized as an authority. This often prompts people to **refuse to believe** what they are told. Information can be discarded by not recognizing the authority of the group of senders; by denying the credibility of the knowledge itself; and/or avoiding settings in which information is given. Hence, the most effective strategy for change appears to be when the recipient obtains information from a **trusted person with authority**. Moreover, community-based information campaigns are profitable as the meaning of the information can be discussed with others. (Lien & Schultz, 2013.)

3. The *first level* is when a cultural novice becomes acquainted with the proposition, without assenting to it. At the *second level*, the novice acknowledges the proposition, but does not internalize it. It is received as a cliché (such as knowledge about health risks of FGM/C), implausible or inconceivable. At the *third level* the cultural proposition has been accepted by the person, that it is internalized, and at the *fourth level*, it becomes a genuine belief held to be true, proper, and right. (Lien & Schultz, 2013, p. 3; referring to Spiro, 1997)

2.2 Applying the theories in interventions against FGM/C

In communities affected by FGM/C, people may reasonably believe that the practice is universal and "natural". If almost every girl and woman is genitally cut within one's horizon, being uncut is not seen as an alternative. One of the first steps, therefore, is to **conceive of not cutting as an alternative**. (Mackie & LeJeune, 2009, p. 15.) Also, the fact that empirical expectations have greater weight in influencing choices than normative expectations (see Bicchieri & Xiao, 2009) implies that efforts to mitigate FGM/C should not only emphasize the illegitimacy or the negative consequences, but also stress that more and more people are opposing and actually abandoning the practice. **Public weddings of uncut young women** are an example of a strategy to overcome the self-fulfilling belief that uncut girls are not marriageable. The first such wedding organized by the NGO *KMG* in Ethiopia was attended by 2,000 people and 317 uncut girls as bridesmaids. The bride wore a placard saying she was glad to be uncircumcised and the groom had a similar placard saying he was happy to marry an uncircumcised girl. (Mackie & LeJeune, 2009, p. 16.)

Mackie and LeJeune (2009) write that effective programs reinforce **community values**, make them explicit and stimulate discussion of how these are better upheld by finding alternatives to harmful practices. In communities where FGM/C is practiced, the moral norm to **"do what is best for your child"** often motivates families to cut their daughters. However, once an alternative becomes socially accepted within a community and people realize that the community might be better off if they were to jointly abandon the practice, it is this same basic value – to do what is best for their children – that also motivates communities to abandon FGM/C. For example, medicalization of the practice is still consistent with the fundamental moral norm of doing the best for one's daughter, since medicalization reduces health complications while still enables the daughter to marry.

Participatory human rights education provides a justificatory framework and ennobles the process of more profound norm revision. Individuals are not rejecting the bad but are embracing the good. Once people realize they have rights they attach high value to protecting their rights and those of their children. However, transformative human rights deliberations should not be conceived of as the imperious transmission of international norms to local communities. Human rights ideas need to be translated into local terms and be actively remade in the local vernacular. (Mackie & LeJeune, 2009.)

The process of information transmission, persuasion, and mutual deliberation about the advantages and disadvantages of abandonment spreads through existing and created **social networks within intramarrying communities**. Organized diffusion uses local networks of social relationships to promote conditional commitment to abandon FGM/C, within not only the residential community but also beyond it to other communities that intramarry with the target community. (Mackie & LeJeune, 2009, p. 12.) Referring to what was written above about the internalization models, if communities are to make the decision to abandon the practice, credible new information must be introduced from **trusted sources**. The role of alternative "messengers" is discussed in more detail in Chapter 4.

The static version of the social convention model requires that most or all the intramarrying community simultaneously abandon the practice. A more refined understanding of the process establishes a **sequence of change**. A relatively small core group of first movers (**the critical mass**), can conditionally resolve to abandon FGM/C, and then has an incentive to recruit remaining members of the community to conditionally join in the effort, until a large enough portion (**the tipping point**) is willing to coordinate on stable abandonment. To attain stable abandonment, enough of the intramarrying community must conditionally commit to abandonment, and that conditional commitment must become an actual commitment. A **public commitment** is required so that each member of the intramarrying community can see that most others in the community not only would abandon but do abandon. An ongoing monitoring mechanism provides further assurances by periodically checking on the stability of abandonment, and mobilizing community sanctions against potential or actual transgressors. (Mackie & LeJeune, 2009, pp. 11, 15.)

To fully grasp the social dynamics that perpetuate FGM/C and to strategically encourage its abandonment, **data relating to several aspects of the practice should be collected and analysed**. Important aspect include (UNICEF, 2013, pp. 18–19):

- the degree to which the practice is occurring (prevalence)
- individual preferences regarding the continuation of the practice (attitudes)
- the beliefs of individuals as to whether others are conforming to the practice (empirical expectations[4])
- whether individuals believe they have a social obligation to practise FGM/C (normative expectations[5])

Examining women's perceptions of whether men support FGM/C is key, since the belief that men support FGM/C can be an important motivating factor in women's behaviour with respect to the cutting of their daughters.

4. A relevant question would be e.g. "Are women circumcised in this area/community?"

5. A relevant question would be e.g. "Do you believe that your daughters will be subject to some form of social sanction – such as ridicule, shame, criticism, stigma or exclusion – if not circumcised?" or "Is (Was) there anyone who is encouraging (encouraged) you to have your daughter circumcised?"

2.3 FGM/C and gender

According to the official *United Nations* definition, violence against women "means any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion, or arbitrary deprivation of liberty, whether occurring in public or in private life" (Declaration on the Elimination of Violence against Women, 1993). Female genital mutilation is listed as one of the traditional practices harmful to women, together with battery, the sexual abuse of female children in the household, dowry-related violence, and marital rape.

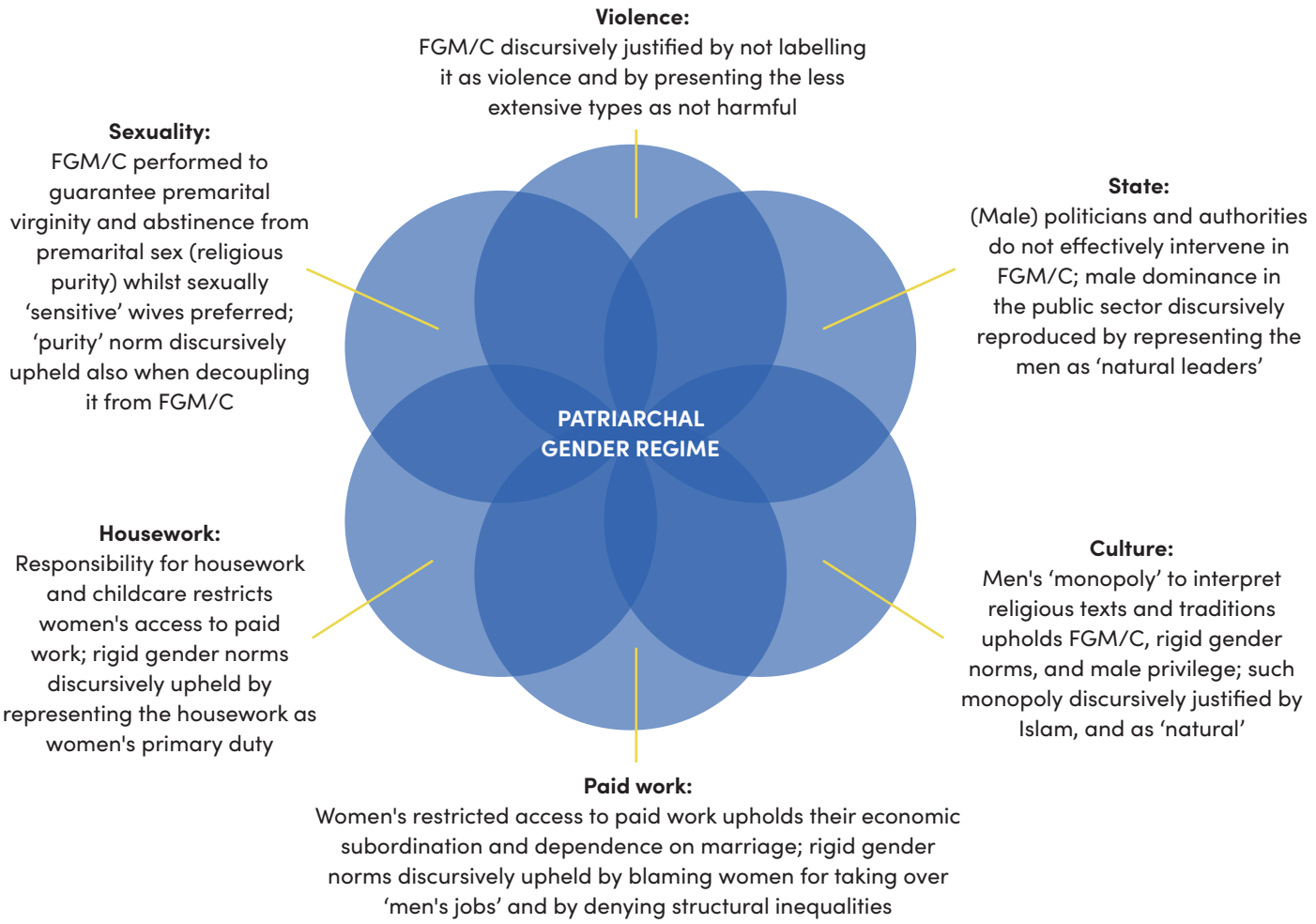
When analysing gender-based violence (GBV), it is important to focus on the **meaning and purpose** of violent acts and their relation to the performance of gender (Bumiller, 2010), on **resources** that enable violence, and the ways in which violence is **justified** to oneself and others (Ronkainen, 2017), as well as how violence **preserves and extends gender inequalities** (Stark, 2010). The principal characteristic of GBV against women lies in that it occurs against women precisely because of their gender (Hunnicutt, 2009).

FGM/C corresponds to the principal characteristic of GBV and occurs against women precisely because of their gender. It is intertwined with other patriarchal practices, as described by, for instance, Wilson (2013) and Gruenbaum (2006) who discusses **patrilineal property inheritance** as a significant feature upholding FGM/C: Families involved in agriculture hand over land to their sons, whilst the daughters are expected to be taken care of by their husband. **Illiteracy and weak employment opportunities** uphold the patriarchal order assigning women the role of giving birth and carrying out domestic duties, whilst men are assigned the role of providers. Marriage is thus often the (only) way for women to earn a living and status. Virginity and chastity exist as prerequisites to marriage, symbolising the honour of the girl's family. Under these circumstances, FGM/C is carried out to preserve the girls' morality, chastity, and fidelity as well as marriageability and family honour. According to Mackie and LeJeune (2009), also social norms that ensure that women have **little voice in matters that affect them**, render them unable to publicly challenge harmful, threatening, and subordinating practices like FGM/C.

Building on these views and on Walby's (1990) theorising on the "fields" of patriarchy (paid work, housework, sexuality, culture, violence, and the state), Väkiparta (2019) presents FGM/C as patriarchal violence that **sustains and is sustained by other patriarchal practices** [Figure 2].

To summarise, FGM/C is a form of patriarchal violence which occurs against women precisely because of their gender and preserves and extends gender inequalities. It is sustained by other patriarchal practices, above all the socio-economic subordination that renders women dependent upon marriage for their material well-being and, therefore, parents (specifically mothers) pressured to expose their daughters to FGM/C. Thus, all programmes and projects aimed at eradicating FGM/C should explore and address the (often hidden) ways in which women's socio-economic subordination and violence to control women and girls are justified and maintained.

Figure 2 Interrelationship between FGM/C and other patriarchal practices (adopted from Väkiparta, 2019, Figure 1)



3. Different approaches to community mobilization

When provided with credible new information and the opportunity for communal reflection, families may change their practices to realize their basic values without harming their girls. Participatory deliberation drawing on human rights principles appears to play a crucial role in bringing about this collective change. It encourages individuals to describe and articulate their own values, come to a consensus on their communal objectives, and think about what obstacles are in the way of achieving their common goals. This leads to a process of reflection and action that can result in social transformation. (Gillespie et al., 2018; referred to in UNICEF, 2010, pp. 6–9.) In this chapter, some community-based, locally led initiatives to eradicate FGM/C are discussed, starting, however, from the importance of context specificity and local terminology. Key points and countries where the approaches have been piloted are bolded to help the reader.

3.1 Context specificity and local terminology

While there is a move away from information, education and campaign (IEC) interventions to behaviour change interventions (BCI), the fact remains that campaigns, messages and materials need to be **targeted to specific audiences and communities** and address the respective root causes, instead of being mass produced—regardless of the messengers mobilized to spread them.

For example, few of the IEC materials and curricula analysed by *WHO* (2011) provided acceptable information about cultural evolution or demystified sexuality in ways understandable to the target community, although tradition and culture, particularly beliefs on sexuality, are the main reasons perpetuating FGM/C in the communities studied. *WHO* concludes that messages such as "FGM reduces women's sexual enjoyment" are not likely to change people's opinions of the practice. Contrary to the intended effect of the message, reducing women's sexual enjoyment is often exactly what supporters of FGM want, believing that unexcised women will be "prone to premarital sex" or "unfaithful to their husbands". Furthermore, messages such as "FGM is used to control women" or that it is "a form of violence against women" often do not resonate with communities. Instead, posters depicting excision of a girl with blood on the knife and girl can be effective, even if sometimes shocking for westerners.

Not only the phrasing of the key messages but also the terminology to describe the cutting of the female genitalia must be carefully considered. While *WHO* (2017) recognises four major types of FGM/C[6], **each society develops its own language and ways of classifying the types of cutting** known to its members, which do not necessarily correspond to *WHO's* classification and terminology. This must be taken into consideration when planning any messages or IEC materials. For instance, while the English acronym FGM refers to all types of procedures amongst most English speakers, in **Somaliland** it only refers to the more extensive type, also referred to as pharaonic circumcision (*gudnin pharaonic* or just *pharaoni*) in Somaliland. Thus, Somalilanders see no contradiction in stating that they would under no circumstances let their daughters undergo FGM, whilst also considering it important that their daughters undergo the less extensive form of cutting, referred to as sunnah circumcision (*gudnin sunna* or just *sunna*) in Somaliland. (Crawford & Ali, 2015; Lunde & Sagbakken, 2014; Newell-Jones, 2016.). Thereby messages such as "stop FGM" are often understood as campaigning against pharaonic cutting only.

Moreover, Somalis often consider sunnah circumcision a religiously recommended act, stemming from the meaning of the word "sunnah" in Arabic as "recommended" (Johnsdotter Carlbom, 2002). Accordingly, the increasing use of the intermediate type of FGM/C, which involves less stitching than the pharaonic practice, likely emerged in response to government interventions to eliminate pharaonic cutting (Crawford & Ali, 2015). To increase its acceptability in comparison to the pharaonic practice, this intermediate type is sometimes called "sunnah" or "sunnah 2", particularly amongst women (Newell-Jones, 2016, p. 12). Hence, ISF, for example, avoids labelling any type of cutting as "sunnah" and instead refers to "pharaonic cutting" and "other types of cutting" when raising awareness on FGM/C in Somaliland.

In 2006, UNICEF **Sudan** office decided to introduce a new term for the uncircumcised state, to replace the existing terms with negative connotations such as *ghalfa* ("slut"). They selected the term *saleema*, an Arabic word for being "whole", healthy in body and mind, unharmed, intact, pristine, and untouched, in a God-given condition (Douglas Evans Id et al., 2019).

The Saleema Initiative (https://www.unicef.org/sudan/saleema-initiative) aims to create positive cultural associations with a girl remaining uncut and hypothesizes that branding the alternative to FGM/C will promote social norms change. The broad objective is to change the way that people talk about FGM by promoting wide usage of **new positive terminology to describe the natural bodies of girls and women**. Saleema also aims to stimulate new "talk pathways" (who talks to whom)

6. The least extensive **type 1**, often referred to as clitoridectomy, involves the partial or total removal of the clitoris. **Type II**, referred to as excision, involves the partial or complete removal of the clitoris and the labia minora, with or without excision of the labia majora. The most radical **type III**, known as infibulation, involves narrowing the vaginal opening by creating a covering seal. **Type IV** includes all other harmful procedures performed on the female genitalia for non-medical purposes, including, for example, pricking, piercing, incising, scraping, and cauterising the genital area.

and new "talk content" (the specific issues discussed) at family and community levels. Spreading a social norm that modern Sudanese society no longer practices FGM is the long-term goal of Saleema. The norm to be changed is that a girl remaining uncut is associated with remaining whole and as God given. The immediate outcome of the program is to increase **social acceptance of uncut girls**, as reflected in increased use of the positive term Saleema and in normative beliefs about the acceptability of being uncut.

The Saleema campaign was implemented through four main activities across Sudan: 1) Sufara Saleema Campaign, 2) Saleema Colors Campaign, 3) community dialogue, and 4) Born Saleema Project. These activities included publicly pledging to abandon FGM and support the Saleema initiative, wearing Saleema colours as a sign of support, public dialogue on the existence of FGM, its role in society, and the need for abandonment, and pledges not to cut new-born daughters immediately after birth. The project worked with communications and media experts to build a positive-message program, using TV ads, billboards, a song on a video, and a host of celebrities and religious leaders who became "Saleema Ambassadors" (Gruenbaum, 2020). Since 2016, the Saleema project has been ramped up to expand too all states in Sudan. There is evidence of the term *saleema* been adopted for uncircumcised girls also in communities where the activities of the Saleema Initiative have yet not been carried out (ibid.).

3.2 Scaling up though organized diffusion within villages

Tostan ("breakthrough" in the Wolof language) is an international NGO founded in 1991 and headquartered in Dakar, **Senegal**. Tostan is currently offering its **30-month (2,5-year) program** in five West African countries. Gillespie et al. (2018) summarize the "Tostan approach" as follows:

> Through a holistic, human rights-based education program, the Community Empowerment Program, Tostan ignites community dialogue on a wide range of topics. The first year of the curriculum is called the Kobi (with sessions on visioning, human rights, democracy, problem-solving, and hygiene and health). Each session builds on previous sessions over a one-year period, leading into the second part of the curriculum.

Participants represent the community at large, including women and men, elders and youth, from various ethnic groups and social strata. Most have never received formal schooling or dropped out at an early age. Sessions last for two hours, three times a week. Each class member agrees to **"adopt a learner"** to share what they learn in each session with someone outside the class. One key to success is the understanding that participants learn at their own pace, become a facilitator by sharing with others, gain confidence and new respect by being viewed as a "teacher," share information, and work in close collaboration with the facilitator (who lives in the community and supports participants outside of the classroom).

At the same time Tostan trains a **Community Management Committee** (CMC) comprised of 17 members (nine of whom must be women) selected by and representative of the community. The committee helps carry out actions decided by the class and community. The committee is left in place after the education program ends, and most become registered community-based organizations. In addition to the Community Empowerment Program covering the class and CMC, Tostan provides a 10-day training for local NGOs, religious leaders, and other interested stakeholders. The training includes a general orientation to Tostan's holistic human-rights based approach.

Tostan's model organically scales during implementation through the process of **organized diffusion**: class members pick an adopted learner to immediately share what they have learned; the class and CMC hold community meetings to spread key information from the classes; class and community members visit neighbouring communities to hold sessions; and highly motivated participants and influential leaders from different communities form social mobilization teams visiting hundreds of communities, even across borders.

Tostan implements only when **invited by communities**. Participating communities must house and feed the facilitator and create the classroom space. Tostan pays for the facilitator's stipend and for facilitator training and educational materials. During the second phase of the 30-month program, Tostan also provides a $800 community development grant.

Diop et al. (2004, pp. i–ii) evaluated the Tostan program in 20 villages. They conclude that the program was able to bring about a social change within the community and to mobilize the villagers for better environmental hygiene, and respect for human rights and improvement of health, as well as specifically reducing support for and practice of FGM/C. According to their summary of the evaluation results:

> The education program significantly increased the awareness of women and men about human rights, gender-based violence, FGC and reproductive health, but awareness of human rights, violence and FGC also increased in the comparison site, although to a lesser extent. The consequences of FGC were better known, as were issues concerning contraception, pregnancy surveillance and child survival. In general, women's knowledge improved more than men's, except for STI/HIV. Diffusion of information from the education program within villages worked well, as other women and

men living in the intervention villages also increased their knowledge on most indicators. For all indicators, apart from those concerning violence, the experimental group improved significantly more than the comparison group.

Attitudes improved significantly in the experimental group, with women and men denouncing discrimination, violence and FGC. Attitudes towards FGC also improved significantly in the comparison group, but to a lesser extent than in the experimental group. There was a dramatic decrease in the approval of FGC, although a small proportion of women (16%) participating in the program did not change their attitude. Regret for having cut their daughters increased and fewer women were willing to cut their daughters in the future. Women perceived men's attitudes towards contraception as improving. However, the intervention group showed higher levels of positive attitudes than the comparison group.

There also appears to have been a positive improvement in behavior in terms of FGC and some aspects of reproductive health. The prevalence of FGC reported among daughters aged 0 – 10 years decreased significantly among women directly and indirectly exposed to the program. Life table analysis confirmed this change in the intervention group, but also that the girls who were cut were being cut earlier than before.

Community Management Committee members in rural Somaliland participate in a training on the health risks and Islamic perspectives on FGM/C. Photo: Nyasha Kadandara

Following the example of the Tostan approach in rural villages in **Somaliland**, the **community facilitator approach** implemented by ISF partner *Candlelight for Environment, Education and Health* has appeared successful. Facilitators based in target villages provided weekly training to CMC members. In addition to knowledge on the social and health consequences, human rights and Islamic perspectives on FGM/C, the CMCs are provided with literacy and numeracy trainings to support their capacity to pass the knowledge to their communities. Moreover, CMCs from different target villages are supported to share experiences and discuss ways to abandon FGM/C, as well as make public declarations to end FGM/C in the villages.

3.3 Linking public declarations with local surveillance systems

In the eight countries where Tostan has been active over the past 20 years, over 8,500 communities have decided to come together to abandon FGM/C through **public declarations**:

> A public declaration to support abandonment of FGC took place in 2002 to reinforce these changes in attitudes and behavior. Representatives from approximately 300 villages gathered in Karcia to denounce the practice. The forum organized by young girls was an opportunity to express strongly their opposition to FGC, and early and forced marriage. Although only a small proportion of people from the intervention villages attended this event, those men and women who attended expressed confidence that the declaration would be respected and that no more girls would be cut in those villages. Overall, women were more confident than men, but women who were indirectly exposed to the program were less confident. (N. Diop et al., 2004, pp. i–ii.)

In a later evaluation of the long-term impact of the Tostan approach on the abandonment of FGM/C and early marriage in Senegal, Diop, Moreau, and Benga (2008) conclude that the program improved knowledge of rights and responsibilities among both participating and non-participating women, particularly with respect to the place and role of women in the community. Regarding public declarations to end FGM/C in the target villages the researchers write as follows:

> The organization of public declarations evolved significantly over time, even as early as 1996 – 2000. The idea of a public declaration was initially suggested by Tostan and acted upon later by the women of Malicounda, the first village where this process took place. However, changes occurred later in the process of organizing the public declarations. In Medina Cheriff, another village that participated in a subsequent program, several other parties played an active role in the public declaration and mobilization efforts to abandon FGM/C. This change was guided by recognition that the implementation of the decisions announced at the public declaration required the involvement of several social groups in the villages. Information from the interviews indicates that collective determination on the part of the communities to honour these commitments, along with the support of leaders, committees and women, influenced how effective the declaration would ultimately be. However, type B villages were not truly associated with the public declarations. Some people in these villages simply heard that festivities were being held in a neighbouring village, so a few representatives decided to attend. They learned of the public declaration to abandon FGM/C only after their arrival. (N. Diop et al., 2008, p. ii.)

In some areas, public declarations seem to have played a role in bolstering the established Community Management Committees' (CMC) efforts to monitor the enforcement of the declarations. However, at the time of the evaluation seven years later, these committees no longer existed. Diop et al. (2008) claim that the lack of systematic follow-up and basic infrastructure in the villages is preventing the populations from making full use of their new capacities and is a significant barrier hindering their ability to apply the knowledge gained from the program.

Rumsey (2013) notes that community efforts to abandon FGM/C cannot start with public declarations. Targeted preparatory work addressing both potential change agents and members of the wider community is required first to increase public awareness of reasons for the declaration, and to enable support for its implementation. Public declarations do not in themselves create or guarantee changes in community behaviour. They do, however, offer justification for subsequent efforts by FGM/C activists. Moreover, public declarations can influence individual and collective expectations of socially acceptable and desired behaviour. This norm setting function is influenced by the extent to which the group issuing the declaration is acknowledged as representing and guiding the community in matters of culture and tradition, and by whether the group can enforce effective sanctions. After the declaration, both media and local authorities play a role in amplifying the effect of the declaration:

> [...] if program actions succeed in giving greater voice, visibility and resonance to those who have committed to the new norm of keeping girls intact, then discovery and discussion will be stimulated, strengthening the movement to end the practice. This can be accomplished by encouraging manifestations of commitment, including public declarations to end harmful practices by communities, religious leaders and groups, and other personalities. The media can also play a central role in amplifying their effect by publicizing these manifestations throughout a country and beyond. Visible support for the new social norm from within the services—legal/ security personnel, health and social workers, and teachers—provides reinforcement. Manifestations of commitment and action can also be reflected in government policies, resource allocation and high- level statements from different parts and levels of government. Rather than occurring only at the community level, the process of change becomes society-wide. (UNFPA & UNICEF, 2015, p. 11.)

One of the challenges regarding public declarations is to ensure that these promises are kept. In two sub-zones of **Eritrea's** Anseba region (Asmat and Habero), the Ministry of Health devised a simple way to follow up on declarations that encourages transparency, visibility, affirmation and competition. The ministry produced a simple **"My house is FGM-free" decal in the local language**. Ten thousand stickers were printed, and now adorn many entryways. The decals are frequently placed on outer doorways, while some are found inside houses, depending on the nature of the doorways. The decals, which serve as a public declaration of individual actions, make changing attitudes and behaviour apparent and provide affirmation for the new behaviour. (UNFPA, 2017 chapter 6.) Additionally, seminars, general knowledge, competitions, poems, dramas, house-to-

house campaigns and regular community dialogue sessions were used to reach every household in the targeted area. On the other hand, when assessing why there was less success in some of the regions compared to others, UNICEF found a degree of **sensitization fatigue**: community members telling UNICEF staff that they are tired of hearing the same messages, especially when they consider that the practice has reduced considerably or even stopped. (UNICEF, 2021 Eritrea case study.)

UNICEF (2020b) notes that following public declarations to end FGM/C, it is critical to establish or strengthen local surveillance systems such as **Child Protection Committees** to sustain a collective commitment to end FGM/C. This has been the case in for example **Burkina Faso**, where also the following mechanisms uphold commitment to end FGM/C (UNFPA, 2017 chapter 9):

- continued pressure is being applied by community leaders
- awareness-raising activities are being carried out by monitoring networks and committees
- health facilities are increasingly providing care to those suffering from complications of FGM/C
- communication activities to encourage health-care providers to promote abandonment are being organized
- people are increasingly reporting cases of FGM/C through the helpline, which enables callers to register anonymous reports of violence against children.

3.4 Mainstreaming FGM prevention into community development

DFID (2012) and *UNICEF* (2010) describe a highly successful project implemented by **Ethiopian** NGO *KMG*[7] to tackle FGM/C in the Kembatta Tembaro Zone. To build rapport with communities, the project set up a range of community development projects to meet **practical needs**, such as health centres and livelihood projects. Once trust was established, the project provided space for reflection through **community conversations**, where whole communities came together to discuss their values and concerns.

Human rights concepts were introduced but were closely related to the concrete local circumstances and concerns identified through the community conversations. For example, participants moved from identifying **concrete challenges** in their daily lives and communities (such as, "some of our friends are victims of domestic violence") to identifying **concrete actions** (such as, "we need a committee that can protect survivors of violence and intervene when necessary to stop girls from being cut") **to linking this to human rights** (such as, "everyone has the right to be free from violence").

KMG trained girls to become community conversation facilitators and to motivate their peers to take action. Groups of women, uncut girls and students became active promoters of women's rights. Nearly all traditional leaders (*edir*) in the seven districts declared their intention to abandon FGM/C. A number of *edir* associations drew up a list of sanctions, including expulsion, to be imposed on those who failed to comply. This was followed by more public declarations at the sub-district and district levels. Involvement of government officials meant that they were obliged, but also willing, to take action to enforce these declarations. Community conversation members also reported violations.

Key factors identified as contributing to the changes in attitudes and prevalence are:

- Using a rights-based approach, which encourages discussion of concrete local circumstances and concerns, and links these to human rights principles.
- Introducing community discussions as part of broader community development.
- Developing interventions which address practical needs rather than functioning as stand-alone activities.
- Holding community conversations at the village level and not only the district or sub-district levels. Programs in other parts of Ethiopia which engaged only at higher levels failed to change social norms and behaviour because village members did not feel the same sense of membership and shared concern.
- Working with existing clan or community structures and securing the backing of traditional and religious leaders, and sub-district and district structures.
- Ensuring project implementation was led by a local organisation trusted by the community.
- Having a national legislative framework that could be used to mobilise the community and community leaders and hold government service providers to account

In 2020, the Community Conversations approach was implemented in four regions for FGM (Oromia, Afar, Somali and SNNP) and in six regions for child marriage (Amhara, Oromia, Gambella, Afar, Southern Nations, Nationalities and People (SNNP) and Somali). 15 Woredas (districts) and kebeles (wards) are selected in each region based on prevalence. In 2020, there were 1,275 community conversation groups across the six regions, reaching 87,975 regular participants. Conversations are facilitated by two members of the community who have

7. KMG stands for Kembatti Mentti-Gezimma-Topee, a phrase in the local language of Kembatta that reflects the power women generate when working together (see www.kmgselfhelp.org)

been selected and trained by the Bureau of Women, Children and Youth. The training is based on a **community conversations facilitation manual**. The facilitators then hold 2-3 hours long conversations twice a month with a group of 60 to 70 men and women from each kebele, including parents, elders, religious leaders, the kebele administrator, a community police officer, a school director, teachers, a former circumciser, and youth. To have a broader reach, each participant is expected to relay information to other community members. Thereby community members gain information from trusted sources and resume discussions and debates in between scheduled conversations. **By-laws** have also been put in place in kebeles and community members are now increasingly reporting families who may be considering child marriage and/or FGM to the police. (UNICEF, 2021 case study Ethiopia.)

A Christian relief, development and advocacy organization *World Vision* has been working in **Kenya** since 1974 to help communities with their urgent needs. In many communities in Kenya, World Vision has been able to do more than the Government in terms of provision of water, food and nutrition, health care and education, thereby building trust and respect among the community members. This includes putting up infrastructure where none is available to assist children, especially the girls, to go to school, and responding to humanitarian crises in times of disaster, conflict and drought. World Vision has developed a methodology for this process called *"Channels of Hope*[8]*"* with a version tailored specifically to gender issues, child protection and community change. The methodology helps structure community dialogues specifically tailored to women, men, youth and children. It offers participants factually correct information and insight, and empowers them to become agents of change. (UNFPA, 2017 chapter 16.)

Within rural and/or internally displaced communities in **Somaliland**, ISF has been carrying out FGM prevention activities integrated into economic empowerment projects since 2001. Engaging communities in the prevention of FGM through income-generating activities helps ISF and its local partners to establish legitimacy and build a relationship of trust in communities where FGM is deeply rooted and often seen as mandated by Islam. In the longer term, this mainstreaming approach addresses one of the root causes of the persistence of FGM: the socio-economic subordination of women and their dependence on marriage for their social security and status. By enabling women to engage in income-generating activities, ISF enables women to secure their social status within their families and communities, challenges the rigidity of gender roles and strengthens women's self-determination. As concrete examples, with its local partner *Candlelight for Environment, Education and Health*, ISF mainstreams FGM awareness raising into livelihood projects that develop sisal value chain in four rural villages. With its other local partner *Somaliland Youth Development and Voluntary Organization* (SOYDAVO), ISF mainstreams FGM awareness raising into literacy and numeracy classes provided for female micro-entrepreneurs who belong to women's self-help groups.

Engaging communities in the prevention of FGM/C through income-generating activities helps to establish legitimacy and build a relationship of trust in communities. Photo: Nyasha Kadandara

8. https://www.wvi.org/church-and-interfaith-engagement/channels-hope-gender

3.5 Replacing FGM/C with an alternative rite of passage

In many communities, FGM/C is practiced as an initiation into womanhood, guaranteeing a girl's marriageability. It is seen as proof of her strength and bravery and allows her to gain respect of other women. Alternative Rites of Passage (ARP) are touted by NGOs and international donors as an alternative to female initiation into womanhood, but without female genital cutting (Hughes, 2018). In this way, ARP aims to offer a harmless alternative to FGM while fulfilling the function that FGM has in some communities: to mark the passage from childhood to womanhood. The known ARPs are mostly implemented in Kenya, but the strategy has also been used in for example Uganda. The ARPs implemented in 1996 in Meru community in **Kenya** by *Maendeleo ya Wanawake* and *Programme for Alternative Technology in Health (PATH)* were among the first documented. FGM/C was part of a larger initiation process in Meru, and the spirit of the initial rite was maintained in the ARP. Hence, girls received an education on family and women's social role, a public celebration with exchange of gifts was organized. The ceremony was concluded by a public declaration stating the community's recognition of the girls' passage to womanhood. (Oloo et al., 2011.)

World Vision starts the ARP process in Kenya six months before the initiation, by identifying girls to participate and coaching them on the importance of the alternative rite. Their male cohorts and their parents or caregivers also learn about its significance. A **mentorship programme**, which pairs accomplished women from the community with younger girls, offers another system of support. The objective is to improve personal value, self-worth, self-esteem and self-confidence by walking together with those being mentored to teach life skills beyond the home or classroom environment. The mentors are women who have a role in society and who are willing to take on one to three girls. A structured **life skills manual** addresses the holistic maturation of young girls for competence in many areas of life. Components focus on character development, cognitive restructuring, life skills training, anger management, foundations for a healthy and strong future, and vocational skills. Girls who have been mentored typically go on to mentor younger girls in the community. (UNFPA, 2017 chapter 16.)

The role of **elders, traditional cutters and parents** in the public ceremonies and the whole process differs from one community to another. For instance, in the **Ugandan** community of semi-nomadic Pokot and Karimojong, FGM is often perpetrated by highly respected traditional healers who are considered as guardians of traditions. Thus, the traditional healers were targeted by the sensitization and training campaigns led by *Vision Care Foundation*. (UNFPA, 2017 Chapter 7.)

Recently, ARP has received some critique, after having been completely unquestioned for years. While ARPs are considered a catalyst for change, outcomes within a community vary and are dependent on the context, time and the manner in which the intervention is implemented (Mwendwa et al., 2020, p. 2). The lack of community's involvement and inclusion in trainings, sensitization campaigns or during the ARP brings distrust and gives the impression of something imposed by the outside interfering in the community's affairs and culture[9].

Few academic studies have been conducted on ARP. In one of them—based on observation of three ARPs run by World Vision in West Pokot and Narok counties, and one ARP organized by *Amref* in Kajiado County—Hughes (2018) discusses the "important, if sometimes problematic, contributions of Christian faith leaders, and biblical influences more broadly", to both the instruction and ceremonial components of ARP in Kenya. She argues that "faith leaders' contribution to ARP constitutes significant ritualised cultural performance, but religious messages do not necessarily sit well with the more secular discourses of rights and law around FGM." She concludes:

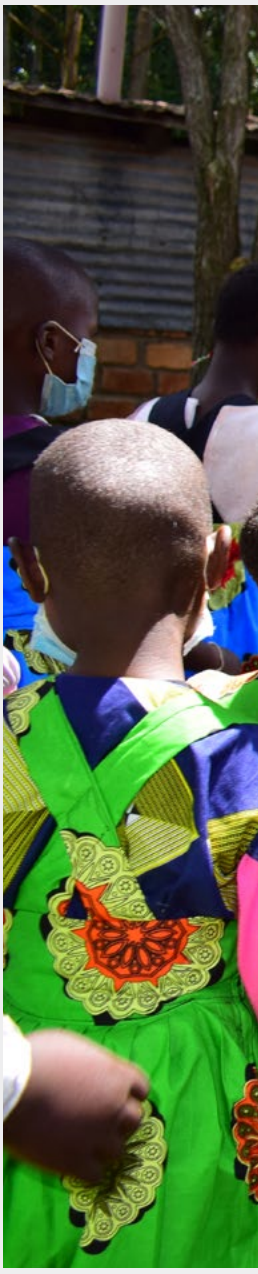
> But it is fair to ask whether ARP is an entirely 'harmless' intervention, since it involves church, state and NGOs working in partnership on a social engineering experiment that promotes a very particular ideal of 'modern' citizenship, morality, civic and cultural virtue couched in predominantly Christian terms. This is not to criticise the latter, but to point out its significance in a hybridised cultural assemblage. Also, in teaching girls to be good wives and mothers, to fear God, and to obey their parents, husbands and elders (in mimicry of traditional instruction), there is a risk of outmoded gender roles being reinforced that may not fit these girls for life as empowered 21st century women. Though girls are taught about empowerment and rights in these lessons, from observation the human rights content is relatively little – drowned out, in some ARPs, by 'fire and brimstone'. Furthermore, the so-called cultural components of ARP are presented as elements that represent the 'timelessly traditional' when they are in fact partially invented; for example, candlelit ceremonies, customised initiates' headbands, customised songs, self-styled cultural entrepreneurs, and so on. One could argue that the ends justify the means; hang 'authenticity', why not make creative use of whatever is available in order to gain people's acceptance of ARP? (Hughes, 2018, pp. 285-286.)

9. https://copfgm.org/alternative-rites-of-passage

Some key factors have been identified as essential to ensure the success of an ARP[10]:

- FGM/C must be part of a larger transition process from childhood to womanhood (ex: ARP may not be useful if FGM is performed to ensure women's virginity).
- FGM/C must be a public affair and not just considered as a private and family issue.
- Any planning of ARP must take into consideration the specific socio-cultural context of the community, power imbalances between its members, financial gains and incentives to the practice of FGM/C.
- The involvement of the whole community and especially the elders and traditional cutters is essential to sensitize them to the harmful effects of FGM and ensure the recognition of the ARP's value as equivalent to FGM.
- The community's involvement in the creative process leading to the implementation of an ARP is also central for its acceptance. Involving the community avoids its members from considering the ARP as an external cultural interference. To ensure this, training change agents can be useful.
- ARP must be part of a larger process ensuring education on female genital cutting, sexuality and sexual and reproductive health and rights, as well as sensitization campaigns targeting the whole community, to change mindsets and stereotypes about uncut girls.
- Male involvement and support of the ARP must be ensured.
- Religious aspects should be integrated in the ARP if religion is very strong and important for the community.
- Adequate monitoring and evaluation of the process is essential to have evidence on what works and what does not.

In their case study on the role of ARP in Kisii and Kuria districts, **Kenya**, Oloo, Wanjiru, and Newell-Jones (2011) conclude that ARP is most effective when it takes place at the end of a structured girls empowerment programme and involves a community ceremony, and is explicitly recognised as an alternative to undergoing FGM. Also, ISF and its Kenyan partners *Manga Heart Orphan Care* and *Centre for Community Mobilization and Empowerment (CECOME)* are currently piloting an ARP model in Kisii and Nyamira counties, aligned with the findings of Oloo et al., as well as the Guidelines for Conducting an Alternative Rite of Passage developed by the national *Anti-FGM Board* (2018).



In the Abagusii community in Kenya, FGM/C is practiced as an initiation into womanhood. An Alternative Rite of Passage provides an initiation without cutting, allowing girls to gain respect in their communities. Photo: ISF

10. https://copfgm.org/alternative-rites-of-passage


MANGA HEART
Lets stop FGM now!
Creating awareness on the effects of FGM

4. The role of different change agents

Social and attitudinal change can happen slowly or in an instant. Internal psychological processes and social processes are interlinked through talk, discourse, and the flow of information. The most effective strategy for change appears to be when the recipient obtains information from a trusted person with authority. (Lien & Schultz, 2013.) According to Mackie and LeJeune (2009, p. 18), **credibility of the messenger** has two aspects: good will and competence. Notables, political and religious leaders, medical and other professionals often have a reputation for proven good will and competence. **Good will** is also estimated by whether the sender of information has the same or similar interests as the receiver or is similar in characteristics. In the absence of having similar interests or characteristics, there must be good evidence that the sender cares about the welfare of the receiver. **Competence** is estimated by proven past successes, professional authority, quality argument, and effective response to contrary views, among other strategies. Credibility is also bolstered by the **weight of sources**: the more notable are more persuasive than the less notable, many notables more persuasive than a few, many peers more than a few peers, many media messages more than a few, and so on. Much of our learning is based on testimony rather than on direct experience, and the weight of sources helps us to evaluate the credibility of that testimony.

This chapter illuminates the roles of different "messengers" or "change agents" in raising awareness and advocating against FGM/C. Key points and countries where the group has played a role are bolded to help the reader.

4.1 Mobilizing religious leaders and traditional chiefs to support the abandonment of FGM/C

While FGM is not required by the founding doctrines of the three monotheist religions, it is often seen as a religious practice by the affected communities. In other words, while FGM is not religious in theory it can be lived as such in practice. (Community of Practice on Female Genital Mutilation, 2020). Hence, it is essential to deconstruct such religious interpretations as they often constitute main reasons upholding FGM. Position taken by religious figures are essential in disarticulating the **false links between FGM and religious obligation**.

There are, however, several obstacles to religious leaders publicly speaking against FGM: they may lack knowledge about the real consequences of FGM and about whether the practice is religious or not as well as face social pressure and fear losing status within the (professional) community. Sometimes, religious leaders may even receive death threats which prevents them from expressing themselves openly. Furthermore, in Muslim societies where the practice is prevalent, FGM is often seen as a "women's issue". As women do not take part in Friday prayers where preaching against FGM is broadcast, they do not benefit from messages that detach FGM from Islam. (CoP FGM, Religion as a strategy to tackle FGM[11].)

In for example Djibouti, Ethiopia, Kenya and Somalia, religious leaders generally agree that the most extreme forms of the practice should be abolished, but they are divided about whether a less extreme cut (sometimes called sunna) is permitted or recommended. The **continued support for the lighter forms makes** it difficult to pursue policies aimed at ending all forms of FGM/C. (UNFPA & UNICEF, 2015.)

Yet, a shift has occurred among religious leaders, many of whom have gone from endorsing FGM/C to actively condemning it (N. J. Diop et al., 2012).Their views carry considerable weight, with Friday prayers and church services constituting an influential channel for sharing information. To foster consensus-building among those religious groups who support abandonment, and those who are either undecided or still condone FGM/C, the *UNFPA Arab States Regional Office* helped establish a **Faith Network** covering Djibouti, Egypt, Somalia and Sudan. Leaning on this network, Somali leaders and religious scholars from Egypt and other Arab States collaborated on a draft declaration that distances Islam from FGM/C. (UNFPA & UNICEF, 2015.)

In **Guinea** where FGM/C is almost universally practiced among all religious, regions, and ethnic groups, the *UNFPA-UNICEF Joint Programme* provided 1,087 religious leaders from across the country an intensive briefing on FGM/C in workshops in six regions. Soon after, 50 of the most influential religious leaders were invited to a two-day high-level workshop, which led to consensus and collective action, including a conference of 350 religious leaders opened by the Head of State and the Prime Minister. Later in the year, the Religious Affairs Secretariat General launched a national campaign urging abandonment of the practice, with the support of the Ministry for Social Action. In collaboration with scholars from Mauritania, a fatwa (non-binding legal opinion on a point of Islamic law [sharia] given by a qualified religious scholar) against FGM/C was adopted. It was popularized throughout the country through a coordinated sermon encouraging abandonment, delivered by imams in 50 mosques in Conakry and 3,300 across the rest of the country. (UNFPA, 2017.)

Also, in **Somaliland**, a religious fatwa was issued by the Ministry

11. https://copfgm.org/2020/09/religion-as-a-strategy-to-tackle-fgm & https://copfgm.org/religion-fgm

of Religious Affairs in 2018. CSOs advocating for a zero tolerance of all types of FGM/C, however, raised their concern and required rephrasing of the fatwa which they claimed legitimises sunnah cutting, as the initial formulation stated: "[i]t's forbidden to perform any circumcision that is contrary to the religion which involves cutting and sewing up, like pharaoh [pharaonic] circumcision" (Ahmed et al., 2018). In SIHA's (2018) interpretation, the fatwa was problematic because it also frames FGM/C as a religious matter, thereby maintaining—not challenging—the understanding of (some type of) FGM/C as a religious obligation. Furthermore, the fatwa vowed to punish violators and allowed victims to receive compensation, but it did not describe the type or severity of punishment nor indicate whether compensation is paid by the government or by those who violate the ban (Ahmed et al., 2018). Regardless of the problematic wording, however, the fatwa implies to Somalilanders that opposition to the practice comes from within the country, not from outside.

Besides religious leaders, traditional and cultural leaders such yield considerable authority in issues around social and moral norms. In **Nigeria**, for instance, traditional rulers from the various ethnic groups mediate between their people and other authorities, serving as interpreters, spokespersons and ombudsmen. They are legally recognized and vested with authority by the federal and various provincial state governments that they both collectively and individually serve. They help maintain peace among their constituents and wield considerable power in upholding social norms. In 2016, the *UNFPA-UNICEF Joint Programme* on FGM/C mobilized traditional chiefs and religious leaders to support community declarations of abandonment of FGM/C in the three states with the highest prevalence.

Initial discussions focused on chiefs and religious **leaders who were known to be sympathetic** to the elimination of harmful traditional practices, and to improving the status of women and girls. These initial visits cascaded into subsequent negotiations through familial and clan relationships, supported by formal discussions Justifications for FGM/C and its origins in the community were discussed, to enable the chiefs to question and redefine the value and relevance of FGM/C in relation to its consequences for girls, women, and the community at large. They enabled consensus building and the collective agreement to abandon FGM/C, which were marked by ceremonies, broad representation of both traditional and government leaders. (UNFPA, 2017 chapter 15.)

In their synthesis on the best practices (funded by the UN Trust Fund to End Violence Against Women), Le Roux and Palm (2021) give three recommendations for practioners who engage faith-based and traditional actors in preventing violence against women and girls VAWG:

- Understanding how faith-based systems work in practice as well as their core values in relation to VAWG is a prerequisite for effective engagement
- Recognizing that VAWG prevention requires a multi-sectoral approach with faith based and traditional actors treated as just one stakeholder amongst other actors in a wider system
- Ensuring that women religious and traditional actors are meaningfully represented and involved in programme design and senior decision making (noting that women can also support patriarchy and attention is needed to which women's groups are chosen and whether their hierarchical structures may exclude more vulnerable women)
- Engaging these actors around entrenched harmful social norms, and not merely with condemning practices only
- A positive framing (such as reclaiming core spiritual values like justice) is seen to encourage uptake and support by these groups in some contexts.

4.2 Training teachers and health professionals to advocate for FGM/C abandonment

Sustainability of anti-FGM interventions often relies on mainstreaming them into relevant government ministerial programmes such as health and education. For example, in **Burkina Faso**, the National Committee has piloted **training for teachers** as well as the incorporation of FGM/C into the **natural sciences curriculum** within schools (WHO, 2011).

Sometimes more targeted and local efforts are in place instead of national level programmes. In **Egypt**, where the overall support for FGM/C has dropped quite rapidly, *UNFPA-UNICEF Joint Programme* targets pockets of resistance, where support for FGM/C remains high. Schools are the focus of efforts, hosting activities with parents, teachers and religious and community leaders. The work goes beyond ending FGM/C to supporting **girls' overall wellbeing**, empowering them to understand and claim their rights, and build life skills that can help them avoid early marriage and complete their education. The focus is on girls most at risk of dropping out. In many cases, school fees and educational materials are paid for. (UNFPA, 2017 chapter 5.)

Also, in **Kenya**, the overall support for FGM/C has dropped quite rapidly, while there remain pockets of resistance, where support for FGM/C remains high, as the Kisii and Nyamira counties where ISF works. With is local partners *Manga Heart Orphan Care* and Centre for *Community Mobilization and Empowerment (CECOME)*, ISF educates parents, teachers and local duty bearers about the negative consequences of FGM. It disseminates information in schools through **extracurricular activities** (such as poems, dances, and plays) and organizes children's holiday mentorship programmes (see also Chapter 3.5 Alternative Rites of Passage) during school holidays, when girls face high risk for undergoing FGM.

In schools, teachers educate children about sexual and reproductive health and rights, as well as negative consequences of FGM. Photo: ISF

For several years, efforts to end FGM/C focused primarily on the health risks associated with the practice. Possibly as a result of these messages, some parents turned to medical practitioners to cut their daughters or chose less severe forms of cutting. **Medicalization** or "clinicalization" of the practice was perceived to reduce the immediate health complications without compromising the marriageability of the girl. Traditional birth attendants and circumcisers were encouraged to perform milder forms of cutting, were trained on anatomy and septic procedures as well as instructed to use new clean razors, dispending antibiotics and using local anaesthesia. In some urban areas it has become common to have girls operated in hospitals or clinics. (UNICEF, 2010.)

However, medicalization institutionalizes FGM/C and counteracts efforts to eliminate it. Thus, the official stance of *WHO* and many other organizations (e.g., UNICEF, *Inter-African Committee*, *International Federation of Gynecology and Obstetrics*) is that the procedure should not be performed by health professionals under any circumstances. Some examples from e.g., **Nigeria**, however, show that the medicalization does not necessarily hinder efforts to eliminate FGM/C: the practice is gradually declining in urban areas where clinic-based procedures are available. Moreover, strong stances against the medicalization and intermediate solutions have been seen illogical "if the improvement of women's health is truly targeted as priority". There is a profoundly **moral dilemma**: Should we assist in the improved health of women while lending legitimacy to a destructive practice? Or should we hasten the elimination of the practice while allowing girls and women to die from preventable conditions? (Shell-Duncan & Hernlund, 2000, pp. 31–32.)

As Lunde (2012, p. 79) summarizes, the criticism of approaching FGM/C as a purely health issue is based firstly on the fact that although the severity of the practice may have been reduced, little progress appears to have been made in reducing prevalence rates (Black, 2010). Secondly, conceptualizing FGM/C in health terms may simply legitimize procedures that are conducted within a medical environment. While circumcisers are getting less popular, a range of people can now gain the skills or the status as someone who can rightfully circumcise. Thirdly, medicalization implies that the practice is undertaken in a "safe" environment. Thereby the risks of complications such as infections due to using unsterile equipment and the trauma of the girl without anaesthesia are reduced. Moreover, modern medical equipment is viewed as more efficient than traditional methods. Pain-relief, for example, may mean that the girl does not scream or struggle as much as in the past. The net result of this may be that it becomes easier to access and cut more tissue than it has been in the past. (Talle, 2010.) This entails a risk of institutionalizing the practice, making FGM/C acceptable and encouraging its continuation.

As summarized by the *Community of Practice on FGM*[12], except for Egypt where doctors are the main practitioners of FGM, it is **mostly nurses and midwives** who practice FGM in countries with a high rate of medicalization of FGM. To combat medicalization, it is necessary to understand why health personnel agree to perform such an act: First, it is in line with their beliefs as they belong to a community that practises FGM and feel it is their duty to support a patient's request for FGM. Secondly, they consider medicalization to be a "lesser evil" and to reduce risks and complications. Thirdly, they consider FGM to be harmless and even medically indicated. Lastly, they are attracted by financial gain.

Activities to strengthen the role of public health services in preventing FGM/C (and simultaneously mitigating medicalization) have been conducted in, for example, **Senegal**, where a course on FGM/C was **integrated into the curriculum of high schools and colleges** (N. J. Diop et al., 2012). In **Kenya**, health-care service providers have started a **WhatsApp group** to support each other on clinical issues, and compare notes and experiences as expert witnesses on FGM/C court cases (UNFPA, 2017 chapter 12). Strengthening the inclusion of the health professionals in prevention programmes run by NGOs have the potential of increasing their knowledge and action against FGM, particularly because health professionals benefit from the confidence of the communities that listen to them. For example, in **Mauritania**, a declaration by doctors demonstrating the harms that FGM causes girls and women and the risk of losing their lives—strictly forbidden by religion—was needed to obtain the adherence of the imams through a fatwa. In **Mali**, *Plan International* brought together 80 NGO workers and health workers from the project intervention zones, to identify all the terms used to designate FGM and genital organs in local languages. In the second workshop, a local medical doctor presented photos of the complications he was facing, and explained their medical and psychological management, as well as the sometimes very complicated follow-up. Clear position of the Ministry of Health condemning medicalization, as well as **legal framework explicitly and/or clearly criminalizing** medicalization are crucial in fighting the medicalization. Health professionals who practice FGM must be brought to justice, as in the **Ivory Coast** where the law **doubles the penalty** when FGM is practiced by a member of the medical profession[13].

12. https://copfgm.org/medicalization-of-fgm and https://copfgm.org/2020/09/what-can-be-done

13. https://copfgm.org/2020/09/what-can-be-done

According to the recommendations of UNFPA, UNICEF and WHO, a holistic approach is needed to combat medicalization, including eight interventions[14]:

- legal framework, adherence to the code of conduct, sanctions and advocacy for law enforcement
- integration of female genital mutilation and related ethical principles into medical, nursing and obstetric education
- treatment and prevention of FGM integrated into service delivery (e.g., deliveries, antenatal and postnatal care and immunization campaigns)
- engaging national human rights institutions and CSOs to strengthen social accountability
- create a cadre of health care providers advocating for an end to the medicalization of FGM
- monitoring mechanisms and data collection for better policy and program development
- establish partnerships, engage health professional associations/organizations and link with other services (e.g., social and community services) for referrals and cross-referrals
- strengthening communities for the abandonment of FGM

4.3 Enhancing collaboration between the justice system and communities

Criminalization has been seen to foster environment that is clearly intolerant to FGM/C, and to provide support against social pressures for those already opposing the practice. However, legislation has often proven to be a poor instrument of cultural change. It may undermine the success of programs aimed at ending FGM/C, and at worst, trigger a rise in the practice and other childhood risks. In **Senegal** for example, an NGO-driven voluntary abandonment project was stalled by opposition to a coercive law being prepared simultaneously. In **Sudan**, when the British in 1945 informed that infibulation would soon become illegal, parents rushed to have all uncut females including infants infibulated, leading to an unprecedented wave of cutting. Elsewhere, adolescent girls have defied the ban by excising each other. Victims of botched infibulations have blead to death instead of getting medical care, when parents, circumcisers and the community members fear prosecution. (Shell-Duncan & Hernlund, 2000). In, for example, **Ethiopia**, some of the girls are resorting to being circumcised at night, rendering the operation far more dangerous. The ban has also lowered the age of FGM/C in certain areas, like among the Kisii region in **Kenya**, where girls would traditionally be circumcised at around age 15 (Boyden et al., 2012.)

There is a growing consensus now that laws should be one of a set of interventions to support a social movement towards elimination of FGM/C. Legislative reforms should consider the degree of social support for the practice. In settings where segments of practising populations agree that girls and women should not undergo FGM/C, institutional frameworks can play an important role in supporting social change. However, in communities with broad support for FGM/C, the challenge is to develop legislative reform strategies that complement efforts in the social sphere and contribute to collective abandonment of the practice. (UNICEF, 2013, p. 8.)

According to *UNFPA* (2017 chapter 10), **Burkina Faso** provides an example of a country that has enforced FGM/C law in an incremental, progressive, community-based and effective manner. By 2017, 65 cases had been prosecuted, and 47 individuals sentenced to between one month and three years in prison. After passing a law criminalizing FGM/C in 1996, the Government did not initially attempt to impose harsh penalties. It focused first on making practising communities more aware of the harms caused by FGM/C. In 2016, for example, nearly 200 police officers from nine provinces fanned out across the country to convince people to reject FGM/C. As support for the practice has declined dramatically, stronger collaboration between the justice system and communities has been possible.

An innovative centrepiece of the process has been the establishment of **mobile courts**, whereby judicial hearings that take place near the communities in which the cases arise, instead of bringing defendants to hearings in the capital. This encourages discussion and dialogue, highlights the political will towards ending the practice, and fosters collaboration between the communities and the justice system. Moreover, **collaboration between services and the criminal justice system** is pursued in ways that build the capacity of the system to deal with FGM/C. For instance, girls whose cases are reported through the **"SOS Excision" helpline** are first taken to health-care providers who have been trained to deal with the issue sensitively. To sum up, the system aims to do more than punish perpetrators; it also seeks to change attitudes and create agents of change. Those found responsible for acts of FGM/C are **counselled after their conviction**. (UNFPA, 2017 chapter 10.)

4.4 Conversing traditional cutters

Excisers/cutters (traditional practitioners of FGM/C) often serve as guardians of traditions such as FGM and have a lot of influence and respectability within their community. Also, they may have their main income in this practice. Hence, they are often reluctant to end the practice. Interventions, referred to as "conversion strategies", focus on converting excisers/cutters to stop the practice and at best, become agents of change,

14. Ibid.

Traditional practitioners of FGM/C often serve as guardians of traditions and have a lot of influence within their community. Photo: Nyasha Kadandara

spreading the anti-FGM message to other communities. The strategy may include providing **alternative sources of income** to ensure that excisers do not revert back to the practice, such as training in farming, baking, entrepreneurship, or any other skill that can provide income. This method, however, has faced a lot of criticism by opponents who claim that it is not efficient as traditional cutters pick up their functions once the programs are finished. Some of the risks and shortcoming identified include **replacement by new cutters** and/or development of **cross-border FGM**, and lack of information on whether ex-cutters advocating against FGM have authority in their community as voices against the practice.[15]

Sustainable results on conversing cutters have been identified in, for example, **Mauritania**, where most cutters had actually been forced to resort to excision as the only means of subsistence, and in **Sierra Leone**, where cutters made public declarations to drop the knife[16]. Examples of less successful efforts seem, however, more numerous[17]. For example, in 2018 and 2019, *Respect for Change/Belgium* paid around 150 elders and 20 cutters from the 4 clans of Migori county in **Kenya** in cash a monthly allowance of 2,000 Kenyan shillings to abandon the practice. Late in 2018 and in November 2019 altogether 4 clans cut all the girls during the cutting season. *Respect for Change* concludes that people's **norms cannot be changed using the money as a tool**. Alternative source of income at best will stop few excisers from practicing for few weeks or months. Once the sewing machine or any other alternative source of income is broken and/or once the exciser misses her prestigious position in the village, she will go back to practice.

Another example comes from **Senegal**, based on Middelburg's (2016) research, concluding that there is no need to specifically target cutters, because most cutters receive only a "modest fee" that cannot be considered a significant source of income. Her respondents explained that not so much the financial compensation, but the fact that **cutting is an honourable profession conferring respect and prestige** within the community is the real problem. Cutters have status and recognition in the community and when they stop cutting, they are losing their power.

According to Middelburg's informants, a pilot project with a Senegalese NGO and the Ministry of Women, targeting cutters, proved to be unsuccessful firstly, because the micro-credit project and **income generating activities for cutters attracted women who had never performed FGM/C**. Secondly, and more importantly, the approach focused only on the supply of the cutters, but not on the "demand side" of the cutting. The project was not accompanied by awareness raising campaigns addressing the community as a whole to promote community consensus to abandon FGM/C. One participant to Middelburg's study, a civil society representative clearly illustrated the problems that were faced on the ground during the pilot project:

> When she was working in a community in the northern part of Senegal, she noticed that a baby was crying a lot. After a few days she went to the house of the mother to find out what was happening. After she had spoken with the mother, she discovered that the baby underwent FGM/C, but also that a 'former cutter' performed the procedure on her daughter. This 'former cutter' received training to become a professional midwife: "They gave her money, credit, trainings in the hospital, they gave her many things. They transformed this lady to become a midwife." However, although this lady participated in the pilot project, received money and a training to adopt an alternative profession and was offered a job at the hospital, she continued to perform the FGM/C after working hours. When the civil society representative confronted the cutter with the fact that she was still performing FGM/C, while she was trained as a midwife and worked in the hospital now, the cutter explained: "The mothers come here to my

15. https://copfgm.org/conversion-of-cutters
16. https://copfgm.org/2020/10/positive-experiences-of-the-strategy
17. https://copfgm.org/2020/10/critical-voices-against-conversion-as-a-strategy-to-end-fgm

> house with their daughters, because the community choose me to do this. I cannot abandon this." In addition, the 'former cutter' told the civil society representative: "Because of my job in the hospital, in my house, I now have a table, a scissor, alcohol and many other things to make sure that now I do the cutting well." (Middelburg, CoP FGM thematic discussion on traditional cutters)

Another study participant, also a representative of civil society said:

> Cutters won't stop if you give them money. They will only stop if they do not have any clients or customers anymore. It is like a store. The store does not work if the customers do not come. How are you going to sell if you don't have customers in your shop? You won't be able to sell anything. This is the same. If the cutter does not have customers anymore, she will do agriculture or other kinds of jobs, like all the other women. Only then they will stop. (Middelburg, CoP FGM thematic discussion on traditional cutters)

Also, the *WHO* (2011) review of Burkina Faso, Egypt, Ethiopia, Mali and Uganda country assessments found that many excisers could not keep their promise since excision is a lucrative business. Furthermore, many excisers who stop are quickly replaced by another due to demand. *WHO* and Middelburg both suggest that while excisers should be included in programming against FGM/C, finding alternative income for them should not be the major strategy for change. Middleburg also notes that it is important to not focus on the cutters in isolation, but to look at them as part of the community.

4.5 Transforming grandmothers into agents of change

Like other social norms, FGM is transmitted from generation to generation. It is instilled by the family during childhood (primary socialization) and developed through appropriation or rejection in adulthood (secondary socialization). The prestige of such norms explains why even when the law condemns FGM, it continues to be favoured by most of the people who may rather break the law than challenge the norm.

In many communities, it is particularly difficult for people to discuss taboo issues such as reproductive and sexual health, including FGM, with members of another generation. Questioning the tradition around FGM is seen as particularly threatening to older generations. Moreover, FGM is traditionally performed by traditional cutters to whom the profession has been transmitted from mother to daughter. Rejecting FGM thus implies, for some, rejecting the profession to which one was destined. (CoP FGM, Intergenerational aspects of FGM[18].)

There are preconceived notions that older women would not be able to integrate new ideas or learn new practices. However, Shell-Duncan et al. (2018) believe that older women are well positioned to change the practice of FGM: **who could have more power to change the practice than those who perpetuate it?** They analysed focus group data from **Senegambian** women, exploring what are the constellation of norms associated with FGM/C, when are existing practices and norms being contested, and how does this reflect prevailing structures of power. Their research identifies four overarching themes: 1) pressure to conform with FGM/C arising from sanctions such as ostracization, and moral norms linked to the embodiment of virtue; 2) upholding tradition as a means of venerating ancestors; 3) upholding social hierarchy by displaying respect for elders; and 4) shifting beliefs about the healthful vs. harmful nature of FGM/C. While strong value is placed on upholding tradition, there is also an appreciation that elements of tradition must be revised to meet fluctuating realities.

Shell-Duncan et al. (2018) found that older women are uniquely positioned to realize the dual goal of **honouring tradition while negotiating change**. Rather than resisting change, some older women express an openness to reassessing norms and practices as they seek solutions to maintaining the physical well-being, moral integrity and cultural identity of girls in their families. Moreover, given the **authority of older women over younger women**, they also have power to negotiate change. The authors thereby suggest that by recognizing older women as potential change leaders, and drawing on variability and fluidity in social norms, it may be increasingly possible to design interventions that will shape possibilities for action and accelerate abandonment of FGM/C without undermining the cultural value of tradition. When the wisdom of grandmothers and other elders is recognized by all, and when tradition serves to maintain this social hierarchy by transmitting values such as respect for elders, grandmothers can indeed become agents of positive change.

> Despite their role as guardians of tradition, we found many instances where older women's views on FGM/C show great fluidity…In essence, they ensure the continuity of tradition and cultural identity by carefully negotiating change. In contrast, younger women who lack the moral authority to question norms and challenge the custom of elders were much less likely to express ambivalence or opposition to the norms surrounding FGM/C. (Shell-Duncan et al., 2018)

"Grandmother projects" implemented in Uganda and Senegal rely on this logic. In the Amudat region of **Uganda**, 50 grandmothers were trained to advocate against FGM. By 2013, they had conducted 10 exchange sessions to encourage abandoning FGM among 114 girls. In **Senegal**, a "grandmother project" was

18. https://copfgm.org/intergenerational

Kenyan grandmother Alice belongs to a generation who did not question FGM/C. However, when the practice was criminalized, she decided to save her granddaughter Rael from FGM/C. Photo: Nyasha Kandandara

implemented by *World Vision* in 2008 with the objective of promoting positive community attitudes and social norms regarding FGM, early marriage and physical punishment and reducing pregnancy among teenagers. The approach incorporated **intergenerational dialogue** in community and school activities and the active participation of elders, particularly grandmothers.[19] A group of grandmothers who act as role models were trained and sensitized on issues of child protection especially the need for them to appreciate raising children as children and not to be married off when young. They were thereafter encouraged to pass on the same messages to their **grandchildren** with the confidence that the grandmothers/elders in the communities are influential and champions. Also, the grandmothers' **sons** listened to them and they possess a lot of influence on who their sons marry in addition to undertaking interactions with their **daughters-in-law**. (Ntabadde Makumbi, 2017.)

In **Sudan**, the transformation of grandmothers, long-term advocates for the practice, into agents of positive change began with organized discussions over coffee, an important tradition in the community. Talk centred around the health and emotional consequences of FGM/C, and the fact that it was not a religious obligation. The grandmothers used their newly acquired knowledge, which echoed the wisdom of their forefathers, to raise awareness among their families and communities. Community groups were established in each of targeted Tutti Island's five neighbourhoods to build consensus, sustain the discussion and flag girls in danger of being cut. (UNFPA, 2017 Chapter 2.)

19. https://copfgm.org/2021/06/the-role-of-each-generation-in-the-abolition-of-fgm

4.6 Empowering women and girls into role models and activists

To claim and protect their rights, women and girls need knowledge on their legal and human rights, and on existing referral mechanisms and services if they experience or fear being exposed to FGM/C. They also need safe platforms to discuss challenges and solutions, as well as role models, solidarity groups, and peer support networks to collectively claim their rights.

In rural and internally displaced people's (IDP) communities in **Somaliland**, ISF partner *Somaliland Youth Development and Voluntary Organization (SOYDAVO)* has established a local **Anti-FGM/C committee** consisting of 100 women from the local communities in Togdheer region. Women from the 20 target villages selected from amongst themselves five Committee members from each village. *SOYDAVO* trained the selected women on FGM/C, community mobilization and organizing skills. Women appointed from among themselves a 5-member executive committee that meets with the village focal points on quarterly basis to develop their next quarter activities. The plan is shared and implemented in close collaboration with the village heads, traditional leaders and other village committees. Mostly the activities are door-to-door awareness raising, family visiting and consultation with the parents on the issues of FGM/C and SGBV. In 2019, the committee conducted 480 awareness sessions, mainly door to door visits and parent counselling. The committee launched a big campaign promoting zero tolerance of FGM/C, including street walks to claim the anti-FGM/C bill to be passed in the Parliament.

To claim and protect their rights, women and girls need safe platforms such as solidarity groups and peer support networks to collectively claim their rights. Photo: Nyasha Kandandara

Similarly, ISF partner *Network against FGM/C in Somaliland (NAFIS)* has trained **female Human Rights Ambassadors** from among IDP women who are engaged in self-help groups and related cluster level associations (CLA). The aim is to empower women to identify, respect and claim for women's right to bodily integrity, and to further train and engage peer women.

After one year of weekly community mobilization and door to door outreach sessions, there is evidence of SGBV survivors increasingly seeking legal support and reporting rape and domestic violence to the authority. Moreover, informed of the various health consequences of FGM/C, and where to seek help, women suffering from complications like cysts and fistulas are now increasingly going to the health facilities. Moreover, number of girls are saved from being cut after the CLA women have consulted their parents, after first abandoning the practice themselves and thereby becoming role models to other women in the community.

In **Ethiopia**, about half of women are illiterate, and about 85% reside in rural areas, with limited communications infrastructure. Over the past two decades, semi-formal community structures have been put in place to inform women and to drive development at the grass-roots level. **Community mobilizers** facilitate discussions among members of a women's development group made up of 30 to 35 volunteers who meet monthly to discuss various development issues, including harmful traditional practices such as FGM/C and child marriage. Each of the women in the group goes back to her neighbourhood and shares what she has learned in smaller groups comprising five or six neighbours. They can also report back to the women's development group on specific needs, such as visits from health workers who bring primary care to the villages These **neighbourhood get-togethers**—the "1-to5" networks, piggyback on the age-old tradition of conversing over coffee. FGM/C and child marriage are also the topics of parallel organized discussions, called Community Conversations (see also Chapter 3.4), which engage in biweekly meetings a wider group of men and women, religious and clan leaders, health workers and law enforcement officials. Clubs of both unmarried and married girls hold similar discussions. (UNFPA, 2017 chapter 4.)

4.7 Engaging fathers, brothers, and (future) husbands

As summarized by *UNFPA* (2017 chapter 14), especially in patriarchal cultures, male opposition to FGM/C—coming from traditional and religious leaders; respected elders, rulers and chiefs; local and national government and law enforcement officials—carries great weight. However, increasingly, the informal, personal power of men and boys—raising their voices as friends, brothers, husbands, boyfriends, and sons—is also having a huge impact on social norms and family decisions. For instance, in the *#TouchePasAMaSoeur* social media campaign from **Senegal**, men of all ages, classes, styles, professions were pictured proudly **holding signs or wearing T-shirts** that disavowed FGM/C with a slogan that was at once protective and assertive: "Don't touch my sister." Male voices are prominent also in the social media campaigns established through the *Young Advocacy Network* in **Nigeria** in 2016:

> These voices are featured on End cutting social media platforms, including a website and blog, Twitter feed (www.twitter.com/endcuttinggirls), Facebook page (www.facebook.com/endcuttinggirls) and WhatsApp (EndFGM/C#endcuttinggirls). These platforms feature poems, essays, stories from survivors, a calendar of activities, infographics and other resources. They also broadcast events taking place at the national, state and community levels. And, in 2016, the Twitter handle www.twitter.com/endcuttinggirls was used to host 46 weekly Twitter conferences on FGM/C using the hashtag #Endcuttinggirls. Each week, the conferences address a different aspect of FGM/C—human rights, legal, health and social—garnering the attention of an average of 5,000 visitors per week. The related Facebook page (www.facebook.com/endcuttinggirls), launched in October 2016, has nearly 10,0000 followers. The campaign is produced by social media advocates (most of them men), many with considerable communications expertise, who received training to enhance their capacity and build on the efforts of other partners. (UNFPA, 2017 chapter 14.)

Amplification of men's voices is crucial not only because of the power they wield, but also because their views are often misunderstood. The largest discordance between men's and women's perceptions regarding FGM/C is in **Guinea**, where 46% of men and boys say that FGM/C has no benefit, compared with just 10% of women and girls. The fact that so many men and women, including long-married couples, are unaware of their partner's opinion about the practice highlights that this long-taboo subject is generally **discussed in separate spheres**.

Despite some geographical variation, **men seldom directly participate in the decision-making** surrounding and the execution of FGM/C (Kaplan et al., 2013). Whilst mothers, grandmothers, or other elderly community women appear to stand at the forefront of perpetuating FGM/C, men also play a significant role in its continuation as fathers, husbands, and community and religious leaders (Kaplan et al., 2013; Varol et al., 2015). Correspondingly, women who decide that their daughters will not undergo FGM/C often face both peer pressure and helplessness, particularly when not actively supported by their husbands or influential male leaders from their communities (Kaplan et al., 2013). The belief that men support FGM/C alone can represent an important motivating factor influencing women's behaviour vis-à-vis cutting their daughters (UNICEF, 2013).

Varol et al.'s (2015) systematic review of studies exploring men's attitudes, beliefs, and behaviours concerning FGM/C in 15 countries, as well as a UNICEF (2013) investigation conducted in 16 countries, revealed the **ambiguity in men's views** regarding the continuation of FGM/C. In most countries analysed by *UNICEF*, both women and men expressed similar levels of support for FGM/C. In some countries, more men than women want to end FGM/C, whilst in other countries more women than men would like the practice to stop. In **Senegal** and **Gambia**, for example, Shell-Duncan et al. (2010) found that more men than women favoured ending FGM/C, and when men were involved in deciding whether their daughters should undergo FGM/C, daughters more often remained uncut.

Varol et al. (2015) claimed that notions of social obligation, religion, education, ethnicity, urban living, and migration, and an understanding of the negative consequences of the practice influenced men's support for abandoning FGM/C. They found that **education most strongly influenced support for ending FGM/C**. Similarly, *UNICEF* (2013) demonstrated that uneducated men were more likely to support FGM/C than men with a secondary or higher education, while household wealth associated with relatively lower levels of support for FGM/C. Both patterns mirror those from a *UNICEF* investigation amongst girls and women.

Moreover, socio-demographic factors influence how men frame and value FGM/C, and the benefits and advantages they associate with the practice. In 8 of 11 countries included in a *UNICEF* (2013) investigation amongst men aged 15 to 49, the most widely mentioned benefit of FGM/C for a girl was "no benefit". Often mentioned benefits included social acceptance, preservation of virginity, and religious requirement. Other reasons cited consisted of cleanliness or hygiene, marriage prospects, and sexual pleasure for the man.

By contrast, the reasons men cite for abandoning FGM/C stem from an understanding that **religion does not mandate** it and that it may **negatively impact sexual relationships**, whilst few men conceptualise FGM/C as an act of violence or as an infringement of women's rights (UNICEF, 2010). Also, some men view themselves as victims of FGM/C, describing complications such as sexual dissatisfaction and difficulty during sexual penetration, resulting in wounds on or infections in the penis as well as psychological problems (for example, Almroth et al., 2001; and Berggren et al., 2006 on Sudanese men; Fahmy et al., 2010 on Egyptian men). In studies by Warsame and Talle (2011) and Vestbøstad and Blystad (2014), respondents in **Somaliland** reported men beginning to prefer entirely uncut or mildly cut wives given the diminished sexual drive of infibulated women.

It is important to engage men in gender equality and anti-violence efforts. Fatherhood is an important motivator for men to join such efforts. Photo: ISF

Also Bruchhaus (2013) found an emerging trend in the urban Somaliland and amongst educated young men to marry "untouched" (uncut or "mildly" cut) girls, also referred to as "digital" reflecting their modernity.

Whilst younger men in particular are becoming more critical of FGM/C, **women typically underestimate the proportion of men wanting FGM/C to end**. This results from many couples considering FGM/C an inappropriate topic for discussion between a husband and a wife, as well as because men hesitate to approach a topic often considered a **"women's issue"** (Johnsdotter Carlbom, 2002, p. 143; Kaplan et al., 2017). Furthermore, organisations that deal with FGM/C are primarily women's organisations, whose grassroots audiences consist of other women, whereby men often lack information on the practice of FGM/C (Gele et al., 2012).

Väkiparta's (2019) doctoral study on young men's activism against FGM/C in **Somaliland** illustrates the complex and subtle ways in which **taken-for-granted gendered assumptions and hegemonic power relations** that uphold FGM/C are (re)produced as commonsensical and natural, also by people aiming to prevent FGM/C. The study shows how men's domination is upheld and legitimated by **patriarchal interpretations of ideologies**, such as religion. Drawing upon medical "facts", pharaonic cutting (cf. WHO type III) represents a harmful and unnecessary *cultural* practice, which is against Islam, but is not framed as violence. Sunnah cutting (cf. WHO type I), in turn, is understood as neither required nor forbidden by Islam, as harmless—"just pricking" and "not a big deal". Tradition and culture, in other words, represent illegitimate justifications for FGM/C, whereas acts understood as required or not specifically forbidden by Islam are represented as acceptable. Control over women's sexuality is perpetuated by emphasising the importance of their premarital virginity, even if virginity is decoupled from FGM/C. Taken together with gender stereotypes (for instance, "women prefer to stay at home", "women need protection"), religion is used to justify not only sunnah cutting, but also strict gender segregation, relegating women to the domestic sphere and privileging men in the fields of paid work and political decision-making.

Väkiparta suggests that both men and women engaged in FGM/C prevention must understand the interrelations between FGM/C and the patriarchal power relations perpetuating it. FGM/C should be seen as a symptom of gender inequality and oppression, not only as a contributor to women's health problems. Participants should develop critical consciousness of the structures that uphold men's superiority—including men's monopoly to interpret constructions of reality regarding what is "natural", "normal" and desirable (Jokinen, 2010). Moreover, interventions should not draw on ideas associated with hegemonic masculinity, such as strength, warrior, protector, or leader, as they reinforce the gender-inequitable masculine ideals (Jewkes et al., 2015).

4.8 Utilizing diaspora's context insight and development efforts

A diaspora is a scattered population whose origin lies in a separate geographic locale. Historically, the word diaspora was used to refer to the mass dispersion of a population from its indigenous territories, specifically the dispersion of Jews. While the term was originally used to describe the forced displacement of certain peoples, "diasporas" is now generally used to describe those who identify with a "homeland" but live outside of it. (https://en.wikipedia.org/wiki/Diaspora)

The review pays special attention to the **Somali Diaspora** due to the focus of the review on ISF programme development in Eastern Africa, and the fact that Somalis constitute one of the largest ethnic minorities and the largest group of people of non-European origin in Finland where ISF is headquartered. The Somali Diaspora refers to Somalis who were born in Greater Somalia and reside in areas of the world that they were not born in. The civil war which started in 1988 and spread to the whole country in 1991 greatly increased the size of the Somali diaspora. Many Somalis moved from Greater Somalia primarily to the Arabian Peninsula, Europe, North America, Southern Africa and Australia. Since then, Somalia has been affected by political instability, humanitarian catastrophes and insurgencies. The UN estimated in 2015 that approximately 2 million people from Somalia were living outside of the country's borders. Many Somalis remain oriented towards Somalia, following news, maintaining contact with relatives, remitting money, supporting reconstruction projects, or investing in land or business. (Hansen, 2008; Kleist, 2010; https://en.wikipedia.org/wiki/Somali_diaspora).

According to an ISF commissioned study on the influence and potential of the Finnish Somali Diaspora as an change agent in gender equality in Somaliland (Sato & Hussein, 2014), there are **strong connections between Diaspora members and locals** in Somaliland. These linkages are social, cultural, economic, familial, and political. The linkages are extensively **mediated through social media and Diaspora visits and return migration** to Somaliland. The younger generation Diaspora members appear to be less in touch with locals in Somaliland, and there are concerns that remittances to Somaliland will discontinue. However, younger generation Diaspora members do seem to be highly interested in taking part in development cooperation and state-building activities, therefore emphasizing the role of Diaspora engagement in development cooperation.

According to the study, Diaspora members have brough concrete changes to the lives of people in Somaliland. The most notable contribution is that of remittances, which though valuable to households, does not necessarily lead to a wider development effect. Diaspora members also invest in businesses in Somaliland, creating job opportunities and services for locals. In addition to economic effects, Diaspora members influence local attitudes and perceptions regarding for instance domestic violence, FGM, and women's emancipation. Especially female Diaspora members have an urge to influence local opinions related to gender equality in Somaliland, but felt that they did not possess the authority in the eyes of locals to do so:

> Issues related to gender equality, FGM/C, and SGBV can also be discussed in some contacts, but do not seem to be a common point of discussion. Some Diaspora members, most notably female Diaspora members, expressed feeling strongly about gender equality issues and wish to influence the attitudes and practices of friends and relatives in Somaliland, but even these stated in interviews that these are not common topics of discussion, and that they are very selective in choosing who they discuss these matters with as they perceive local family members and friends in Somaliland to be a somewhat 'ungrateful audience' for 'lectures on gender stuff'. (Sato & Hussein, 2014, p. 31.)

The study identifies several factors that provide a conducive environment for the Diaspora to support gender equality in "homeland". Firstly, Diaspora members have **insight on the context**, the local way of life, and the people. Secondly, Diaspora members are **eager to take part** in development cooperation, including gender equality and elimination of harmful practices. The Diaspora can engage by contributing time, skills, social networks, and knowledge, financial resources and fund-raising capacities to activities either in the country of residence or the country of origin. To be successful, Diaspora engagement should be viewed as a **tool and means to achieve specific development targets, not as an aim on its own**. Otherwise, there is a risk of losing clarity in activities and Diaspora engagement can overshadow actual development cooperation aims.

It is worth mentioning that some members of the local community have negative perceptions of the Diaspora and thus it can be difficult for Diaspora members to gain their trust for a fruitful cooperative relationship. If Diaspora members are **viewed by locals as being detached** from the local way of life, and the cultural and religious practices, it may be difficult for them to present themselves as legitimate actors. Moreover, it is noteworthy that Diaspora members are also reported to be responsible for promoting some negative practices such as bringing their daughters to their countries of origin to have them cut.

The specific suggestions given by the study (Sato & Hussein, 2014) regarding Diaspora engagement in FGM/C and SGBV prevention are:

- Raise awareness on FGM/C among the Diaspora community through engaging with NGOs working with/among these topics and Diaspora communities.
- Engage Diaspora members and Diaspora-led NGOs in lobbying for anti-FGM legislation though their contacts with government, administration, community leaders, religious leaders and political parties in the country of origin.
- Engage Diaspora members and Diaspora-led NGOs in public awareness work on gender equality, FGM, and SGBV through public debate, formal/non-formal meetings, media, social media platforms etc.
- Involve Diaspora members in planning and making training materials on FGM and SGBV intended for training trainers and beneficiaries in the country of origin.
- Include Diaspora members in training the trainers through video manuals etc.
- Assist Diaspora members and Diaspora-led NGOs to get involved in the capacity development of CBOs and NGOs working to promote gender equity in the country of origin.

4.9 Reaching youth via traditional/social media and edutainment

Traditional communications structures should not be overlooked. For example, in Afar—the north-eastern region of **Ethiopia** where infibulation has been traditionally practised, the pastoralists who herd their livestock across the region have their own time-honoured and remarkably effective ways of disseminating information and making communal decisions:

> **"Dagu"** is a sophisticated indigenous system that keeps accurate, sourced information flowing among the Afar people across vast distances with remarkable speed. It is sometimes called the **Internet of Afar**—a flow of current and reliable information for people who rely on a deep understanding of their changing social and physical environment for their very survival. The information may involve an upcoming storm, which could mean flooding, a violation of local laws, or word of pasture or water sources. Tradition requires that, when Afar people meet, they must exchange information ("do dagu"), regardless of their acquaintance, and provide the source of their information so that its credibility can be weighed. ("What have your ears heard?" the exchange might begin "What have your eyes witnessed?"). False dagu can carry high penalties. In recent years, dagu, along with another traditional structure—formal community dialogues, or "meblo"—have helped disseminate new knowledge about FGM/C and build consensus towards abandoning the practice. (UNFPA, 2017 chapter 4.)

Also in rural **Kenya**, participants to Mwenda et al. (2020) study argued for building on systems already in place, such as the **Nyumba Kumi** which focuses on information sharing, especially over security threats. While participants also underscored the shortcomings of this **community policing**, there was consensus that if strengthened it would be the most effective and potentially the most sustainable to help determine households that were still practicing FGM/C and girls that are vulnerable.

Increasingly, mainstream and social media are being utilized in efforts to raise awareness against FGM/C. Innovations in the use of widespread **media campaigns** to galvanize public opinion have shown some results. In some countries radio waves are buzzing with discussions and call-in shows about the harm caused by FGM/C. The **sub-regional television channel AFRICABLE** reached a global audience by broadcasting sermons of a leading Islamic cleric supporting public declarations of abandonment of FGM/C. (N. J. Diop et al., 2012.)

For example, in **Somaliland**, ISF partner *Network against FGM/C in Somaliland (NAFIS)* **sensitizes journalists** from local TV, radio and newspaper companies to raise awareness of the negative consequences of FGM/C and to advocate for the enactment of the anti-FGM/C law. In **Djibouti**, *UNFPA-UNICEF Joint Programme* arranged workshops for 90 journalists from 30 media outlets on communication techniques related to FGM/C, resulting in more than 60 broadcast or printed reports. In **Burkina Faso**, radio stations, television, newspapers and leaflets have all been used to highlight the dangers of the practice, including the fact that it is illegal. Much of the information has been translated so that it is accessible even in rural areas, where dozens of local languages are spoken. Because literacy rates are low, **community radio** is an important part of the media mix, as is **popular music**. For instance, a song *Tomber la Lame (Drop the Blade)* by the popular rapper Smockey presents an anti-FGM/C message through poetic yet graphic lyrics. Community radio is an important media channel also in **Gambia**, where live **phone-in radio programmes** have sparked considerable interest and debate on FGM/C. Prominent Islamic religious leaders and scholars serve as resource people in the live radio panel discussions. (UNFPA, 2017 chapter 9 & 13.)

In **Senegal**, UNFPA-UNICEF Joint Programme built on the 2015 success of *C'est la Vie (That's Life)*, a major West African television production funded by Muskoka French Fund. Through the relationships and dramas, the serial sheds light on the health-care system and on a number of reproductive health issues, including FGM/C, while exploring the interactions of life, cultures and beliefs. In 2016,

Increasingly, mainstream and social media are being utilized in efforts to raise awareness against FGM/C. Photo: Open Hand Studios

a **Youth Awareness Caravan** fanned out across eight regions of Senegal, screening of *C'est la Vie* episodes to stimulate discussions on sexuality education for young people, FGM/C and social norms. In conjunction with local media and civil society organizations, dialogue was encouraged through phone-in talk shows on television or radio. Viewers were also encouraged to express themselves through **social media platforms, SMS campaigns or Internet games.** (UNFPA, 2017 chapter 12.)

Senegal also conducted the *TouchePasAmaSoeur (Don't Touch My Sister)* **digital campaign** that encourages young people to advocate for abandonment with decision makers, including by warning authorities of girls at risk of cutting within their communities. By 2017, the campaign had garnered more than 3 million visits on social networks. Expanding on the digital outreach, internationally known popular and crossover musicians have addressed the issue at concerts and social mobilization meetings. The campaign also presented the "Green Line", **anonymous 24/7 hotline** which provided young people accurate information in French or Wolof on FGM/C or any aspects of sexual and reproductive health, without exposing themselves to embarrassment. Complementing the "Green Line" is the "SR Minute," a series of **short, lively videos** on reproductive health and FGM/C, which feature the phone number at the end. The Senegal team also supported a summer education **television competition** for creating short films using phones, tablets and computer cameras. (UNFPA, 2017 chapter 12.)

Studies have shown the efficacy of **theatre-based training**, especially in reaching young people. Using theatre provides an opportunity to debunk myths and address sensitive topics and social norms not usually discussed in public. Dramatic contexts allow audiences to receive these messages in an entertaining and exciting way. According to *UNFPA-UNICEF* (2017 p. 28) experience, of central importance is the transitional model: "the character who changes his or her behaviour from risky to safe, demonstrating to the audience that change is possible, and that a young person is capable and powerful enough to control his or her own life." *Y-PEER's* work provides an example of theatre-based training:

> Engaging, participatory activities, often rooted in theatre, are a specialty of Y-PEER, a youth-led organization that has been especially active in Egypt. The group creates and produces community performances and peer education seminars, as well as training additional peer educators. The popular Y-PEER trainings focus on informing and exploring values using games, humour, role play and other theatre-based techniques. These are used to break the ice about sensitive subjects, and create openings to encourage self-expression and foster a deeper understanding of peer pressure and other social dynamics. (UNFPA, 2017 chapter 5.)

Social media is also used by youth peer educators to reach young people, and has proven to be effective for generating reflection and discussion among young people on sensitive issues that they cannot easily bring up in other settings. (UNFPA & UNICEF, 2015.) One successful example on engaging youth comes from **Guinea**:

> A pool of 32 Guinean youth from across the country (four per region) were trained to organize community dialogues and discussions about FGM/C and other forms of gender-based violence. These were conducted across social media platforms, including Facebook, Twitter, Google and Instagram. Eight thousand youth and 400 opinion leaders participated in community dialogues, and more than 3,000 young people joined in the conversations about FGM/C on social media. Moreover, 87 people followed the Programme of Ambassadors in fighting against FGM/C, which has the slogan "A non-excised girl is pure and complete." (UNFPA, 2017 Chapter 1.)

In **Somalia**, an emotional Youtube video Why Circumcise Me?[20], created by the Somali Artist Group, has been viewed over 66,000 times by now. It begins with a young girl playing hopscotch and concludes with her lying on a bed, post cutting. In **Egypt**, on Zero Tolerance Day against FGM/C, *UNFPA-UNICEF Joint Programme* launched an emotional Facebook campaign which addressed the fear young girls suffer during the FGM/C procedure:

> The six-day campaign targeted groups most likely to cut their daughters. It built interest with two teaser posts, which were followed by human interest stories, public service announcements, videos and infographics, and concluded with Joint Programme interventions to end FGM/C. The campaign generated around 3.5 million impressions, reached more than 2 million Facebook users, and garnered more than 900,000 shares, likes and comments from users. (UNFPA, 2017 chapter 12)

Joint Programme had **prepared answers** to respond to the vigorous debate that ensued from the campaign. UNFPA also contributed to a series of radio episodes on FGM/C during the month of Ramadan, when a larger-than-usual audience tuned in to the popular Radio Masr Network.

In **Somaliland**, ISF partner *Candlelight for Environment, Education and Health* has mobilised both journalists and university students to advocate against FGM/C. Student participants were nominated by the respective university management in accordance with criteria such as interest in the subject, preliminary awareness of the health consequences as well as Qur'anic verses and the Hadiths of FGM/C, willingness to volunteer, capability to influence through various media and to confidently debate and talk about FGM/C in public, and balance between both men and women from different faculties. In 2016, 30 students (15 men and 15 women) from two universities in Hargeisa participated in training sessions on the medical and historical facts about FGM/C, as well as human rights and religious perspectives to the practice. Following the training, students were writing and sharing Facebook updates and academic articles on FGM/C, raising awareness amongst their family members and in their neighbourhoods, and participating in radio and television debates. Starting from 2018, some of the trained students were selected as peer mentors to the next group of 100 students from both Hargeisa and Burao.

A young male student Hudayfi from Somaliland is one of the university students who have been mobilised to advocate against FGM/C through ISF partner Candlelight.

20. https://www.youtube.com/watch?v=u_Fg7aqlN44

4.10 Safeguarding and expanding access via digital platforms

The physical distancing requirements during the **COVID-19 pandemic** have strengthened reliance on mass media, social media and mobile technology as a way of reaching and engaging with intended audiences. As identified by *UNICEF* (2020a), digital platforms can be used for gathering social data, sharing information and providing services, facilitating dialogue and engagement with intended audiences, supporting training and capacity-building, tracking and addressing sentiment and misinformation. However, before launching digital approaches, programmes should analyse how the pandemic is affecting people's thoughts, beliefs, attitudes, and intention around FGM. Developing a plan for digital engagement requires an understanding of the social, political and economic context, as these often define access and use of digital resources by intended audiences. A rapid desk review should look at media habits of intended audiences, trusted and utilized information sources, and credible spokespersons. UNICEF (2020a Table 2) summarizes the commonly used digital platforms and their pros and cons:

Table 2 Commonly used digital platforms and their functions (UNICEF, 2020a Table 2)

Remote engagement option	2-way commun.	Network/bandwidth requirement	Burden of scale	Device requirement
Radio	no	none	none	radio
Television	no	Television cable or satellite	note	television
Interactive Voice Response (IVR)	yes	Edge network	High: talk-time costs often borne by project	Basic feature phone
SMS	yes	Edge network	High: SMS costs often borne by project	Basic feature phone
Web, Free Basics	yes	Edge network	none	Basic feature phone
Web. Facebook Lite	yes	2G	End user bears burden of data bundle	Some feature phones, smart phones
Facebook, WhatsApp Messenger, Viber	yes	2G	End user bears burden of data bundle	Smart phones

When face-to-face awareness sessions were banned or restricted during the COVID-19 outbreak in **Somaliland**, *Network against FGM/C in Somaliland, NAFIS* (partnering with ISF), took the opportunity to test awareness raising on FGM, other forms of VAW, and COVID-19 via an **Interactive Voice Response (IVR) system**. *NAFIS'* existing register of women belonging to cluster level associations (CLA) and related self-help groups (SHGs) constituted the database for the IVR system. A confidentiality agreement was signed with Telesom, imposing that all data to be stored in a hosted server, into which only authorized Telecom staff has access. List of target beneficiaries' phone numbers was provided to Telesom, after which the CLA and SHG members were encouraged to use a short code (e.g., 333) shared with them by *NAFIS*. The beneficiaries initiate the call, and the system will automatically guide the dialler with pre-recorded messages about the prevention and response of COVID 19, FGM and VAW (e.g., "If you are looking for information about COVID-19 please dial 1" or "If you are looking or information about FGM please dial 2" etc.). A regular automated SMS was also be sent out to the target beneficiaries twice a month to remind about the seriousness of the COVID 19. There is also an alternative strategy available whereby the system calls 60 numbers every minute and the voice message is delivered once the call is answered. If the subscriber does not answer or misses the call, the platform will put the number in a queue and initiates another call once the previous list has been completed.

In **Kenya**, *UNICEF Kenya* and the *Anti-FGM Board* have launched a **mobile phone application called "pasha" to realize timely reporting and tracking** of planned FGM cases. The application also aims to improve in-action and hold respective duty bearers to account (including police officers, children's officers, chiefs, etc.), increase community FGM reporting by reducing fear of retaliation through confidential anonymous reporting, connect girls at risk of FGM or who has undergone FGM to the nearest service provider; and provide data on the number of reported FGM cases, status/action taken, and services provided by the different stakeholders. The application is connected to a dashboard manned by the immediate relevant government agencies to take action. The application can be accessed through smart phones and basic phones via short text messages. The application also has a knowledge management section where new data and knowledge can be accessed and shared. The intended users of the application are girls, any other person in the community, civil society organizations, Government line departments and the Anti-FGM Board.

Tips for effective digital engagement are summarized by UNICEF (2020a, p. 6) as follows:

- Link your digital efforts to your programme's theory of change.
- Tailor activities to your intended audiences' habits and preferences.
- Reach both girls and boys.
- Provide opportunities for audiences to interact with your digital content.
- Build trust and use credible champions.
- Develop engaging concise content.
- Pre-test your concepts.
- Think carefully about language and literacy.
- Factor in costs and data limitations.
- Promote your digital platform.
- Budget for moderation and management of content and comments.
- Avail capacity to respond to additional demand generated.
- Put digital safeguarding in place.
- Make a plan for feedback to your users.

Most importantly, there is little evidence that digital approaches, will succeed in changing behaviours and social and gender norms if used in isolation. For effective engagement, they need to be complemented by other channels and reinforced through multiple media.

4.11 Coordinating for efficient resource utilization and harmonized messages

To ensure better resource utilization and a shared message to communities, to avoid duplication of work, and to reduce a sense of competition, it is crucial to **coordinate the efforts** between various change agents, between local and national level actors, and between NGOs, governmental institutions, and donors working to stop FGM/C in a specific context. In for example Burkina Faso, Egypt, Ethiopia, Mali and Uganda, *WHO* (2011) found that while an array of collaborative efforts was taken to facilitate exchange of information and resources, the efforts were impeded by competition for funding, disapproval of each other's strategies and personality differences.

UNFPA (2017 chapter 3) reports a successful example of national level coordination from **Sudan** where it has funded a "Tutti Initiative" to end FGM/C since 2009. Beginning in 2013, the funds have been channelled through the *Ahfad University for Women (AUW)*, a long-time partner of *UNFPA* in the region. AUW was given the role of managing a **consortium of grassroots organizations** working on FGM/C. Before 2013, managing and harmonizing the campaign in Sudan was difficult and expensive because of the number of diverse actors, including academia, media, and community and faith-based organizations. *AUW* created **coordination and partnership mechanisms** that improved the quality of activities, reduced duplication of efforts, ensured unity of action in the face of disruptive forces and encouraged mutual empowerment.

As the leader of the consortium, *AUW* has developed a checklist and training workshop to encourage effective coordination; organized a training workshop on intergenerational dialogue; established quarterly review meetings with implementing partners in which participants present success stories, best practices and challenges faced; and helped partners prepare 14 communities in four states for public declarations of abandonment of FGM/C. The consortium has also produced several manuals and guidelines such as *Advocacy Skills Training Manual, Guidelines on Results-based Leadership, Community Dialogues and Public Declarations, and Results-Based Leadership, Communication and Management*. It also produced a *Manual on Community Engagement* that includes tools to encourage individuals to become agents of positive change. (UNFPA, 2017 chapter 3.)

To promote local level coordination In the Kisii region in Kenya, ISF established *Muungano Gender Forum*[21] in 2018. It is a **monthly multisectoral platform for state and non-state actors** to identify and discuss local problems and solutions related to gender equality and women's rights, including FGM/C which remains rampant in the county regardless of the decreasing national prevalence. The forum has quickly gained popularity and achieved an established status in Kisii and Nyamira counties. An external evaluation of the forum conducted in 2020 found that the county collaboration has led to enhanced, effective, and harmonized coordination among stakeholders to address gender inequality in key sectors of Kisii and Nyamira counties.

21. https://solidaarisuus.fi/en/muungano-gender-forum/

Nancy's mother was educated about the negative consequences of FGM and saved Nancy from cutting.
Now as a teenager, Nancy is proud to be uncut and wants to become a nurse. Photo: Nyasha Kadandara

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