

# Researching Female Genital Mutilation / Cutting

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**Els Leye &  
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**MAP-FGM**

MULTISECTORAL ACADEMIC PROGRAMME  
TO PREVENT & COMBAT FEMALE  
GENITAL MUTILATION / CUTTING

**Researching  
Female Genital Mutilation/Cutting**



# **Researching Female Genital Mutilation/Cutting**

Proceedings of the 2nd International Academic Seminar  
of MAP-FGM Project

*Els Leye & Gily Coene (eds.)*



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# Preface

*Karin Vanderkerken, Vice Rector Research Policy, Vrije Universiteit Brussel*

Female genital mutilation or genital cutting, is widely recognised as a form of violence against women and a human rights violation. With more than 200 million women and girls affected by it worldwide, this is not a marginal phenomenon. Moreover, migration has spread the practice beyond the continent where it is most widespread, namely Africa. In Europe, an increasing number of professionals are or will be confronted with it, and need to be aware therefore of female genital mutilation, its meanings, its consequences, and the most effective ways to prevent it, protect girls and women and support those that have already been cut.

It is therefore of the utmost importance to raise awareness of the issue in Europe, and to share knowledge and experiences within Europe and Africa. Research plays a crucial role in this as knowledge and best practices should be based on evidence provided by academics and researchers.

The VUB, and RHEA – the Centre of Expertise on Gender, Diversity and Intersectionality- in particular – have always put diversity and gender at the centre of their activities. I believe therefore that initiatives such as the Academic Multisectoral Programme on Female Genital Mutilation/Cutting that the seminar and these proceedings formed part of, need support in order to further disseminate lessons learned.

As vice-rector of the VUB, it is my privilege to have been part of the seminar. These proceedings provide a wealth of insights into the phenomenon of female genital mutilation/cutting and hope you will enjoy reading.



# Voorwoord

*Karin Vanderkerken, Vice Rector Onderzoeksbeleid Vrije Universiteit Brussel*

Vrouwelijke genitale verminking, of vrouwenbesnijdenis, wordt wereldwijd erkend als een vorm van geweld tegen vrouwen en meisjes, en als een schending van hun mensenrechten. Met meer dan 200 miljoen meisjes en vrouwen die wereldwijd het slachtoffer zijn, is dit geen marginaal probleem. Meer zelfs, migratie bracht de praktijk ook naar andere continenten buiten Afrika. Een stijgend aantal professionelen in Europa worden er al mee geconfronteerd, of zullen ermee in contact komen in de toekomst. Daarom is het nodig dat zij weten dat dit bestaat, welke betekenis dit heeft, wat de gevolgen zijn en wat de meest effectieve manieren zijn om het te voorkomen, om meisjes en vrouwen te beschermen én om diegenen te ondersteunen die reeds besneden zijn.

Het is daarom uitermate belangrijk om over dit fenomeen te informeren en om kennis en ervaringen te delen tussen Europa en Afrika. Onderzoek speelt daarbij een cruciale rol, omdat kennis en goede praktijken gebaseerd dienen te zijn op data en gegevens uit wetenschappelijk onderzoek, dat kan aangeleverd worden door academici en onderzoekers.

De VUB, en RHEA – het Expertisecentrum Gender, Diversiteit en Intersectionaliteit – in het bijzonder, hebben altijd diversiteit en gender op de voorgrond geplaatst. Ik ben er daarom van overtuigd dat initiatieven zoals het Academisch Multisectorieel Programma over Vrouwelijke Genitale Verminking/Vrouwenbesnijdenis, waarvan het seminarie en deze proceedings een onderdeel van zijn, alle steun moeten krijgen om de ervaringen en lessen uit het verleden verder te verspreiden.

Als vice-rector van de VUB is het een privilege om te hebben kunnen deelnemen aan het seminarie. Deze proceedings geven u een rijkelijk aanbod aan inzichten omtrent het fenomeen van vrouwelijke genitale verminking/vrouwenbesnijdenis, waarmee ik u veel leesplezier toewens.



# Introduction

*Els Leye and Gily Coene*

*RHEA, Centre of Expertise Gender, Diversity and Intersectionality*

This book provides an overview of the papers presented during the Second Academic Seminar called ‘Female Genital Mutilation/Cutting at the intersection of qualitative, quantitative and mixed method research. Experiences from Africa and Europe’, which took place in Brussels on June 8<sup>th</sup> and 9<sup>th</sup> 2017.

This seminar was organised as part of the MAP-FGM project, the ‘Multisectoral Academic Programme to Prevent and Combat Female Genital Mutilation (FGM/C)’. This project aims at raising awareness, knowledge and skills among university students (the future professionals who might come in contact with possible victims of FGM/C) and professors. It is a collaborative effort of 5 universities in 4 EU countries: Universidad Rey Juan Carlos in Madrid (URJC), coordinator of the project, the Center for International Studies of the University Institute of Lisbon (ISCTE-IUL), Fundacion Wassu Universidad Autonoma de Barcelona, Universita Roma Tre Italy, the Vrije Universiteit Brussel, and Fondazione Angelo Celli in Italy. The project started in 2016, and finished end of January 2018.

The goal of the seminar was to discuss the added value of research in abandoning FGM/C, the do’s and don’ts and to discuss recommendations for researching FGM/C. It consisted of 7 sessions. The opening session was opened by the vice-rector of Research of the Vrije Universiteit Brussel, Prof. Karin Vanderkerken, the director of RHEA Centre of Expertise on Gender, Diversity and Intersectionality of the Vrije Universiteit Brussel, Prof. Gily Coene, and by Mrs An Van Nistelrooij, Policy Officer at the Gender Equality Unit of the Directorate General Justice of the European Commission. The other sessions focused on the crucial role of research in abandoning female genital mutilation, in which gaps in research, the need to integrate an intersectionality perspective in research, and evaluations of current strategies on FGM/C were identified. Presenters from both African and European countries shared exam-

ples of their qualitative, quantitative and mixed method research on FGM/C, and each session was followed by a discussion. Research was presented from a wide range of countries including Belgium, Egypt, Ethiopia, The Gambia, Ireland, Mali, Nigeria, Norway, Portugal, Senegal, Sweden, the Netherlands, and the UK.

The topics covered in all these sessions included medicalisation of FGM/C, associations between FGM/C and child marriage, estimates of prevalence, surveys on knowledge about attitudes and practices, use and interpretation of survey data, organisation of focus group discussions on FGM/C, assessing FGM/C in refugee populations, assessing attitudinal changes among generations, research on behaviour change towards FGM/C, research into male involvement, research into the transposition of the human rights framework on FGM/C and research into changes in social norms due to migration.

The presentations from the 2<sup>nd</sup> Academic Seminar have now been compiled into comprehensive papers that are presented in this book volume. We would like to thank all the contributors for their input and the participants in the seminar for the contributions they made to a stimulating and interesting debate.

The MAP-FGM seminar and the project were financially supported by DG Justice of the European Commission.

# Introductie

*Els Leye en Gily Coene*

*RHEA Expertise Centrum Gender, Diversiteit en Intersectionaliteit*

Dit boek geeft een overzicht van alle presentaties van het Tweede Academische Seminarie 'Female Genital Mutilation/Cutting at the intersection of qualitative, quantitative and mixed method research. Experiences from Africa and Europe', dat plaatsvond in Brussel op 8 en 9 juni 2017.

Het seminarie werd georganiseerd in het kader van het MAP-FGM project, het 'Multisectorieel academisch programma ter preventie en aanpak van vrouwelijke genitale verminking'. Dit project heeft als doel om de aandacht voor vrouwelijke genitale verminking/vrouwenbesnijdenis (VGV/VB), kennis en skills van universiteitsstudenten (de toekomstige professionelen die mogelijks in contact zullen komen met vrouwelijke genitale verminking) en professoren omtrent deze problematiek aan te zwengelen. Het is een samenwerking tussen vijf universiteiten in vier Europese landen: Universidad Rey Juan Carlos in Madrid (URJC), coordinator van het project, het Center for International Studies van het University Institute of Lisbon (ISCTE-IUL), Fundacion Wassu Universidad Autonoma de Barcelona, Universita Roma Tre Italy, de Vrije Universiteit Brussel, en Fondazione Angelo Celli in Italy. Het project ging van start in 2016, en eindigde eind januari 2018.

Het seminarie beoogde de discussie te bevorderen omtrent de meerwaarde van onderzoek in het uitbannen van vrouwelijke genitale verminking/vrouwenbesnijdenis, waarbij de goede praktijken en valkuilen aan bod kwamen, en enkele aanbevelingen werden meegegeven omtrent het onderzoek doen naar VGV/VB. De conferentie werd geopend door de vice-rector Onderzoek van de Vrije Universiteit Brussel, Prof Karin Vanderkerken, door de directeur van RHEA Expertisecentrum Gender, Diversiteit en Intersectionaliteit van de Vrije Universiteit Brussel, Prof. Gily Coene en door Mevrouw An Van Nistelrooij, beleidsmedewerker van de Cel Gendergelijkheid van het Directoraat Generaal 'Justitie' van de Europese Commissie.



De verschillende sessies focusten op de cruciale rol van onderzoek in de strijd tegen VGV/VB, waarbij de lacunes in onderzoek, de noodzaak om een intersectioneel perspectief te hanteren en evaluaties van huidige strategieën werden geïdentificeerd. Sprekers uit Afrika, Europa en Amerika deelden hun ervaringen met kwalitatieve, kwantitatieve en mixed method onderzoeksmethoden omtrent VGV/VB, waarbij elke sessie werd gevolgd door een discussie met de toehoorders. Onderzoek werd gepresenteerd uit diverse landen, waaronder België, Egypte, Gambia, Ierland, Mali, Nederland, Nigeria, Noorwegen, Portugal, Senegal, Verenigd Koninkrijk en Zweden.

De topics die werden gepresenteerd, waren onder andere medicalisatie van VGV/VB, de associaties tussen VGV en kindhuwelijken, prevalentieschattingen, surveys naar kennis, attitudes en ervaringen van professionelen, gebruik en interpretatie van survey data, de organisatie van focusgroep discussies over VGV, onderzoek naar VGV in vluchtelingenpopulaties, onderzoek naar veranderingen in attitudes in verschillende generaties, onderzoek naar gedragsveranderingen, onderzoek naar het betrekken van mannen in de strijd tegen VGV, onderzoek naar de transitie van mensenrechtenkader met betrekking tot VGV en onderzoek naar de veranderingen in sociale normen door migratie.

De presentaties van het Tweede Academische Seminarie werden door de sprekers vastgelegd in een aantal papers, die werden samengevoegd in dit boek. We willen daarom ook alle sprekers/auteurs hartelijk danken voor hun inspanningen, alsook alle deelnemers die aan de debatten deelnamen, waardoor het een stimulerend en interessant seminarie werd.

Het seminarie en het project MAP-FGM werden financieel ondersteund door de Europese Commissie DG JUST.

# Changes in Intergenerational Attitudes to Female Genital Cutting in Nigeria: Lessons Learnt from Qualitative and Quantitative Analyses of Primary and Secondary Data

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## Background

Female genital cutting (FGC), locally known as female circumcision in Nigeria, includes all procedures involving partial or total removal of the external genitalia or other injuries to the female genital organs whether for cultural or non-therapeutic reasons (OHCHR, et al, 2008). Globally, an estimated 200 million and in Africa, approximately 125 million girls and women have undergone FGC (WHO, 2016). It is seen as a socio-cultural practice in thirty nations scattered across Africa, the Middle East, and Asia (WHO, 2016).

Although FGC is widespread in Nigeria and cuts across all ethnic groups in the country especially among the Yoruba of the South Western Nigeria (Gbadebo et al, 2015), the practice is rare among the Ijebus, the Egbas and the Itshekiris in the South-West and the Fulanis in the North-East (Hosken, 1979; Caldwell et al, 2000). According to a survey, one in four women of reproductive age was genitally cut in 2013 compared to 30 per cent in 2008 (NPC [Nigeria] & ICF Macro Int. [USA] 2013). The practice is seen as a cultural practice; a way of protecting women and girls against promiscuity; reducing women's sex urge, enhancing fertility, promoting husband's sexual pleasure and initiating girls into womanhood. Female genital cutting is usually carried out on young girls during infancy, before the age of 15, before marriage or

immediately after the birth of their first child (WHO, 2012). It is mostly carried out by local circumcisers and Traditional Birth Attendants (TBAs) but its medicalisation is found among a few health practitioners. Among local circumcisers it is typically performed with crude and unsterilized instruments such as sharp stones, broken glasses, scissors or unsterilized razor blades without anaesthesia (WHO, 2014).

Female genital cutting has no health benefits but imposes health risks on its victims especially during their reproductive lives. The health consequences which are both immediate and long term include haemorrhage, pain, shock, bleeding, infections, urination problems, depression, and sometimes infant death. Victims of FGC also face all sorts of gynaecological challenges (NPC [Nigeria] and ICF [Macro], 2009; WHO, 2016).

Cognisant of the harm which FGC poses to women, the Nigerian government, NGOs and international bodies such as WHO have put FGC on the human rights' agenda meriting condemnation (WHO, 2014). Some researchers into FGC have carried out quantitative studies while others carried out qualitative studies into the attitudes towards FGC but there is no consensus about the outcomes. This study, therefore, investigated attitudes towards the practice of female genital cutting using mixed methods.

## Methods

The study was conducted among Nigerian women of reproductive age (15-49). Nigeria has a heterogeneous population of approximately 170 million people comprising more than 250 ethnic groups, with Hausa/Fulani, Yoruba and Ibo being the three dominant ethnic groups (PRB, 2013). Women and girls constitute about 52 % of the country's population. The study made use of both primary and secondary data. The secondary data were extracted from the 2008 and 2013 Nigeria Demographic and Health Survey which was jointly conducted by ICF Macro International and the Nigerian Population Commission. Both surveys collected information about FGC from all women of reproductive age. The 2013 DHS survey collected data from a nationally representative probability sample of households, women of reproductive age and men in sampled households. The survey used a three-stage cluster sampling model.

For the primary data, 12 focus group discussions and 6 Key Informant Interviews (KII) were conducted in South-West Nigeria. The group discussions primarily focused on the general opinions about FGC. The focus group discussions were conducted among women of reproductive age while the KII were conducted among local

circumcisers, traditional birth attendants, Community Health Workers, nurses and midwives.

Analyses of quantitative data were carried out at univariate, bivariate and multivariate levels using frequency distributions, Chi-square test and logistic regression respectively. Analysis was weighted to obtain national estimates of FGC prevalence and its differentials. The independent variables for this study are the socio-demographic variables (age of respondents, education, wealth index, residence among others). The dependent variables relate to the practice of FGC among the respondents; among daughters and the future intention to practice FGC. The qualitative data were analysed thematically.

## Results

The results of the study showed that the number of women who have circumcised daughters decreased from 30.6 % to 14.2 % between 2008 and 2013. However, the number of women who wanted FGC to continue increased from 25.8 % to 26.4 % and the number of women who have circumcised daughters also increased proportionally to the age of the women in both surveys. Women with no education (37.4 % & 21.2 %), those residing in rural areas (32.2 % & 16.8 %), poor women (37.8 % & 20.9 %) and Muslims (40.3 % & 20.0 %) have more circumcised daughters than their counterparts. The Hausa/Fulani (44.1 % & 22.5 % in 2008 and 2013 respectively) and women from the North-West (46.8 % & 23.8 % in 2008 and 2013 respectively) have circumcised more daughters than their counterparts.

In addition, more women with no formal education in both surveys (34.0 % and 35.5 %) and those residing in rural areas (28.0 % and 29.7 %) wanted the practice of FGC to continue than their counterparts. Furthermore, more poor women, traditional worshippers and Hausa/Fulani wanted the practice to continue.

At the multivariate level, age of women, education, residence, marital status, wealth, religion and region were found to be predictors of circumcising daughters. Similarly, the predictors of the future intention to practice FGC were the age of the respondents, their education, marital status, wealth, religion, region, being circumcised and already having a circumcised daughter. Furthermore, women who have circumcised at least one daughter were found to be 1.5 times more likely to continue the practice of FGC in the future.

Results from the focus group discussions revealed deep cultural beliefs that perpetuate the practice of FGC. These beliefs are reinforced by the community's imposed obligation to preserve the society and are compelled by the expectation of negative

consequences. These are revealed in the responses from the participants in the FGD reproduced below:

‘It is a traditional practice in our society which must be passed to younger generations.’

‘A girl must be genitally cut. If she is not cut, she will be promiscuous like dogs.’

‘A girl’s genitalia must be cut. The head of the baby must not touch the clitoris, if it does, the baby will die.’

On attitudes about continuing the practice, responses include:

‘If I have a daughter, I will want her circumcised. It is a custom that must be passed to younger generation.’

‘Because I was circumcised, I must also circumcise my daughter.’

In the KII, economic reasons were shown as the basis for advocating the promotion of FGC. This is revealed in the responses of the FGC practitioners as follows:

‘If people come to me, I will still do it for them. It is in the hospital that they are not doing it. Are you going to feed me or what? After all it is a tradition, why are you people trying to turn the world upside down?’ ...TBA

## Conclusion

Despite the fact that FGC is reducing in Nigeria, the findings revealed positive attitudes towards FGC and show that the practice is deeply rooted in Nigerian cultural beliefs. These beliefs are based on the attempts to preserve the society from negative consequences. There is, therefore, need for a multi-dimensional approach to bring about attitudinal change in the country. This attitudinal change will involve improving girl’s education and status.

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# Engaging Communities to Implement Behaviour Change to End FGM in the EU: Lessons from the REPLACE Project

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## The REPLACE Approach

The REPLACE Approach is an innovative and effective community-based methodology for tackling FGM in the EU (Barrett et al, 2015a, 2015b). It was developed, implemented and evaluated between 2010 and 2016 with funding from the EC Daphne III Programme<sup>1</sup> in five EU countries (Italy, the Netherlands, Portugal, Spain and the UK) and has subsequently been rolled out in the CHANGE Plus Project (JUST/2014/RDAP/AG/HARM) to Germany and France. The project worked with FGM-affected African migrant groups from the following countries: Eritrea, Ethiopia, The Gambia, Guinea Bissau, Senegal, Somalia and Sudan. The REPLACE Approach has been developed with the goal of ending FGM in the EU. It is a community-based approach that empowers communities and puts them at the centre of social norm transformation by applying behaviour change theory.

The REPLACE Approach recognises that whilst communities are made up of individuals, these individuals, particularly recent migrants, belong to communities and thus are subject to the social norms and enforcement mechanisms of that community. REPLACE recognises that the practice of FGM occurs within a wider socio-cultural context and the behaviour and decisions of others are critical in relation to the outcome of whether or not FGM is carried out. The Approach recognises that

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<sup>1</sup> JLS/2008/DAP3/AG/1193-3DCE03118760084; JUST/2012/DAP/AG/3273

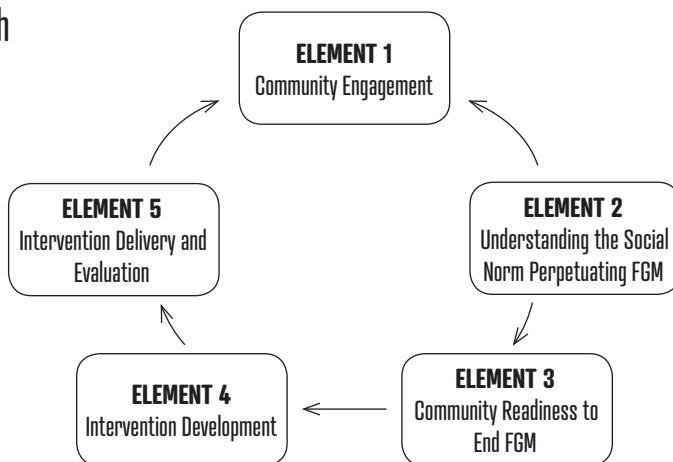


some individuals are in less powerful, less influential positions within their communities than others and are therefore unable to implement behaviours that will lead to the abandonment of FGM. REPLACE has therefore adopted relevant elements from individually focused behaviour change theories and combined these with behaviour change theories that concentrate on the role of society (Brown et al, 2013). The result is the REPLACE Cyclic Framework for Social Norm Transformation which is shown in Figure 1. This Cyclic Framework comprises five elements that represent the flow of motivation and behaviour change within a community, stressing the important role played by community leaders, influential people and peer group champions (Change Agents) in working towards social norm transformation (Barrett et al, 2015a). The Approach does not regard ending FGM as a behaviour, but as a goal. The achievement of that goal may require a number of cycles of the Cyclic Framework.

**Figure 1** The REPLACE Cyclic Framework for Social Norm Transformation in relation to FGM. (Barrett, et al, 2015a)

## The REPLACE Approach

The REPLACE Cyclic Framework for Social Norm Transformation in relation to FGM



## Community Engagement for Behaviour Change

The REPLACE Approach is based on the premise that if members of a community support and enforce a social norm such as FGM, they could be the key to overturning the norm (Johansen et al, 2013). Thus effective community engagement underpins

the REPLACE Approach. REPLACE recognises that communities have a wealth of knowledge and resources that can be harnessed to address issues that affect them, such as FGM. The Approach therefore emphasises a community approach to ending FGM (Mackie, 2000; Unicef, 2010). This suggests that interventionists should work with communities and community members as collaborators and partners rather than as top-down solution prescribers. The REPLACE Approach requires the community to be extensively involved in all aspects of the Cyclic Framework (Figure 1), including research, design, implementation and evaluation. The community engagement approach of REPLACE is underpinned by four key principles: inclusion; respect; effectiveness; and transparency (see Table 1).

**Table 1** Principles of Community Engagement (Barrett et al, 2015a)

Engagement Principles	Description
Inclusion	The involvement of different individuals or groups affected by the FGM-related issue being tackled regardless of their position in society. This suggests building ethno-cultural, gender and intergenerational diversity in the engagement process. It also means the need to eliminate physical, psychological and socio-economic barriers to participation by all groups.
Respect	Recognising the autonomy of community members over decisions that affect them and their ability to bring about change over issues that affect them. This also means recognising the knowledge and resources of community members and the need to take their views and inputs seriously. Respect for community members also suggests adapting community engagement to the needs of the community.
Empowerment	Adequate measures are taken to ensure that community members are adequately empowered through information and education and the provision of resources needed to enable them to engage effectively with the project.
Transparency	The need for community members to be adequately informed about the intervention project, including the purpose and limitations of the project, as well as the nature of their involvement.

## Benefits of Community Engagement

Community engagement means different things to different people. However, the REPLACE Approach used community engagement to refer to the process and practice in which individuals of a particular community participate in an intervention or

project in order to achieve a common goal through behaviour change. There are many benefits to be derived from community engagement. These include the fact that community engagement:

1. Allows for community knowledge and resources to be brought to bear on an issue, intervention or project in order to enhance effectiveness and encourage behaviour change.
2. Creates a sense of ownership over the intervention or project by community members and enables them to work together with interventionists to determine the most appropriate way to address the issue and which behaviour to target.
3. Increases the uptake of intervention programmes. There is greater possibility for an intervention to be adopted and behaviour change to occur if community members are involved in devising and implementing the intervention.
4. Reduces community resistance to intervention programmes and allows current behaviour to be challenged.
5. Enhances the long-term sustainability of an intervention project and the likelihood of sustained behaviour change. By actively participating in an intervention, community members learn new skills that they can use to continue the intervention and behaviour change beyond the lifetime of the project.
6. Provides avenues for developing rapport and trust with community members giving them support to continue with new behaviours.

## Challenges of Community Engagement

Engaging with FGM affected communities can be very challenging as the issue of FGM is a deeply rooted traditional practice that is culturally sensitive and often a taboo subject. REPLACE used a range of different mechanisms to engage with FGM affected communities. These can be broadly categorised into: information dissemination; consultation/research; and active participation (Queensland Department of Communities, 2005). These can be conceptualised as consisting of a continuum of activities with an increasing level of community influence, ranging from passive recipients of information through to involvement in consultation and research to active participation and leadership, which is what REPLACE was aiming for.

1. Information dissemination is an essential element of effective community engagement and can act as a first stage in changing attitudes and behaviours. Very often few people will be interested in the issue at the initial stages of a community engagement process, in this case ending FGM. There is a need therefore for intensive communications between interventionists and community

members using both face-to-face and other information dissemination tools, such as posters and social media, to inform and stimulate interest in the issue. During REPLACE, as the project came to be known within the communities, community members began to talk to other community members about FGM and interest snowballed. Community Peer Group Champions began to emerge from the community. This phase in community engagement can be time consuming and cannot be hurried as trust and mutual respect have to be developed.

2. The consultation and research community engagement phase involved seeking the advice and views of community members on the issue of ending FGM. It is a two-way process that involves sharing ideas between the interventionist and community members. REPLACE used a range of different tools to undertake this phase, including face-to-face interviews with leaders and influential people within the community, undertaking focus group discussions and community workshops. This phase enabled both the REPLACE team and the community to interrogate the barriers and facilitators of FGM and to explore with communities the behaviours that needed to be challenged if FGM was to end. The Community Peer Group Champions were trained (CHANGE Plus, 2016) to lead this phase of community engagement. Depending on the stage of readiness of the community to end FGM, the time needed to complete this stage varied. In communities where there was resistance to change, more time and energy was required than with communities that wanted to end FGM but did not have the confidence to challenge the social norm that perpetuated the practice. During this phase, groups of active participants emerged.
3. Active participation involves substantial participation of community members in the development, design, implementation and evaluation of behaviour change activities. It involves supporting community members in taking responsibility for ending FGM in their communities. It inevitably means handing over leadership from interventionist to the community. REPLACE achieved this by facilitating workshops, setting up steering committees and working groups from within the community, often led by the Community Peer Group Champions. As the community moves towards active participation they begin to feel increasingly committed, have ownership of the process and a vested interest in the outcomes of the project. However this can be disconcerting for funders and project implementers who have to let go of control.

## Conclusion

The REPLACE Approach is a new way to tackle FGM in the EU and complements the current dominant methods used to end FGM in the EU which focus on raising awareness about the health and legal issues associated with the practice. Behaviour change theories combined with community engagement are central to the REPLACE Approach and empower FGM affected communities through community leaders, influential people within the community and Community Peer Group Champions to challenge the social norm and associated behaviours associated with perpetuating FGM. Underpinning the Approach is effective active community engagement which will facilitate behaviour change and the end of FGM. Community engagement is challenging especially when tackling a deep-rooted, culturally sensitive and taboo issue such as FGM. It is time consuming, requires the building of trust and respect and the empowerment of community members who are ready to end the practice. But it is the only sustainable way to achieve the behaviour change needed to end the practice of FGM in the EU.

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# Female Genital Mutilation after immigration to Sweden

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## Background

Sweden was the first country in Europe to legislate against Female Genital Mutilation (FGM) (Lag 1982:316) and had two court cases in 2006/2007. (Berggren and Franck, 2008) There are around 38,000 women and girls who originate from countries with a confirmed FGM prevalence of over 50 % living in Sweden (The Social Authority of Welfare, 2015).

Research on FGM post immigration to Sweden is scarce. One qualitative study indicates a decline in FGM after immigration (Johnsdotter et al, 2009). Another quantitative study mentioned that 19 % of girls still underwent FGM after immigration to Scandinavia (Elgali et.al, 2005). A recent government mission (2013/5292/JÄM) described that more knowledge is needed about FGM in Sweden (The County Administrative Board of Östergötland, 2015). This paper provides an overview of a qualitative survey on FGM after immigration to Sweden (Isman, Ekeus, Berggren, 2013).

## Aim

The aim of the study was to elucidate perceptions and experiences of FGM after immigration to Sweden.

## Method

The qualitative survey had an inductive qualitative design. Interviews were carried out in Swedish with eight women originally from Somalia and currently living in Sweden. Data was collected via so called chain- or snowball sampling via NGOs, with the aim of recruiting a meaningful sample of different ages, levels of education and origins of the participants.

The respondents were aged between 19 and 45. The women had lived in Sweden between 13 and 20 years apart from one woman who was born in Sweden. Four of them were married and had children. Two women had five children, one woman had two children and one woman had one child. The other women were not married and had no children. Two of them had finished high school and one was studying at university to become a nurse. One woman was on maternity leave. The interviews involved open ended questions at locations chosen by the participants themselves. A pilot study resulted in changes to the interview guide that was updated with more probing questions into honour and purity. The interviews were recorded and the transcribed data was analysed using content analysis. The ethic committee in Stockholm issued a positive advisory recommendation (Isman, Ekeus, Berggren, 2013).

## Findings

Overall the analysis of the qualitative data showed that FGM is sometimes an important symbol of a person's culture after immigration to Sweden, explained as a question of honour regarding the perceived value of female virginity. The analysis of the qualitative data produced four different themes. These were: Ensure virginity to protect family honour, Avoiding shame and enhancing purity, Social pressure to perform FGM after immigration and A symbol of the country of origin.

The women started by talking about their experiences of everyday life and childbirth. Some women spontaneously mentioned sexuality and that more knowledge was needed regarding FGM and sexuality. All the women who had been infibulated described the procedure as having negatively affected their lives. They had for example experienced painful menstruations. Two women, who had been infibulated, reported that their sexual life was difficult, characterised by a lack of pleasure and joy for them, and that this had a negative effect on their husbands who felt guilty for wanting to have sex.

The overall understanding was that the women felt ambivalent about the practice of FGM. On the one hand they recognised the negative health effects of FGM, but on the other hand, they still acknowledged the positive cultural value of the tradition. They explained that in their social context having undergone the traditional procedure of FGM was perceived positively, even though the experience of cutting was traumatic and painful for the individual.

### Theme 1: Ensuring virginity to protect family honour

The first theme explained a perceived importance of FGM in order to ensure virginity to protect the honour of the family. FGM was explained as prevention, as a measure taken in order to avoid rumours of presumed 'bad behaviour' – namely premarital sexual activity – and the procedure is important in avoiding possible shame and disgrace.

'You circumcise so you don't have to feel shame...damage the family's honour... I protect my sexuality and this protects my family's honour. It is the family's shar-  
aff you protect, the family's honour.' (Interview 5)

### Theme 2: Avoiding shame and enhancing purity

Shame and purity were mentioned repeatedly in the narratives. Shame emerged both in relation to lack of purity and pain experienced during the FGM cutting procedure. This theme appeared in the sub-themes: Enduring suffering and pain and Valuing social purity, physical purity and religious purity.

#### *Enduring suffering and pain*

The cultural importance of having the strength to endure suffering and pain of different kinds in life emerged as a sub-theme of avoiding shame. The narratives contained rich descriptions of shame connected to expressing pain during the FGM procedure. The women recounted that they had been taught even as children not to show pain. Trying to hide the expressions of pain was something that was an important reminder throughout the entire lives of the woman including during childbirth.

'If you scream, you are supposed to feel shame ... the women do everything, build the house and everything. Yes, even if the guys are fighting in the war and come home, they don't care if their legs are broken or chopped off or bombed ... you just have to endure.' (Interview 7)



One woman indicated that the shame of showing pain remained present during her encounter with the Swedish health care system. Even though she was informed that it was acceptable to show pain when giving birth here, it was not easy for her do so.

‘...we’re made to endure...well you have piece of fabric in your mouth so you can’t scream, and you bite to it, yes you clench your teeth, you cling tight to your scarf.’ (Interview 7)

### *Valuing social purity, physical purity and religious purity*

Purity, or cleanness, was expressed in three different forms: social purity, physical purity and religious purity. Social purity was explained as an essential foundation in the women’s culture of origin. To be seen as pure was important for girls and women in order to be part of society. Striving for purity was perceived as being achieved through FGM which secures pride for the family. Social purity was seen in the future marriageability of the girl and in the alleged expectation among men of circumcised women. Physical purity was also mentioned recurrently as an important reason for cutting.

‘Many men say they’re against it...but they don’t want to marry a woman who isn’t circumcised, so I mean they try to blame the mothers but it’s their fault that it’s happening...’ (Interview 2)

‘If your daughter isn’t circumcised, she isn’t clean. You have to, even if you don’t want to, you have to circumcise to prove that your daughter is clean. For the sake of the family.’ (Interview 3)

‘... if you take away that little part, it is kind of clean, then you are pure as a woman, then you are considered pure ... you just take away a piece of skin and then you feel that purity inside you ... because you have to, it has to do with cleanliness, there’s a lot of bacteria and stuff that’s held back ...’ (Interview 4)

Religious purity was explained in relation to an Islamic process that began in Somalia in 1990, after the outbreak of the civil war. According to the participants, women were not required to wear veils or covering themselves up that time. When people become more religious they tried to improve themselves as Muslims. Some of the women described religion as an argument against FGM, whereas some were in favour of FGM because they said it was a good religious practice.

‘Yes we went to an Iman and thought that they could help us with this...and since it is not in the religion it changed my mother’s view on all of it’ (Interview 1)

'But now that something has started to happen maybe now, somehow, it will be possible to save many girls or many women too.' (Interview 7)

### Theme 3: Social pressure to perform FGM after immigration

All the participants described feeling social pressure to perform FGM on their own daughters after their immigration to Sweden. Despite an inner conviction that they should not submit their daughters to the procedure, they feared being persuaded during family visits to their homeland on vacation. The fear also included the risk that their daughters might be submitted to FGM even without their consent.

All the participating women except one described the on-going risk that girls, now growing up in Sweden, might be subjected to FGM. Some women personally knew families who had sent daughters abroad for FGM, or had it performed on their daughters when in Syria, on their migration route to Sweden.

The following sub-themes emerged from the third theme: Fearing risk after immigration to Sweden, Fearing risk when on vacation in their homeland and the Belief that FGM takes place in every third or fourth family after immigration to Sweden.

'So my mother chose to circumcise us in Syria before we came to Sweden, I was the last girl in the family.' (Interview 2)

'Lots of women cut the girls, they go there for holidays and they do it on the girls. You hear about it secretively. They know in Sweden they (the authorities) are against it, even the parents lie and deny and say no, I will never do it to my children but they do it anyway.' (Interview 7)

### Theme 4: A symbol of the country of origin

All the women said that the tradition of FGM is strongly linked to culture. This, together with positive aspects of FGM (such as enhancing purity and honour) might, according to the respondents, contribute to the fact that young women also argue in favour of FGM. The fourth theme emerged in the following sub-themes: Feelings of completeness, Feelings of belonging and Support for changing the tradition. Participants talked about the perceived value of either themselves being and/or letting their daughters undergo FGM after immigration to Sweden. Being cut gave women a feeling of belonging to something familiar in this case to their own culture and their country of origin. This also meant that working against FGM was sometimes seen as a threat to Somalian culture as a whole.

‘... for me it’s a big relief to be circumcised, because then I have a kind of symbol from Somalia. I stick to my culture. She (a circumcised woman) feels she is part of her culture.’ (Interview 8)

‘... I think you preserve it (the tradition) because of culture, to have something cultural, do you understand? Strong culture, like a bond through everything.’ (Interview 3)

### *Support for changing the tradition*

All the respondents stated that they opposed FGM and each expressed a desire to support change in the tradition. Rich accounts were provided on how to change the tradition of FGM. The importance of supporting girls in abstaining sexually through puberty was emphasised. Abstinence was regarded as a preferable way to preserve virginity and an alternative to performing FGM. The participants expressed a need for more knowledge and for information about FGM targeted at parents in order to strengthen and empower them in the decision to abandon the practice.

‘You shouldn’t do it to the girls, it’s haram. Just talk to the girls they shouldn’t go out and go with guys and, this is the only support the girls need in their teens.’ (Interview 8)

‘You circumcise because of the parents, you don’t want them to speak about the family, maybe that’s what you can call honour.’ (Interview 6)

## **Conclusions**

These qualitative findings indicate that the honour-related cultural value of FGM could persist after immigration to Sweden. The study also shows that more knowledge is needed in order to understand the reasoning among those concerned and to find out more about attitudes, behaviours and the risks for girls vacationing in the country of origin of their parents, as well as about the prevalence of FGM after immigration.

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# **‘What works?’: effectiveness of interventions to end female genital mutilation/cutting**

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## **Overview of the Issue**

Female Genital Mutilation/Cutting involves the cutting or alteration of the female external genitalia for non-medical reasons (WHO 2000). It is a problem of global magnitude as it affects over 200 million girls and women with 44 million girls below the age of 15 at risk of being cut annually majorly in Africa, Asia, the Middle-East and increasingly among immigrant populations of Europe, UK, USA and Australia among others (UNICEF 2014). There have been many campaigns against the practice by various organisations, institutions and individuals. This has resulted in a declining prevalence with rates of decline varying across and within geographies, and some countries achieving a steady decline in prevalence over the past few decades (UNICEF 2014, PRB 2016).

With the current climate being ripe for increased focus and investment in FGM/C interventions, it is important to know what works, why and in which contexts. The purpose of this evidence brief therefore is to share some of the findings from a Rapid Evidence Assessment (REA) study commissioned by DFID on the effectiveness of interventions to end FGM/C. The study presents the high-quality studies that evaluated the impact of FGM/C interventions, describes the interventions evaluated and why and where they were found to be effective. It therefore contributes to the ongoing interrogation about ‘what works’ in FGM/C abandonment.

## The goal of the study

The goal was to determine the effectiveness of interventions to end FGM/C. The following were the specific objectives:

1. To assess the quality of studies that have evaluated different interventions for prevention of FGM/C; and
2. To describe which FGM/C interventions were evaluated by high-quality studies, why and where they were found to be effective.

### *Determining the criteria for quality of studies*

A systematic literature search of studies was conducted. The key words used for this search were ‘female genital mutilation’, ‘female genital cutting’, ‘female genital mutilation/cutting’, ‘FGM’, ‘FGC’, ‘FGM/C’, ‘female circumcision’, ‘clitoridectomy’, ‘excision’, ‘infibulation’, ‘sunna’, ‘FGM/C Interventions’, and ‘FGM/C Programme’. Any studies that did not meet the inclusion criteria were dropped from the study (see table 2).

**Table 2** Inclusion/exclusion criteria

Item	Inclusion criteria	Exclusion criteria
<b>Geographical Location</b>	Studies investigating FGM/C interventions globally	Any other studies not looking at FGM/C interventions
<b>Language</b>	English	Non-English literature
<b>Publication date</b>	1 January 2000 – 31 August 2016	Pre-2000 literature
<b>Publication format</b>	Evaluation, research studies and student thesis.	Theoretical notes
<b>Aim of study</b>	The studies must have focused on assessing the impact of FGM/C interventions	Studies that assessed consequences of FGM/C
<b>Study design</b>	All study types, designs, and methodologies including primary and secondary studies with clear methodologies to enable an assessment of quality	Studies without a clear methodology to enable assessment of the study design

The categorisation of studies was carried out in 3 steps.

**Table 3** Categorisation of studies

Study Type	Study design	Study method
Primary Studies (PS)	Experimental (EXP)	Qualitative; Quantitative; Mixed methods
	Quasi-experimental (QEX)	Qualitative; Quantitative; Mixed methods
	Observational (OBS)	Qualitative; Quantitative; Mixed methods
Secondary Studies (SS)	Systematic Review (SR)	
	Other reviews (OR)	

In Step 1, studies were categorised by study design and type: primary or secondary studies such as experimental (EXP), quasi-experimental (QEX), observational (OBS), qualitative, quantitative, mixed methods (see table 3).

In the second step, the quality assessment criteria of primary studies was carried out by appraising various domains such as conceptual framing, transparency, appropriateness, cultural/context sensitivity, reliability and validity. All the scores achieved by each domain were summed up with 0-4 as low, 5-8 moderate and 9-12 as high quality.

**Table 4** Quality Assessment Criteria for Primary Studies

Principles of Quality	Indicators	Score
Conceptual framing	Does the study acknowledge existing research?	0 = major issues
	Does the study pose a research question or outline a hypothesis?	1 = Some issues 2 = No issues
Transparency	Does the study present or link to the raw data it analyses?	0 = major issues 1 = Some issues
	Does the study declare sources of support/funding?	2 = No issues
Appropriateness	Does the study identify a research design, methods and analysis approach?	0 = major issues 1 = Some issues
	Does the study demonstrate why the chosen design and method are well suited to the research question?	2 = No issues



Principles of Quality	Indicators	Score
Cultural/Context sensitivity	What is the geography/context in which the study was conducted?	0 = major issues
	Does the study explicitly consider any context-specific cultural factors that may bias the analysis/findings?	1 = Some issues 2 = No issues
Validity	To what extent is the study internally valid?	0 = major issues
	To what extent is the study externally valid? How representative is the sample used in the study?	1 = Some issues 2 = No issues
Reliability	To what extent are the measures used in the study stable? (What measures were put in place to ensure consistency of data collection?)	0 = major issues
	To what extent are the measures used in the study internally reliable?	1 = Some issues 2 = No issues
Score (sum)	0-4 (Low Quality), 5-8 (Moderate Quality), 9-12 (High Quality)	0 - 12

The final step consisted of a quality assessment of secondary studies by appraising domains such as transparency, validity and reliability. Scores for each domain were added with a score of 0-2 as low, 3-4 moderate and 5-6 as high quality.

**Table 5** Quality Assessment Criteria for Secondary Studies

Quality Principle	Question	Scoring
Transparency	Does the study describe where and how studies were selected for inclusion?	No=0
		Unclear=1
		Yes=2
Validity	Does the study assess the quality of the studies included?	No=0
		Unclear=1
		Yes=2
Reliability	Does the study draw conclusions based on the reviews conducted?	No=0
		Unclear=1
		Yes=2
	Score	0 - 6
	Scoring: 0–2 low, 3-4 moderate and 5-6 High	

## General findings

Seventy studies, mostly from Africa, met the inclusion criteria and described a variety of interventions including awareness generating campaigns, capacity building, institutional strengthening, advocacy and community education, women empowerment interventions, among others. This review found that only 10 studies were of high quality. The majority of the studies did not answer the question about what works and this was attributed to a lack of baseline data required in order to make claims about effectiveness. Studies that evaluated these interventions, did not provide sufficient information to enable an appropriate assessment of quality.

### What does the evidence tell us about effectiveness?

This evidence analysis focused on interventions evaluated by the high-quality studies. Of the 10 high quality studies, seven primary studies were included in this analysis, while three high-quality systematic studies were omitted in order to avoid duplicating interventions that had already been reviewed. Evidence analysis of selected studies indicated effectiveness of three FGM/C interventions. Of the seven studies representing high-quality primary research, three explored effectiveness of Alternative Rites of Passage (ARP) in Kenya (Chege et al, 2001 P; OBS↑, Oloo 2011, P; OBS↑, Mepukori 2016, P; OBS↑). This programme offered an alternative form of transition from childhood to adulthood in communities where FGM/C signifies the entry of a girl into mature adulthood. These studies showed a significant increase in knowledge about the health effects of FGM/C and, subsequently, the long-term abandonment of the practice by communities embracing ARP. This success was attributed to strategies for facilitating community readiness and goodwill towards accepting the programme with them spearheading the initiative. It also involved creating community awareness by working with existing institutions such as schools, health providers, and religious and community leaders.

Three other studies evaluated the impact of wider TOSTAN Community Education Programmes (CEP) in Senegal, Ethiopia, and Somalia (Diop and Askew 2009, P; QEX↑, UNICEF 2012a, P; OBS↑, UNICEF 2012b, P; OBS↑). The TOSTAN programme implements a holistic approach through community education on human rights, problem solving, basic hygiene, and women's health, including women empowerment strategies. These studies reported a significant increase in awareness of FGM/C consequences, a reduction in the proportion of those who view FGM/C as a necessity, and an increased number of girls under 10 years of age not being cut. The

studies attributed the TOSTAN programme's success to its multi-pronged approach, using advocacy and awareness strategies before introducing the programme's community participation and dialogue, as well as passive diffusion of messages to people outside the programme in the countries where it was implemented.

One study evaluated the impact of legislation in Burkina Faso (Crisman et al., 2016, P; OBS↑), and revealed that the legislation had resulted in a 25 to 30 percent reduction in the probability of a girl being cut before the age of five. This success was attributed to the sustained awareness campaigns and community education initiatives that started in 1975, creating fertile ground for generating awareness about the law banning FGM/C as well as political goodwill supporting the implementation of the law.

## What do we still need to better understand?

The quality of the evidence on the effectiveness and impact of FGM/C interventions is generally moderate to low. This is not due to a lack of robust interventions, but rather a lack of robust studies evaluating these interventions. In addition, only a few baseline surveys were conducted prior to implementing interventions, making an assessment of impact and generalisability difficult. Despite a high concentration of sub-Saharan African studies evaluating anti-FGM/C interventions, few emphasise adequate reporting on cultural sensitivity and contexts during the design stage, or on the interpretation of findings regarding local policy.

This REA provides valuable methodological lessons for the design of future high-quality assessments or evaluations of FGM/C interventions:

1. There is a need for high quality studies to evaluate interventions in those regions where people who practice FGM/C have immigrated. This will be crucial in order to build a picture of effectiveness of FGM/C interventions in communities or countries that do not commonly practice FGM/C. This is because the high-quality studies from this REA, were conducted in Africa.
2. Many published reports assessing or evaluating FGM/C interventions offer a poor description of the interventions, so reviewers were unable to fully understand what was implemented, why, and to what effect, thus limiting their abilities to replicate or adapt these interventions. These challenges are becoming apparent in other areas of reporting evaluations of health and behaviour change interventions.
3. There is a need for guidelines for documenting and reporting FGM/C intervention design and implementation processes in order to improve the scientific reporting of FGM/C interventions drawing on the recommendations of the

Work Group for Intervention Development and Evaluation Research (WIDER).

4. Research designs need to be strengthened so they consider both the intermediate outcomes of the interventions and the overall impacts, with more robust methodologies involving comparable case selections, longitudinal research, and baseline surveys.
5. Triangulation of findings using multiple methodologies to address the same research question should be encouraged in order to address concerns of internal validity. A strong evidence base is required to accelerate the abandonment of FGM/C.

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# Researching female genital mutilation in Western countries of asylum: a case study of Syria

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## Introduction

In 2015, the Netherlands experienced an increased influx of Syrian refugees. Syria is not listed by the World Health Organization (WHO) as a country in which FGM has been documented as a traditional practice. Prevalence of FGM among Syrian girls and women is unknown, and there are conflicting statements both confirming and denying the existence of the practice (Geraci & Mulders, 2016). Pharos, being the centre of expertise on health of refugees as well as the centre of expertise on FGM, received many inquiries from schools and the Dutch youth healthcare agency about the new group of refugees. Mainly about their psychosocial wellbeing, but also whether or not FGM is prevalent in Syria. These inquiries were fed by the message spread by a United Nations humanitarian coordinator that ISIS was ordering FGM on women living in the so-called caliphate (Geraci & Mulders, 2016). To respond to those raising questions, Pharos decided to explore whether FGM is a (traditional) practice in Syria and if women and girls who immigrated from Syria to the Netherlands are subsequently at risk of FGM.

Data collection on female genital mutilation (FGM) can be a very challenging task and is often fraught with difficulties due to the sensitivity of the topic. This article describes our inquiry into the existence of FGM in Syria and its results. We concluded that there is no substantiated indication that Syrian women and girls in the Netherlands are circumcised or are at risk of being circumcised. This document will provide an overview of how we came to this conclusion. A second aim of this

article is to describe a combination of research strategies that could be applied in other Western countries of asylum when confronted with a new flow of refugees about whom little information regarding FGM is available.

## Rationale

FGM is not restricted to (traditional) practising countries. This is due to increasing globalisation and individuals from FGM practising communities migrating to the EU and other developed regions for economic reasons or to seek (political) asylum (Bommes, Fassmann & Sievers, 2014). The EU currently has substantial populations of women who have been subjected to FGM or who are at risk of FGM. The exact number of women and girls living with FGM in Europe is however unknown. Data is often – where possible – extrapolated from prevalence data in countries of origin (EIGE, 2013). In recent years more information has become available on the practice of FGM occurring in the Middle East. Discussing and researching FGM is complex in the Middle East. It is not spoken about and mostly referred to as an ‘African phenomenon’ (Piecha, 2013). Many governments in the Middle East deny the presence of FGM and dispute its prevalence in their counties (Abadeer, 2015). Apart from Iran (Ahmady, 2015) and the Kurdish autonomous region in Iraq (WADI, 2010) no large-scale prevalence studies have been carried out in the Middle East. No prevalence data was available on Syria. In addition, the current war and humanitarian situation impacts the ability to research the possible existence of FGM in the Syrian context. The sensitivity of the subject, the lack of prevalence studies and the complexity of the acute humanitarian needs required a combination of research strategies.

## Methodology and results

The following research questions were formulated:

Focused on Syria:

- Is there a tradition of FGM in Syria?
- What do we know about the prevalence of FGM in Syria? Are there any recent developments that have led to FGM?
- If so, in which regions? Among which ethnic or religious groups? What form(s)?
- Focused on the Netherlands:
- Are there women and girls among Syrian refugees in the Netherlands who have been circumcised?
- Are Syrian women and girls in the Netherlands at risk of FGM?

## The research strategy contained the following activities:

### *a. Review of scientific literature and grey sources*

As there was no prevalence data available, the first step was a review of scientific literature and grey sources like blogs, news articles, online platforms and websites of human rights organisations or activists for example.

### *b. Quick scan: survey set out in international network*

The next step was an online survey set out in the international network of Pharos, among professionals working in the field with Syrian refugees, human rights activists, government officials and healthcare professionals. We reached out to 500 contacts. Follow-up consultation took place via e-mail and via phone.

### *c. Consultation of (healthcare) professionals in the Netherlands*

An online questionnaire was circulated twice via the newsletter of the professional association of midwives. Almost 4000 midwives are connected to this association.

### *d. Action research Dutch youth healthcare agency (JGZ)*

The JGZ has a specific working method on how to discuss FGM with parents with daughters originating from countries where FGM is practiced and how to assess the risk of FGM. Normally they wouldn't discuss FGM with parents from Syria, since Syria is not known to be a country where FGM is practiced. For our research, a female youth healthcare professional discussed FGM with Syrian parents of daughters who came to her consultation in a reception centre. She asked all parents whether FGM was prevalent in Syria and if they had any intention to circumcise their daughter(s). This was carried out during a period of three months. She spoke with them with the help of a female Syrian-Arabic translator by phone. After every consultation the youth healthcare professional filled in the answers provided by the parents as well as her observation on their reactions on an anonymous form and sent it to Pharos.

### *e. Action research at the Asylum Reception Centre*

During the research period, a cultural health educator gave three courses on Women's Health especially for newly arrived Syrian women. She included one session on FGM and discussed the different types of FGM; where and why it is practiced and the physical and psychosocial consequences of FGM. During the discussion she asked if women were aware of its existence at all and in Syria particularly. At the end of this meeting, the women were asked to fill in a short questionnaire about FGM.



*f. In-depth interviews with key informants in the Syrian community*

Lastly, seven key informants in the Syrian community were interviewed about health-care for women and taboo subjects such as domestic violence, child abuse and FGM in relation to the Syrian healthcare system. These individuals were all healthcare professionals and had fled Syria in 2015 and 2016.

## Results

*a. Review of scientific literature and grey sources*

There were no research results available that explicitly studied the Syrian context in relation to FGM. However, in scientific literature and in grey sources Syria was occasionally mentioned in lists of countries where FGM supposedly does or does not exist. In all cases this no explanation or specification and no backing with references were provided.

*b. Quick scan: survey set out in international network*

We reached out to around 500 professionals. However, only five individuals responded to the survey. All indicated that FGM is not identified as a possible risk within their organisations. In addition to the survey, we consulted the WHO on the availability of prevalence data on FGM in Syria. We also asked if they recognised any rumours about FGM in Syria.

*c. Consultation of (healthcare) professionals in the Netherlands*

Five midwives completed the survey. All together they had supervised 27 pregnant Syrian women. They all claimed to have never observed FGM being an issue among Syrian women.

*d. Action research Dutch youth healthcare agency (JGZ)*

The youth healthcare professional had ten consultations with Syrian parents with daughters. All of them denied explicitly that FGM is taking place in Syria. The youth health care nurse expressed surprise and disbelief at the suggestion that this could be happening.

*e. Action research at the Asylum Reception Centre*

Forty-six women filled in the questionnaire. All of them said that FGM was not practiced in Syria. The health educator also gave her feedback about the responses of the women in class. She found women were shocked at the suggestion that FGM was being practiced in Syria.

*f. In-depth interviews with key-informants in the Syrian community*

Interviews lasted for over 3 hours. All respondents stated that FGM is not prevalent in Syria.

## Conclusion

Research activities and responses were influenced by the conflict situation in Syria and the extensive needs of refugees and the pressure on humanitarian care. We didn't find any substantiated indication that the practice of FGM occurs in Syria nor that women in the Netherlands are at risk. We hope our study with mixed method strategies contributes to a relatively new field of study and provides an entry point for further research activities in the Middle East.

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# FGM surveys on Knowledge, Attitudes and Practices in the Gambia

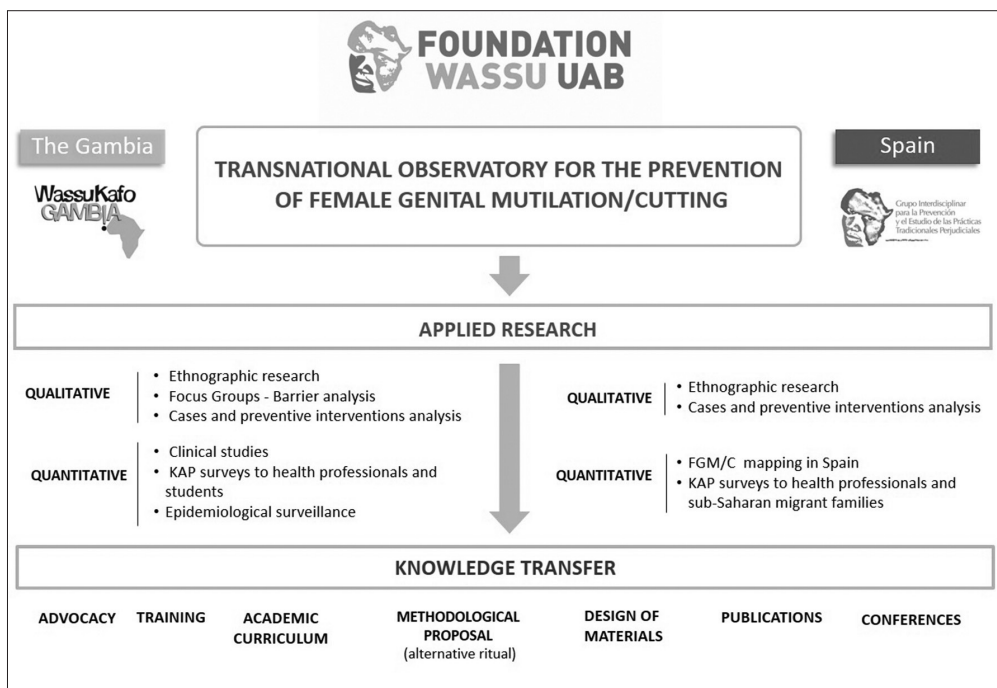
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The overall prevalence of Female Genital Mutilation (FGM) in the Gambia is estimated at 76.3 % – meaning that it affects approximately 3 out of 4 women. 78.3 % of the women have had it performed and 71.1 % believe FGM should continue. However, this global figure obviates important discrepancies within regions and ethnic groups. It is also important to understand this data within the context of gender-based violence in the country, where 74 % of women believe a husband is justified in beating his wife/partner (GBoS, 2011).

Wassu Gambia Kafo (WGK) is a local NGO that promotes development and cooperation between the Gambia and Spain in the fields of health, research and education. WGK is one of the Research and Training Centres of the Transnational Observatory of Applied Research to New Strategies for the Management and Prevention of Female Genital Mutilation/Cutting (FGM/C) hosted by the Wassu-UAB Foundation, at the Autonomous University of Barcelona (UAB), in Spain. The Transnational Observatory works for the management and prevention of FGM through anthropological and medical research applied to knowledge transfer.

- Its vision is to improve the living conditions of women and girls, recognising their right to personal integrity and freedom based on social equality.
- Its mission is to design, develop and implement a scientific methodology to transfer knowledge in order to draw attention to the consequences of FGM/C and promote the abandonment of the practice through preventive strategies both in Africa and among the Diaspora.

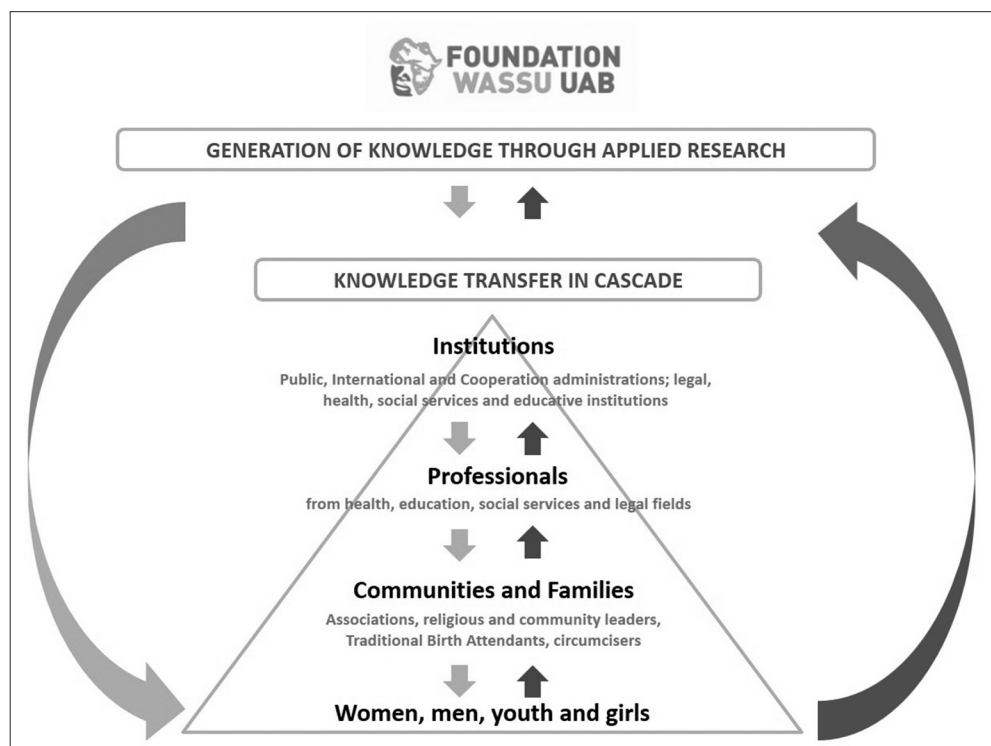
**Figure 2** Transnational Observatory



Since 1989, research has been carried out in order to develop a comprehensive, innovative, sustainable and pioneering methodology that is evidence-based, culturally sensitive and results-oriented, and that focuses on the management and prevention of FGM/C. Based on a unique model, applied qualitative and quantitative research is conducted that enables cascade knowledge transfer to key agents.

At the request of the Vice-President of the Gambia, WGK conducted the first local clinical study between 2008-2009 focusing on the ethnic groups practising FGM, the types practised and the health consequences as revealed in health facilities (Kaplan et al., 2011). The results obtained from a sample of 871 women and girls were published in 2011 and demonstrated that FGM was still practised in the six regions of the country. Moreover, type I was the most common, followed by type II. The study also proved that all forms of FGM (including type I) produced significant percentage rates of health complications (particularly infections).

**Figure 3** Generation of Knowledge



The second clinical study (Kaplan et al., 2013a) collected information about 588 women who attended hospitals and healthcare facilities in the Western Region. 75.6 % of the women had undergone FGM and had a higher prevalence of suffering long-term consequences compared to the ones who had not undergone FGM. This study proved that women who have undergone FGM are four times more likely to suffer complications during delivery and for the new-born child, showing a clear link between health consequences and the practice of FGM (often unacknowledged in the Gambian health system).

A study on the Knowledge, Attitudes and Practices of Health Professionals about FGM in rural areas (2008-2010) revealed that 42.5 % supported the practice, and that medicalisation was already a reality in the country (Kaplan et al., 2013b). In 2016, a comparative study was published between the first KAP survey (2008-2010) and the second (2011-2014) among 1,288 health professionals in order to explore

trends, measure and determine changes in knowledge, attitudes and practices. The study shows a positive impact of the National Training Programme for Health Professionals on FGM, designed and developed by WGK and implemented in close collaboration with the Ministry of Health and Social Welfare through an MoU. The comparison confirms that professionals today are more able to identify the health consequences of the practice (41 % < 62 %); they give less support to the perpetuation of the practice (42 % > 25 %); and the link between FGM and religion has diminished (54 % > 25 %). At the same time, the study highlights an increase in medicalisation trends (8 % < 10 %) (Kaplan et al., 2016).

A further KAP study focused on exploring Gambian men's perceptions of FGM was conducted. It revealed that only 8 % of men took part in the decision about the performance of the practice on their daughters, and that 71.7 % were unaware of its health consequences. 51.6 % thought men had a role to play in its prevention (Kaplan et al., 2013c).

Since 2010, with strict observation of the results of applied research, WGK has trained over 6,800 key agents (mainly health professionals, students, community and religious leaders and traditional birth attendants) in all regions of the Gambia. Knowledge is transferred in close collaboration with Gambian institutions with Memorandums of Understanding in place (Women's Bureau, Ministry of Health and Social Welfare, the Cuban Medical Mission and all Health Sciences Schools in The Gambia). The Gambia is the first country in Africa where FGM is integrated in the academic curriculum in all health science studies in order to train future health professionals on this issue.

The trainees are shown in figure 4.

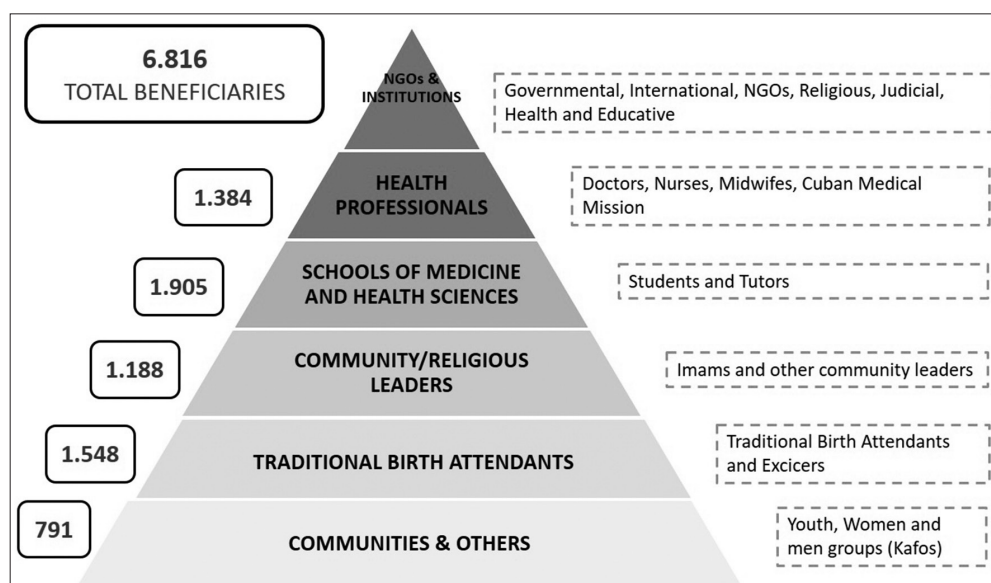
Since 2012, the methodology of using applied research in cascade knowledge transfer has scaled up to Kenya and Tanzania, and FGM has been incorporated in the Academic Curriculum of Degrees in Health and Social Sciences in cooperation with four universities (between 2012 and 2015).

The main impact and results of WGK' interventions are as follows:

- The promulgation of a Fatwa in 2011 expressing the commitment of Islamic authorities to preventing FGM and organised by UN agencies through a Colloquium with West African Religious Leaders in Mauritania.
- The training of Religious Leaders in the Gambia between 2011 and 2016, which created room for dialogue about the negative consequences of the practice (organised by the Women's Bureau).
- The design and the implementation of the unique National Training Programme for Health Professionals on FGM (2011-2020) through the Ministry of Health and Social Welfare with the support of Unicef and WHO.

- The scaling up of Wassu's methodology to 4 universities in Kenya and Tanzania (2012-2015).
- Provision of evidence through research to the Gambian government to enact a law against FGM/C (December 2015).

**Figure 4** Total Beneficiaries



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# Prevalence and associated factors of female genital cutting among young adult females in Jigjiga district, Eastern Ethiopia: a cross-sectional mixed study

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## Background

Female genital cutting (FGC) is a traditional modification of the female genitalia comprising all procedures involving partial or total removal of the external female genitalia or another injury for cultural or non-therapeutic reasons. More than 200 million women in the world are circumcised. An average of about four girls a minute continue to be mutilated (WHO 2008).

Worldwide, 200 million women have been subjected to the practice and over 30 countries are affected (UNICEF, 2016).

FGC is common among Ethiopian women, 65% of women aged 15-49 years are circumcised. (CSA, 2016) Ethiopia launched educational programmes 20 years ago in consultation with traditional community associations and local healers. Similarly, different non-government organisations, embassies, and the regional governments have been implementing different intervention programmes in the Somali region (CSA

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<sup>2</sup> The author wishes to acknowledge Demeke A(DA) Reproductive Health and Health Service Management, School of Public Health, Addis Ababa University, Addis Ababa, Ethiopia and Fitsum W, Medical Laboratory Science, College of Health and Medical Sciences, Haramaya University, Harar, Ethiopia, for their valuable contributions to the paper.

2005; Tonje B, 2007). The main arguments for FGC are: to safeguard against premarital sexual activity, prevent female promiscuity and preserve virginity, for religious reasons, for the sake of tradition and for socio-economic related reasons (Samia, 2012; Debruyne M, 2003). This paper aims at assessing the prevalence and factors associated with FGM/C among young adult females.

## Methods

We employed cross-sectional mixed methods to assess the prevalence and associated factors of FGM/C among young adult females (aged 15–24), in 2014. The sample size was determined using a single population proportion formula by assuming 95 % confidence level, 5 % degree of precision, design effect of 2 %, 15 % non-response rate and 74 % of the proportion of circumcised female (aged 15–49) (CSA, 2005). A multi-stage sampling technique was employed to select study subjects. In all, two secondary schools and two high schools were selected using a lottery method. All sections of each class from selected high schools and secondary schools were taken as strata. Finally, 679 female students were selected using stratified random sampling technique. Four focus group discussions were undertaken among women, local leaders, community leaders and circumcisers.

## Data collection

Field workers collected data using a standardised and self-administered Somalia language version questionnaire. Three trained supervisors and six female data collectors participated in the data collection. The qualitative data were audio taped, transcribed, and coded with open-code version 3.6 and inductive content analysis was applied.

## Ethical consideration

We obtained verbal consent/assent from the study participants. The study protocol was approved by the Institutional Ethical Review board of School of Public Health, University of Addis Ababa.

## Results

In all, 662 respondents participated making a response rate of 97.5 % among young-adult females. Of these, the majority, 374 (56.5 %), were aged between 15 and 19. The mean age of the respondents was 20 ( $\pm 2.4$ ) ranging from 15-24 years. The majority of the respondents, 511 (77.2 %), were Muslim. More than half, 430 (65 %) of the respondents were members of the Somali ethnic group. Nearly half of the respondents, 355 (53.6 %), resided in rural areas.

**Table 6** Socio-eco-demographic characteristics of young adult female students in Jigjiga district, Somali regional state, Ethiopia, 2013 (n=662)

Variable	Frequency	Percent
<b>Age</b>		
15-19	374	56.5
20-24	288	43.5
<b>Religion</b>		
Muslim	511	77.2
Orthodox	132	19.9
Protestant	19	2.9
<b>Ethnicity</b>		
Somali	430	65
Amhara	124	18.7
Oromo	19	2.9
Other	89	13.4
<b>Residence</b>		
Rural	355	53.6
Urban	307	46.4
<b>Marital status (students)</b>		
Never-married	626	94.6
Married/cohabited/separated/divorced	36	5.6
<b>Educational stage of student</b>		
Preparatory/secondary	330	49.8
College /TVET	332	50.2

Variable	Frequency	Percent
<b>Occupation (mother)</b>		
Housewife	347	52.4
Unemployed	105	15.9
Others**	210	31.8
<b>Educational status (mother)</b>		
Illiterate	243	36.7
Primary	206	31.1
Secondary and above	213	32.2
<b>Educational status (father)</b>		
Illiterate	214	32.3
Primary	206	31.1
Secondary and above	242	36.6
<b>Monthly income</b>		
<500	88	13.3
500-1000	344	52.0
>1000	230	34.7

Other \*\* e.g. circumciser, merchant, employee etc.

A total of 538 (82.6 %) study participants underwent one or more of the different forms of FGC. This is supported by qualitative data:

‘Uncircumcised girls may not get married and respect from the society. The families as well as the girls themselves are asking the circumciser to perform the procedure by preparing ceremony in their home as to ensure and enhance marriage probability of the girls and their possibilities of fulfilling lives as mothers and responsible wives if not, she remains with her family until the end of life without any husband.’ (50 year-old woman)

Of these, 268 (49.9 %) were circumcised at the age of 7–10 with a mean age of eight years. In all, 573 (88.3 %) of the young adult females had a good knowledge of FGC practice and its complications. The majority, 473 (72.7 %), of FGCs were performed by a traditional circumciser and traditional birth attendant, 166 (25.5 %). A total of 265 (49.3 %) respondents had type I FGC, 244 (45.4 %) type III and 29 (5.3 %) type

II. With regard to the attitude towards the continuation of the practice: 244 (37.5 %) respondents were in favour of continuing the practice. Of these, 190 (79.5 %) said this was due to religious demand, 219 (91.6 %) to preserve virginity, 175 (73.2 %) to increase marriage prospects, 141 (59 %) to keep good tradition, 104 (43.5 %) for hygienic reasons and 60 (25.4 %) as a good custom. This is also supported by qualitative data:

‘From my point of view, an uncircumcised woman is hypersexual, infidel, non-Muslim, and non-pure. Even if she gets married, she may face immediate divorce or forced excision. So, FGC is pre-condition for girls to get married. Girls who do undergo FGC receive rewards, including public recognition and celebrations, gifts (gebartin in Somali language ፤ ስጦታ በከማረኛ), the potential for marriage, respect and the opportunity to engage in adult social events.’  
(45 year-old circumciser)

Multiple logistic regression analysis was done: Muslims were subjected significantly to FGC practice compared to Christian respondents (AOR=3.7; 95 %CI=1.1, 12). The prevalence of FGC was four times more likely among rural residents compared to their counterparts in urban regions (AOR=4; 95 %CI=2.4, 6.8). The odds of female students with illiterate mothers being circumcised were twice as high as those whose mothers had completed high school and above (AOR=2.4;95 %CI=1.3,4.3). The prevalence of FGC is 50 % less among those who had a positive attitude toward the discontinuation of the practice compared to those with a negative attitude (AOR=0.5;95 %CI=0.3,0.8). Female students at high school level were less likely to be circumcised compared to those at secondary school level (AOR=0.5;95 %CI=0.3, 0.8). The odds of the practice being carried out are higher among those who believe FGM/C is required by their religion compared to those who do not believe (AOR=2.3;95 %CI=1.5,3.5).

**Table 7** Factors associated with FGM/C among young adult female students in Jijjiga district, Somali regional state, Ethiopia, 2013

Variable	Circumcision status			
	No ( %)	Yes ( %)	COR(95 %CI)	AOR(95 %CI)
<b>Religion (n=651)</b>	<b>**</b>			
Muslim	61(12.1)	445(87.7)	3.7(1.3,10.1)	3.7(1.1, 12)
All Christian	52(35.9)	93(64.1)	1	1
<b>Residence (n=651)</b>	<b>**</b>			

Variable	Circumcision status			
Rural	41(11.8)	305(88.2)	2.9 (1.5,3.5)	4(2.4,6.8)
Urban	72(23.6)	233(76.4)	1	1
<b>Ethnicity (n=651)</b>				
Somali	56(13.2)	369(86.8)	2.2(1.5,3.4)	1.3(0.8,2.1)
Others <sup>††</sup>	57(25.2)	169(74.8)	1	1
<b>Age of female students (n=651)</b>				
15-19	83(22.7)	282(77.3)	0.5(0.3,0.76)	1(0.52,1.9)
20-24	30(10.5)	256(89.5)	1	1
<b>Educational level (n=651)**</b>				
High school	83(25.9)	238(74.1)	0.29 (0.18,0.45)	0.5(0.3, 0.8)
Secondary?	30(9.1)	300(90.9)	1	1
<b>Mother's education (n=651)**</b>				
Illiterate	27(11.4)	210(88.6)	3.6 (1.89,6.71)	2.4(1.3, 4.3)
Primary	35(17.2)	169(82.8)	2.1(1.05, 4.37)	0.96(0.5,1.7)
Secondary & above	51(24.3)	159(75.7)	1	1
<b>FGM/C required by religion(n=651)*</b>				
Yes	81(35.2)	149(64.8)	2.3(1.5, 3.5)	1.7(1.07, 2.8)
No	32(7.6)	389(92.4)	1	1

Employee<sup>\*\*\*</sup>- currently employed, circumciser, religious leader, teacher, pretty trader

Others<sup>††</sup>-Amhara, Oromo,

Significant at \**p*-value < 0.05 and \*\**p*-value < 0.001

Fitted Model, *p*=0.809

## Discussion

The overall prevalence of female circumcision was as high as 82.6 % among the respondents. This was supported by qualitative data where an uncircumcised woman was considered as sexually hyperactive, infidelity, non-Muslim, refused to marry, and non-pure. It is higher than from the 2005 national figures reported (74 %) and close to that of the Somali region (97.3 %)(CSA 2005). This finding is also higher than the national prevalence for 15–19 year-olds (62.1 %) and 20–24 year-olds (73 %) and other sub-Saharan countries (CSA 2005, Berg RC,2012). This might be because of the deep-seated negative values attributed by society to uncircumcised girls consid-

ered to be unfaithful and sexually hyperactive. And the practice could be supported by the local religion and direct legal measures might not be taken seriously. Moreover, the overall prevalence in the study area among the younger group was somehow lower, which might be attributed to the time gap and the increasing understanding among parents about the effects of FGC, which could be the result of different awareness-raising anti-FGC interventions implemented in the area and the advancement of educational provision compared to the past. The reason could be due to a sample size variation and skew to one ethnicity when compared with that of the national study.

Almost three-quarters of FGCs were performed by local traditional circumcisers (73 %), traditional birth attendants 166 (25.5 %) and health professionals (1.6 %). This matches a study conducted in Somali refugee camps and other studies (Getnet M 2009; CSA 2005). This might be due to the community's belief that traditional practitioners are experienced, accepted, respected and allow for FGC to continue. Health professional involvement in the procedure and lack of coordination in the fight against the practice may contribute to the continuation of FGC; this needs attention from the anti-FGC interventions.

The prevalence of FGC was more likely to be higher among rural respondents compared to their counterparts. This is consistent with the Ethiopian Demographic and Health Survey of 2005. This may be due to the strict tradition, religious association and loose legal concerns in the rural areas that persist in the area.

Women's education appears to be an independent predictor for the occurrence of FGC. Mothers with no formal education were more likely to perform the procedure on their daughters compared to mothers who had completed secondary education and above. Educational levels of the respondent were also an important independent predictor of FGC. The practice of FGC in this study was less likely to occur in those who were high school female students compared to those who attended secondary school level only.

Despite the girls' good knowledge and attitudes towards the negative effects of FGC, the prevalence of FGC was high. FGC is a violation of human rights of girls that may affect the efforts towards empowering women and gender equity. There should be a concerted effort among women/men, religious leaders, and other concerned bodies in understanding and clarifying the erroneous link between the practice and religion through communications about behavioural change and the advocacy thereof at all levels.



## Acknowledgments

The authors are grateful to the study participants. The study was financially supported by Addis Ababa University.

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# **Female genital mutilation and migration in Mali. Do return migrants transfer social norms?**

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## **Introduction**

The aim of our communication was to present results of a study that analyses the impact of migration on FGM in African countries, taking Mali as a case study (Diabate and Mesplé-Somps, 2014; Mesplé-Somps, 2016). Mali has one of the highest FGM prevalence rates in the world: in 2009, 84 % of 0 to 14 year-old girls were circumcised. Concomitantly, Malians have a long-standing history of migration and usually migrate predominantly to other African countries where female circumcision is uncommon (e.g. Côte d'Ivoire) and to countries where FGM is totally banned (France and other developed countries) and where anti-FGM information campaigns frequently target African migrants. With migration having been shown to be an important vehicle for political and social changes, it is worth considering the potential role of migrants in the fight against FGM/C. However, a downturn in FGM prompted by a migration-driven transfer of norms is not at all evident in this African context. Prohibition of the practice by host countries does not appear to be enough of a reason for Malian migrants to change their attitudes towards the practice. In addition, Malians tend to migrate to countries where action to prevent FGM is thin on the ground.

Beyond beliefs about the benefits of FGM on health and physical hygiene, the causes of female genital mutilation include a mix of cultural and social factors within families and communities. FGM is seen as a way of preparing girls for adulthood and marriage, tying this practice in with premarital virginity (and marital fidelity thereafter) (Bellas Cabane, 2006; Chesnokova and Vaithianathan, 2010). It is also perceived as an identity marker defining community group affiliation (Coyne and Coyne, 2014).

People cut their daughters to show that they have adopted their community's social norms, whatever their beliefs about the health consequences or its effect on the marriage status of women.

To our knowledge, studies on the links between migration and FGM have exclusively focused on female circumcision practices among African migrants in their host countries rather than in the countries of origin. These studies produce contrasting results. Some of them show that immigrant women want to keep the traditions of their countries of origin, as they believe they would not be able to return to their own country if they accepted some of the rules and practices of their host country, including the ban on circumcision (Gillette-Faye, 1998; OFPRA, 2008). On the other hand, other works contradict this view. For instance, Farina and Ortensi (2012) report that FGM prevalence is lower among immigrant women in Italy than non-migrant women interviewed in their countries of origin and that immigrant women strongly disagree with the continuation of this practice, suggesting that female migrants have a different attitude to FGM than non-migrants. Johnsdotter et al. (2009) conducted interviews with men and women from Ethiopia and Eritrea in Sweden. They found firm rejection of all forms of FGC and absence of a guiding motive.

## Methodology

Using an original household-level database, we analyse whether migrants have a potential role to play in the fight against FGM/C. The data used for this study are taken from an individual survey called ENEM-2009 (Enquête Nationale sur l'Excision au Mali) on a representative sample of girls aged 0 to 14 and adults over 15. The sample covers 3,330 girls aged 0 to 14 and 4,029 adults spread out over 75 villages. The survey contains questions about the method used for FGM in addition to the adults' knowledge of the health repercussions of FGM and their attitudes to FGM. We couple these individual data with the 2009 population census, (Recensement général de la Population et de l'Habitat, INSTAT, Mali 2009) and compute, among a vector of the socio-demographic characteristics of the interviewees' villages of residence, the intensity of return and current migration.

## Results

Taking a two-step instrumental variable approach to control for the endogeneity of migration and return decisions, the empirical evidence suggests that girls living in villages with return migrants are less likely to be circumcised than others. This result

appears to be mainly driven by the percentage of returnees from Côte d'Ivoire. The fact that only returnees from Côte d'Ivoire have a significant negative impact on FGM and that returnees from other countries even from European ones have no significant impact may suggest that what matters in the social norm process is not just the repressive action against those who practice FGM in the host country, but also the fact that the migrants lived in an African country where FGM is not the customary habit. Consequently, they are well aware that non-circumcised girls do not suffer from social exclusion problems as this risk is often invoked to justify this practice in the African context. Moreover, more than 69 % of female return migrants from Côte d'Ivoire are actually born in this country. It can be assumed that most of them are not circumcised and can more readily convince non-migrant women not to cut their daughters. This is all the more plausible since returnees from Côte d'Ivoire are in the majority among return migrants.

We also show that the stock of returnees and more particularly of returnees from Côte d'Ivoire appears to impact the degree of information from interviews about the health issues caused by FGM. Consequently, they are more likely to know the health consequences of FGM for girls and women. Returnees also have a positive impact on the interviewee's desire for a law against FGM. This then suggests that people living in villages with returnees are well informed about health issues due to FGM and are in favour of a ban on FGM, irrespective of their own characteristics (age, education, etc.) or the characteristics of the village in which they live. This means that returnees from Côte d'Ivoire manage to convince people from their home village to refrain from circumcising their daughters, and manage to persuade them of the advantages of introducing a law against FGM. We also show that current migrants do not appear to affect FGM practices. The fact of being a long distance away makes the interrelations with those left behind weaker. In addition, returnees are older than current migrants and therefore hold a higher rank in the social hierarchy, which should make their transfer of norms more effective than those potentially spread by current emigrants.

## Conclusion

By supporting opposition to the practice within communities, return migrants could help drive information campaigns about the negative health effects of FGM and its violation of human rights and help enforce laws banning female circumcision. Return migrants should therefore be more involved in actions to counter FGM.

However, not all migration experiences generate the process of social remittances. Host countries need to provide immigrants with an environment in which they can become aware of new ideas and opinions.

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# **Studying Compliance with the Human Rights Framework in relation to Female Genital Mutilation/Cutting in Senegal: A Research Methodology**

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## **Introduction**

This paper focuses on the methodology of my PhD research entitled, Empty Promises? Compliance with the Human Rights Framework in relation to Female Genital Mutilation/Cutting in Senegal, My PhD research addresses the practice of Female Genital Mutilation/Cutting (FGM/C) from an international human rights law perspective. Over the last decades, discourse in relation to the elimination of FGM/C is positioned within the scope of international and regional human rights law. The practice is considered a form of Violence Against Women (VAW) and a human rights violation. A comprehensive human rights framework exists at both international and regional levels that addresses VAW and harmful practices in general, and FGM/C in particular. Despite the various international and regional (quasi) legal norms addressing the practice of FGM/C, prevalence rates have remained high in many of the countries where FGM/C occurs. This raises the question as to what extent and why States comply, or in the case of FGM/C, appear not to comply with the human rights framework that is designed to eliminate the practice worldwide. The central research question of my PhD research is the following: ‘Which factors explain compliance and/or non-compliance with the human rights framework in relation to the practice of Female Genital Mutilation/Cutting in Senegal?’

## **Interdisciplinary Research**

Since no single discipline has the answer to the rather complex ‘compliance question’, my PhD research is interdisciplinary. Taking an interdisciplinary approach makes it possible to fully grasp the conditions under which the human rights framework does (or does not) work in a particular context. My research ultimately aims to bridge legal scholarship with other disciplines in order to provide a platform for generating new insights and to contribute to complex problem solving. In so doing, my PhD research touches on three disciplines, i.e. law (international human rights law), political science (international relations) and social science (anthropology).

## **Innovative Research Design**

Given the interdisciplinary nature of my PhD research, a combination of research methods is required. Traditional legal research methods revolving around the study and interpretation of primary legal resources (e.g. legislation, case law) and secondary resources (e.g. literature) are combined with social sciences research methods and techniques. Desk research is combined with empirical research in Senegal. More specifically, a qualitative case study research strategy is used ‘because of its attention to detail, complexity and contextuality’ (Hancock, 2006). The main methods of data collection are desk research and semi-structured interviews.

## **Case study in Senegal**

The challenge to ensure that human rights standards are translated into effective action and bring positive change to the girls and women (at risk of) undergoing this practice, remains a national issue. Four selection criteria are used to determine which country would be most interesting and best suited for a case study, including: (i) FGM/C prevalence rate; (ii) treaty ratification; (iii) level of democracy; and (iv) strength of civil society. Taking into account these criteria, Senegal has been selected.

## **Fieldwork in Senegal**

A two-week pilot study in Dakar was conducted to map out the field and prepare for the subsequent field research period (4.5 months). Semi-structured in-depth interviewing represented the primary method of data collection. In-depth interviews were

optimal for collecting data on respondents’ personal perspectives and experiences. The semi-structured interviews were informal in tone and focused on specific themes that provided a degree of flexibility in order to explore certain themes more in detail. An interview guide was prepared that included a list of 11 themes and 36 questions that were covered during the interviews.

**Table 8** Themes Interview Guide

Themes	INTERVIEW GUIDE
I	Ratification of human rights treaties
II	Cooperation with Treaty Monitoring Bodies
III	Criminalising FGM/C
IV	Policies and National Action Plans
V	Role of Government
VI	Role of Civil Society Organisations
VII	Role of the UNICEF-UNFPA Joint Programme
VIII	Data collection and research
IX	Support services
X	Training for students and professionals
XI	Alternatives

The semi-structured format made it easier to achieve a flowing discussion and allowed for open responses in the respondents’ own words rather than a ‘yes or no’ type answer. The interviews unfolded in a conversational manner offering respondents the chance to explore issues they felt were important. This method of data collection allowed new ideas to be brought up during the interview.

In total, 54 interviews were conducted in Senegal: 12 interviews with representatives of the Senegalese government, 30 interviews with representatives of Civil Society Organisations (CSOs) and 12 interviews with representatives of international organisations. The knowledge, experiences and opinions of these respondents were considered relevant and necessary in order to be able to answer the central research question.



## The Concept of Compliance

Before answering the research question, it is essential to define the concept of compliance and to distinguish between ‘implementation’ and ‘effectiveness’ (or ‘impact’). Although there are many overlaps and links between these concepts, they do have a different meaning and focus. For example, an international human rights treaty could on the one hand be perfectly implemented, but still be ineffective in attaining its objectives. I define the concept of compliance as ‘a state of conformity between an actor’s behaviour and a legal rule.’ This process includes the following five stages (Kent, 2011):

**Figure 5** Five stages of compliance



## Research Results

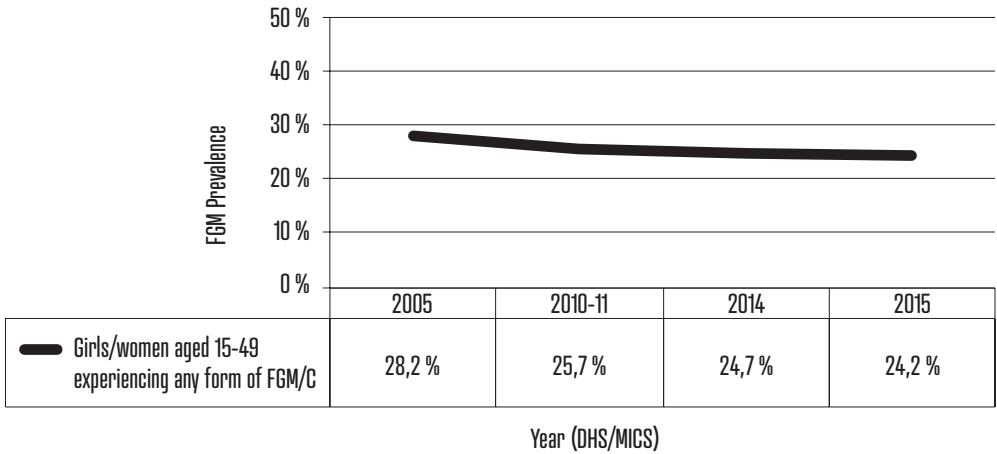
The ultimate goal of the human rights framework is to generate real change, more specifically to reduce and eventually eliminate the practice of FGM/C worldwide. However, ratifying human rights treaties (stage 1) itself does not guarantee automatic compliance behaviour.

At first glance, the extent of compliance in Senegal might seem rather promising: the Senegalese Constitution establishes the enjoyment of rights without discrimination, a national law criminalising FGM/C was adopted in 1999, National Action Plans (NAPs) and many other policies have been adopted aimed at preventing and eliminating FGM/C, and CSOs are actively involved in raising awareness at the community level. Senegal has often been referred to as a ‘promising practice’ in this regard because it was the first country in which a series of public declarations of FGM/C abandonment were made. However, my research indicates that a discrepancy exists in Senegal between *de jure* (stage 4) and *de facto* compliance (stage 5).

Careful analysis of the Demographic and Health Surveys (DHS) and Multiple Indicator Cluster Surveys (MICS) regarding Senegal shows that the national prevalence of FGM/C is not declining as rapidly as the Senegalese government, UNFPA-

UNICEF Joint Programme and CSOs might have hoped. Between 2005 and 2015 the national prevalence of FGM/C declined in Senegal by 4.0 % (from 28.2 % in 2005 to 24.2 % in 2015).

**Figure 6** FGM/C FGM Prevalence in Senegal



Despite the efforts of the Senegalese government, which must be acknowledged, the extent of compliance with the human rights framework on FGM/C in Senegal is limited. Enacting laws criminalising FGM/C and adopting policies is the beginning, but not the end (Shell-Duncan, 2013), because the law criminalising FGM/C is not sufficiently implemented or enforced. Only a handful of individuals have been prosecuted for FGM/C since the adoption of the law in 1999. Adequate social and/or psychological support services are not available for girls and women who have been subjected to FGM/C and those at risk. Awareness of FGM/C is not integrated in the curricula of (medical, legal, social work) students. There are no training programmes for health professionals (doctors, nurses, midwives, psychologists) to detect, manage and counsel on FGM/C. Non-formal and informal educational activities and training on FGM/C are sporadically provided in the relevant sectors. Therefore, there is a clear need to intensify, expand and improve efforts in relation to FGM/C in order to achieve greater compliance with the human rights framework.

My PhD research demonstrates that there is no clear-cut answer to the ‘compliance question’ in relation to the practice of FGM/C in Senegal, but a complicated mix of

factors interact, work together and clarify the behaviour of Senegal. These factors include: (i) lack of capacity and resources at government level, (ii) lack of deterrence and the fear of punishment and sanctions, (iii) fear of damaged reputations; (iv) power and coercion, including pressure from the international community; (v) political personalities; (vi) legitimacy and fairness; (vii) temporal dimension; (viii) pressure of influential parties (such as *Marabouts*) and/or the pressure of domestic interest groups (such as CSOs).

## Conclusion

Does this mean that the commitments of Senegal in relation to the elimination of FGM/C should be regarded as ‘empty promises’? My PhD research concluded that this is not the case. Generating the real change that is necessary to modify the status quo is a complicated process. The main difficulty is the fact that cultural change is required. FGM/C remains a persistent practice and the elimination has not, and will not, be achieved overnight, and most probably not in one generation (Sepper, 2008). Cultural norms, practices and traditions need to change, as well as patriarchal attitudes and deep-rooted stereotypes regarding the roles, responsibilities and identities of girls and women in the family and society (CEDAW, 2015). However, if the factors that have been identified in my PhD research are addressed in the (near) future, Senegal will most probably be able to turn its promises into a lasting reality, and generate positive change for girls and women at risk of FGM/C.

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# Exploring the associations between FGM/C and early/child marriage: a review of the evidence

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## Introduction

Over the last several decades, global efforts to end female genital cutting/mutilation (FGM/C) have intensified through the combined efforts of international and non-governmental organisations (NGOs), governments, and religious and civil society groups. The existing evidence base on the wider impacts of practising FGM/C and on abandonment interventions is small but emerging. Of the many adverse health outcomes thought to be associated with FGM/C, four are frequently cited by policy-makers and advocates —the link between FGM/C and HIV, infertility, fistulas, and Early/Child Marriage — because of their severity and the associated stigmatisation, yet relatively little rigorous evidence is available for each.

FGM/C and Early/Child Marriage are linked practices prevalent in sub-Saharan Africa (SSA). Although the age of marriage has been rising in Africa, over a third of women are married before age 18. FGM/C and Early/Child Marriage constitute harmful practices affecting not only the health of the girl children, but also their development and quality of life. Consider:

- FGM/C has affected an estimated 200 million women in 29 countries, 27 of which are in Africa, and up to 30 million girls are considered to be at risk during the next decade (UNICEF 2013).

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<sup>3</sup> The authors kindly acknowledge Dr David Gathara (Ph.D. Postdoctoral Fellow at KEMRI Wellcome Trust, Kenya) for his valuable inputs in the paper.

- An estimated 15 million girls marry each year before the age of 18 and without interventions to stop Early/Child Marriage the total number of girls who will be married before age 18 years will rise from the current 720 million to an estimated 1.2 billion by the year 2050 (UNFPA 2014).<sup>4</sup>
- While Early/Child Marriage occurs across the globe, FGM/C is most prevalent in regions of SSA and South Asia.
- Both traditions seem to have similar factors and consequences and may therefore, have some form of association, e.g. FGM/C is part of the transition from childhood to adulthood, and is more often than not a prerequisite for marriage.
- There are global efforts to reduce and ultimately eliminate these practices as stated in the Sustainable Development Goal on gender equality (Target 5.3).

## Study Rationale and Methodology

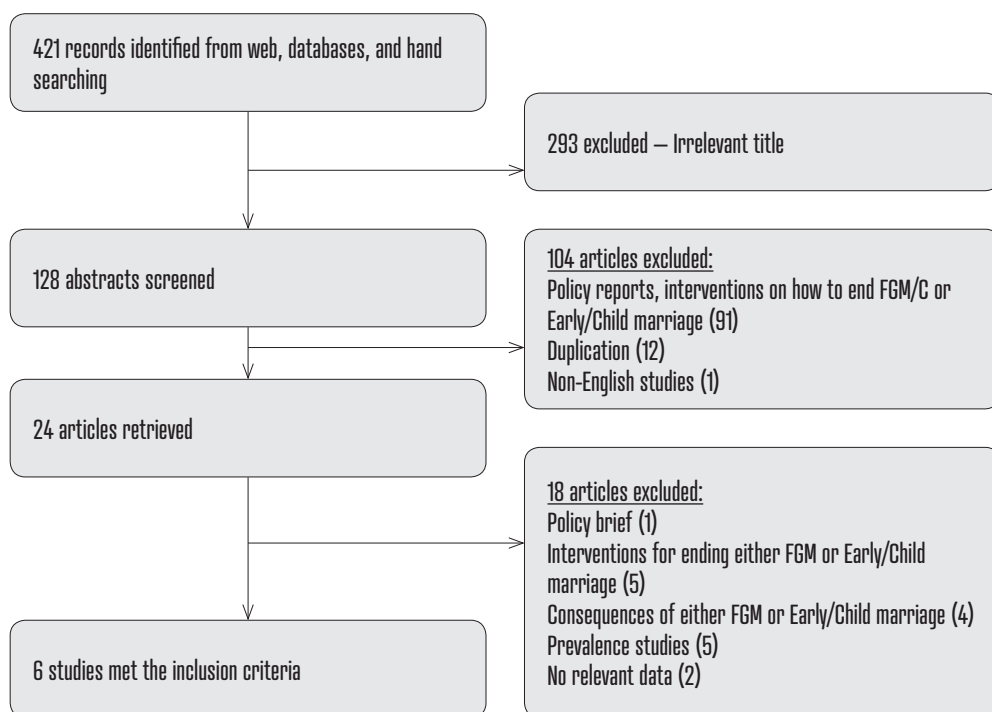
FGM/C has been frequently linked to marriageability and thought to be associated with child marriage, yet there is remarkably little rigorous research to clarify the relationship between these two practices to inform discussions and responses. Furthermore, trends are also shifting in the timing of FGM/C from adolescence to early childhood, and the implications this might have on the links between Early/Child Marriage and FGM/C are not well understood.

This review of current available evidence aims to assess the association between FGM/C and Early/Child Marriage in contexts where both practices are carried out. It includes evidence from English-language peer-reviewed and grey literature. The quality of the studies to be included was appraised using the Department for International Development (DfID) 2014 guidance *How to Note: Assessing Strength of Evidence*.

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<sup>4</sup> See Girls Not Brides Fact Sheet. 2014. [www.girlsnotbrides.org/wpcontent/uploads/2014/10/GNB-factsheet-on-child-marriage-numbers-Oct-2014.pdf](http://www.girlsnotbrides.org/wpcontent/uploads/2014/10/GNB-factsheet-on-child-marriage-numbers-Oct-2014.pdf)

**Figure 7** Study Selection



What does the evidence tell us about the association between FGM/C and Early/Child Marriage?

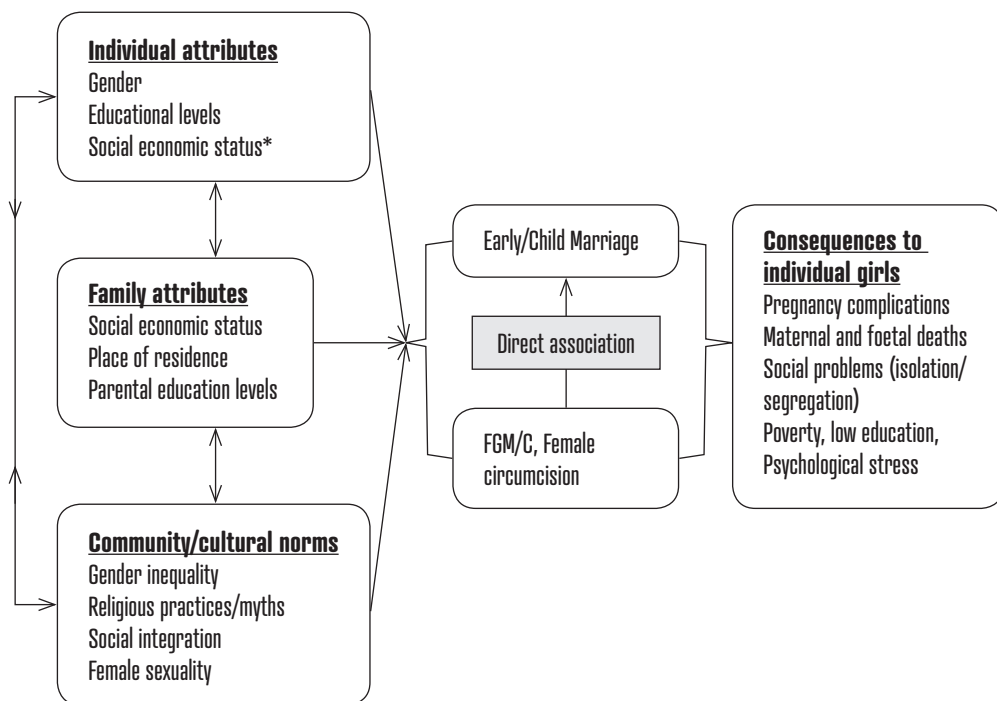
- Only six studies of low to moderate quality met the inclusion criteria – four primary studies of moderate quality and two reviews of low quality.
- There was no quantitative evidence to quantify an association or lack of it. The evidence describing the association between FGM/C and Early/Child Marriage was qualitative.
- Evidence from three studies in Somaliland<sup>5</sup> and Ethiopia<sup>6</sup> show a direct association, with FGM/C transitioning a girl from childhood to adulthood, which leads to child marriage.

<sup>5</sup> Rural Oromia people (World Vision UK 2014) and Somali people who practice the Sunna type of FGM/C in Somaliland. (World Vision UK 2013).

<sup>6</sup> Wolayta people in Southern Ethiopia (Boyden 2013)

- All included studies reported an indirect association between the two practices. This is based on the similarity of causes or underlying drivers behind each such as poverty – the need to secure a financially stable future for the girl, circumcised girls are easily married off and often fetch a higher bride price; and social cultural norms and beliefs – the need to maintain chastity and virginity among girls and make them more submissive to males. The negative consequences of child marriage and FGM/C are also similar, including maternal and neonatal deaths, birth complications, stigmatisation and social isolation, domestic or intimate partner abuse, among others.
- Using the available literature, a conceptual framework outlining some of the commonalities in causes and consequences was developed (Figure 8).

**Figure 8** Conceptual mapping of associations between FGM/C and Early/Child Marriage<sup>7</sup>



\*educational status here can be used as a proxy measure of social economic status.

<sup>7</sup> In phase 2 of this study, the conceptual framework will be further refined based on the planned multivariate analysis of DHS/MICs data.

**Table 9** Classification of Literature Retrieved

Study	Association	Study method	Quality
Diop, N.J., Moreau, A. & Benga, H., 2008.	Indirect association Similar causes and consequences and one type of intervention (education) having an effect of reducing the practice, though to differing extents. (more reduction/abandonment of FGM/C as opposed to child marriage)	Primary Qualitative	Moderate
Avalos, L. et al., 2015.	Indirect association Similar causes and consequences	Secondary; review	Low
Boyden, J., Pankhurst, A. & Tafere, Y., 2013.	Direct association FGMC is a pre-requisite for marriage in the Wolayta community in Southern Ethiopia.  Indirect association Similar drivers and/or reasons for carrying out the practices.	Primary; qualitative	Moderate
Wadesango, N., Rembe, S. & Chabaya, O., 2011.	Indirect association Similar causes.	Primary; mixed methods	moderate
World Vision UK, 2014.	Direct association Rural Oromia people practice FGM/C as a rite of passage and publicly celebrate it and this then leads to marriage.  Indirect association Urban Oromia people perform FGM/C in privacy and during infancy.	Secondary; review	Low



Study	Association	Study method	Quality
World Vision UK, 2013.	Direct association Sunna FGM/C leads to early marriage Indirect association Common drivers	Primary; qualitative	Moderate

### What do we still need in order to better understand the associations between FGM/C and Early/Child Marriage?

Evidence about the associations between FGM/C and Early/Child Marriage is generally scant. This review highlights valuable methodological and reporting lessons for the design of high-quality studies to assess the relationship between the two practices. Some of these lessons include:

1. The sampling needs to be robust and representative of the different cultures and contexts if we are to say something meaningful about a given region. Alternatively, studies need to be conducted in a context that is homogenous to allow for a better understanding of these practices;
2. There is need for better documentation and/or the use of robust and temporal study designs to enable a more complete analysis of any possible causal relationships between child marriage and FGM/C;
3. Longitudinal studies would further enhance the reliability of findings on FGM/C and/or child marriage status; and
4. The triangulation of data, especially in contexts where marriages and births are registered, would greatly enhance the validity and reliability of studies; until now researchers have relied on participant self-reporting, which can be biased.

From the evidence, it is hard to describe clearly the quantitative associations between FGM/C and Early/Child Marriage. Using data already available (like DHS and MICS data), we can attempt to answer some of these questions:

1. What is the association of FGM/C and Early/Child Marriage in different ethnic groups but within the same country?
2. Why do these practices continue in one ethnic group in rural settings while they are abandoned in urban areas?

There also needs to be a deliberate attempt to assess and evaluate interventions aimed at eliminating these practices. Efforts to monitor and evaluate interventions have been poor making it hard to infer reasons as to why interventions work in one setting and not in another. Governments need to improve data collection of vital statistics, e.g. birth and marriage dates, so that there is more reliable data; and to enforce laws which have been enacted to control these practices. Implementing partners and governments need to design integrated interventions and strategies to tackle FGM/C and child marriage in contexts where both practices are prevalent. The social and cultural norms that underpin both practices and thus their continuation may vary across cultures and countries and even change over time; the challenge is to understand how social norms will and could be changed in order to end harmful practices that affect the lives of girls and women.

## Conclusion

A second phase of the study on FGM/C and early/child marriage is planned (2017) in order to investigate the relationship between FGM/C and child/early marriage and the possible correlates of early/child marriage, make comparisons of FGM/C practice across the regions, and examine the correlates for FGM/C. The analysis will use the latest DHS data from 10 sub-Saharan African countries (7 focus countries<sup>8</sup> under the DFID funded 'Evidence to End FGM/C: Research to Help Girls and Women Thrive' programme, and three additional countries of interest – Burkina Faso, the Gambia and Sierra Leone).

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# Organising Focus Groups: process and logistics

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## Introduction

This paper is based on the author's experience of commissioning and undertaking research on a range of topics and areas such as: sexual and reproductive health; domestic/intimate partner violence; sexual violence; and female genital mutilation (FGM), over a period of 13 years. During this time a variety of qualitative and quantitative research methods were employed including: semi-structured and structured interviews (both with individuals and dyad or friendship pairs); surveys (online and face to face); statistical extrapolations; secondary data analysis; evaluations; desk research and focus groups (for example: SAFE Ireland 2013, 2015; Comhlámh, 2014). The author has also advised a range of research studies, including those investigating gender-based violence (GBV) and FGM (WHC, 2009; FGM-PREV 2014-16). The author teaches social science undergraduate and postgraduate students and a key module, 'Sexual and Reproductive Health Research' at University College Dublin, specifically focuses on research methods, approaches and ethical considerations in relation to collecting and analysing data and information on sensitive issues and topics with hard-to-reach study populations. Key expertise and insights in relation to focus groups and FGM were gained during the preparation, organisation and field work for the European Institute for Gender Equality (EIGE) mixed methods research study to estimate the numbers of girls at risk of FGM in the European Union (EU) during 2014. The findings arising from the focus groups for this study were published by EIGE in their subsequent report (EIGE, 2015). Of particular significance regarding expertise gained that is relevant to this paper, are the EIGE study estimating girls at risk of

FGM in the EU; the Senperforto Project outputs Irish launch in June 2011; and producing the first clinical handbook for healthcare professionals working in Ireland on FGM, launched in 2009 (EIGE, 2015; Frans & Keygnaert, 2009; O'Brien Green et al, 2008). In what follows, the author will share some key insights in conducting focus groups when working with hard-to-reach and/or vulnerable populations on sensitive topics, often considered private by research participants, as is the case with FGM.

## **Why focus groups and FGM?**

Focus groups are a form of group interview which are utilised in qualitative research for data collection. Focus groups are particularly beneficial for data collection when one-to-one or dyad interviews are not feasible, or when a deeper understanding of the shared and/or community meaning of a phenomenon is required. Focus groups can bring together a varied range of participants who may not generally interact on the topic of discussion, thereby adding breadth and depth to research findings that emerge, as was the case in the EIGE study on girls at risk of FGM where countries of origin and ethnicities of focus group participants were very diverse (EIGE, 2015). Focus groups can provide participant observation and comparative data via discussion, interaction and sharing during the group, as group members are likely to have varying experiences and opinions (Sprague, 2005). Given the potential for focus groups to explore phenomena from the perspective of a range of individuals in a community or social grouping within a variety of contexts, they are a useful method for researchers to utilise when investigating FGM. Bryman suggests that focus groups allow participants, as well as the facilitator, to discover why individuals hold specific viewpoints and as such offer a valuable tool for researchers to examine individual and collective attitudes and beliefs in relation to FGM (2012). Focus groups can also be used to ascertain group norms and potential for social change (Macnaghten & Myers, 2004). It is possible that participants in a focus group may hold supportive or opposing views in relation to continuing or abandoning FGM. As a result, it requires a skilled and sensitive researcher to facilitate and moderate focus groups composed of participants holding both disparate and deeply held opinions. Given the sensitivity of the issue and the potential for disclosures, or possibly distress, during and after focus groups which are exploring and discussing FGM, additional planning and processes are recommended.

## Planning

Approaching focus group planning with an end result, envisaged as participants leaving when the group has concluded feeling stimulated, valued, empowered and respected, is a useful starting point. Focus groups can present a number of logistical, organisational and implementation issues for the researcher: conscientious and rigorous planning can help alleviate potential challenges, emerging problems and allow for the full involvement of group participants during the discussion. The location of the proposed groups is imperative: it needs to be accessible via public transport, easy to locate and safe to travel to and from. To assist with locating the venue on the day of the group, a map of the venue and relevant details of public transport routes can be circulated in advance to potential group participants. The venue should provide a neutral and private location for the focus group and to put participants at ease. The time and date of the focus group are also important. Participant recruitment is likely to be challenging if a group is scheduled during national holidays, religious occasions and/or times of worship or during school holidays (EIGE, 2015). Awareness of school collection times and term dates is vital if parents of school-age children are amongst the participants of the planned focus group. This was the situation, for example, when focus groups for the 2014 EIGE FGM and risk study were scheduled in August, during school holidays which required childcare planning, budgeting and meant that the groups had to take place on Saturdays. Child care provision for young children who are verbal but are not yet in school, may also need to be provided or budgeted, in addition to participant travel expenses (Sprague, 2005). Advance planning for language needs of participants is practical and focus group information and consent forms in a range of languages may be required. Above all, make it logistically feasible and a viable, positive process to attend the focus group by ensuring comprehensive and sensitive planning and by allowing sufficient time to inform and recruit group participants.

### On the day of the focus groups

Female genital mutilation can be considered a taboo and complex topic that is challenging to discuss in an open, candid and sensitive manner in a group setting. As a result, the welcome when participants arrive, the venue set up, the overall organisation and confident group facilitation can contribute to attendees feeling relaxed and secure. Co-facilitators and support staff who welcome, register, talk through informed consent forms and trouble shoot any logistical issues are a vital part of a focus group team. When attendees give their consent to participate in the focus group and again



at the start of the group, explain any legal mandatory reporting requirements as a result of disclosures during the group: be ready to clearly explain these requirements again verbally, as needed. Utilising co-facilitators who are appropriate to the group members in terms of sex, age and ethnicity and with pertinent language skills can be helpful and reassuring to participants. However, issues of confidentiality may need to be considered in relation to the focus group team and venue, as the team may need to sign confidentiality and non-disclosure forms prior to the group. Skilled co-facilitators can take notes, document non-verbal communication and group dynamics and at a later stage assist with data write up and/or data triangulation.

At the beginning of the meeting it can be useful to have 'ground rules' or group agreements drafted so that group members can discuss and agree on issues of mobile or cell phone use, listening and sharing respectfully and concerns about confidentiality or gossip after the group. Planning appropriate group introductions or 'warm-ups' as well as a closing process at the end of the focus group is important to ensure participants leave in a positive frame of mind and feeling appreciated. Scheduling breaks for food and drinks is necessary. As the most important people in the venue are the group participants the food and refreshments should reflect this as much as any budget constraints allow. By providing plentiful, healthy and delicious snacks this reaffirms the group as special and valued. Some women may not have extended family or community supports available for infant childcare, so it is wise to anticipate that babies may be in the room during the focus group. Having baby changing facilities and a selection of infant toys is a wise idea to provide a welcome distraction for infants during the group. It is very important that the venue used for the group is time flexible and not time limited or pressured, should the group start and/or run late or participants be especially eager to continue the discussions.

### **After the focus group(s)**

Once the group is over, thank each participant individually for their contribution and time, this can be via a SMS/text message, email or short phone call. Following a focus group discussion, issues and concerns may arise for participants, stimulated by the content of the conversation during the group. As a result, it is important to ensure that participants leave with relevant contact details and referral routes for services and supports which can respond to these issues: include details of service locations, any costs to access and opening hours in the information provided. Some participants may contact the facilitator or group organiser for additional information or referral queries; being prepared to respond in a prompt and professional manner with accurate

information is recommended. If participating in focus groups is to be an empowering event and potentially form a part of community reflection and engagement on FGM and change, focus group participants need to be informed of research milestones such as interim reports, publications, launches, etc. (Sprague, 2005). Participants should be acknowledged and thanked at these milestones and invited to attend, where feasible and appropriate, research presentations or launches. The final research report should be available to all focus group participants by post or email should they wish to receive a copy. For researchers much of the ‘work’ is done once a focus group has been organised, facilitated, transcribed and data analysis undertaken: for the group participants this may be the start of a process to discuss, examine, un-pack and ultimately reject the practice of FGM or other forms of gender-based violence in a communal context. Enabling this process to continue and supporting the group to meet again, if desired by the participants, and continue discussions on an ongoing basis ensures that data collection via focus groups is respectful, collaborative and empowering and not extractive, data-driven and exclusive.

## Conclusions

Utilising focus groups for data collection in relation to FGM, and issues related to it, such as migration, integration, and other forms of GBV can be both a challenging and rewarding experience. The depth of data generated through discussion and debate in a focus group can be unparalleled and offer unique and valuable insights into a phenomenon. However, sensitive and thorough planning is needed to ensure the groups run smoothly, are respectful and produce robust, quality data. This data should be used to generate research which can be utilised by many actors (policy makers, researchers, communities, academics, women’s groups, etc.) to substantiate and leverage change in order to work towards abandonment and rejection of FGM for future generations of girls and women.

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# Men, religion and FGM in Belgium, the Netherlands and the UK: a mixed methods study

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## Introduction

Since FGM was brought up as an important health issue by the WHO in 1975, it has often been taken for granted that men's domination and control of women has an important role to play in the perpetuation of the practice (Almroth et al. 2001; O'Neil 2013). The UNICEF report (2013), however, showed that in 16 African countries the percentage of men who want to stop FGM is higher than the rate of women who want to stop FGM, apart from in Sudan and Nigeria (UNICEF 2013:70). The UNICEF report further shows that in 8 countries the rate of women who think that men want FGM to end is significantly lower than the reality. In Guinea Conakry, for example, 12 % of women think that men want to stop whereas in reality 42 % of men want the practice to end (2013:72). This seems to point to a lack of communication between men and women, which the report confirms (2013:72).

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<sup>9</sup> The presentation on which this chapter builds, was based on the publication O'Neil S., Dubourg D., Florquin S., Bos M., Zewolde S., Richard F. (2017) 'Men have a role to play but they don't play it': A mixed methods study exploring men's involvement in Female Genital Mutilation in Belgium, the Netherlands and the UK. Report.

<sup>10</sup> The authors wish to acknowledge Dominique Dubourg for her contributions to the chapter.

It has also often been claimed that in African countries where FGM is practised, men have a sexual preference for women who have undergone FGM (Hosken 1993). The recent UNICEF (2013) report however, shows that in 12 countries, only between 1-7 % of men feel that the practice increases their sexual pleasure (UNICEF 2013:76).

A mixed methods study (qualitative and quantitative research) was conducted in Belgium, the UK and the Netherlands to increase the knowledge of men's role in the perpetuation of the practice. This research is part of a European Daphne project 'Men Speak Out' coordinated by GAMS Belgique with three main work streams: research, training and an awareness campaign aimed at engaging men in the prevention of FGM.

## Methods

### Qualitative study

The objective of the qualitative research was to increase knowledge about men's role in the perpetuation of the practice by addressing (i) men's understanding of FGM as a health risk and human rights violation ; (ii) communication between women and men about the practice of FGM ; (iii) men's opinions about FGM ; (iv) male involvement in the decision-making process to end the practice.

Purposive and snowball sampling techniques were used to identify participants who met the selection criteria, which included:

1. gender and age
2. originating from an African country where FGM is practised
3. the role within the community
4. some men from non-practising communities.

The research participants were selected on the basis of being able to provide crucial information on FGM, i.e., African migrants from communities that have the highest prevalence of FGM, opinion leaders whose views are crucial for FGM-practising immigrant communities.

In total 60 in-depth interviews (IDI) were conducted (20 per country). In each country 16 were undertaken with men and 4 with women. In total, 9 Focus Group Discussions were undertaken (3 per country). In each country FGDs were conducted with:

1. senior Somalian/Djiboutian men
2. young men from different African countries
3. women.

## Quantitative study

The objective of the quantitative study was to estimate the proportion of men who are in favour of the continuation of FGM in Europe as compared to their country of origin. The aim was therefore to find out whether migration and residence in Europe affects men's attitudes towards FGM. We chose to conduct the survey with migrants from Guinea, Sierra Leone, Sudan and Somalia.

Guinea and Sierra Leone were selected (i) because of the large number of migrants originating from these countries living in Belgium, the Netherlands and the UK and (ii) because a baseline was available in the DHS surveys of the countries of origin. Somalia and Sudan are important groups of migrants in the three European hosting countries, and it was decided to add interviews with Somali and Sudanese men as well, even if a baseline of comparison is not available in MICS survey.

The sample size was based on the hypothesis that, after migration to the UK, The Netherlands or Belgium, the proportion of men who think the practice should continue would be significantly lower.

The baseline for the study was men's views of FGM as indicated in the Demographic and Health surveys (DHS) or the Multiple Indicator Cluster Surveys (MICS). The sample size in United Kingdom, The Netherlands and Belgium was calculated for an expected decrease of 8 points between the proportions of men who think the practice should be continued in the country of origin and the country of actual residence.

The required samples in each country are:

- Belgium: Guinean migrants: 331 + Somali migrants: 120
- UK (England and Wales): Sudanese migrants: 239 + Sierra Leonean migrants: 196
- The Netherlands: Sierra Leonean migrants: 113 + Somali migrants: 265

The questions were identical to those in the questionnaire used for the Demographic Health Surveys of Guinea 2012 and Sierra Leone 2013. A few additional questions were included to capture some demographic characteristics.

Migrant populations are potentially considered as 'hard-to-reach', as they are effectively impossible to sample using conventional survey methods with predefined sampling frames. The sampling was purposive – a systematic method by which controlled lists of specific populations within geographical districts are created, and detailed plans are designed to recruit adequate numbers of cases within each of the targets. The interviewers identified and targeted social spaces and areas inhabited by community

members and visited these locations to randomly pick potential respondents who consented to participate.

In total 1,618 men between 15 and 59 years of age were interviewed.

## Data Analysis

Framework analysis (Ritchie and Spencer 1994, Srivastava & Thomson 2009) was used for the analysis of the qualitative data. This method involves the organisation and management of responses through the process of summarising data according to pre-defined categories, until a robust but flexible matrix is obtained.

For the quantitative part, the completed questionnaires were entered into EPI Info in each study country (Belgium, the Netherlands and UK) and subsequently cleaned and analysed in Belgium with SPSS.

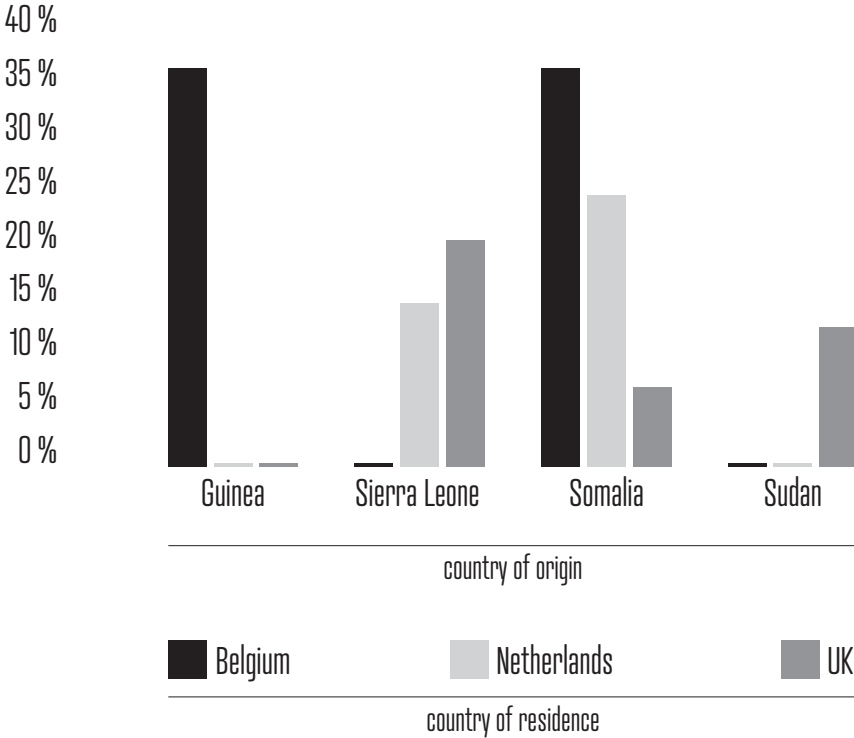
## Results

The qualitative research found that across all three countries commonly mentioned reasons for practising were religion (although the practice is not mentioned in the Koran or the Bible), control of desire, the preservation of virginity, marriageability, cleanliness and aesthetics as well as social pressure. In the quantitative survey, 23 % of respondents believed that religion required female genital mutilation (see Figure 9). Guinean men living in Belgium were more numerous to think so (36.7 %) compared to Sudanese men (13 %). The opinion of Somali men varied in the three countries of residence. The qualitative research showed that younger research participants from West Africa were more uncertain as to whether FGM was a religious obligation than older research participants who had resided in Europe for longer. The latter suggested that FGM was commonly believed to be a religious requirement in their communities but that this belief was erroneous.

The belief that FGM is a religious requirement is an important factor influencing attitudes regarding the continuation of the practice. Men who thought that FGM was required by religion were 15 times more likely to think the practice should continue. This finding corresponds with the DHS Guinea, which showed that if FGM was considered to be accepted by religion, men were more likely to be supportive of the practice (Gage & Van Rossem 2006).

**Figure 9** Percentage of respondents between 15-59 years of age, who have heard about FGM by opinion on whether their religion requires female mutilation (by country of origin and country of residence)

% of men who think FGM is required by the religion



Source: Men Speak Out survey 2016

In Belgium 16.2 % of Somali respondents thought that the practice should continue in contrast to 7.2 % in the UK and 5.2 % in the Netherlands. The stark contrast between Somali men’s opinions in the three countries may be linked to immigration policies and the information migrants and asylum seekers receive upon arrival. In the Netherlands research participants spoke of how useful they felt the information they received was.



The quantitative and qualitative data also show that migration influences men's attitudes regarding the continuation of the practice. Men who have been in Europe for a long time were less likely to think that the practice should continue. In the qualitative research men reported that they changed their minds about the practice after migrating to Europe when they learned that it was harmful to women's health.

## Conclusion

The belief that FGM is a religious requirement affects men's attitudes towards the continuation of the practice. The cross-country comparison shows that access to information on FGM also affects men's attitudes towards the practice. More research on differences in the attitudes between migrants from the same FGM practising communities living in different European host countries is needed.

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# Consideration on the use and interpretation of survey data on FGM/C<sup>11</sup>

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## Introduction

Scholars and reformers have long sought reliable figures on the prevalence and geographic distribution of FGM/C. Important sources of reliable data have been generated, in large part from a number of cross-sectional population-based surveys:

- Demographic and Health Surveys (DHS)
- Multiple Indicator Cluster Surveys (MICS)
- Sudan Health and Household Survey (SHHS)
- Risetkesehatan Dasar, Basic Health Research Survey (RISKESDAS)
- Zambia Sexual Behaviour Survey (ZSBS)

The strengths and limitations of this cross-sectional survey research approach should be borne in mind when using and interpreting these data.

Table 10 provides an example of survey types and patterns available as of August 2016. The module developed by DHS and MICS prior to 2010 commonly included questions about four topics:

1. The circumcision status of the respondent herself (targeting women between ages 15 and 49);

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<sup>11</sup> This paper is based on the technical brief, 'Considerations on the use and interpretation of survey data on FGM/C,' prepared by Bettina Shell-Duncan as an addendum to the trends presented in the 'State of-Art-Synthesis of Female Genital Mutilation/Cutting: What Do We Know Now?' published in October 2016. For more information, please visit [www.popcouncil.org](http://www.popcouncil.org).

2. Information about the event for those respondents who were circumcised;
3. Information about the status of one daughter (sometimes the eldest and sometimes the most recently cut daughter) and details about the event in cases where a daughter had undergone FGC; and
4. Women's (and sometimes men's) opinion of the practice.

**Table 10** Examples of Survey Types and Patterns

Country	Survey
Benin	DHS 2001, DHS 2006, DHS/MICS 2010
Cameroon	DHS 2004
Ethiopia	DHS 2000, DHS 2005 (no FGC in DHS 2010)
Gambia	MICS 2005-6, MICS 2010, DHS 2013
Somalia	MICS 2006, MICS 2011 (separate for Somaliland and Northeastern Zone only)
Sudan	DHS 1989-90, MICS 2000, SHHS 2006, SHHS 2010, MICS 2014

The form in which questions were asked has varied significantly across different survey questionnaire-creating challenges in comparing data from consecutive surveys in a single country or in surveys across countries. Therefore, DHS and UNICEF agreed to coordinate module revisions, and in 2010 they adopted a standardised module on FGM/C. This module differs from the one used in DHS surveys between 2001 and 2009 in several respects:

1. Questions on the benefits or effects of FGC for daughters were dropped because they did not produce reliable data that was easy to interpret;
2. The question on intention to circumcise a daughter was dropped due to concerns about reliability;
3. The module asks each respondent with at least one living daughter about the current FGC status of all daughters under the age of 15 (not just the eldest or most recently cut); and
4. The number of questions about opinions about FGC is reduced.

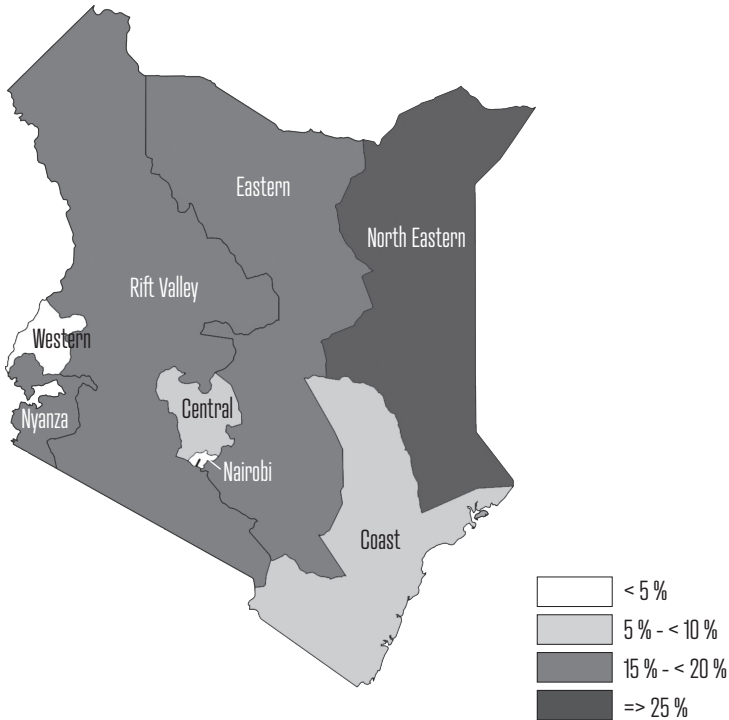
With the revision and standardisation of the FGC modules, repeat data collection allows for comparison of trends across five year intervals, comparison of data across countries, and analyses of rates and correlates of change in the nature and practice of FGM/C.

The sampling strategy for DHS and MICS surveys is designed to be nationally representative, and ideally provide information for each region. A two-stage sampling process is typically employed. First, clusters are selected from a list of enumeration areas with probability proportional to size. In the second stage, a complete household listing is drawn up in each selected cluster, followed by the random selection of a set number of households per cluster. In each household, all women age 15-49 are typically interviewed.

At times there are variations in sampling frames that need to be taken into account when comparing data from two or more consecutive surveys. In such instances, the data may need to be adjusted to ensure comparability. Examples from Kenya and Egypt illustrate two important cases in point.

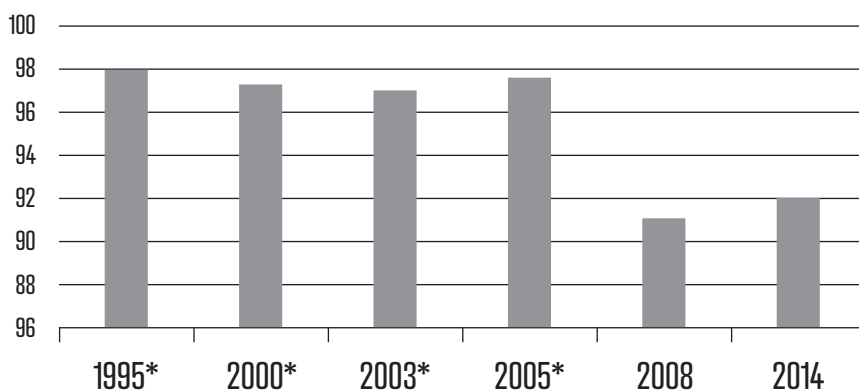
In the Kenya DHS 1998, the North Eastern Province was not included. It was added in the 2003, 2008-09 and 2014 DHS (see Figure 10). This change in sampling frame makes unadjusted comparison of the 1998 national prevalence rates to those from later surveys inappropriate.

**Figure 10** Prevalence of FGM/C in Kenya in 2014, by Region



In Egypt there is a different change in the sampling frame across repeat surveys that results from a change in the eligibility criteria (see figure 11). The DHS surveys conducted between 1995 and 2000 sampled ever-married women between the ages of 15 and 49. In the 2008 and 2014 DHS, both ever-married and never-married women between the ages of 15 and 49 were eligible. The apparent decline in the prevalence from 96 % in 2005 to 91 % in 2008 is largely due to the fact that the prevalence of FGM/C is lower among never-married women. Cross-survey comparisons need to adjust for these differences in sampling frame.

**Figure 11** Prevalence of FGM/C in Egypt



Self-reported data on FGM/C also needs to be treated with caution as inaccuracies may arise for a number of reasons. Because of the sensitivity of the topic or illegal status, women may be unwilling to disclose having undergone FGM/C (Askew, 2005). Additionally, women may be unaware of whether they have been cut or of the extent of the cutting. Recall bias is also a possibility if the woman is reporting about an event that occurred years ago. The translation of survey questions also opens possibilities for ambiguity and the choice of wording may influence which types of cutting are understood to be FGM/C. Finally, a number of studies have attempted to determine the reliability of self-reports of FGC status by verifying them through clinical examinations. Studies that have compared women's self-report of being cut or not to clinically observed signs of FGM/C have reported variable rates of concordance and are thus imperfect.

The reliability of survey data before and after passage of laws concerning FGM/C must also be considered. Legislative measures that prohibit the practice of FGM/C have been put in place in countries where survey data have been collected both before and after enacting criminal bans. Change across surveys in FGM/C practices and attitudes may result from deterrence or, alternatively, reflect unwillingness to honestly disclose FGM/C status or views due to fear of prosecution or courtesy bias.

When looking at data on daughters, information about the girls' FGM/C status has been collected in a variety of ways. In surveys up to 1999, female respondents were in some instances asked about their eldest daughter, and in others about their most recently cut daughter. Beginning in 1999, DHS surveys began asking respondents about the cutting status of all daughters age 0-14 years; this change was incorporated into the 2010 standardised MICS and DHS survey module on FGM/C.

Complete data on FGM/C among all daughters age 0-14 has two benefits:

- It allows for the estimation of prevalence of FGM/C at the youngest ages where effects of recent changes will be detected, and
- It allows for the analysis of trends in age at FGM/C across generations.

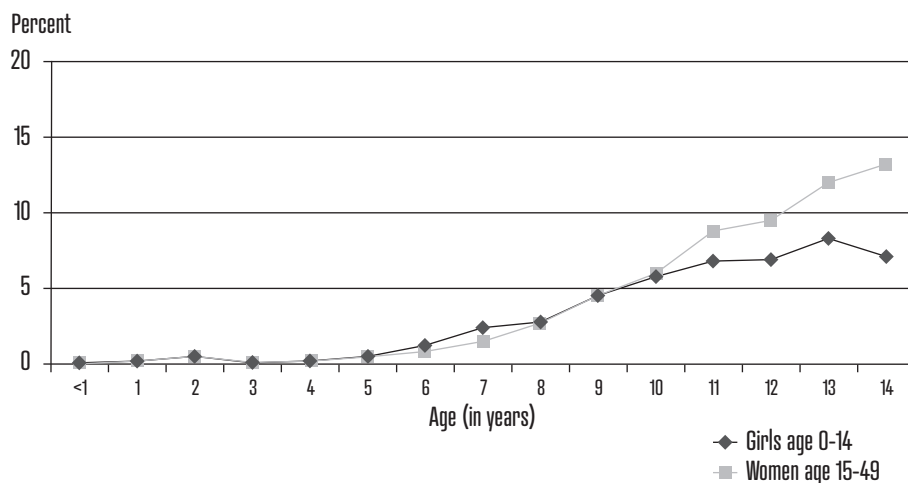
The analysis and interpretation of complete daughter data are, however, not straightforward since not all girls have reached their final cutting status. Girls under the age of 15 include three groups:

1. girls who are currently cut;
2. girls who are currently uncut, but will be cut in the future; and
3. girls who are currently uncut, and never will be cut.

One simple method that has greater validity, though is still not perfect, is to compare the age-specific cutting rates of women and girls of different ages. Data from the 2014 Kenya DHS illustrate this (see Figure 12). It is important to note a key difference between the data on girls and women: women age 15-49 are presumed to be at the final cutting status, while girls age 0-14 reflect current cutting status. A portion of these girls may still be cut in the future. This portion, however, decreases as age goes up providing clues that rates of cutting appear to be declining in the younger generation of Kenyan women.

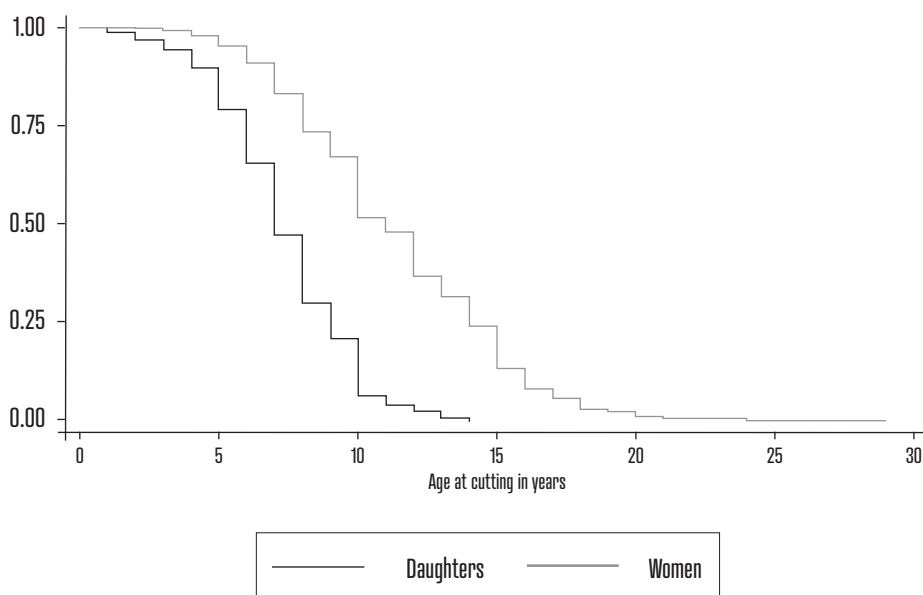


**Figure 12** Age-specific rates of FGM/C among Kenyan women aged 15-49 and girls aged 0-14 (Kenya Demographic and Health Survey 2014 Report)



Cases in which a girl may still be at risk of being cut in the future are described as statistically ‘censored’ observations. An analytical technique known as survival analysis can handle censored data, allowing for analysis of factors associated with rates of FGM/C in girls, as well as comparison of age at cutting in two or more groups, such as mothers and daughters. Data analysis of the 2008 Egypt data illustrate this. Overall, the mean age at FGM/C for mothers was 9.4 years, and the mean age at FGM/C for daughters was 8.5 years. A direct comparison of the mean age at FGM/C, uncorrected for censoring, would suggest that the age at FGM/C is declining across generations. However, a survival analysis that statistically adjusts for censoring provides a different result. The survivor functions, shown in Figure 13, reveal that the age at FGM/C is higher among daughters than among mothers. This suggests that the trend toward increased age at FGM/C detected across cohorts of adult women is continuing in the next generation.

**Figure 13** Eldest daughter vs Woman aged 15-49 KDHS 2014



## Conclusion

There are still many gaps to fill in order to produce global estimates of the number of girls and women affected by FGM/C and those at risk of being cut in the future. However, when interpreting and using the survey data currently available on FGM/C, several items must be considered. In making comparisons across surveys, close attention must be paid to potential differences in question forms and sampling frame. Also, issues regarding the validity of self-reported data on FGM/C must be considered. Finally, data on FGM/C among girls aged 0-14 provide information only on current cutting status, but determinants of rates can be analysed using specialised methods (survival analysis).

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# The association between women's social status and the medicalisation of female genital cutting in Egypt

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## Introduction

Female genital cutting (FGC) refers to all procedures involving partial or total removal of the external genitalia or other injury to the female genital organs for non-medical reasons. FGC is harmful to girls and women in many ways. For this reason, numerous national and international initiatives attempted to abandon the practice, with only partial success. While the prevalence of FGC in more recent birth cohorts decreased in nearly all countries, one of the most notable changes is the current trend to medicalise the practice (Yoder et al., 2013). According to the World Health Organization (2010) FGC is medicalised when it is performed by a trained health professional regardless of the place of performance.

The majority of research aimed at examining trends in FGC has focused on changes in attitudes towards FGC or changing prevalence rates of FGC. These studies found that both the prevalence of FGC and attitudes towards the practice are strongly related to women's social status (Van Rossem et al., 2015, El-Gibaly et al., 2002). Despite the importance of upcoming medicalisation as an issue, a notable lack of evidence exists regarding up-to-date research on the association between women's status and medicalisation of the practice. With this study we aim to fill this hiatus in the literature. We examine the association between women's status and medicalisation

of FGC using the two most recent waves of the Egyptian Demographic Health Survey. A comprehensive conceptualisation of women's social status, broadly defined as women's ability to have control over the circumstances of their lives (Besera and Roess, 2014), is incorporated by taking women's status both within and outside the household into account.

## Methods

For this study we use data from the fifth and the sixth wave of the Egypt Demographic and Health Survey (EDHS 2008 and 2014). The EDHS surveys provide information about large nationally representative samples of ever-married women aged 15 to 49 . For the current study, we select women whose most recently born daughter had undergone FGC. The analytical sample consists of 3,664 respondents.

Applying logistic regression analyses, we examine how the respondents' women's status associates with whether their most recent daughters underwent a medicalised FGC. Medicalisation is measured by differentiating between daughters whose FGC was performed by a trained health professional or by a traditional practitioner. In order to capture the social status of the respondents, we include information on their current employment, educational level and household wealth (women's social status outside the household). Information on spousal differences in age and education as well as whether the women had a final say in household decisions are additionally included (women's social status within the household). The latter variable is based on the question whether the respondents have a shared or final say in their own health care, in large household purchases, in visits to family or relatives and what to do with the money their husbands earn. The original items, being categorical variables, are recoded to value 1 if the respondents indicated having full or shared say with partner or others – the created variable is the sum of these recoded item variables divided by four. It is included as a continuous scale (range 0 to 1) with higher scores indicating more household autonomy. We additionally differentiate between respondents living in urban and rural areas and adjust for the age of the mothers at the moment their most recently born daughters underwent FGC.

## Results

Our results presented in table 11 show that 9.1 % of the variability of our outcome variable can be attributed to women's social status. Overall, our results indicate that women's social status outside the household is more strongly associated with medical-

isation of FGC than social status within the household. On the one hand, women from wealthier households and women who received at least primary levels of education are significantly more likely to have their daughters cut by a trained health professional. However, when levels of education between the respondents and their partners were equal, or when they received higher levels of education than their partners, this decreases the likelihood that their daughters would be cut under medicalised conditions. We additionally find that living in an urban region increases the likelihood of medicalisation. If FGC is not performed by professional health personnel it is generally done by a traditional practitioner, also known as a ‘daya’.

On the other hand, daughters of employed women, as well as women with higher levels of household decision-making autonomy are not more likely to have been cut under medicalised conditions. In the same line, age differences between the respondents and their spouse do not significantly reflect the trend for medicalised FGC.

**Table 11** Results Logistic Regression on Medicalisation of youngest cut daughter FGC

	Medicalisation youngest cut daughter FGC	
	Odds ratios	
Women’s status outside the household		
Employment		
(Mother currently not working)		
Mother currently working	1,005	
Highest educational level		
(No education)		
Primary education	1,564	*
Secondary or higher education	3,599	***
Household Wealth		
(Poorest)		
Poorer	1,153	
Middle	1,508	**
Richer	2,265	***
Women’s status within the household		
Spousal age difference	0,984	*

Medicalisation youngest cut daughter FGC		
	Odds ratios	
Spousal educational difference		
(Husband higher educated)		
Mother & husband no education	0,688	**
Mother & husband same educational level	0,599	*
Mother higher educated then husband	0,399	***
Voice in Family	1,052	
Control variables		
Age of mother when youngest daughter was cut	1,047	***
Urban	0,77	*
Intercept	0,605	
Nagelkerke R2	0,091	

Reference category between brackets

(\*):  $p < 0,05$  (\*\*):  $p < 0,01$  (\*\*\*):  $p < 0,001$

## Discussion

Our study, examining the association between women's social status and medicalisation, finds especially strong effects of the social status of women outside the household. Being a member of a wealthier household and being more educated increases the likelihood of mothers opting for a medicalised FGC for their daughters. Additionally we found that respondents who live in an urban area are more likely to have a daughter who is cut in medicalised settings. These findings are in line with the available literature on the association between women's status and changes in the prevalence and/or attitudes towards FGC (El-Gibaly et al., 2002, Van Rossem et al., 2015). Our findings indicate that medicalisation of FGC is stratified. Access to health services, availability of health information, education in general and economic resources can influence whether a mother is able to opt for medicalisation. Further, being economically able to medicalise can act as a status symbol on its own (Clarke et al., 2003).

To our surprise, women's status within the household does not influence the likelihood of medicalisation. These findings contrast with research on prevalence and attitudes towards FGC (Afifi, 2009). This may possibly indicate that the option to medicalise is a concern of both knowledge and economical ability, rather than an outcome of women having sufficient authority within the household to enforce their decisions.

Our study has several limitations. First, previous research showed that FGC is not merely determined by individual considerations, but also by group norms. Mothers will feel they have to conform to social norms regarding FGC in order to ensure their daughters' social position (Mackie, 2000, Mackie, 1996). While the current study does not examine how these social norms may influence medicalisation of FGC, we underline the importance of taking account of this social aspect of FGC in future research. An additional limitation of this study is the shortage of three possibly important factors influencing the association between women's status and medicalisation due to data issues, i.e. religion, hurdles to accessing health care and influence of the mothers' native family. Generally, more research is needed to understand how women's status leads to these changing preferences, and to explore the rationale behind this association.

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# Researching Harmful Cultural Practices: Values and limits of an intersectional perspective

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## Introduction

For many years now, female genital mutilation/cutting (FGM/C) has been considered as a ‘harmful cultural practice’ (HCP). This recognition implies a recategorisation from being considered as a ‘tradition’ – understood as part of a social group’s ‘culture’ and therefore deemed unchangeable – to a serious form of harm to girls’ and women’s well-being that reproduces gender inequality and impairs women’s freedom of choice and bodily integrity. The terminology of HCPs has largely been developed within commissions and conventions of the United Nations; categorising certain practices as FGM/C has been instrumental in expanding the protective force of human and women’s rights conventions towards those practices formerly shielded from intervention by naming them as part of ‘culture’ and ‘tradition’.

Nevertheless, the concept of HCP has also been subject to critiques and debates. Developed essentially within Western institutions to particularly call out non-Western practices as sexist and violent, it has been criticised for its inherent biases and the ways it might be abused to justify neo-colonial interventions and oppression in non-Western settings. Categorising FGM/C as a ‘harmful cultural practice’ may therefore serve to reproduce stereotyping and racist discourses that portray non-Western men and women as determined by ‘culture’ and as needing the intervention of ‘universal’ human rights discourse and its underlying basis of Western Enlightenment

values. As these pitfalls may also affect research on HCPs, they present important challenges for researchers studying these practices.

In this contribution, I explore how intersectionality theory may be useful for researchers studying harmful cultural practices in general and FGM/C in particular. Intersectionality, initially developed by black feminists as an emancipatory tool to theorise oppression, is characterised by its commitment towards social justice and stresses the interlocking nature of forms of oppression based on social categorisations like gender, 'race', class and sexual orientation. Therefore, it might be a useful tool for researchers who, working from a privileged position, are faced with the challenges of researching gender-based violence in contexts where this research itself may be complicit in reproducing neo-colonial representations and interventions.

## Harmful Cultural Practices: Contours of the debate

Ever since its articulation and definition within UN-circles, the concept of HCP has been the subject of heated debates. The concept has gradually evolved from the 1950s onwards, when concerns about 'customary practices' that restrained the rights and well-being of women and girls had first been expressed within UN-resolutions and commissions<sup>12</sup> (Longman & Bradley, 2015).

A clear definition was given in the 1995 UN Factsheet entitled 'Harmful Traditional Practices affecting the health of women and children', from which following characteristics can be inferred:

- HCP are seen as normal and even as morally good in the eyes of those practising them.
- In fact, they reproduce patriarchal oppression of women by men.
- These practices are harmful for women's and girls' mental and physical well-being.
- They persist because they are not questioned; abolition may even meet fierce resistance.

Not explicitly stated in the definition, but clear from the many descriptions of HCP, is that they are particularly associated with non-Western regions and customs. Western HCP were only taken up quite late in UN-policies after feminist criticism (Winter, Thompson, & Jeffreys, 2001).

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<sup>12</sup> The first of these explicitly named 'customary practices' included forced marriage, child marriage and the practice of bride price and also FGM/C, which has since been the focus of much attention in UN-policies.

The attention directed toward FGM/C and the way it has been debated in UN-discourse, has been subject to controversies. One example is the influential Hosken report, credited with influencing the UN and WHO in putting the issue on the agenda, but severely criticised by Chandra Mohanty (1988) among others in her well-known critique on Western feminists' representations of 'the Third World Woman'. Her critique pointed to the pitfalls that arise when studying gender-based violence from positions of (unacknowledged) privilege, as Western scholarships on HCP reproduces representations of non-Western women as eternal and passive victims of their 'culture'. These issues are complicated by the differing views of morality involved and the difficulties that arise when exposing practices considered as 'normal' and inherently 'good' by some, but described as 'harmful', oppressive and 'bad' by others. Because: Who exactly is exposing these practices as 'harmful'? Whose voices are heard in research and which perspectives are dismissed? How does a concept like HCP – with its emphasis on 'culture' – obscure the impact of racial, economic and neo-colonial exploitation in the persistence of these practices? The discussion can therefore not be cut loose of global inequalities and the West's presumed moral superiority that infuses the discourse on HCP.

Alternative approaches try to undermine stereotypical views and neo-colonial tendencies by pointing to the universal occurrence of patriarchal oppression. From this perspective, comparisons are made with practices occurring in the West (Jeffreys, 2005; Winter et al., 2001), like the pressure of unrealistic beauty standards and the normalisation of plastic surgery. Another perspective may consist in challenging the passivity inscribed upon non-Western women, by valorising women's capacity for choice and decision-making, even in patriarchal or constraining environments (Mahmood, 2001). In the case of FGM/C for example, research by African scholars centralises African women's views and demonstrates that this practice may also be experienced as empowering for women (Abusharaf, 2001; Njambi, 2004). As this last perspective may possibly result in a form of cultural relativism, an additional perspective points to the importance of historicity, contextuality and change when understanding HCP (Esho, Van Wolputte, & Enzlin, 2011; Pedwell, 2008; Phillips, 2010). In what follows, I discuss the opportunities that an intersectional perspective may offer in the study of HCP.

## What can an intersectional perspective offer?

Although the term ‘intersectionality’ has become widespread since Crenshaw first named it as such in the 1990s, the theoretical background that it refers to had already been articulated by black feminists in the 1960s and 1970s, and can even be traced back to the 19<sup>th</sup> century (Collins & Bilge, 2016; Williams-Crenshaw, 1994). Intersectionality developed out of black feminist critiques on unidimensional perspectives in both the (mostly white) feminist movement and the (mostly male) black anti-racist movement, as black feminists demonstrated how their specific experience as black women was simultaneously shaped by their gender and race. Intersectionality can be defined as a theory studying the nature and complexity of inequality by pointing out how systems of oppression (based on gender, race, class, sexual orientation, religion and other relevant categories of differentiation) interact and mutually construct each other. However, intersectionality is more than a theory, as it is essentially rooted in praxis: it is thus also ‘an analytical and political tool elaborated by less powerful social actors facing multiple minoritisations in order to confront and combat the interlocking systems of power shaping their lives’ (Bilge, 2013)

Choo & Ferree point to three important characteristics that distinguish intersectional research projects from ‘mainstream’ research (Choo & Ferree, 2010)

A first defining characteristic is the inclusion of marginalised perspectives. This implies ‘giving voice’ to (multiply) marginalised groups and making their experiences visible. Secondly, intersectional research is process-centred and explores how different structures of domination interact. This means for example ‘asking the other question’ in order to examine which categories of social differentiation are relevant and how exactly they relate to each other. Thirdly, intersectional research implies an integrative view, in which no a priori primacy is given to one structure of domination above any other.

When applied in studying FGM/C, this means for example decentring culture, whose impact is strongly stressed by the term HCP itself. However, an exaggerated focus on culture contributes highly to the stereotyping of non-Western others as determined by culture and tradition (Phillips, 2010; Withaecx & Coene, 2011). Applying an intersectional analysis would result in an examination of the impact of less obvious power differences – like age, class and sexual orientation for example – that may prove essential in understanding how and why some categories of women are heavily invested in the reproduction of FGM. It would also shed light on the impact of (neo)colonial oppression in the genesis and reproduction of these practices, and might even

reveal the complicity of anti-FGM/C discourses in perpetuating the practice (Esho et al., 2011).

For individual researchers working on HCP, the following 'intersectional checklist' may be useful when reflecting on the impact of privilege on their work:

1. Is my research doing more than just portraying black women and describing 'their' habits? How does my research unveil the workings of systems of oppression that are responsible for their marginalised position? And how may my research itself be complicit in reproducing inequality; in the ways my respondents are represented and how my findings are represented, and how these may or may not empower the individuals and communities I have studied?
2. Does my research disproportionately focus on one or a limited number of structures of domination (culture, ethnicity, etc.) at the expense of other meaningful factors that might provide insight in the phenomenon at hand?
3. How do gender, race, class, age, heteronormativity... interact in specific manifestations of FGM/C?
4. ...

Asking such questions, creates the opportunity to recognise the impact of privilege inherent in conducting research on marginalised communities and to explore more profoundly how HCPs are shaped in concrete historical and political contexts.

While intersectionality thus provides a useful lens for studying HCP, there are also some limits. Intersectionality remains a concept that emerged in the global North. In order to avoid a new form of academic imperialism, it should be recognised that concepts cannot always be unproblematically 'transplanted' in other contexts, and that scholars working in other contexts could equally provide useful concepts that could inform research. Intersectionality may also focus too much on the stability of categories instead of on the underlying dynamics that have created them and may be too oblivious to transnational dimensions of social inequality (Dhawan & do Mar Castro Varela, 2016; Puar, 2012).

Despite these limits, it is clear that intersectionality could provide useful perspectives and innovative insights when studying HCP. Nevertheless, more important than the label itself, is the rationale behind it: a commitment to social justice, a close examination of the simultaneous impact of different forms of oppression in shaping gender-based violence, and a recognition of how privilege impacts upon our position as researchers and on our research itself.

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# Extrapolation model in estimating the prevalence of FGM/C: The Norwegian experience

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## Background

Girls and women who have been subjected to Female Genital Mutilation/Cutting (FGM/C) and in particular infibulation, have a greater risk of developing a series of physical and psychological complications that require healthcare (Hearst and Molnar, 2013). For effective planning on accommodating the healthcare needs for this vulnerable group of girls and women, it is important to have reliable data on the magnitude of the problem. Reliable prevalence estimates on FGM/C can help to guide local health policies and increase the cost-effectiveness of its allocation of resources.

Prevalence estimates on FGM/C in countries where FGM/C is a traditional practice (countries of origin), are derived from population-based survey data such as Demographic Health Survey (DHS) and Multiple Indicator Cluster Survey (MICS) (UNICEF, 2013). In countries of immigration where FGM/C is practised mainly by immigrant minorities, employing similar population-based surveys to estimate the prevalence of FGM/C would be extremely challenging. Alternative models with wide variation in methodologies, definitions and approaches have therefore been explored in various countries of immigration (European Institute for Gender Equality, 2013, Leye et al., 2014). One of these, an extrapolation model, is more frequently used. In this model, prevalence data from countries of origin is extrapolated to the corresponding resident female immigrant population (European Institute for Gender Equality, 2013, Leye et al., 2014).

To enhance the comparability of prevalence estimates for FGM/C from Norway



with other prevalence estimates in Europe, we have therefore adopted the extrapolation model in our estimation study of 2015 (Ziyada et al., 2016). Please refer to the article for the findings as well as a more detailed description of the methodology.

This paper focuses on the considerations that we have to take into account while implementing the extrapolation model (Ziyada et al., 2016) and our reflections on how we can enhance the quality of FGM/C prevalence estimates in future studies.

## Considerations and assumptions in the implementation of the extrapolation model

We have paid especial attention to providing clear definitions of the key groups and central terminologies used in our analysis (Ziyada et al., 2016).

Instead of using the total female population as a denominator for our prevalence estimate on FGM/C, we followed suit of Leye et al. (2014, p. 100) and expressed the prevalence of FGM/C as a proportion between the numerator 'the number of women and girls in that country who have undergone FGM at a certain point in time' and the denominator 'the total number of women living in the country, but originating from countries where FGM is practised'. This is because FGM/C in countries of immigration is limited to minority groups.

Further, we decided to limit our estimation to the female population originating from 29 countries of origin where data on FGM/C is collected regularly through population-based surveys. This population includes both first- and second-generation immigrants. First-generation immigrant girls and women were defined as those who have immigrated to Norway from one of the 29 countries, whereas second-generation immigrant girls and women were those born in Norway to two first-generation immigrant parents.

Consequently, we have requested and obtained a population register dataset from Statistics Norway (SSB) for the cut-off point 31.12.2013 that includes all current female residents in Norway who have emigrated or whose parents emigrated from one of the aforementioned 29 countries and that is stratified by country of origin, age on arrival in Norway and current age (Ziyada et al., 2016).

Departing from the fact that there is a customary age in countries of origin within which FGM/C is performed (UNICEF, 2013), we assumed that first-generation immigrant females, who were older than that age upon arrival, had already been subjected to FGM/C in corresponding proportion to the prevalence rates in their countries of origin. Therefore, for this group we used the national prevalence rates for the age group 15–49 from their countries of origin to calculate the number of those subjected to FGM/C prior to immigration (Ziyada et al., 2016). Our data sources for national

prevalence rates and customary age for FGM/C were the latest available DHS and MICS country reports (USAID, Unicef).

We also assumed that none of the first-generation immigrants who were under the customary age on arrival in Norway, or second-generation immigrants had been subjected to FGM/C. The justifications for this latter assumption were: 1) the growing evidence that FGM/C is practised at much lower rates in countries of immigration than in countries of origin (Gele et al., 2012a, Gele et al., 2012b, Gele et al., 2015, Johnsdotter et al., 2009), and 2) the expected overestimation if extrapolation of prevalence rates from countries of origin were to be used.

## Limitations and opportunities for improvement

One of the strengths of the extrapolation model stems from the use of population survey data from countries of origin such as DHS and MICS. Nonetheless, the inherent limitations of the DHS and MICS surveys, such as reporting bias and the inability to reflect recent FGM/C trends in practising countries (Behrendt, 2011, Ortensi et al., 2015), are consequently similar to limitations for the extrapolation model. Furthermore, in our analysis of 2015 (Ziyada et al., 2016), we have used national prevalence rates that may obscure the variation in prevalence levels among different ethnicities in the different countries (UNICEF, 2013, Leye et al., 2014, Exterkate, 2013). As in other European countries, the National Registry office in Norway (Statistics Norway) does not provide information on ethnicity for ethical and legal reasons (Ziyada et al., 2016). Nevertheless, the use of regional prevalence rates could be a viable alternative as there is a close correlation between ethnicities and sub-regions within countries of origin (UNICEF, 2013). Additional data on place of birth could therefore be requested from Statistics Norway for future studies.

The inability to address the selection process of immigrants is another limitation linked to the use of national prevalence levels (Ortensi et al., 2015). Migration is arguably a selective process resulting in younger, wealthier, and more educated immigrant populations compared to those who did not emigrate. Failing to adjust for age, wealth and education could consequently result in an overestimation of FGM/C prevalence (Ortensi et al., 2015). Incorporating the model proposed by Ortensi et al., 2015 should be considered for future studies in Norway.

Finally, the assumption that none of the first-generation immigrant females under the customary age on arrival in Norway, or the second-generation immigrant females have been subjected to FGM/C is not accurate. There is a great need therefore for direct estimates on the performance of FGM/C after arrival in countries of

immigration. In countries where all cases of FGM/C are systematically recorded in medical registers (e.g. the Netherland and the UK), calculating the number of second-generation immigrant females who have been subjected to FGM/C in particular, could help to improve future prevalence estimations.

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# Contributor Profiles

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Gbadebo Babatunde Makinde obtained a Bachelor's Degree in Science in Demography and Social Statistics in 1998, a Master's Degree in Science (Demography and Social Statistics) in 2003 and a PhD (Demography and Social Statistics, 2016) from the Obafemi Awolowo University in Nigeria. Dr Gbadebo Babatunde started working as an academic at the Joseph Ayo Babalola University, and has been a Lecturer I at the University of Ibadan in Nigeria since 2016. He is also involved in teaching postgraduate students of the Pan African University Institute of Life and Sciences, an affiliation of the Africa Union. Dr. Gbadebo has authored and collaborated in publishing scholarly research findings in the field of Population, Reproductive Health and Mortality.

## Hazel Barrett

Hazel Barrett is a social scientist who undertook her degree at the University of Sussex (UK) in the School of African and Asian Studies. She then moved to the University of Birmingham to undertake her MA and PhD in West African Studies. Hazel has worked at Coventry University since 1992 and in 2006 she was conferred a Chair in Development Geography. She is currently Research Professor at the Centre for Trust, Peace and Social Relations. Her main areas of research are the socioeconomic aspects of development, in particular gender, health and rural development in sub-Saharan Africa. Over the last decade her research has focused on FGM in Africa and amongst the African diaspora in the EU. She has published books and chapters on health and development issues and has over 50 refereed articles to her name.

## Vanja Berggren

Vanja Berggren has a Master's Degree in Public Health and a PhD in International Health from the Karolinska Institute in Sweden (2005). She held a post-doctoral position in the Middle East, in Syria and Saudi Arabia, from 2008 to 2010. Her main research interests are FGM, maternal and child health, both from a quantitative and qualitative perspective. She recently finished a ten-year collaboration project on women's health in Uganda with Makerere University, supported by the Swedish Scientific Council (Sida/VR). She has published over 50 scientific papers and several book chapters.

## Gily Coene

Gily Coene is Associate Professor at the Vrije Universiteit Brussel at the Department of Philosophy and Ethics and the Political Science Department. She is director of RHEA, Centre for Research on Gender, Diversity and Intersectionality and co-founder of the Inter-University Master in Gender. Gily Coene has a background in Social Work (1993) and Moral Sciences (1996) and obtained a PhD on Gender, Migration and Justice at Ghent University in 2004. She has been a post-doctoral Marie Curie fellow at the University of Warwick and joined the VUB in 2006. Her research is at the intersection of descriptive and normative ethics, feminist theory and gender studies, and covers a wide range of issues related to gender equality and cultural diversity, sexual and reproductive rights, human rights and democratic citizenship.

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Tammary Esho has a background in Clinical Medicine and Surgery from Kenya Medical Training College, MSc in Human Sexuality, and a PhD in Biomedical Sciences from the University of Leuven, Belgium. She is currently Head of Department, Community and Public Health at the Technical University of Kenya in Nairobi. She also works as a clinical sexologist. Her main research interests are in the psychosexual consequences of female genital cutting among the Maasai ethnic group of Kenya and complications of FGM/C. She works in collaboration with both local and international organisations and academic institutions including the African Coordinating Centre for Abandonment of Female Genital Mutilation (ACCAF) at the University of Nairobi, Population Council, UN Joint Programme on FGM, Kenya Anti-FGM Board, University of Leuven, ICRH.

## **Diana Geraci**

Diana Geraci has a Master's Degree in Social Sciences. Her main areas of expertise are health disparities, asylum seekers and refugees' healthcare and FGM. At Pharos, being the Dutch Focal Point on FGM, she coordinates the programme on FGM, which focuses on both prevention and healthcare provision. She has conducted focus groups on the healthcare experiences of women with FGM and is involved in the development of the multidisciplinary guideline on healthcare for women with FGM. She is also co-researcher in the prevalence study on FGM in the Netherlands. Furthermore, she published the book 'Facing Return. An approach to psychosocial assistance for (former) asylum seekers and undocumented migrants'; 'Interculturele diagnostiek' a manual on intercultural diagnostics and several articles on culturally tailored interventions.

## **Adriana Kaplan**

Adriana Kaplan is a professor of Medical Anthropology, Director of the Chair of Knowledge Transfer at the Dept. of Social Anthropology, Universitat Autònoma de Barcelona (UAB) in Spain. She is the Executive Director of the Wassu-UAB Foundation. Her major fieldwork since 1989 has been in Spain and West Africa, mainly in The Gambia on issues concerning reproductive and sexual health and rights, from an interdisciplinary, transnational and longitudinal approach. Prof. Kaplan is leading the "Transnational Observatory on Applied Research and Knowledge Transfer on Female Genital Mutilation", with two research and training stations in The Gambia and Spain, developing an innovative, sustainable, evidence-based and results-oriented methodology, now being replicated in Kenya, Tanzania and Senegal.

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Most of her research centres on Africa, namely poverty and inequality in Africa, the social and economic impact of migration and remittances in host countries as well as the impact of economic policy in developing countries.



## **Annemarie Middelburg**

Annemarie Middelburg is an independent consultant in the field of women's rights, with a unique expertise in FGM/C. She holds an LLM in International Law & Human Rights and received her PhD from Tilburg University in the Netherlands. Her PhD thesis, entitled *'Empty Promises? Compliance with the Human Rights Framework in relation to Female Genital Mutilation/Cutting in Senegal'* contains a legal analysis, literature research and an in depth empirical study, conducted in Senegal. In 2015, she founded her own company 'Middelburg Human Rights Law Consultancy'. In recent years, she has carried out assignments for the United Nations Population Fund (UNFPA), Save the Children International, University of Amsterdam, Amnesty International and several NGOs in the Netherlands and Europe.

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## **Jacqueline Mulders**

Jacqueline Mulders is a youth care professional with (inter)national work experience at policy level as well as in the field, working directly with children and their families. Her work has focused on understanding health issues related to (forced) migration, the role of culture in perceptions on (mental) health and illness, and possibilities of (mental) health care institutions to offer culturally sensitive care. She received her MA from The Fletcher School of Law and Diplomacy. She currently works with unaccompanied refugee minors at a Dutch youth care agency.

## **Jacinta Muteshi**

Jacinta Muteshi, PhD provides leadership, research, and advisory work in the field of human rights, gender equality, and social policy. She has managed multi-country FGM/C programmes across the Africa region for CARE, PATH and the Population Council. Other key roles have included the Chair of Kenya's National Commission on Gender and Development (2004-2007), the Committee of Eminent Persons on the Constitutional Review Process-Kenya (2006), Board Director of the Kenya Human Rights Commission (2001-2003) and Board Member of the Consortium for National Health Research (CNHR). She has published widely in peer-reviewed journals and has extensive experience as an academic lecturer. Dr Muteshi received her Master's Degree in Education from McGill University and her PhD from the University of Toronto. Dr Muteshi is currently Senior Associate and Programme Director-FGM/C at the Population Council.



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Siobán O'Brien Green has worked in government agencies and the non-profit, research and academic sectors. She has worked in service provision, communications, teaching, training and research on national and European multi-country research projects, relating to sexual and reproductive health, violence against women and female genital mutilation (FGM). Siobán holds a Master's Degree in Social Policy from University College Dublin (UCD) and teaches in the UCD School of Social Policy, Social Work and Social Justice. In 2015 Siobán was awarded an Ussher Postgraduate PhD Fellowship by Trinity College Dublin (TCD). She is currently carrying out PhD research in the Trinity Research in Childhood Centre (TRICC), focusing on help, support and safety seeking by women who have experienced domestic violence during pregnancy.

## **Sarah O'Neill**

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Bettina Shell Duncan is a professor in the Department of Anthropology of the University of Washington. Throughout her career she has conducted mixed method bio-cultural research on maternal and child health in sub-Saharan Africa. A major focus of her research has been on the study of FGM. Through her work with WHO and UNICEF, she has examined the politics of the international campaign to end FGC, and the implication of adopting a health and human rights framework. She has recently been conducting mixed method research on the theoretical and empirical dimensions of the dynamics of behaviour change towards FGC in Senegal and The Gambia. She also is involved in an international research consortium, funded by the U.K.'s Department of International Development that investigates factors influencing decision-making regarding FGC and intervention strategies in 6 African countries.

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Sarah Van de Velde is currently employed as Assistant Professor at the Centre for Longitudinal and Lifecourse Studies at the Department of Sociology, University of Antwerp, Belgium. She is an Honorary Fellow of the Department of Sociology at the University of York, UK. She holds a PhD in Sociology from Ghent University, Belgium. She carries out research in the field of medical sociology and family sociology. Most prominent research strands are studies on gender differences in mental health and health care use, as well as reproductive health and female genital cutting. She is a member of the editorial board of the *Journal of Diversity and Gender Studies*, as well as the *Flemish Journal of Sociology (Sociologos)*. She is a board member of the Flemish Association of Sociology, as well as Oxot, a socio-cultural organisation that supports the reintegration of people with mental disorders. She is a guest member of the expert meeting organised by the European Institute for Gender Equality on the revision of the Gender Equality Index (GEI), as well as the expert meeting organised by the Flemish government on the revision of the Flemish Gender Monitor 2016.

## **Nina Van Eekert**

Nina Van Eekert is a PhD student researching the association between women's status and prevalence and medicalisation of Female Genital Cutting (FGC). She is currently working on research focusing on the Egyptian context. The research project is a joint PhD associated with the Sociology Department at the University of Antwerp and the department of Medicine and Health Sciences at the University of Ghent. Nina holds a Professional Bachelor's Degree in Social Work and a Master's Degree in Sociology. She first came into contact with the issue of female genital cutting while working in an asylum centre as procedure assistant. In Belgium, asylum is given to women who fled their country to prevent themselves and/or their daughters being circumcised.

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Mai Ziyada is a researcher at the Norwegian Centre for Violence and Traumatic Stress Studies, and a PhD candidate at the Faculty of Medicine, University of Oslo. She holds a medical degree from her country of origin Sudan and an M.Phil. Degree in International Community Health from the University of Oslo. Her main research interest is sexual and reproductive health rights. She is currently working on the project 'physical and psychological healthcare in Norway for girls and women who have been subjected to FGM/C.

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