2015

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

Community Handbook

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

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FOREWORD by Neena Gill MEP

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

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

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

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

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

Neena Gill, West Midlands MEP

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Glossary

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

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

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

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

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

Community-based Participatory Action Research (CPAR): This is the approach that REPLACE used to engage members of FGM affected communities to understand the social norm supporting FGM. It is an approach to collecting information that puts communities at the centre of the research process and enables them to contribute to the research, to be listened to and to be empowered by the process so that that they can take action to tackle FGM.

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

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

Cultural 'Insiders': When individuals share a similar social location. For example, a Somali researcher is more likely to share a cultural, social and linguistic understanding with another Somali than a European researcher. We use the term cultural 'outsider' to refer to the opposite of cultural 'insider'

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sunna/Sunnah: This is a term used by some communities to refer to a form of FGM. People tend to use it to describe less severe types of FGM, such as those classified as Types I, II and IV by the WHO. It is an Arabic word meaning "habitual practice" and refers to

"the body of traditional social and legal custom and practice of the Muslim community" (www.britannica.com/EBchecked/topic/573993/sunna.

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

ABBREVIATIONS

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

BCC - Behaviour Change Communication

BCI - Behaviour Change Interventions

BCT - Behaviour Change Techniques

CBR – Community Based Researcher

CESIE – (Italian REPLACE Partner)

COM-B – Capability, Opportunity, Motivation and Behaviour

CPAR - Community-based Participatory Action Research

DoH - Department of Health (UK)

EC – European Commission

EIGE - European Institute for Gender Equality

EP – European Parliament

EU – European Union

FG – Focus Group

FGD – Focus Group Discussion

FGM - Female Genital Mutilation

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

FSAN - Federation of Somali Associations Netherlands REPLACE Partner)

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

HIV - Human Immunodeficiency Virus

IEC - Information, Education and Communication

NGO – Non-governmental Organisation

PATH - Programme for Appropriate Technology in Health

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

SD – Standard Deviation

UK – United Kingdom

UNHCR – High Commissioner for Refugees

UNICEF - United Nations International Children's Emergency Fund

WHO – World Health Organisation

Section 1: Introduction to the REPLACE Approach

The REPLACE Approach is an innovative and effective approach to ending FGM in the EU. It was conceived in 2009 and has received two Daphne III action grants (REPLACE1: JLS/2008/DAP3/AG/1193-3DCE03118760084; REPLACE2: JUST/2012/DAP/AG/3273). Together with REPLACE partners and over a period of five years, the REPLACE Approach has been developed, trialled, improved, implemented and evaluated. The REPLACE Approach is presented in this Community Handbook which has been written to give interventionists, community leaders and others working with communities to end FGM, practical guidance on how to implement the REPLACE Approach. It is a stand alone handbook, but those using it may benefit from reading the REPLACE Toolkit (Barrett et al, 2015) which gives more information on the REPLACE Approach with examples and findings from the REPLACE Project.

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

1. Engaging with affected communities and ensuring they are active participants in the development and implementation of an intervention in order to gain their trust and commitment to the project and to identify key people in the community to work with, such as community leaders and peer group champions (Section 3).
2. Understanding the nuances of the social norms that perpetuate FGM amongst FGM affected communities living in the EU and the enforcement mechanisms used by the community to ensure individuals continue the practice. This is achieved using community-based participatory action research methods (CPAR) (Section 4).
3. Drawing on community readiness theory (e.g. Edwards et al., 2000), successfully applied to other community issues including drug abuse and domestic violence, to assess where the whole community sits in relation to addressing FGM (Section 5).

This helps to identify intervention actions that can be targeted at the community level by community members to achieve change.

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

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

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

1.0 How to use the REPLACE Community Handbook

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

The Community Handbook provides practical, 'hands on' guidance on how to effectively apply the REPLACE Approach. Following an introduction to the REPLACE Approach and the ethical considerations that must be considered and acted on before and during the implementation of the REPLACE Approach (Section 2), the Community Handbook describes in a logical manner how to undertake each Element of the Cyclic Framework in a way that is accessible to practitioners and communities. How to apply each element is explained and then practical examples and tips are given to assist in carrying out the activities. Figure 1.1 gives an outline of what is included in this Community Handbook.

Figure 1.1 Summary of the Community Handbook Sections with their aims and objectives as well as tools and techniques included

Section Number	Aim/Objectives of the Section	Tools and Techniques
Section 2: **The REPLACE Approach and Ethical Considerations**	To be fully informed of the REPLACE Approach. To be aware of the ethical considerations associated with applying the REPLACE Approach	Read Section 2 of the REPLACE Community Handbook and if possible the accompanying REPLACE Toolkit (or Executive Summary). Prepare: Participant Information Sheet; Consent Form; and Debrief Sheet. Prepare a policy and procedures document on what to do should a participant disclose intent to perform FGM or information concerning a recent case of FGM. Prepare training materials for Community Based Researchers and Peer Group Champions (not yet recruited) on: general facts and background concerning FGM; the legal situation concerning FGM; issues associated with confidentiality and data protection; risk analysis, health and safety; how to deal with distressed participants; what to do in cases of disclosure.
Section 3: **Element 1: Community Engagement**	To identify the target community To identify key stakeholders in the	Identify suitable community using secondary information and by informal interactions with members of the community. Undertake a stakeholder analysis.

	target community	
	Appoint Community Based Researchers and Community Peer Group Champions	Recruit and select Community Based Researchers and Community Peer group Champions, to ensure representation of both genders, different ages and marital status. Train them in: context and background of FGM; legal status of FGM, REPLACE Approach; ethical issues; risk assessment and health and safety; issues associated with confidentiality and data protection; policy and procedures associated with disclosure of intent to perform or recent cases of FGM; how to deal with distressed participants; effective communication; relevant community engagement techniques such as community fora and community workshops.
	To gain the trust and buy-in of the community to engage with the project	Prepare material, disseminate information and deliver community fora and community workshops to raise awareness of the project and get community support for the project. Undertake monitoring and evaluation to ensure community engagement process has been effective.
Section 4: **Element 2: Understanding the Social Norm Perpetuating FGM**	To understand the beliefs and social norms supporting the continuation of FGM and identify the barriers to ending the practice.	Train Community Based Researchers in Community-based Participatory Action Research (CPAR) methods, in particular in undertaking focus group discussions and narrative interviews. Identify and recruit participants using a suitable sampling method. Undertake focus group discussions and narrative interviews. Transcribe and translate the results of the focus group discussions and narrative interviews. Analyse the information by coding (either manually or using appropriate software such as Nvivo) and identifying themes. Validate the findings.
Section 5:	To assess the	Apply the REPLACE Community Readiness to End

Element 3: Community Readiness to End FGM	community's readiness to end FGM	FGM Model Allocate the community a stage of readiness to end FGM score.
Section 6: Element 4: Intervention Development	To identify and develop a community activity/intervention designed to change attitudes and behaviour concerning FGM	Community Peer Group Champions to work with the community to identify a target activity/intervention consistent with the community's stage of readiness to end FGM. Undertake a Capability, Opportunity, Motivation and Behaviour (COM-B) assessment of the Peer Group Champions and others involved in developing and delivering the activity/intervention. Using appropriate Behaviour Change Techniques (BCTs) train/mentor Peer Group Champions and others involved in developing and delivering the activity/intervention in the aspects of COM-B that they show weaknesses in. .
Section 7: Element 5: Intervention Delivery and Evaluation	To effectively deliver the intervention/activity developed in Element 4.	Deliver the intervention/activity according to: the nature of the intervention; the stage of community readiness to end FGM; and the COM-B of the Community Peer Group Champions and others delivering the intervention/activity.
	To evaluate the impact of the intervention/activity on the community and individual attitudes and behaviour towards FGM.	Develop an evaluation strategy to include: REPLACE Community Readiness to End FGM Model; focus group discussions and interviews; questionnaires; and objective assessments of the reach of the intervention/activity. Review the results of the evaluation. Use the results of the evaluation to inform the next cycle of the REPLACE Cyclic Framework for Social Norm Transformation.

1.1 The REPLACE Website

The REPLACE website contains more material and examples, as well as help and advice on the REPLACE Approach. This can be accessed at: www.REPLACE2FGM.eu.

Section 2: Introduction to the REPLACE Approach and Ethical Considerations

2.0 Introduction

The REPLACE Approach is a new innovative methodology to end FGM in the EU. It is designed to compliment and build upon the current dominant methods used to tackle FGM which focus on raising awareness of the health and human rights issues associated with the practice. Whilst recognising that awareness raising is important in the fight to end FGM the REPLACE Approach goes further. It aims to change behaviour concerning FGM amongst FGM affected communities living in the EU by empowering them to challenge the social norms perpetuating FGM and thus moving towards the goal of abandoning FGM.

REPLACE recognises that FGM is a deeply rooted cultural practice that is a social norm for those communities practising FGM that is enforced by various social mechanisms. It also acknowledges that different communities have different beliefs, different social norms and different enforcement mechanisms concerning FGM. It is for this reason that the REPLACE Approach puts communities at its centre, appreciating that FGM communities living in the EU are different and are constantly changing as a result of their interaction with their new host country and their response to FGM interventions.

The REPLACE Approach is based on three pillars:

1. **Behavioural Change**: REPLACE accepts that FGM occurs within a wider socio-cultural context and that the behaviour and decisions of others are critical in relation to whether or not FGM is carried out. It also recognises that some individuals are in less powerful/influential positions than others and even if they wanted to abandon FGM feel they are not able to do so for fear of social sanctions and community rejection. The REPLACE Approach therefore incorporates both individualistic as well as community-focussed behaviour change theories.
2. **Engaging and working with communities**: When implementing interventions based on behaviour change theories it is very important to understand the beliefs and the social norm supporting the continuation of FGM and identifying the barriers to change. The REPLACE Approach uses Community-based Participatory Action Research (CPAR) to engage with communities and to collect information regarding individual and community practices and beliefs associated with FGM and the perceived barriers to ending the practice. CPAR is committed to the active participation of communities as collaborators in information collection and intervention development and delivery. It empowers communities and ensures interventions are sustainable. REPLACE recruited community based researchers and peer group champions and trained them in CPAR methods in order to allow them to fully participate in the REPLACE Approach and to ensure interventions were culturally sensitive and appropriate.
3. **Evaluation**: Evaluation underpins the REPLACE Approach. It is an iterative and empowering process that allows communities and organisations working with them to target, implement and assess the effect of activities and interventions to ensure the efficient use of limited resources for maximum impact. It allows interventionists to learn what works and what does not, as well as what needs improving or changing.

As communities move towards ending FGM it allows the assessment of progress. Evaluation methods also need to be suitable for use by communities and organisations working with them.

2.1 The REPLACE Cyclic Framework for Social Norm Transformation

The REPLACE Cyclic Framework for Social Norm Transformation comprises five elements that support systematic consideration of how to influence motivation and behaviour change within a community, stressing the important roles played by community leaders, influential people in the community and peer group champions. It is a cyclic model that aims to bring about small shifts in behaviour targeted at the goal of ending FGM. Thus the Cyclic Framework might have to be repeated a number of times before the goal of ending FGM is achieved within a given community. The Cyclic Framework is shown in Figure 1.1.

Figure 2.1 The REPLACE Cyclic Framework for Social Norm Transformation
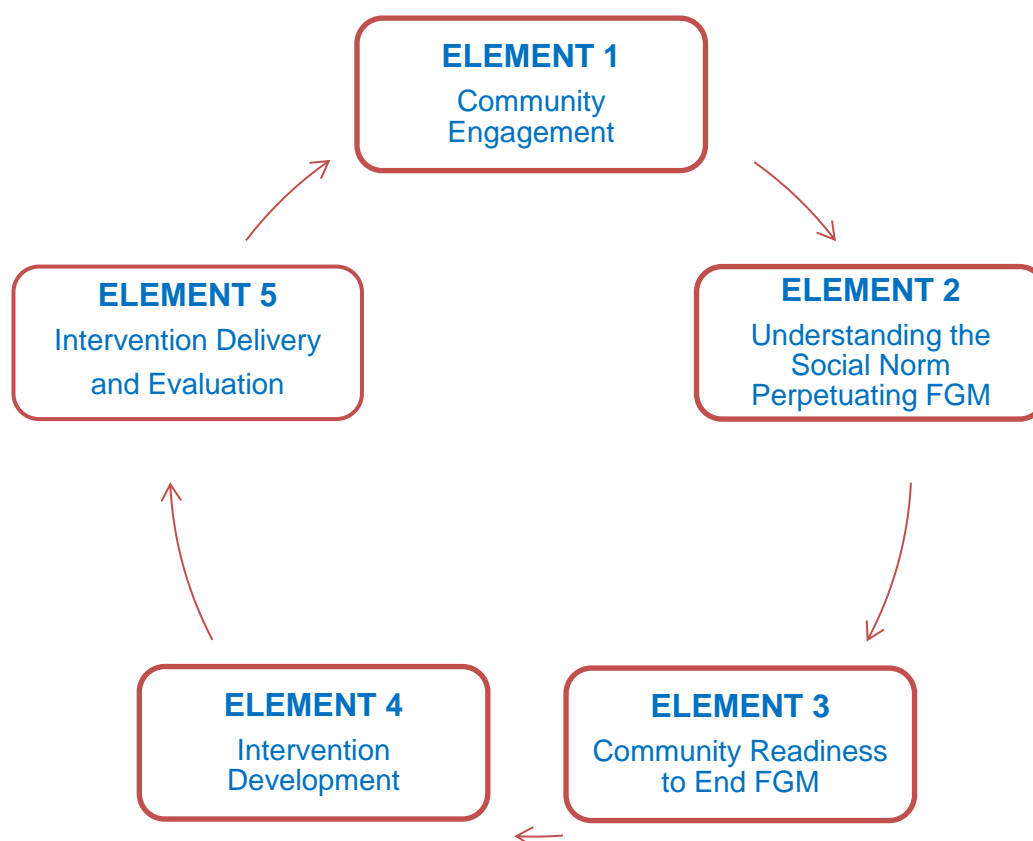
Source: REPLACE

Element 1: Community engagement

This element involves engaging with the FGM affected community, gaining their trust and involvement in the project. In this element community leaders, influential people and peer

group champions are identified and motivated to begin to challenge the social norm perpetuating FGM in their community. See Section 3 on how to undertake this Element.

Element 2: Understanding the Social Norm Perpetuating FGM

In this Element CPAR is used to identify the belief systems and enforcement mechanisms that support the continuation of FGM in the community and to identify the barriers to ending FGM. Section 4 explains how to undertake this Element.

Element 3: Community Readiness to End FGM

This Element involves assessing the community's level of readiness to end FGM by applying the REPLACE Community Readiness to End FGM Model. See Section 5 for information on how to undertake this assessment.

Element 4: Intervention Development

Using the information collected from Elements 1, 2 and 3, the community based researchers and peer group champions agree an appropriate target intervention activity. Using the capabilities, motivation, opportunity and behaviour model, peer group champions are trained and supported in developing and implementing the target intervention action. See Section 6 for advice on how to undertake this Element.

Element 5: Intervention Delivery and Evaluation

In this element the intervention is delivered and evaluation undertaken. The evaluation methods are described in Section 7 and include both qualitative and quantitative methods which are used before and after intervention delivery. The results of the evaluation inform future action and the next iteration of the Cyclic Framework. Through intervention delivery and evaluation greater and greater numbers of community members with an interest in the issue are identified and incorporated into activities in the next iteration of the cycle.

2.2 Ethical Considerations

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

1. *Community engagement and identifying the target community*
   On initial contact with the community the project/intervention should be explained and any benefits or disadvantages of participation fully discussed. Care must be taken to ensure that participants fully understand what they are being asked to do, and why they have been approached to participate. If members of the community want to take part in the project./intervention full informed consent has to be given by the participant. To aid this, a Participant Information Sheet (PIS) should be produced in an appropriate language. A PIS explains what the project/intervention is about, why the participant has been asked to take part, what will happen if they agree to take part, the possible disadvantages and risks of taking part. It should also inform them how the information they disclose will be kept confidential and anonymous. It should include the contact details of the people or organisation organising the project./intervention. It is important that participants are reassured that all identifiable information, such as their names and names of family and friends will be removed or changed in transcriptions of information, providing anonymity. See Figure 2.2 for an example of a PIS that can be adapted.

   In addition to the PIS, a Consent Form should be produced in an appropriate language. All participants need to indicate on the Consent Form that they are willing to take part. An example of a Consent Form is given in Figure 2.3. If participants are not willing or are unable to give written consent, it is acceptable to ask them to provide this verbally at the beginning of an audio recording of an interview or focus group discussion. It is important that permission to audio record an interview or focus group discussion is given by all participants involved in the recording.

   The information on both the PIS and Consent Form should be read out to participants to ensure they understand the project/intervention and have the opportunity to ask questions. It should be emphasised that participants are under no obligation to take part in the project/intervention nor answer questions or take part in any activity that they feel uncomfortable with. Participants should be able to withdraw from the project/intervention at any time without giving a reason and any information they have already provided removed from the project/intervention.

2. *Recruiting community based researchers and peer group champions*
   The same ethical procedures as described above apply to the recruitment of community based researchers and peer group champions. In addition, those recruited to these roles need to be trained in the ethical issues associated with dealing with a sensitive topic, such as FGM; how to ensure confidentiality and the safe storage of information (see below) and what to do if a disclose of intent to perform FGM or recent case of FGM occurs (see below).

3. *Confidentiality and the handling and storage of information*
   Each participant should be allocated a unique identification code or pseudonym to ensure their anonymity whilst allowing the participant to be identified by project/intervention managers if the participant decides to withdraw at a later date.

   Conducting a focus group discussion can pose particular problems in maintaining participant confidentiality. Indeed this is one of the disadvantages of employing this method, particularly with a subject as sensitive as FGM. With tremendous social pressure for individuals to perform FGM on their daughters, it may be extremely difficult for focus group participants to express their feelings and beliefs, due to the fear that a fellow participant will divulge this information to others outside the focus group. Those facilitating focus group discussions should ask everyone who takes

part to respect other participant's right to confidentiality and not discuss anything that is said outside of the focus group.

During a focus group discussion or interview a participant may ask those facilitating the discussion what others have said about a particular issue or topic. Facilitators must not disclose what others have said, as this may breach confidentiality and indicate to the participant making the request that their own views might not be kept confidential. In addition revealing what others have said could influence how the current participant answers. If participants do ask what others have said, it is best to respond with generalities, or not to answer at all.

Recordings, transcripts and consent forms must be stored in a secure location, such as locked cabinets in a secure office. Information that is stored electronically, must be password protected. Consent Forms which will have identifying information on them should be stored separately from other data and information. After information has been transcribed and translations checked with audio recordings, the recordings should be erased.

All those involved in collecting data and information must comply with the data protection legislation applicable in their country.

4. *The development and implementation of the intervention and its evaluation*
Principles of co-creation are important and the views and input of all community members who are involved should be respected, acknowledged and incorporated. In recruiting participants for the evaluation of intervention activity, the same ethical principles that apply to all other recruitment should be applied as outlined above and in Box 7.2 (Section 7 of this Handbook).

5. *Ensuring participant and researcher safety and emotional well-being*
The well being of participants and the researcher is an ethical priority in any project/intervention.

In focus group discussions there is the possibility that participants can become offended or upset by the comments or opinions of others. In order to minimise participant emotional distress, focus group facilitators should emphasise the need to be respectful of others' views. Facilitators need to be able to identify when a discussion is becoming problematic and step in to either redirect the discussion or in serious situations, terminate the focus group.

It is possible that during focus group discussions or interviews participants may disclose events or emotions that they have not yet come to terms with. In these circumstances participants may become distressed. If a participant becomes distressed during an interview the facilitator needs to find out if the participant wishes to continue. If distress occurs within a focus group discussion then the facilitator should temporarily stop the discussion to allow the participant to regain composure and to decide if they wish to continue. All distressed participants should be referred to an appropriate source of help. Information relating to counselling services and sources of support and advice should be distributed to all participants during the debriefing (see below).

At the end of each focus group discussion/interview participants should be given a Debriefing Sheet (which should also be explained verbally and in an appropriate language). This should contain information regarding organisations specialising in the field of FGM which can provide advice or support if required. An example is given in

Figure 2.4. During the debriefing it is a good opportunity to ask participants if they have any questions or concerns regarding the issues raised or their participation. During the debriefing facilitators should reconfirm participants' consent by informing participants of their right to withdraw from the project/intervention. If participants indicate they wish to withdraw from the project/intervention at this stage, that is fine. In such a case the participant should be informed that all information they have given during interviews will be removed and the audio recording will be erased. If a focus group participant wishes to withdraw it should be explained to them that their contribution to the discussion will not be transcribed.

Investigating sensitive topics such as FGM can have an impact on researcher and facilitator emotional well-being. It is important that researchers and facilitators have access to support and guidance. Information on sources of advice and support should be given to researchers and facilitators by those organising the project/intervention. It should be included as part of the initial training given to community based researchers and peer group champions.

The safety of researchers and facilitators must also be considered. Researchers and facilitators must always ensure a responsible person knows where they are going and when, as well as when they are expected to return. Where possible researchers/facilitators should avoid collecting information alone in participant's homes, as this may put them at risk. Neutral venues where other people are close by are to be preferred, such as a private room at a community centre. Having access to a mobile phone, in case of emergencies, is recommended..

6. *Processes to follow if a participant discloses intent to practise FGM or a recent case of FGM.*
   All forms of FGM are illegal in the EU. In many EU Member States it is also illegal to take somebody out of that country to have FGM performed in another country. However there is evidence that FGM is taking place in the EU with EU residents being sent outside the EU for the purpose of FGM.

   Researchers, facilitators and participants must be made aware of the legal situation concerning FGM in the country in which they reside.

   The REPLACE Approach does not ask participants direct questions about their intention to perform or if they have performed or encouraged others to perform FGM. It is very unlikely that participants will disclose a direct intention to perform FGM. Nevertheless researchers and facilitators need to have contingency measures in place to deal with such a disclosure of intent or disclosure of recent FGM.

   Researchers, facilitators, project/intervention managers need to consider the following:

   - Seek advice on how to deal with FGM disclosure before commencing the REPLACE Approach.
   - Have a clear action plan on how to deal with disclosure and ensure all researchers, facilitators and project/intervention managers are aware of what they should do in the event of disclosure.
   - If your plan includes the need to inform legal or child protection authorities of a disclosure, then you MUST ensure that participants are aware that this will be the case through the information provided in the Participant Information

Sheet and Consent Form before they agree to be part of the project/intervention.
- Ensure that you have available information and sources of help and advice to provide to participants concerning the legal status of FGM in their country of residence. This should be in the Debriefing Sheet.
- Researchers, facilitators and project/intervention managers should be ready to answer questions about the law and FGM if they are asked. .

The following sections of this Community Handbook gives you practical hands-on advice as how to implement the REPLACE Approach. More information is available on the REPLACE website: www.REPLACEFGM2.eu.

We wish you luck in implementing the REPLACE Approach and look forward to receiving any feedback.

Figure 2.2 Example of Participant Information Sheet

Below is an example of a Participant Information Sheet (PIS) used by REPLACE - recruiting participants to attend focus group discussions - in the UK. Note the use of the term 'female circumcision/cutting' rather than FGM. REPLACE decided that this term was more appropriate and would not deter individuals from participating. The Participant Information Sheet should be translated accordingly. If participants have difficulty reading, the researcher should read the information to the participant

The PIS should provided participants with the following information:
- *Information regarding the aims of the project*
- *Why they have been chosen to take part*
- *The positive and negative aspects of taking part*
- *How the information they provide will be stored and used by the researchers.*
- *Emphasise confidentiality and anonymity and the right to withdraw.*
- *Provide contact details of organisations, from which participants can gain more information.*

Participant Information Sheet

Study Title

Researching the FGM Intervention programmes linked to African communities in the EU (REPLACE)

What is the purpose of this study?

The aim of the study is to find out the beliefs regarding female circumcision/cutting among the ??? community and how people come to decisions about whether to circumcise their girls or not.

Why have I been chosen?

You have been asked to take part because you are connected with the ??? community and we are interested in your views and what you have to say.

Do I have to take part?

Participation in the research is voluntary and if you change your mind you can withdraw your consent at any time.

What will happen to me if I take part?

You will be asked to attend a focus group discussion consisting of no more than eight other people of the same sex. The meeting will take place at a location convenient to you. Refreshments will be provided and transport costs reimbursed. The focus group discussion will be tape recorded. At the end of the focus group discussion the facilitator will de-brief you about the research and you will be given an opportunity to ask questions and discuss matters relating to your participation. You will also be given contact details of the facilitator and the research team at Coventry University.

What are the possible disadvantages and risks of taking part?

There is a time cost as we will ask you to give up some of your time to take part in the focus group discussion. It might also be that you find talking about the subject difficult or uncomfortable. You do not have to talk about personal experiences unless you want to and you can stop the discussion at any time if you do not wish to continue.

What are the possible benefits of taking part?

By taking part in the research you will have the opportunity to have your say about the important issue of female circumcision/cutting. It will also give you the chance to contribute to research aimed at developing our understanding of female circumcision and best practice.

What if something goes wrong/I am not happy about something?

If there is anything you are unhappy about let us know (our contact details are at the end of this sheet). Alternatively you could speak to the facilitator, who will then contact us on your behalf. We will also give you contact information for sources of help and advice (see last page).

Will my taking part in this study be kept confidential?

The data we collect from you is anonymous; you will not be required to give your full name, only your first name if you are happy to do so. Any other information collected about you (e.g. your age) is only for the purposes of identification in case we need to delete any information if you withdraw your consent but this will not be shared with any third parties.

What will happen to the results of the research study?

The information that is recorded during interviews will be transcribed (written word for word) and analysed using a computer software programme. You can see your transcript and a copy of the final report, if you so wish, by contacting the organisation involved in facilitating this project and/or the research team at Coventry University. The findings of the research will

inform the development of a intervention toolkit that will be shared with those working in the area of female circumcision at a local level (such as community outreach workers, and community leaders).

Who is organising the research?

The research is being conducted by [Insert name of reserachers]. Please visit the website for more information about the research:

www.replacefgm2.eu

Who has reviewed the study?

The study was submitted to the Coventry University Ethics Committee for approval and was approved before we contacted you.

Contact for further information

(Contact details of the REPLACE partners has been omitted)

Other sites that might be of interest:

www.forwarduk.org.uk

www.fsan.nl

www.healthinterventions.co.uk

Figure 2.3 Example of participant Consent Form

Below is an example of a Consent Form used by REPLACE. This can be used as a template. The Consent Form should be translated accordingly. If participants have difficulty reading, the researcher should read the information to the participant and get them to give verbal consent on an audio recording.

<u>Participant Consent Form</u>

Title of Project:

Name of Researcher:

Participant Identification Number for this project:

Please initial or tick box

1. I confirm that I have been informed and understand the nature of the project dated [   ] and have had the opportunity to ask questions.   ☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason. (Contact:
   Tel: Email:)   ☐

3. I understand that my responses will be anonymised before analysis.
   I give permission for the researcher and the research team to have access to my anonymised responses.   ☐

4. I consent to the interview/focus group discussion being digitally recorded and transcribed.   ☐

_____   _____

Name/Identification   Date   Signature

Number of participant

_____   _____

Name of Researcher   Date   Signature

Figure 2.4 Example of a Participant Debriefing Sheet

Below is an example of a Participant Debriefing Sheet used by REPLACE within the UK. It is important that the Debriefing Sheet includes a contact number/address, so that participants can ask questions or withdraw from the research. You should explain what will happen to information they provide. Debriefing Sheets should also provide participants with information regarding services specialising in FGM. The Debriefing Sheet should also be translated accordingly.

Participant Debriefing Sheet

Thank you very much for taking part in this activity/project. Your contribution has been very important to us.

We will be transcribing your interview data and analysing it alongside all the other participants' data to look for common themes and outcomes.

If you have any questions about this or want to add any further information concerning the activity/project then please feel free to contact us. We will be more than happy to answer any questions. Alternatively, if you think of something later and wish to get in touch with us, you can do so using the contact details provided below:

[Contact details of REPLACE project partner has been omitted]

If you would like to have more information about FGM, services provided to survivors of FGM or who to contact concerning suspicions that FGM is about/or has recently taken place, the following list gives you details of organisations to contact:

Acton African Well Women Centre, Mill Hill Surgery Acton, West London 020 8383 8761

Women & Girls Network, London (for Support & counselling for women and girls who have experienced gender based violence) Tel- 020 7610 4345

African Women's Clinic, University College Hospital Central London 0845 155 5000 ext: 2531, or 020 7387 9300

Other FGM support organisations

ACCM (Agency for Culture and Change Management) Sheffield www.accmsheffield.org

AFRUCA (Africans United Against Child Abuse) London www.afruca.org

Black Women's Health and Family Support London www.bwhafs.com

Eritrean Health Support Association London tel- 020 7419 1972

FORWARD (Foundation for Women's Health Research and Development) London www.forwarduk.org.uk

Waltham Forest Somali Women's Association London tel- 020 8503 7121

Somali Welfare Association London tel- 020 8968 1195

List of Specialist Health Services in England & Wales

African Well Women's Clinic
Guy's & St. Thomas's Hospital
8th Floor – c/o Antenatal Clinic
Lambeth Palace Rd.
London, SE1 7EH
Tel: 0207 188 6872
Open: Monday – Friday, 9am – 4pm
Contact: Comfort Momoh MBE
(FGM / Public Health Specialist)
comfort.momoh@gstt.nhs.uk
Mobile: 07956 542 576

African Well Women's Clinic -
Antenatal Clinic
Central Middlesex Hospital
Acton Lane, Park Royal
London, NW10 7NS
Tel: 0208 963 7177 or 0208 965 5733
Open: Friday, 9am – 12pm
Contact: Kamal Shehata Iskander
kamal.shehataiskander@nwlh.nhs.uk

African Well Women's Clinic -
Antenatal Clinic
Northwick Park & St. Mark's Hospital
Watford Rd.
African Women's Clinic
University College Hospital
Huntley St.
London, WC1E 6DH
Tel: 0207 387 9300 ext. 2531
Open: Monday afternoon
Contact: Maligaye Bikoo (Clinical
Nurse Specialist)
maligaye.bikoo@uclh.nhs.uk

Gynaecology & Midwifery Departments
Chelsea & Westminster Hospital
3rd Floor
369 Fulham Rd.
London, SW10 9NH
Tel: 0207 751 4488
Open: Tuesday, 10am – 6:30pm,
Second Thursday of every month, 3:30pm – 6:30pm (by appointment only)
Contact: Gubby Ayida (Obstetrics
Service Director)
gubby.ayida@chelwest.nhs.uk

Harrow
Middlesex, HA1 3UJ
Tel: 0208 869 2870
Open: Friday, 9am – 5pm
Contact: Jeanette Carlsson

African Well Women's Clinic
Whittington Hospital
Level 5
Highgate Hill
London, N19 5NF
Tel: 0207 288 3482 ext. 5954
Open: Last Wednesday of every month,
9am – 5pm
Contact: Joy Clarke or Shamsa Ahmed
joy.clarke@whittington.nhs.uk
Mobile: 0795 625 7992

Women's & Young People's Services
Sylvia Pankhurst Health Centre
Mile End Hospital
Bancroft Rd.
London, E1 4DG
Tel: 0207 377 7898 or 0207 377 7870
Open: Monday – Friday, 9am – 5pm
Contact: Dr. Geetha Subramanian
(Consultant Gynaecologist)
geetha.subramanian@thpct.nhs.uk

Gynecology & Midwifery Department
St. Mary's Hospital
Praed St.
London, W1 1NY
Tel: 0207 886 6691 or 0207 886 1443 or 0207 886 6763
Contact: Judith Robbins or Sister Hany
foong.han@imperial.nhs.uk

Waltham Forest African Well Women's Services
Oliver Road Polyclinics
Upper Ground Floor
75 Oliver Rd, Leyton
London, E10 5LG
Open: Drop-In Thursday 10am – 3pm
Contact:
Dr. Faduma Hussein (Community
Health Advisor)
faduma.hussein@wf-pct.nhs.uk
Tel: 0208 430 7381 or 0788 785 4541

Minority Ethnic Women's &
Girl's Clinic
Charlotte Keel Health Centre
Seymour Road
Easton
Bristol, BS5 OUA
Tel: 0117 902 7100
Open: Drop-In Last Wednesday of every month, 9:30am – 12pm
Contact: Dr. Hilary Cooling

Additional Contacts

Women's Aid – National charity working to end domestic violence against women and children. Provides domestic abuse directory and national helpline.
www.womensaid.org.uk

National Domestic Violence Helpline: **0808 2000 247 (24-hour free helpline)**

NSPCC – National charity working in child protection and the prevention of cruelty to children.
www.nspcc.org.uk

Childline (www.childline.org.uk): 0800 1111 (24-hour free helpline for children)
Child Protection Helpline: 0808 800 5000 (advice for adults worried about a child)

fpa – The UK's leading sexual health charity.
www.fpa.org.uk
fpa Helpline: 0845 122 8690 (Mon-Fri, 9-6)

Rights of Women – National charity working to attain justice and equality by informing, educating and empowering women about their legal rights.

www.rightsofwomen.org.uk
Legal Advice Line: **020 7251 6577** (Tues/Wed/Thurs, 2-4pm/7-9pm; Fri 12-2)

Sexual Violence Legal Advice line: tel- **020 7251 8887** (Mon, 11-1; Tues 10-12)

Southall Black Sisters – A resource centre in West London offering a service to women experiencing violence
and abuse.
www.southallblacksisters.org.uk
Tel- **020 8571 9595** (Mon-Fri, 10-5pm)

2.3 Summary

Section Number	Aim/Objectives of Section	Tools and Techniques
Section 2: **The REPLACE Approach and Ethical Considerations**	To be fully familiar with the REPLACE Approach. To be aware of the ethical considerations associated with applying the REPLACE Approach	Read Section 2 of the REPLACE Community Handbook and if possible the accompanying REPLACE Toolkit (or Executive Summary). Prepare: Participant Information Sheet; Consent Form; and Debrief Sheet. Prepare a policy and procedures document on what to do should a participant disclose intent to perform FGM or gives information concerning a recent case of FGM. Prepare training materials for Community Based Researchers and Peer Group Champions (not yet recruited) on: general facts and background concerning FGM; the legal situation concerning FGM; issues associated with confidentiality and data protection; risk analysis, health and safety; how to deal with distressed participants; what to do in cases of disclosure.

Section 3: The REPLACE Approach
Element 1: Community Engagement

ELEMENT 1
Community Engagement

ELEMENT 5
Intervention Delivery and Evaluation

ELEMENT 2
Understanding the Social Norm Perpetuating FGM

ELEMENT 4
Intervention Development

ELEMENT 3
Community Readiness to End FGM
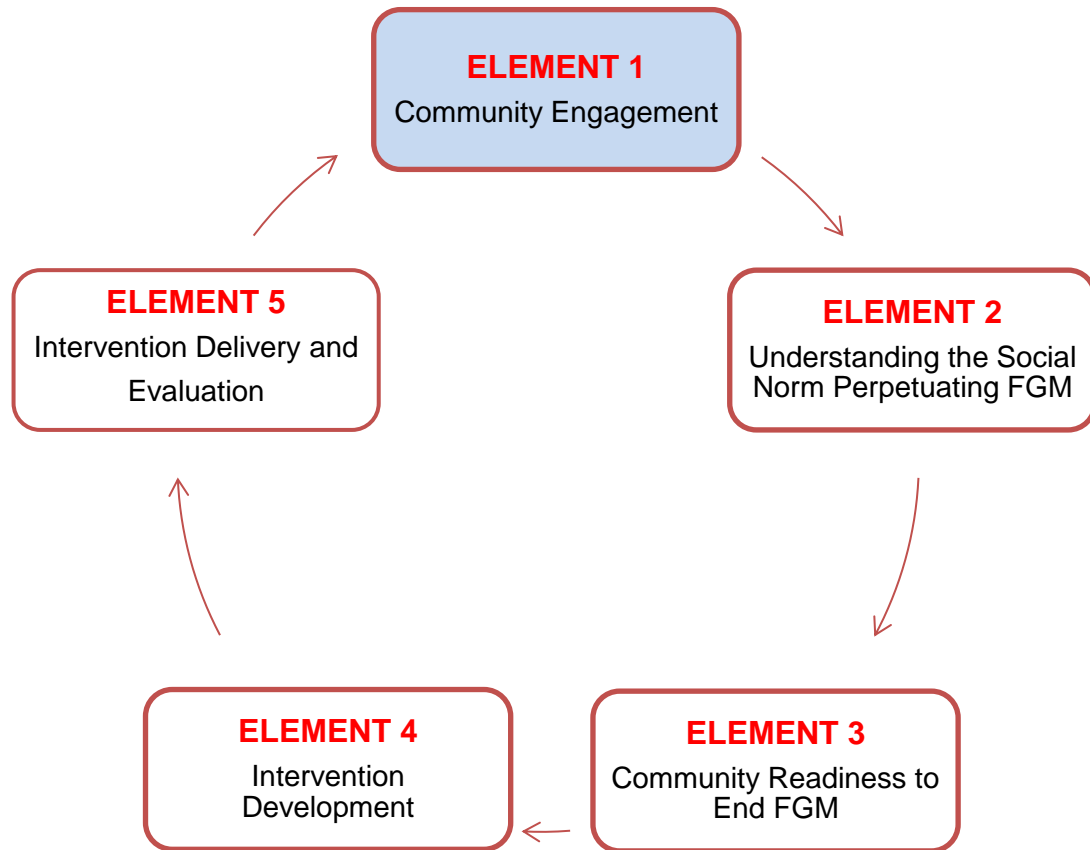
3.0 Introduction

The REPLACE Approach is underpinned by strong community engagement in order to move towards the goal of ending FGM. Each of the five Elements of the Cyclic Framework requires interventionists to work closely with members of the FGM affected community. Thus community engagement should be integrated into all Elements of the Cyclic Framework to ensure social norm transformation. The ultimate goal of REPLACE's community engagement approach is to empower and motivate members of affected communities to take action to overturn the social norm that supports the practice of FGM in their communities.

3.1 Why Community Engagement is Important

Recent research on the influence of social norms on the continuation of FGM has led to an increased emphasis on 'community-led' approaches for tackling FGM (Mackie, 2000;

UNICEF, 2010). In addition, REPLACE discovered several other benefits that can be derived from community engagement. These include the fact that community engagement:

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

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

3.2 The REPLACE Approach to Community Engagement

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

Table 3.1:   Principles of Community Engagement

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

Source: REPLACE

REPLACE used three broad processes to engage with communities; these were:
- knowing the target community
- engaging with the target community
- monitoring and evaluating the community engagement process.

These processes are described below.

3.3 Knowing the Target Community

Effective community engagement depends on identifying and engaging with the 'right' community. Thus it is important to consider from the outset who is the target community of the intervention, the nature and characteristics of the community, and how to mobilise members of the community. A target community could include a range of different social groupings. In terms of FGM interventions, a target community mostly refers to a group of

people who live in a specific geographical area (e.g. town, neighbourhood) or share a common interest, characteristic (e.g. gender), experience, or belief.

In many cases the identification of a target community is quite straight forward because it would have been pre-defined in the broader project (e.g. Sudanese community living in Southwark). But where the target community is not predefined the aim of the intervention should naturally point interventionists to the right target community. This may require the interventionist to undertake a *stakeholder analysis.* Stakeholder analysis basically involves working through the question *"who are the stakeholders of the FGM issue being tackled?"* A stakeholder is any person or group who affects or is affected by a particular issue. Box 3.1 provides a list of questions that REPLACE used to identify the target community and participants for the intervention to end FGM. Table 3.2 shows some of the key community members and stakeholders identified by the REPLACE project.

Box 3.1   Questions Used by REPLACE to Identify a Target Community

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

Source: REPLACE

Table 3.2   Key Communities/Stakeholders on FGM Identified by REPLACE

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

Source: REPLACE

It is crucial for the intervention team to develop a good understanding of the target community and identified stakeholders. Interventionists should aim to understand the political, economic, social and cultural life of the community as well as resources and services available in it. It is also important to understand the motives, influence and concerns of the identified stakeholders, including those that are likely to oppose and derail the project and those that are likely to support it. Information about these can be obtained through brainstorming with influential and respected people within the community, professionals working with the community and secondary sources such as census data and local authority documents. Box 3.2 provides some questions that can be used to help in understanding the target community.

Box 3.2: Key questions for understanding the target community and stakeholders

- ✓ What cultural and social practices are common in/with the target community concerning FGM?
- ✓ What public resources and services are available in the community to tackle FGM?
- ✓ Who are the power brokers and decision makers in the target community concerning FGM?
- ✓ Who are likely to support an intervention against the practice of FGM and who are likely to oppose it?
- ✓ What are the motives of the individuals/groups/organisations that have been identified to have an interest in FGM (stakeholders)?
- ✓ Who influences the opinions of the stakeholders identified?

Before any community engagement activities are undertaken it is important to identify and recruit **Community Based Researchers** and **Peer Group Champions** to facilitate the engagement process. Community Based Researchers should be employed by the project (where budgets allow) and be involved in undertaking research with the community and undertaking analysis (see Elements 2 and 3 of cyclic framework), developing the intervention (Element 4)and evaluation (Element 5). Community Peer Group Champions are volunteers who assist with community engagement, intervention development and delivery as well as evaluation. Carefully selected Community Based Researchers and Peer Group Champions will enable effective access to the target community, mobilisation of community members and research about the belief systems that support FGM (Element 2). Some of the key characteristics and skills needed by Community Based Researchers and Peer Group Champions are shown in Box 3.3.

Box 3.3: Key characteristics and skills needed by Community Based Researchers and Community Peer Group Champions

- ✓ A member of the target community
- ✓ Respectable and influential in the target community
- ✓ Has an interest in FGM
- ✓ Sympathetic and enthusiastic about anti-FGM campaign
- ✓ Has good knowledge of the target community, including the culture, politics, social and economic life of the community
- ✓ Understands the local language
- ✓ Has good communication, social, and organisational skills
- ✓ Has good knowledge of FGM
- ✓ Qualitative research skills (this is not essential but desirable)

Recruiting Community Based Researchers and Community Peer Group Champions can take time, therefore interventionists should allow ample time for recruitment and training. REPLACE used a number of techniques to recruit:

- Conducting a series of community focus groups and discussions and then approaching those individuals who displayed many of the characteristics and skills listed in Box 3.3.
- Getting suggestions from community groups/influential people.
- Asking for volunteers, using word of mouth and snowballing (i.e. people recommended by recruits)

The number of community members that need to be recruited depends on the scale and resources of the project. However, including Community Based Researchers and Peer Group Champions of different genders, marital status and age will improve the participation of a wide spectrum of community members in the project. REPLACE aimed for two male and two female Community Based Researchers with each community.

Once recruited Community Based Researchers and Peer Group Champions need to be trained in the following:

- Ethics and issues of consent and participant confidentiality (see Section 2).
- Legal status of FGM in their country and procedure to follow in situation of FGM disclosure.
- The REPLACE Approach (REPLACE Toolkit)
- Effective communication.
- Techniques to use to engage and mobilise the community (see below)

Techniques used to engage the community.

Techniques used to engage the target community were based on communicating information about the project/intervention and community sensitisation concerning FGM. As an approach Community Based Researchers and Peer Group Champions can organise meetings between the intervention team and key influential people in the community (e.g. cultural leaders, religious leaders, opinion leaders etc.) where the mission of the project is explained and their cooperation and support sought. At this early stage of the engagement process it is useful to first engage people who are likely to support the project. Thus, it is important to first develop a critical mass of community members who are in support of the project and use this as a basis to expand the reach of the programme to others who are likely to oppose it.

Once influential people have been informed about the project and there is some buy-in interventionists can then engage with the wider community. This can be done by conducting community forums followed by community workshops aimed at specific segments of the community to ensure the community is aware of the project/intervention, can ask questions and has the opportunity to become involved. Figures 3.1 and 3.2 below give guidance on how to undertake a community forum and community workshop.

Tip: In the very early days of community engagement it can be good to ensure there is a social element to events/forums/workshops that are organised. In the most basic terms, people will come along if you make it E.A.S.T – EASY, ATTRACTIVE, SOCIAL and TIMELY (Service et al. 2014).

- Consider the audience's other commitments and priorities and fit around them.
- Provide food and drinks if possible.
- If you've already got people signed up to come along tell them how many people from their area are already coming.

- If there are community priorities you are aware of then use them as a hook to attract people to the event, and allow people time to discuss other needs and priorities, as well as the needs and priorities of the project agenda.

Figure 3.1 :How to conduct a community forum

Purpose

✓ Appropriate for community sensitisation, information dissemination and community consultation.

Planning

✓ Set objectives for the forum. Ask yourself: what do I want to achieve from the forum? Make a list of the objectives you want to achieve.
✓ Think about what topics to cover – i.e. what information do you want to give to the participants? What issues do you want to consult community members on? Consider getting professionals/influential people to deliver on key topics if this cannot be covered by a team member. Possible professionals/influential people that can be used include: religious leaders, FGM experts, FGM campaigners etc.
✓ Chose a venue which is neutral and accessible to most members of the community. Ensure that the venue has adequate toileting and childcare facilities
✓ Set a date and time for the forum. Ensure that it does not conflict with working hours or dates of important community events.
✓ Ensure that good publicity is provided to the forum – publicise widely! Consider using advertisements in the local media. Also put up posters and fliers in churches, mosques and at community events.

Preparation

✓ Prepare the venue prior to the meeting. Put poster for directions where appropriate so that participants can easily find the place. Arrange the chairs in a circle or in groups to allow for friendly interaction between participants.
✓ Make sure all the equipment in the venue is working properly. Also provide enough refreshments and necessary logistics that the participants and facilitators may need.

Delivery

✓ Greet people as they come in and ask them to sign the participant sheet so that you have their contact details. It is likely that some people cannot write so make sure there are people who can help. Take name, organisation, email address, telephone numbers so that you can contact them in future.
✓ Introduce yourself and provide brief information about your organisation and purpose of the forum. Also, introduce the speakers at the event, if there are any. If there are only a few participants ask them to introduce themselves.
✓ Present the agenda of the forum. This should be structured in a way that allows for the delivery of information about the intention first, followed by questions and answers, and later discussion and suggestions. Provide sufficient time to each topic. Forums should not be too long preferably about 60 minutes.
✓ Allow for questions and answer time. It is important to facilitate this session and give everyone the opportunity to ask their questions and make comments. The speakers can answer the questions as they are being asked or take them in blocks.
✓ Allow for discussion time. The discussion should be moderated. Respect that other people may have other points of view. Keep out personal matters in the discussion. Ensure that everyone has the chance to participate.
✓ Ensure that somebody is nominated to take notes of proceedings in the forum.
✓ At the end of the forum summarise the issues and conclusions that have been reached for the participants.
✓ Explain what happens next and how people can volunteer to participate in the project.

Evaluation

✓ Administer the evaluation form to participants. Provide support to those who cannot fill the form by themselves.

Figure 3.2: How to conduct a community workshop

<u>**Purpose**</u>

✓ Particularly useful for training, capacity building and awareness-raising.

<u>**Planning**</u>

✓ Be clear what you want to achieve from the workshop. Make sure objectives are clearly set and are in line with the broader project mission.
✓ Consider the topics needed to achieve the objectives of the workshop. Invite professionals or influential people to deliver topics if necessary
✓ Consider how much time will be needed to deliver all the topics and achieve the objectives of the workshop. Be realistic. Remember that you may need several workshops to be able to delivery all the topics.
✓ Consider the workshop size. The size should not be too small or too big so as to promote effective participation between participants. The ideal size of a workshop should be about 8 – 12 people.

<u>**Preparation**</u>

✓ Master the topics! Do your homework well, ensure that you know the topics well and have command over them. If there is a particular topic that you think somebody else is better at delivering then get them to do it instead.
✓ Consider your audience. Do a bit of research to understand their needs and tailor the training material accordingly. Think about how much your audience may already know about the topic and concentrate on filling in the gaps.
✓ Make sure the workshop venue is appropriate with enough room for group exercises and that you have sufficient training materials. Ensure there are facilities such as writing boards, flip charts, projectors, toilets etc. If possible provide refreshments. The location should be clean, safe, accessible, and have multiple meeting rooms to conduct group sessions. Also make sure you think about all the activities that you want the participants to do and provide all the materials they will need to do them (e.g. writing pads, pens etc.). If hand-outs are needed ensure that these are prepared and printed for the workshop.

<u>**Delivery**</u>

✓ Arrive at the venue early. Ensure that the seating is properly arranged and that all the equipment is working.
✓ As the participants arrive greet them and show them their seats. Give plenty of time for participants to settle down and for people who might be late to arrive
✓ Start by introducing yourself and presenters. Allow participants to introduce themselves before you move on to present the agenda and ground rules for the workshop. Ask for feedback on the agenda.
✓ Undertake an ice breaking exercise.
✓ It might be useful to give participants the basic information on FGM: FGM essentials (facts, legal considerations, myths and motives of practice, health consequences) See Section 1 of the REPLACE Toolkit.
✓ The workshop should also seek to empower participants with knowledge and the skills to be able to identify behaviours that perpetuate the practice of FGM and introduce the REPLACE Approach. Explain the ethical aspects of the project.
✓ Keep track of time and stick to the programme of the workshop. Allow for regular comfort breaks. Intersperse the sessions with a mixture of presentations and practical activities. Try to present the materials in a number of different ways and make it entertaining such as presentations, participant led, video etc.
✓ At the end, make time to restate the major points of the workshop. Allow participants to sum up what they have learnt form the workshop and to ask questions and make comments.

<u>**Evaluation**</u>
✓ Administer the evaluation form to participants. Provide support to those who cannot fill the form by themselves.

Inclusion is at the heart of the REPLACE Approach and therefore steps should be taken to ensure proper representation of essential stakeholders and diverse groups of people within the target community in the forum and workshops. It is particularly important to ensure the proper representation of men and women as well as people of different generations and socio-economic status. Community members should be sufficiently informed about the project so that they can make an informed decision over whether to participate in it or not. It is also important to identify and address potential barriers to participation by community members especially the vulnerable. This should include a consideration for addressing barriers that are related to transportation, venue accessibility and childcare.

There is also the need to develop partnership and collaboration with key stakeholder organisations and services in the target community. This is important to create synergies for facilitating the effectiveness of the project and preventing duplication of efforts. In this regard, it is important to consider working with local authorities, community-based organisations, the police, social services and FGM specialist health services.

Transparency and accountability should be taken seriously in all aspects of the community engagement process. Due to the sensitive nature of FGM community members can resist and possibly derail the project if they become mistrustful of its intentions. This can be prevented by adequately informing community members about the mission, expectations and limitations of the project. It is important to also inform community members about the legal and ethical obligations on the part of project officers in respect of dealing with potential FGM cases. There should be proper communication channels established for keeping community members informed about project progress and new developments in the project.

3.5 Monitoring and Evaluating the Community Engagement Process

Monitoring and evaluation is needed in order to assess and improve community engagement. Monitoring and evaluation should therefore form an important part of the community engagement process. This is needed to ensure engagement activities are adapted appropriately to the culture and traditions of the community. The evaluation process should aim to assess the effectiveness and appropriateness of the engagement activities used. It should also aim to gather feedback for future improvement of engagement activities. Evaluation can be done by administering a specially designed form to participants of the intervention activity. It is important to adapt the evaluation form to the literacy levels of participants and provide support to those who cannot fill the evaluation form by themselves. An example of an evaluation form can be found in Figure 3.3. Alternatively, a more participatory approach can be used to undertake the evaluation through a group discussion.

Figure 3.3: Example of a Community Engagement Evaluation Form

1. How do you feel having attended this event? Circle a number to indicate how you feel.
   Wish I hadn't come   1   2   3   4   5   Very glad I came

2. What three things do you most remember about the event?
   i…………………………………………………………………………………………............
   ii…………………………………………………………………………………………………..
   iii…………………………………………………………………………………………………..

3. What did you enjoy the most?
   …………………………………………………………………………………………………
   …………………………………………………………………………………………………
   …………………………………………………………………………………………………

4. What did you enjoy the least?
   …………………………………………………………………………………………………
   …………………………………………………………………………………………………
   …………………………………………………………………………………………………

5. Could things be done better next time, if so, how?
   …………………………………………………………………………………………………..

   …………………………………………………………………………………………………..

   …………………………………………………………………………………………………..

6. Would you be willing to get involved in something like this again? Yes/No/Maybe

7. If yes, can we contact you by email/text/letter to let you know about future events? Provide preferred contact details if you are happy to. We will not share these with any other organisations or persons without your permission.
   …………………………………………………………………………………………………
   …………………………………………………………………………………………………
   …………………………………………………………………………………………………

8. Would you like to comment on anything else?
   …………………………………………………………………………………………………
   …………………………………………………………………………………………………
   …………………………………………………………………………………………………

3.6 Summary

Section Number	Aim/Objectives of the Section	Tools and Techniques
Section 3: **Element 1:** **Community** **Engagement**	To identify the target community	Identify suitable community using secondary information and by informal interactions with members of the community.
	To identify key stakeholders in the target community	Undertake a stakeholder analysis.
	Appoint Community Based Researchers and Community Peer Group Champions	Recruit and select Community Based Researchers and Community Peer Group Champions, to ensure representation of both genders, different ages and marital status. Train them in: context and background of FGM; legal status of FGM, REPLACE Approach; ethical issues; risk assessment and health and safety; issues associated with confidentiality and data protection; policy and procedures associated with disclosure of intent to perform or recent cases of FGM; how to deal with distressed participants; effective communication; relevant community engagement techniques such as community forum and community workshops.
	To gain the trust and buy-in of the community to engage with the project	Prepare material, disseminate information and deliver community forum and community workshops to raise awareness of the project and get community support for the project. Undertake Monitoring and Evaluation to ensure community engagement process has been effective.

Section 4: The REPLACE Approach Element 2: Understanding the Social Norm Perpetuating FGM
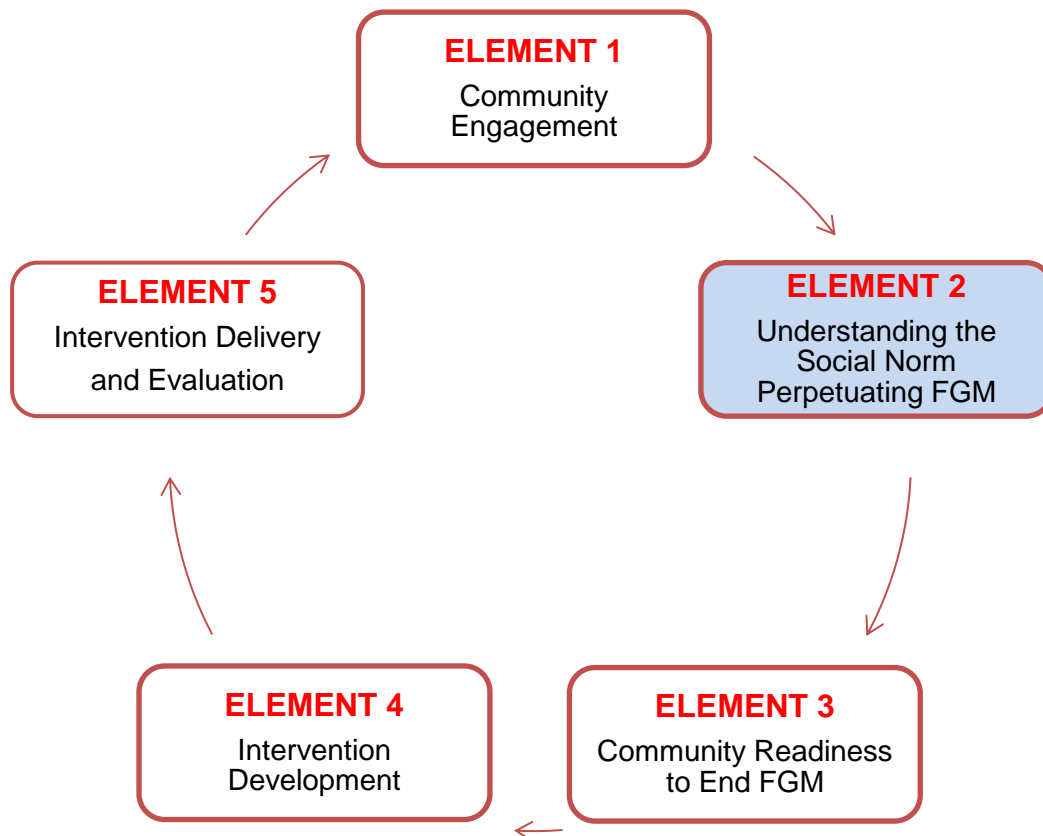
4.0 Introduction

Designing a successful behaviour change intervention to tackle FGM depends on a good understanding of the belief systems and social norm that supports the continuation of the practice of FGM in the affected community. These issues are complex and nuanced and vary from community to community and REPLACE undertook primary research using Community-based Participatory Action Research (CPAR) in order to understand them. CPAR is particularly useful in this context because it allows for the full engagement of the affected community in order to explore the issues that underpin the practice of FGM (see REPLACE Toolkit Section 3). The underlying ethos of CPAR is that it researches *with* the community rather than *on* the community. Thus, it allows for community members to play an active role in shaping the research supporting empowerment and motivation to take action to end FGM. Element 2 of the Cyclic Framework thus involves researching the beliefs and social norms perpetuating FGM in affected communities in the EU using CPAR methods.

This section provides a step-by-step guide for undertaking a successful CPAR. This entails three phases of activities:

- Training and research preparation
- Information collection
- Information analysis and interpretation.

4.1 Training and Research Preparation

Owing to the exploratory nature of CPAR and the cultural sensitivities of FGM, REPLACE recommends that the collection of information concerning the belief systems, enforcement mechanisms and social norm perpetuating FGM is undertaken by Community Based Researchers rather than by interventionists. This is particularly important if members of the intervention team are cultural "outsiders" with limited understanding of the language and culture of the target community. Community Based Researchers can bring their community knowledge to bear to facilitate effective information collection and analysis. They are also representatives of the community and thus contribute to the shaping of the research process.

Community Based Researchers need to be trained in relevant CPAR methods before research can begin. Training needs to be both 'academic' as well as practical including mock focus group discussions and narrative interviews, where Community Based Researchers take turns as participants and narrative interviewers/focus group facilitators to practice what they have been taught. The main CPAR methods used by the REPLACE Approach were: focus group discussions; and narrative interviews.

Focus Group Discussions (FGDs)

A focus group discussion consists of a number of people being invited and agreeing to take part in a discussion in which they not only voice their opinions about certain issues, but also define their beliefs and identities in relation to others in the group. Some people may define themselves by disassociating themselves from some of the other participants and the wider community. The REPLACE project found that often FGDs contained people who supported the continuation of FGM and those who did not. Or those who supported the continuation of 'sunna' but not FGM Type III (infibulation). In many FGDs individuals or groups of people wanted to impose their beliefs or persuade others within the FGD that their perspective was more valid. This needs to be handled very carefully by the FGD facilitator, but such discussions do give an insight into how differences concerning FGM in the community are negotiated. FGD therefore offer a good opportunity for researchers not only to find out people's opinions on FGM, but also how identities and community beliefs and social norms are negotiated and formed. A number of community member participants the REPLACE Project commented that it was rare for a group of people to sit down and discuss FGM in their community. They found the FGD an empowering experience.

At the beginning of the FGD Community Based Researchers must explain to participants the purpose of the FGD by discussing the PIS and then getting informed consent from participants, both to be part of the FGD and agreeing that the FGD can be audio recorded. Issues of confidentiality and respect for other participants' opinions should be reinforced, including asking participants not to repeat outside the FGD what was said and by whom.

FGDs can provide the space for people to talk about issues that are considered inappropriate by others. There is a 'safety in numbers' effect, where people feel they can discuss issues with like minded people. Conversely others may feel intimidated about speaking openly about their beliefs and feelings regarding FGM, particularly if the rest of the group have a different perspective. When facilitating the FGD Community Based Researchers need to be aware of which people are not contributing to the discussion and those whose contribution might be preventing others from speaking. Facilitators need to ensure that all participants have the opportunity to speak and have their voices heard. After the FGD has ended the facilitators should discuss the focus group discussion and make notes on issues that they felt were particularly interesting.

FGD facilitators need to be aware of the terminology that participants use to describe FGM and the various types of FGM (see REPLACE Toolkit Section 1 and 4) and need to use this terminology in the FGD. The REPLACE Project found that confusion can occur in FGDs when participants use local terms for FGM, especially as these may have different meanings and associations for different participants. For example one participant may use the local term for 'female circumcision' to mean all forms of FGM, whereas another participant could use the same term for FGM type III (infibulation). It is therefore important that FGD facilitators ask participants at the beginning of the FGD what terminology they will be using for FGM and get clarification as to what these terms refer to and that all participants agree with this. Throughout the FGD facilitators should regularly ask participants to clarify what they mean when using certain terms to ensure consistency of meaning throughout the FGD.

REPLACE suggests that FGDs contain about 6-10 participants as if the group is any larger then some participants may feel inhibited in contributing and it becomes more difficult for the facilitator to manage. REPLACE conducted FGDs with participants of similar age and marital status. All FGDs were single sex. However it might be useful to conduct at least one FGD with participants from different segments of the community. It could be very enlightening to conduct a FGD with both men and women present, to observe the gender power dynamics. However due to the sensitive nature of FGM in most affected communities, and discussions of sexual issues between the genders being taboo, it might not be appropriate or possible to conduct mixed sex focus groups.

Whilst FGDs are an excellent way of getting information and insight into a community's beliefs and social norms concerning FGM and how these are negotiated within the community, there are also disadvantages with undertaking FGDs, particularly in relation to the topic of FGM, which must be recognised by researchers and mitigated for if possible. Within a FGD there can be tremendous social pressure for participants to conform to the social norm, with people being reluctant to speak against the norm. This is interesting and demonstrates the strength of the social norm within that community. Another disadvantage is that people usually discuss FGM using generalities about the community rather than specifics and issues they have personally had to deal with. Again this shows how the community deals with FGM and issues associated with it. Figure 4.1 gives some practical tips on how to conduct a focus group discussion. Remember that a FGD is a window into the community, its beliefs and social norms concerning FGM and can indicate the strength of the social norm and help identify issues that can be used to challenge the social norm perpetuating FGM.

Narrative Interviews

Narrative interviews are semi-structured qualitative conversations which are used to gain in-depth information about how people make sense of their world. A narrative interview allows individuals to voice their own beliefs and concerns about FGM in a confidential situation on a one-to-one basis with a Community Based Researcher. It allows the participant to describe their lives in their own words and to 'tell it like it is' to the person conducting the narrative interview. They allow researchers to explore people's lived experiences and how they attribute meaning to aspects of their everyday life. The narrative interview provides 'deep' information by asking participants to explain and expand on the 'taken for granted' aspects of their everyday lives and perceived social norms. Only by exploring these 'taken for granted' aspects can we gain an insight into how complex social reality really is. Only by asking people from FGM affected communities are we able to identify what they believe are the consequences of performing or not performing FGM. In other words what are the community mechanisms used to enforce the social norm supporting the practice of FGM. By exploring wider social issues relating to the family, gender roles and their relationship with other members of their community we can move further towards understanding the perceived control participants have over whether their daughters should be subjected to FGM.

When conducting a narrative interview the interviewer needs be mindful of the following:

- *Listen and work through the answers.* Listen very carefully to what the participant is saying, as their response might not actually answer the question, or the participant may give a vague response. In these cases you may have to ask for clarification or further explanation. Or you may need to rephrase the question or explain it. Remember listening is as important as asking the right questions. You need to listen to everything that they say, even if you do not agree with it. Be sure that your body language does not indicate your disapproval of an answer. Do not pass judgement on the participant. Remain neutral. Ask questions in a calm, non-aggressive manner, even if you do not agree with their views. Be sensitive when probing participants for more information.

- *Use appropriate language and terminology when referring to FGM.* The narrative interview should be conducted in the language that the participant is most comfortable with. It is also advisable to avoid using complicated language. At the beginning ask the participant to explain the terminology they will be using for FGM and different types of FGM and how they understand/interpret the terminology.

- *Let participants tell their story in their own way.* Do not interrupt participants when they are in the middle of a sentence or an answer, or even when they pause to collect their thoughts. Do not feel uncomfortable about long silences, the participant could simply be reflecting on the things being discussed. Use your judgement about when to move the conversation forward. Remember that for many participants it will be the first time that they have had the chance to express their thoughts and opinions and describe their experiences of FGM with someone who will actually listen and be interested in what they have to say. Allow participants to expand on their answers without interrupting them. Be gentle and subtle in guiding the interview through the interview schedule (see below). Be patient and sensitive.

Figure 4.1: Tips for conducting a focus group discussion

<u>Purpose</u>

Appropriate for obtaining the opinion of groups, understanding community level beliefs and practices on FGM as well as how social norms are negotiated. Can also be used for community sensitisation and consultation.

<u>Planning & preparation</u>

- ✓ First think about what you want to achieve from the focus group discussion and set your objectives.
- ✓ Prepare your topic guide. Make sure it contains all the key topics you want to be discussed. If possible, test the topics with friends to ensure that they are effective and meaningful. Newspaper articles, music, photographs, stories, videos and poems can all be used to stimulate debate.
- ✓ Think about how many focus group discussions will be needed to serve your need. This will depend on your resources and what other methods are being used. Ensure that you conduct as many focus group discussions as you need to obtain the information you need.
- ✓ Recruit participants.
- ✓ Secure a venue for the focus group discussion. Make sure the venue is local and accessible and people will not experience inconvenience attending.
- ✓ Set a date for the focus group discussion and ensure that it does not conflict with important community events.
- ✓ Make sure the venue has childcare facilities so that you can separate children from the discussion room due to the nature of the topic.
- ✓ The venue should not be associated with anti-FGM campaigns as this could influence participants' opinions and dissuade them from discussing FGM openly.
- ✓ Prepare the venue and arrange the chairs in circular form that allows for effective interaction between participants.
- ✓ Make sure all equipment needed for the discussion is working. Provide refreshments and ensure the logistics meet the needs of the participants and facilitators..

<u>Delivery</u>

- ✓ Think about the composition of the focus group discussion groups. Make sure group size is neither too small nor big; ideally, the number should be 6 to 10 participants. Each group should consist of individuals who share similar characteristics (homogeneous participants) such as gender, age, marital status and ethnicity.
- ✓ Ensure that you have facilitators available to facilitate the discussion. Preferably the facilitator should be the Community Based Researcher. Use a facilitator who shares similar characteristics with the group in terms of their gender, age, and ethno-linguistic identity.
- ✓ Ensure that there is another person to support the facilitator. This person could take notes and record the conversation while the main facilitator concentrates on steering the discussion.
- ✓ Before you start administer the Participant Information Sheet and Consent Form. Ensure that participants understand these and give informed consent to be part of the focus group discussion and to be recorded.
- ✓ At the start of the discussion again brief participants about the purpose of the discussion. Also impress upon the need for confidentiality and to express their views freely.
- ✓ Facilitators should monitor the discussion closely. They should pay attention to people who are likely to dominate the discussion and ensure that they give the chance to other participants to contribute. Also they should pay attention to whether participants are discussing the topics or not and nudge them to the right path if necessary.
- ✓ Facilitators should create a safe and positive atmosphere where individuals can talk openly, as the location or environment in which the discussion takes place can have an impact on the group dynamics
- ✓ Make sure the discussion does not last for too long. Ideally it should be between 1 and half hours to 2 hours long
- ✓ At end of focus group discussion hand out the debrief sheet.
- ✓ Facilitators or their assistants should take notes of key issues that emerge from the discussion.
- ✓ At the end of the FGD facilitators should thank participants and emphasis again about the

- *'Could you tell me'.* This is always a good way of starting a narrative interview or asking a participant to explain a particular point. For example, 'could you tell me about your experiences of coming to the EU?'

- *You do not need to stick rigidly to the interview schedule, you can probe.* You do not have to stick rigidly to the interview schedule for the narrative interview. It is not prescriptive. If participants raise an issue which is relevant and interesting ask them to expand on it. Do not be afraid to ask participants to explain their point of view or an answer to a question. It is through probing deeper that we begin to gain an insight into their beliefs and the barriers to ending FGM in that community.

- *Reassure Participants.* If participants become uncomfortable during the narrative interview, reassure them that FGM is an issue that is hard to talk about. Allow them a break to recompose themselves and ask if they wish to continue. Move to another topic or stop the interview. Hand the participant a Debriefing Sheet and give guidance on what organisations they can go to for help and advice.

- *Do not relate the discussion back to yourself during the interview.* Participants may ask you questions about your experiences of FGM during the narrative interview. It is up to you whether you want to disclose such information. Disclosing certain aspects of your life can produce better rapport with participants, which in turn can make for a better interview. Expressing your own views and opinions on FGM should be avoided during the interview as it will have an impact on the information gathered. If participants want to ask questions, just ask them to wait until the conclusion of the narrative interview.

- *Take notes.* The narrative interview is likely to be recorded (as long as the participant has given informed consent for this to happen). But interviewers should not just listen to the participant's verbal responses (which will be recorded), but should take note of non-verbal cues such as hand gestures, facial expressions and how a person is sitting. This is particularly important if body language changes with different topics of discussion. Sometimes body language can tell us more than the actual verbal answer to a question. During the narrative interview make notes about particular aspects of the participant's body language that made an impression on you. For example when the participant's body language and the verbal answer they have given seem mismatched. Laughter and silences can also be very informative. At the end of the interview spend 30 minutes writing up your notes and impressions.

Narrative interviews can yield very insightful and rich information as to how people feel about the issue of FGM and their beliefs associated with the practice. It may also give valuable information on why some people may wish to continue the practice and others want to end it. It can indicate the strength of the social norm perpetuating the practice and give details of social norm enforcement mechanisms. However some participants may feel uncomfortable

discussing issues they consider 'taboo' or culturally sensitive. Others may feel uncomfortable speaking about certain issues to a Community Based Researcher who is from their own community, often due to a fear that what is discussed will not be kept confidential. Explaining the purpose of the narrative interview and handing out a PIS should be done at the beginning of the interview and before the interview commences issues of confidentiality must be discussed with any questions being answered. Participants must give informed consent before the interview commences. It should be made clear that participants do not have to discuss any topics they feel uncomfortable with and can withdraw from the interview at any time and ask for all their input to be removed from the research. Participants who are survivors of FGM or whose daughters have had FGM might feel particularly uncomfortable discussing FGM, not just because it is illegal in the EU (see Section 2 concerning disclosure), but also because it might make them reflect on their actions and personal experiences of FGM and this could cause emotional distress. If this occurs then hand out the Debriefing Sheet and direct them to an appropriate source of advice and help. Advice on how to carry out a narrative interview is given in Figure 4.2.

Figure 4.2: Tips for conducting narrative interviews

Purpose

- ✓ Appropriate for obtaining individual opinions and for understanding individual beliefs on FGM and the community enforcement mechanisms used to perpetuate FGM in the community.

Planning & preparation

- ✓ Think about what you want to achieve from the interview and set your objectives.

- ✓ Prepare your interview schedule/topic guide. Make sure it contains all the key questions that you want answered. If possible test it on your friends to ensure that the questions are effective and meaningful.

- ✓ Think about how many narrative interviews are needed. Ensure that you conduct as many interviews as you need to obtain all the information that you need.

- ✓ Recruit your participants..

- ✓ Arrange for the interview venue to be available. Ensure that the place is safe for both the researcher and the respondent. If possible allow the respondent to choose a time and location which best suits them.

- ✓ For safety reasons it is advisable to have two Community Based researchers present at every interview session. If you are going alone make sure other members of the project team know where you are. Also have your phone with you so that they can contact you if necessary.

- ✓ Make sure all your recording equipment is working properly.

Delivery

- ✓ Ensure that the interviewer (Community Based Researcher) shares similar characteristics with the participant – i.e. gender, age, and ethno-linguistic identity.

- ✓ Before you start, administer the Participant Information Sheet and Consent Form. Ensure that the respondent understands these and gives informed consent to take part and for the interview to be recorded..

- ✓ At the start of the discussion again brief the respondent about the purpose of the narrative interview and research. Also impress upon them the confidential nature of the interview and ask them to express their views freely.

- ✓ Ask questions politely and in a non-judgmental and non-aggressive manner. Also probe deeply, and allow respondents to express themselves and to tell their stories freely

- ✓ In cases where a respondent provides a vague response to a question, nudge them to answer the question more fully.

- ✓ Ensure that you take notes even if you are recording the conversation. If possible two Community Based Researchers should administer the interview so that one can do the interview while the other concentrates on the recording and taking notes. Observe non-verbal cues from the respondent such as hand gestures and facial expressions and jot these down.

- ✓ Make sure the interview does not last for too long. Ideally it should be between one and one and half hours.

- ✓ At the end of the interview thank the participant. Emphasis the confidentiality of the interview. Leave contact details for the respondent to contact if in future they change their mind about

the research.

✓ Hand interviewees the Debrief Sheet.

Evaluation

✓ You may want to administer and evaluation form after the narrative interview.

Other CPAR Methods

In addition to focus group discussions and narrative interviews the following methods can also be used to obtain rich qualitative information concerning the beliefs and social norms perpetuating FGM in affected communities:

- *Story telling*
  With oral communication being the traditional way by which many African communities pass on information, history and tradition, storytelling can be an effective way by which participants can express themselves concerning their perceptions, beliefs and the social norm associated with FGM in their community.

- *Drawing*
  The use of drawing has been used by anthropologists and sociologists to allow participants another means to express their emotions, feelings and beliefs. This is particularly useful if participants are illiterate or semi-literate. Participants are asked to draw anything which they feel relates to the topic of discussion (in this case FGM) and are then asked to describe and explain the drawing to the researcher. The use of disposable cameras can be used in place of drawing.

- *Keeping a diary*
  Diary writing can be very effective. Participants need to have a reasonable level of literacy to keep a written diary, although it is possible to use an audio recorder instead.

- *Participatory Ethnography Evaluation Research (PEER)*
  PEER has been used by a number of organisations to research FGM at a community level. Peer researchers are recruited from the community, trained and are asked to talk to members of their peer group about FGM. For example a young female Somali peer researcher would talk her friends and relatives who are female and of a similar age and social status. The Peer researcher then writes up these conversations and submits them to the research team. For more information see: www.options.co.uk/peer.

All these methods seek to empower participants to contribute to research that will benefit their community. However not all methods may be appropriate for all FGM research with all FGM affected communities. Interventionists need to decide which methods are most appropriate for their project and match to the resources available.

4.2 Information Collection

Before information collection takes place topic guides and interview schedules need to be developed and piloted and participants have to be recruited. Then information collection can begin!

Developing topic guides and interview schedules

Before conducting any FGDs or narrative interviews topic guides for FGDs and interview schedules for narrative interviews have to be developed and piloted. These guides and schedules need to collect information on the beliefs people hold about FGM, the practice of FGM in the community, the social norm supporting the continuation of FGM and the barriers to ending FGM.

For FGDs a topic guide needs to be developed that broadly covers the issues concerning community attitudes, beliefs, practices, social norms and enforcement mechanisms concerning FGM. These need to be broad topics allowing discussions to be wide ranging and various views to be expressed. An example of a FGD topic guide is shown in Figure 4.3.

Figure 4.3 Example Focus Group Guide

REMEMBER! THIS IS ONLY A GUIDE. IF INTERESTING ISSUES ARISE DURING THE FOCUS GROUP, THEN ASK QUESTIONS TO FIND OUT MORE INFORMATION

Following on from Introduction the first question should open the discussion
1) Which term do you prefer: Female Genital Mutilation/Female Genital Cutting/Circumcision/Sunna?
1a: which term is more favourable and why?
1b: And what type of circumcision/cutting does this term describe i.e. Type 1, 2 or 3?

2) Could you tell us how the (preferred term) is viewed by the ????? community
2a: If participants highlight negative perceptions, you could ask for them to clarify who holds these beliefs, for example, young or old men/women, those who have received little education and why they hold them?
2aii: What is the meaning of FGM (preferred term)?
2b: If participants highlight positive perceptions and meanings, then you could ask them for clarification. Again ask for them to clarify who holds these beliefs, for example, young or old men/women, those who have received little education and why they hold them?
2c: Are participants aware of the legal aspects relating to FGM within the country they are living?
2d: If participants mention other people's perceptions of the ????? community then these can be explored
2e: The group may be aware that there are people campaigning against FGM, you could explore how they feel about this?

3) From the last question, participants could discuss differences between their "home" country and the EU country in which they now live.
This could lead the facilitator to explore:
3a: The group's experiences about coming to the EU
3ai: For those born in the EU, how do they feel about being ?????/British, ?????/Spanish?
3b: Is there anything they like or dislike about living in the EU?

4) Can you tell me about your experiences of health and support services?

GPs
Hospitals (when discussing medical care, you could ask the group their opinion about re-infibulation after childbirth)
Social Services
Community groups
Religious groups
Police
Leisure services

5) What are their experiences of raising a family in the EU?
5a: Is it different from "home" country? How is it different?
5b: What is their opinion of how the family is perceived within the EU?
5c: Is there any communication links between the ????? community in the EU and the "homeland"?
5ci: What form do these communication links take? TV/Internet/travel/visits from family members/community networking (communication via mosque, informal networks etc).
5cii: Do the group think it is important to preserve these links to their "homeland"?
5ciii: For those born in the EU, what are their perceptions of the "homeland"? And do they want to visit it?
5di: If identity is raised by the group, facilitators should explore what this by asking:
5dii: How does FGM (preferred term) relate to ????? identity?

6): What are the personal disadvantages/advantages of performing or not performing FGM?
6a: What are the community disadvantages/advantages of performing or not performing FGM?
6b:Which individuals are the most influential in the decision to conduct or resist practicing FGM?
6bi: Is it a man or a woman and why?
6bii: Who are the key individuals you think about when thinking about performing or not performing FGM?
6biii: Why do some older women decide to have FGM?

7) What constraints do people face when considering practicing of refraining from practicing FGM? (This question is more about the material and social constraints that people face when making their decision to cut or not to cut their girls.)

For narrative interviews an interview schedule should be constructed that targets individual views, beliefs and attitudes towards FGM. The interview schedule should contain a list of general questions addressing beliefs and perceived social pressures to perform FGM. Questions should be open-ended allowing people to 'tell it as it is' in their own words. An example of a narrative interview schedule is shown in Figure 4.4.

Figure 4.4 Example Narrative interview schedule

The following interview schedule should be read carefully by all project interviewers before they begin conducting interviews. If you disagree with anything or think something is missing - please let us know! Once we are all happy, interviewers should make sure they feel very familiar with this schedule before they begin conducting interviews.

During interviews, please let participants talk as much as they want; if they say something but do not expand on it use phrases like, 'Can you explain more about that?', or 'Tell me more', or

'that's interesting, can you expand on that?' or think up your own ways to get people to keep talking. The idea is that the schedule should not be rigid, that you should allow participants' responses to lead the interview (as long as they are within topic of course!). Don't feel you have to ask every single question that appears below - but do try to cover each of the topics - you may find that people venture into a topic of their own accord - let them and make a note to yourself that they have done this so that you do not ask them a question that they have clearly already addressed in great length!

Terminology:
Interviewers should NOT to use the term FGM at the beginning of the interview. They should use the term "female circumcision", as circumcision seems to be the most widely used term and therefore should not make any participant uncomfortable, which "mutilation" seems to do. You risk alienating important community members if you use the term FGM from the outset.

Your first question should focus on exploring what a participant's preferred term actually means in practice and what it means to them emotionally. With many of the comments made by participants in the focus groups such as "FGM sounds quick and normal" or "FGM are shocking and fearful word", it is important to understand the meaning and emotional attachment of their chosen term. Only by having a deep understand of this can one start to address it.

Therefore the first question should be:
1. Although we might use the words "female circumcision", what word or words would you use when talking about it? (Make a note and use this term with them throughout interview) - from here [PT] refers to participant's term

(If participants say, for example, "circumcision", "Gudniin" or "sunna" the interviewer should ask them to describe what this actually means in terms of the actual physical practice).

2. Could you tell me what [PT] describes in terms of the actual physical practice?

3. What is your response to the term FGM, and what do you think it means in terms of actual physical practice?

4. What emotions or thoughts do you associate with [PT], how does this differ when you hear the term FGM?

5. Is [PT] frequently used within your community within EU when discussing the issue?

(If participants say no, ask what term is used, and by whom, and why they think it is used)

6. Depending on the sex of the participant, ask them what they think [PT] means to men/women (Thus, if the participant is female you would say "what does [PT] mean to women" and vic versa).

7. Are girls/women who have not had this done the same as those who have had [PT]? If not, how are they different? (For example - participants may mention cleanness, religious reasons, protects their daughters against western culture, marriage, curbs their sexual drive, indicates honour or indicates that they are a virgin, or something else - ask the participant to expand and explain this. For example, if they say it stops women having illegal sex, ask them how it actually

stops them having illegal sex? If participants say that these women are the same, ask them to explain how they are the same? If they cite religious reasons, ask if they can tell you more about the origin of the religious reasons and how that has an impact on practicing their religion (if at a loss you can always just say - can you expand or tell me more about that?)

Sunna:

If the participant has not used the term "Sunna" then can you try and explore their beliefs relating to this particular term? If a participant states that they believe that girls should have "Sunna" you should explore the following things:

1. What does "sunna" mean to you?

2. How is "sunna" different from [PT]?

3. How is "sunna" different from circumcision or FGM? (if appropriate to ask)

2) Family and Community Pressure

1. How is the issue of [PT] discussed within your community? (if not see below)

2. How is it discussed in your family? (If they say it is not, ask them why they think it is that it is not openly discussed).

3. What proportion of ????? women in the EU do you think have (PT)? Get them to expand on why they think that is (e.g. Can you tell me why you think that is?)

5. Are there pressures to have [PT]? Are there different pressures here (EU) than in "home" country? (If yes or no, why do you think that is?)

5. What do people know about *and* think about the law and [PT]?

6. Do male and female perspectives differ in relation to [PT]? Explain how and in what ways similar/different...

7. What are the reasons [PT] continues to be practiced in the EU? (If they say it is or isn't continued in the EU, ask them why they think this is?)

8. Have you heard people speak openly about not performing [PT]? How are such people treated by the ????? community? (Any support for it?)

9. Are you aware of anyone openly admitting to not having [PT] done? Community response to this? How have they been treated/responded to?

QUICK questions: Name as many people (e.g. mother, aunt, grandmother, grandfather, community leaders) or organisations as you can think of who would approve of/support you performing [PT] on your own daughter. Name as many people/organisations as you can think of who would disapprove of/be against you doing this. Which of these people/organisations is most important to you in making that kind of decision?

3) Health

1. Do you think [PT] has any effects for the girls/women relating to their health?

2. Do you think women have any physical or emotional problems from [PT]?

3. Are the health aspects attributed to [PT] correct? (Get the participant to explain why they think they are correct or incorrect). If they say that there are no health consequences relating to [PT], ask them why women refuse to continue the practice?

4. What do you think about [PT] reducing or enhancing women/men's sexual pleasure?

5. Are there any positive health outcomes of practicing [PT]?

4) Legislation
1. What do you think of EU legislation around [PT]?

2. What aspects of the EU legislation do you think have had an impact on the practice of [PT]?

3. If participants raise the issue of "designer vaginas", piercings etc, ask them to explain how they feel about these issues, whether they feel they are the same as [PT] and how physically they are the same? If they say something about choice, that women in the "west" have a choice to get "designer vaginas", ask them to explain what they mean by "choice" and is this "choice" taken without pressure? In discussion "choice" ask participants how this applies to young girls?

4. Do you think that ????? girls should bet checked within schools for FGM in the EU? (How do they feel about this? What are your concerns?)

5) Marriage
1. Does [PT] have a bearing on marriage in the EU? (For example, "Pharonic circumcision" is seen as physically preventing pre-marital sex, so what meanings are associated with "less severe" forms of [PT] in relation to marriage?

2. Do women in the EU who are not [PT] face difficulties marrying? (What are these difficulties? Do people overcome them? How do potential husbands or their families respond when they know a woman is not [PT]?

3. Does marriage have an impact on identity, for example, does marrying improve people's sense of belonging to the ????? community? And is this different for men and women?

6) Decision Makers:
1. Who tends to make decisions in families/ your community about [PT]?

2. Do you think it is easier or more difficult for families in the EU not to [PT] their daughters? If not, why not and if it is difficult then why? And how does one cope with these difficulties?

3. Do the mother and the father discuss the issue of [PT] in EU? If so who makes the decision? And who has the overall power to implement that decision? (For example, if money is involved, who controls the money?)

4. If a family has decided that they are going to have their daughter done, is the actual physical procedure i.e. how much they want cut agreed with the circumciser?

7) UK Culture/identity:

1. Is [PT] associated with identity? (Get participants to explain their answer, for example, does this differ depending on whether they were born here or in the "homeland". Also ask about how this sits with EU cultural identity?)

2. How does place of birth relate to [PT]? How does place of birth affect feelings of identity? Are the three tings related?

3. Do you feel comfortable about your children attending school within the EU? (If they mention sex education, mixed sex schools or any other aspect, ask them to expand on why they feel uncomfortable/comfortable).

4. Do parents talk to their daughters/sons about the differences between ????? and EU women's genital appearance? (If so, how do they explain the difference)?

QUICK questions:
Name as many advantages as you can think of, of performing [PT]

Name as many disadvantages as you can think of, of performing [PT]

Name as many things as you can think of that make it easy to continue performing [PT]

Name as many things as you can think of that make it difficult to continue performing [PT].

Are there any cultural practices/alternative options that have the same advantages as [PT]?

Community Based Researchers and Community Peer Group Champions should be actively involved in the development of FGD topic guides and narrative interview schedules.

Once FGD topic guides and narrative interview schedules have been developed it is important that they are piloted to determine their cultural sensitivity, and to ensure they will generate conversations and discussions of the issues to be covered. They should first be piloted with the intervention/research team and the topic guide and interview schedule revised before being piloted with members of the target community to ensure that questions are understandable and that the language/terminology is appropriate. Once the piloting process has been completed and all revisions made, information collection can begin.

Recruiting research participants

The intervention team needs to decide on the desired demographic and social characteristics of the participants of the research in order to ensure that the beliefs and social norms perpetuating FGM in the community are fully explored. The systematic process of selecting research participants is called sampling. This process is important because it determines whether the findings that are derived from the research are representative of the FGM affected community. For research on FGM it is essential that individuals of different genders, age groups and marital status are represented in the research to ensure that the findings are representative of the whole community.

There are a range of different methods that can be used to identify and recruit participants for the research, including those outlined in Box 4.1. It is important that the Community Based Researchers and Community Peer Group Champions play an active role in the sampling process as they know the community well and are best placed to tell which sampling techniques are suitable for the community. Each sampling technique has its technical and practical strengths and limitations and the intervention team needs to consider these when choosing which sampling techniques to use.

Box 4.1 Techniques for identifying and recruiting research participants

- ✓ **Snowball sampling:** Here participants are identified and recruited through word-of-mouth recommendation. A participant is asked to recommend his or her friends, relatives, neighbours who possess the required characteristics for the research. This method is particularly effective when conducting research on sensitive topics such as FGM as participants can share their experiences of the research with others in order to encourage them to take part. Although this can be an effective means of recruiting research participants, researchers have to be mindful that there is a strong possibility that participants will recommend people to be participants who hold similar views.
- ✓ **Self-selection sampling**: As the name suggests, community members are invited to volunteer for the research as participants/respondents. This is done by advertising using posters and/or leaflets, in public places such as shops, community halls, churches, mosques, and online social media platforms. Researchers need to be strategic about where they place posters and leaflets and be very clear on selection criteria and processes.
- ✓ **Convenience sampling**: This is where the researcher approaches individuals who they know and have easy access to, such as friends, family, co-workers, neighbors or members of a community group. Because participants are familiar with the researcher they are likely to feel comfortable discussing sensitive issues such as FGM. This approach is quick and convenient.
- ✓ **Quota sampling:** With this method, the researcher selects people from the target population according to a fixed quota. This method is important for ensuring that the views of different population groups in the community are represented in the research. For example, the researcher can allocate quota respondents/participants according to gender, age and marital status.

No specific formula exists for determining the number of participants that are needed in any particular CPAR method. A common approach is to recruit participants until such a time that no further new information is obtained (saturation approach). Basically, it is important to sample enough people to ensure that all the perceptions/views that are needed to address the information needs of the project are captured.

4.3 Information analysis and interpretation

The qualitative information collected through the FGDs and narrative interviews needs to be analysed to transform it into some form of explanation and meaning to address the information needs of the intervention. Although several approaches exist for analysing qualitative data, REPLACE recommends using a thematic approach as it provides structured information that can illuminate different aspects of the beliefs and social norms supporting the practice of FGM in affected communities living in the EU. Thematic analysis essentially entails drawing out important themes from the information collected and seeking

explanations for and relationship between the themes. The analysis can be conducted manually or with computer-assisted analytic software such as Nvivo.

There are five steps in undertaking information analysis and interpretation:

Step 1: Transcribe and translate

In order to obtain accurate and sufficient information, it is essential that all focus group discussions and narrative interviews are audio-recorded so that all the details can be captured and analysed. Once recorded all the information needs to be transcribed and translated (if necessary). There is often a danger that valuable information can be lost during the transcription and translation process; as a result the information needs to be transcribed verbatim (word for word). The transcription needs to be kept very close to the original including the recording of non-verbal expressions such as pauses and laughter as these add important detail to the information. It is recommended that the recordings are transcribed by the Community Based Researchers or Community Peer Group Champions. Where this is not possible a professional should be contracted to do the transcription, preferably one with an understanding of the culture of the community. During the transcription process the researchers can start jotting down their initial observations from the information, which can be used in the latter part of the analysis.

Step 2: Become familiar with and organise the information

Once the transcription is complete, it is important for the research team to familiarise themselves with all the research information (including the FGDs, narrative interviews and any field notes) before beginning the analysis. This is particularly important if there are some members of the research team who did not participate in collecting and transcribing the information. Familiarisation essentially involves the researcher skimming through the data to get a sense of the issues that are covered in the transcripts as well as checking for inconsistencies and gaps. Apart from getting to know the material the researcher needs to organise the information to facilitate effective analysis. In the case of manual analysis, one systematic way of organising the material is to group the transcript texts around their respective interview questions so that the responses of all participants to a particular question are grouped together in one place. If the data is analysed with Nvivo, each transcript and field note needs to be formatted appropriately by ensuring that the questions look different from the responses before they are transferred into Nvivo.

Step 3: Code your information and develop themes

Coding can be done deductively or inductively, or a combination of the two. Deductive coding, also referred to as open coding, is an approach where the information is coded freely without being guided by any preconceptions about what is expected from the information. Inductive coding on the other hand is guided by a framework of what information needs to be coded. Even though REPLACE recommend that coding should be guided by a coding framework, it is important that researchers analysing the information keep an open mind and note down any 'eye openers' that may not have been anticipated in the information. Thus, where deductive coding is employed the research team needs to first develop a coding framework, or template to guide the coding process. This is particularly useful for consistency if several people are involved in the coding process.

Once the coding framework has been set up, the information can be coded. A code is basically a word or phrase that captures the primary essence or content of a piece of information (Saldana, 2009). This simply entails carefully reading each transcript line-by-line, making sense of the text and applying a word or a phrase that captures the essence of the text. The aim of coding is to classify all portions of the information that are similar, into a single category so that they can be compared with others within and across different respondents' responses.

No formula for coding exists; it is essentially an interpretative act which means that a piece of text could be coded differently by different people. The process however requires that the researcher thinks creatively and explores the data iteratively until all relevant codes are identified. Once the codes have been obtained, similar coded text should be regrouped into broader categories of meaningful patterns. This process should be repeated until themes are ultimately derived from the information.

Themes are basically concepts or ideas that describe or explain something. Themes are different from codes in the sense that codes tend to be shorter and succinct basic analytic units, themes are more meaningful and are expressed in longer phrases or sentences.

Step 4: Interpret the findings

This step involves seeking plausible explanations for the themes that emerged from the information in step 3. Interpretation requires using a combination of the findings from the information (as reflected in the themes), relevant secondary literature, as well as the researcher's general observations and intuition. The researcher should then reflect on these to see how they relate to the research questions. In some cases the findings are quite direct but in others they may contradict existing thinking in the general literature and therefore explanations need to be found.

The outcome of the interpretation process would normally be in the form of the description of a particular FGM belief or an explanation or evidence that explains the reasons why FGM is practiced in the study community. These can then be used as evidence to support the intervention work in Element 4 of the Cyclic Framework.

Step 5: Validate the findings

It is important that findings are validated to ensure that they are accurate and representative of the issues identified in the community. There are a number of ways of doing this:

- One way of doing this is for the research team to carefully search through the information to see if some of the themes deviate from the dominant patterns of the findings identified ('outliers'). Identifying such outliers and seeking explanations to them will provide valuable insight into the findings.
- Findings can also be validated through data triangulation. The research team compares findings on each question from different respondents, or methods (i.e. FGD, narrative interviews) or researchers to see if they support with each other. Sometimes the findings will not be corroborated, which may not necessarily be a bad thing because such contradictions may provide alternative explanations or deeper insights into the findings or open up new lines of enquiry.

- Another way to validate the findings is to present them to the research participants in a workshop or focus group and get their feedback.

4.4 Think and act ethically

As with all other types of research, research on FGM needs to be conducted in accordance with ethical standards. This is important to ensure the safety of all those involved in the research, including the researchers, participants and research community. it is therefore important to undertake a comprehensive risk assessment prior to the research to map out potential risks associated with the research process and remedial measures that can be used to mitigate them.

It is essential to ensure that the informed consent of all participants is obtained before they participate in the research. Where a participant is less than 18 years of age consent for their participation should be obtained from their parents or guardians. Participants should be given a participant information sheet (PIS) which explains why they have been chosen for the research, what their involvement in the research will entail, potential risks for participating in the research, data confidentiality, and right of withdrawal from the research. The PIS should also include contact details of the researchers so that they can contact them if in future they decide to withdraw their views from the research.

It is vital to observe confidentiality throughout the research. This is important to ensure the safety of participants and to obtain accurate and detailed information from participants. Participants are more likely to open up and express their views if they are confident that everything they say to the researcher will be kept in strictest confidence. The need for data confidentiality could create ethical dilemmas, especially in respect of expectation for researchers report suspected cases of FGM practice on a girl. Therefore, it is important for researchers to be honest to participants about the limits to confidentiality. Confidentiality can be particularly tricky in FGD as other members might divulge what someone else has said, so it is important to remind participants about the need for confidentiality during FGD sessions. Data confidentiality is also about protecting participant's information securely. This means allocating pseudonyms to participants so that their data cannot be identified. Thus all research recordings, transcripts and consent forms must be stored in a secured location and protected with password if necessary.

Investigating sensitive topics such as FGM can have an impact on participant and researcher emotional well-being. Therefore researchers need to familiarise themselves about services that are available in the community such as healthcare and counseling so that in a case where a research participant experiences emotional discomfort they can be referred to the appropriate services. Information relating these services and other forms of support should be distributed to all research participants on the Debriefing Sheet.

4.5 Summary

Section Number	*Aim/Objectives of Section*	*Tools and Techniques*
Section 4: **Element 2: Understanding the Social Norm Perpetuating FGM**	To understand the beliefs and social norms supporting the continuation of FGM and identify the barriers to ending the practice.	Train Community Based Researchers in Community-based Participatory Action Research (CPAR) methods, in particular in undertaking focus group discussions and narrative interviews. Identify and recruit participants using a suitable sampling method. Undertake focus group discussions and narrative interviews. Transcribe and translate the results of the focus group discussions and narrative interviews. Analyse the information by coding (either manually or using appropriate software such as Nvivo) and identifying themes. Validate the findings.

Section 5: The REPLACE Approach Element 3: Community Readiness to end FGM

ELEMENT 1
Community Engagement

ELEMENT 2
Understanding the Social Norm Perpetuating FGM

ELEMENT 3
Community Readiness to End FGM

ELEMENT 4
Intervention Development

ELEMENT 5
Intervention Delivery and evaluation
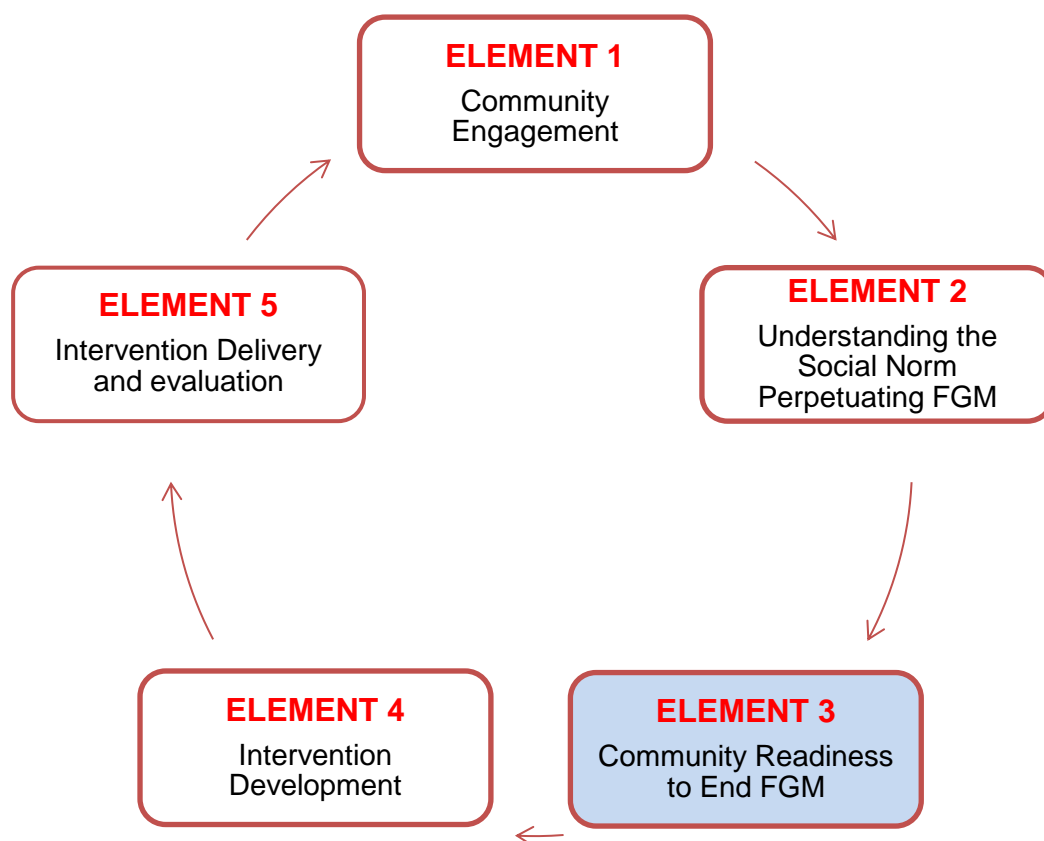
Source: REPLACE

5.0 Introduction

Element 3 of the REPLACE Approach is the assessment of a community's readiness to end FGM using the REPLACE Community Readiness to End FGM Model. This is an innovative method for assessing the level of readiness of a community to work towards ending FGM and is used by the REPLACE Approach to inform intervention development appropriate to the stage of readiness of the community and also to evaluate progress towards the goal of ending FGM.

The REPLACE Community Readiness to End FGM Model is based on the *Handbook for using the Community Readiness Model* (Plested *et al,* 2006) produced by the Tri-Ethnic Centre for Prevention Research at Colorado University. It has been adapted by the REPLACE team for working with FGM affected communities living in the EU. It has been

trialled and evaluated by all REPLACE partners with the FGM communities engaged in the REPLACE Project.

The REPLACE Community Readiness to end FGM Model is multi-dimensional assessing six dimensions of change which are scored and then equated to one of nine stages of readiness to change. These are shown in Figure 5.1.

The community's stage of readiness to end FGM gives a strong indication of where a community is on the continuum of social norm transformation and helps inform the type and content of activities and interventions that should be used with the community to shift behavioural change towards the goal of ending FGM. The link between the dimensions of change, the stages of readiness and associated activities and interventions are shown in Figure 5.2.

The Model is a culturally sensitive measurement that puts communities at the centre of the assessment with independent scorers undertaking the final ratings and calculating the overall stage of readiness of the community to end FGM. It is also a useful evaluation tool that when undertaken before, immediately after and sometime after the delivery of an intervention can indicate if there has been a shift in community readiness to end FGM.

Figure 5.1: Dimensions of Change and Stages of Readiness to Change

Dimensions of Community Readiness		Community Readiness to End FGM (stages)	
A	Community Knowledge concerning FGM	1	NO COMMUNITY AWARNESS: FGM/C PRACTICE IS SOCIAL NORM
B	Community belief systems and attitudes towards FGM	2	COMMUNITY DENIAL/RESISTANCE: SOME COMMUNITY MEMBERS RECOGNISE FGM IS AN ISSUE
		3	VAGUE COMMUNITY AWARENESS: MANY HAVE CONCERNS ABOUT FGM BUT NO COMMUNITY MOTIVATION TO CHANGE
C	Community efforts to ending FGM	4	PREPLANNING: COMMUNITY RECOGNITION THAT SOMETHING MUST BE DONE ABOUT FGM, BUT EFFORTS LACK FOCUS
D	Community knowledge of the efforts to end FGM	5	PREPARATION: COMMUNITY LEADERS BEGIN PLANNING IN EARNEST TO END FGM IN THE COMMUNITY
		6	INITIATION: COMMUNITY ACTIVITIES & INTERVENTIONS UNDERWAY TO END FGM
E	Community leaders' and influential peoples' attitudes to ending FGM	7	STABILISATION:COMMUNITY LEADERS SUPPORT ENDING FGM IN THEIR COMMUNITY
		8	EXPANSION: COMMUNITY MEMBERS FEEL COMFORTABLE WITH ENDING FGM
F	Community resources available to support efforts to end FGM	9	COMMUNITY OWNERSHIP: HIGH LEVEL OF COMMUNITY BUY-IN TO END FGM WHICH BECOMES THE SOCIAL NORM

Source: REPLACE

Figure 5.2: REPLACE: Community Readiness to end FGM Model

DIMENSIONS OF CHANGE	1	2	3	4	5	6	7	8	9
	LOW (1-3)	MEDIUM (4-6)	HIGH (7-9)						
A. Community Knowledge Concerning FGM	L	M	M	M	H	H	H	H	H
B. Community belief systems and attitudes towards FGM	L	L	M	M	M	H	H	H	H
C. Community efforts to ending FGM	L	L	L	M	M	M	M	H	H
D. Community Knowledge of the efforts to end FGM	L	L	L	L	L	M	H	H	H
E. Community leaders and influential people's attitudes to ending FGM	L	L	L	M	M	H	H	H	H
F. Community resources available to support efforts to end FGM	L	L	L	L	L	M	M	M	H

STAGES OF COMMUNITY READINESS TO END FGM	1	2	3	4	5	6	7	8	9
	No community awareness	Community Denial/ Resistance	Vague Community Awareness	Preplanning	Preparation	Initiation	Stabilisation	Expansion	Community Ownership

FOCUS OF INTERVENTION

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

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

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

COMMUNITY/INDVIDUAL EMPOWERMENT BALANCE

Community Empowerment — Individual Empowerment — Community Empowerment

SOCIAL NORM CHANGE

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

Source: REPLACE

5.2 Undertaking the REPLACE Community Readiness to End FGM assessment

Undertaking the REPLACE Community Readiness to End FGM assessment involves 5 steps as follows:

Step 1: Representatives of the FGM affected community have to be identified. These people should represent different segments of the community including: men and women (all should be over 18 years old); different generations (unmarried, newly married but with no

children, parents with young children, grandparents); people with different roles within the community (such as religious and community leaders); and length of time the person has been living in the community (such as established members of the community and those recently arrived). The REPLACE Community Readiness to End FGM Model should be explained to them, a Participant Information Sheet should be handed out and consent to participate should be sought. It is suggested that 5-10 people are identified and give their consent to be part of the Community Readiness assessment.

Step 2: Community-based researchers or peer group champions must decide if they will undertake individual Community Readiness interviews or a number of Community Readiness focus groups. This decision will be informed by time and resource constraints. The REPLACE team undertook the assessments using each method and found both to be effective. If undertaking focus groups it is advisable to have separate focus groups for different genders and/or age groups.

Step 3: Undertaking the Community Readiness interviews or focus group discussions. The interview/focus group schedule is given in Figure 5.3. There are 24 questions, organised by the six dimensions and should take about 30-60 minutes to complete. Those undertaking the interviews or facilitating the focus groups should transcribe the responses to the questions as accurately as possible, avoiding discussion and only clarifying when necessary.

Step 4: Independent scorers (not those involved in undertaking the interviews or facilitating focus groups) to be identified and to become familiar with the REPLACE Community Readiness to End FGM Model (Figure 5.1, Figure 5.2; REPLACE Toolkit, Barrett *et al* 2015), the interview/focus group schedule (Figure 5.3), the anchor ratings for scoring the schedule (Figure 5.4) and the scoring sheet (Figure 5.5). It is recommended that two scorers are used for each community and undertake their scoring independently of each other.

Step 5: Independent scorers assess the interview/focus group schedules on a scoring sheet (Figure 5.5) using the anchor ratings (Figure 5.4). Once scorers have completed their independent scoring then these should be discussed and averaged using the scoring sheet (Figure 5.5).This will produce an overall Stage of Readiness to Change for each community which will inform Element 4 of the REPLACE Approach.

Figure 5.3: The REPLACE Community Readiness to End FGM Model

Interview/Focus Group Questions.

Identification code for interview/focus group:

Community name:

Date:

Dimension A: COMMUNITY KNOWLEDGE CONCERNING FGM

A1 How knowledgeable are members of your community on the issue of FGM? Is it viewed as an issue? Are some members of the community more knowledgeable than others? Please give examples.

A2 What information is available concerning FGM in your community and through what channels? Please give examples.

A3 Do people know about the health impacts and legal aspects concerning FGM and where do they get this information from? Please give examples.

A4 On a scale 1-9 (with 1 being very low and 9 being very high) how knowledgeable is your community about FGM?

Dimension B: COMMUNITY BELIEF SYSTEMS AND ATTITUDES TOWARDS FGM

B1 Does your community support the continuation or ending of FGM? Why?

B2 What are the main obstacles to ending FGM in your community? Please give examples.

B3 Would the community support efforts to end FGM? What type of efforts would the community support? Explain your answer.

On a scale 1-9 (with 1 being very low and 9 being very high) what is your view of your community's attitudes towards ending FGM?

Dimension C: COMMUNITY EFFORTS TO ENDING FGM

C1 Are there any efforts being made or being planned by your community to end FGM? If so please give examples.

C2 If so, how long have these efforts been going on in your community and who are they aimed at? Give examples.

C3 Are efforts are routinely evaluated and the results used to make changes and improve the activity/intervention? Give examples.

C4 On a scale 1-9 (with 1 being very low and 9 being very high) what is your view of the community's efforts to end FGM?

Dimension D: COMMUNITY KNOWLEDGE OF THE EFFORTS TO END FGM

D1 Does the community know of any efforts aimed at ending FGM and how effective they are? Is so please give examples.

D2 Are there any sections of your community that know little (or a lot) of the efforts to end FGM? If so please give examples.

D3 Who (what organisation) do members of the community go to get information about FGM? Please give examples.

On a scale 1-9 (with 1 being very low and 9 being very high) what is your view of your community's knowledge of efforts to end FGM ?

Dimension E: COMMUNITY LEADERS' AND INFLUENTIAL PEOPLES' ATTITTUDES TO ENDING FGM

E1 Who are the leaders and influential people in your community that have a view on FGM? What are their views on FGM e.g. support the practice, ambivalent, disagree with FGM? Give examples.

E2 How are these leaders and influential people involved in effort to end FGM? Please explain how they are involved e.g. on a committee, task force, working with NGO, campaigning to end FGM, evaluating existing efforts etc.

E3 How committed are these leaders and influential people in supporting the end to FGM in your community? Give examples.

E4 On a scale 1-9 (with 1 being very low and 9 being very high) what is your view of community leaders and influential peoples' attitudes towards ending FGM in your community?

Dimension F: COMMUNITY RESOURCES AVAILABLE TO SUPPORT EFFORTS TO END FGM

F1.Do activities/interventions to end FGM have a broad base of support within the community? Please give examples.

F2 How are current community activities /interventions funded and resourced? How is resourcing secured and from whom? Please give specific examples

F3 Do community activities/interventions have a broad base of community volunteers working with them? Why? Give examples.

F4 On a scale 1-9 (with 1 being very low and 9 being very high) what is your view of the community resources available to support efforts to end FGM?

(Adapted from Plested et al, 2006)

Figure 5.4: The REPLACE Community Readiness to End FGM Model

Anchor Ratings for Scoring Each Dimension.

Dimension A: COMMUNITY KNOWLEDGE CONCERNING FGM

Score	Anchor Rating
1	FGM is not viewed as an issue
2	No knowledge about FGM
3	A few people in the community have some knowledge about FGM
4	Some community members know about the health impacts and legal status of FGM, but information is lacking
5	Community knows that FGM occurs within the community and general information is available
6	A majority of community members know about the health impacts and legal status of FGM and recognise it is a problem within their community
7	Community has knowledge of and access to detailed information about FGM in their community
8	Community members have knowledge about FGM within their community, and understand the consequences and risk factors
9	Communities have detailed information about FGM within their community, as well as information concerning the effectiveness of local activities and interventions to end the practice

Dimension B: COMMUNITY BELIEF SYSTEMS AND ATTITUDES TOWARDS FGM

Score	Anchor Rating
1	The prevailing attitude is that FGM is not considered and is not commented on in the community. 'FGM not a concern for the community'
2	The prevailing attitude is: 'There is nothing we can do to stop FGM' or 'Only 'those' people do it' or 'We do not think it should end'.
3	Community is neutral, disinterested or believes FGM is not an issue that does not affect the community as a whole
4	The attitude in the community is now beginning to reflect an interest in ending FGM. 'We have to do something, but we do not know what to do.'
5	The community are concerned about FGM and community members are beginning

	to reflect modest support for efforts to end FGM
6	The community believe it is their responsibility to end FGM and are beginning to be involved in efforts to end FGM
7	The majority of the community supports efforts to end FGM.
8	Some community members or segments challenge specific activities and interventions, but in general are strongly supportive of the need for activities and interventions to tackle FGM. 'We need to keep up on this issue and make sure what we are doing is effective.'
9	All segments of the community are highly supportive and community members are actively involved in evaluating and improving efforts to end FGM

Dimension C: COMMUNITY EFFORTS TO END FGM

Score	*Anchor Rating*
1	No awareness of efforts to address FGM
2	No efforts addressing the issue
3	A few individuals recognise the need to initiate some type of effort to end FGM, but there is no immediate motivation to do anything
4	Some community members have met and have begun a discussion of developing community efforts to end FGM
5	Efforts to end FGM are being planned
6	Efforts to end FGM have been implemented
7	Efforts to end FGM have been running for several years
8	Several different activities/interventions are in place, covering different segments of the community and reaching a wide range of people. New efforts being developed based on evaluation results
9	Evaluation is routinely used to assess the effectiveness of different efforts to end FGM and the results are used to make changes and improvements in activities and interventions.

Dimension D: COMMUNITY KNOWLEDGE OF THE EFFORTS TO END FGM

Score	*Anchor Rating*
1	Community has no knowledge of the need for efforts to address FGM

2	Community has no knowledge of efforts addressing FGM
3	A few members of the community have heard about efforts to end FGM but their knowledge is limited
4	Some members of the community know about local efforts to end FGM
5	Members of the community have basic knowledge about local efforts to end FGM
6	An increasing number of community members have knowledge of local efforts and are trying to increase the knowledge of the general community about these efforts
7	There is evidence that the community has specific knowledge of local efforts to end FGM including who to contact concerning FGM
8	There is considerable community knowledge about different community efforts to end FGM as well as the level of activity/intervention effectiveness
9	Community knowledge on activity/intervention evaluation and on how well local efforts to end FGM are working

Dimension E: COMMUNITY LEADERS' AND INFLUENTIAL PEOPLES' ATTITTUDES TO ENDING FGM

Score	Anchor Rating
1	Community leaders and influential people do not recognise FGM as an issue
2	Community leaders and influential people do not believe FGM is an issue
3	Community leaders and influential people recognise the need to do something to end FGM
4	Community leaders and influential people are trying to get efforts started to address FGM
5	Community leaders and influential people are members of committees, groups and organisations that are addressing FGM in the community
6	Community leaders and influential people are active and supportive of efforts to end FGM
7	Community leaders and influential people are supportive of continuing basic efforts to end FGM and are considering what resources are needed from the community
8	Community leaders and influential people support expanding and improving efforts to end FGM through active participation
9	Community leaders and influential people are continually reviewing evaluation results of efforts to end FGM and are modifying support accordingly

Dimension F: COMMUNITY RESOURCES AVAILABLE TO SUPPORT EFFORTS TO END FGM

Score	Anchor Rating
1	There is no awareness of the need for resources to deal with FGM
2	There are no resources available to deal with FGM in the community
3	The community is not sure where to get resources to begin efforts to end FGM
4	The community has volunteers, organisations and/or space available that could be used as resources
5	Some members of the community are actively investigating how to get resources
6	Resources have been obtained and/or allocated to tackle FGM in the community
7	A considerable part of the support for on-going efforts to end FGM come from community resources. Community leaders and influential people are trying to access additional resources
8	Different resources and funds have been secured for existing efforts to end FGM and additional support has been secured for future activities and interventions
9	There is continuous and secure support for activities and interventions to end FGM in the community. Evaluation is routinely undertaken and there are resources for trying new activities and interventions

(Adapted from Plested et al, 2006)

Figure 5.5: The REPLACE Community Readiness to End FGM Model

Community Readiness Assessment Independent Scoring Sheet.

Name of Scorer:

Date of scoring:

Community name:

Independent Scoring:

1. Ideally interview/focus group results should be rated by two independent scorers.
2. Using the Anchoring Ratings for each dimension (Figure 5.4), independent scorers should allocate a score of between 1-9 to each dimension for each interview/focus group.
3. For each community all interviews/focus groups should be added together and then divided by the total number of interviews/focus groups to give an average for each community.
4. The scores of the independent scorers for each dimension should be averaged and an average total for all dimensions given.
5. The average total for all dimensions should then be divided by 6 (the number of dimensions) to give the overall stage of readiness of the community. The scores correspond with the numbered stages, with a score of between 1-1.9 equating with the first stage of readiness, 2-2.9 with stage 2 etc.
6. Disagreements between the independent scorers and any impressions about the community should be noted.

Scorer 1: Independent Scoring of interviews/focus groups

	Interview/focus group 1	Interview/focus group 2	Interview/focus group 3	Interview/focus group 4	Interview/focus group 5	Etc	Total	Average Dimension Score (total divided by number of interviews/focus groups)
Dimension A								
Dimension B								
Dimension C								
Dimension D								
Dimension E								

Dimension F								

	Interview/focus group 1	Interview/focus group 2	Interview/focus group 3	Interview/focus group 4	Interview/focus group 5	Etc	Total	Average Dimension Score (total divided by number of interviews/focus groups)
Dimension A								
Dimension B								
Dimension C								
Dimension D								
Dimension E								
Dimension F								

Combined Independent scores of interviews/focus groups

	Independent scorer 1 Average Dimension score	Independent scorer 2 Average Dimension score	Total independent scores	Average Dimension Score (total divided by number of independent scorers)
Dimension A				
Dimension B				
Dimension C				
Dimension				

D				
Dimension E				
Dimension F				

Average Dimension Scores

	Average Dimension Score
Dimension A	
Dimension B	
Dimension C	
Dimension D	
Dimension E	
Dimension F	
Total	

Total Average Dimension Score *divided by* six (number of Dimensions) = _____ (community stage of readiness to end FGM)

Stages	Community Readiness to End FGM
1	No community awareness: FGM practice is a social norm
2	Community denial/resistance: some community members recognise FGM is an

	issue
3	Vague community awareness; many have concerns about FGM but no community motivation to change
4	Preplanning: community recognition that something must be done about FGM, but efforts lack focus
5	Preparation: community leaders begin planning in earnest to end FGM in the community
6	Initiation: community activities and interventions underway to end FGM
7	Stabilisation: community leaders support ending FGM in their community
8	Expansion: community members feel comfortable with ending FGM
9	Community ownership: high level of community buy-in to end FGM which becomes the social norm

Comments, impressions and qualifying statements about the community.

(Adapted from Plested et al, 2006)

5.3 Summary

Section Number	Aim/Objectives of the Section	Tools and Techniques
Section 5: **Element 3: Community Readiness to End FGM**	To assess the community's readiness to end FGM	Apply the REPLACE Community Readiness to End FGM Model. Allocate the community a stage of readiness to end FGM score.

Section 6: The REPLACE Approach
Element 4: Intervention Development

ELEMENT 1
Community Engagement

ELEMENT 2
Understanding the Social Norm Perpetuating FGM

ELEMENT 3
Community Readiness to End FGM

ELEMENT 4
Intervention Development

ELEMENT 5
Intervention Delivery and Evaluation
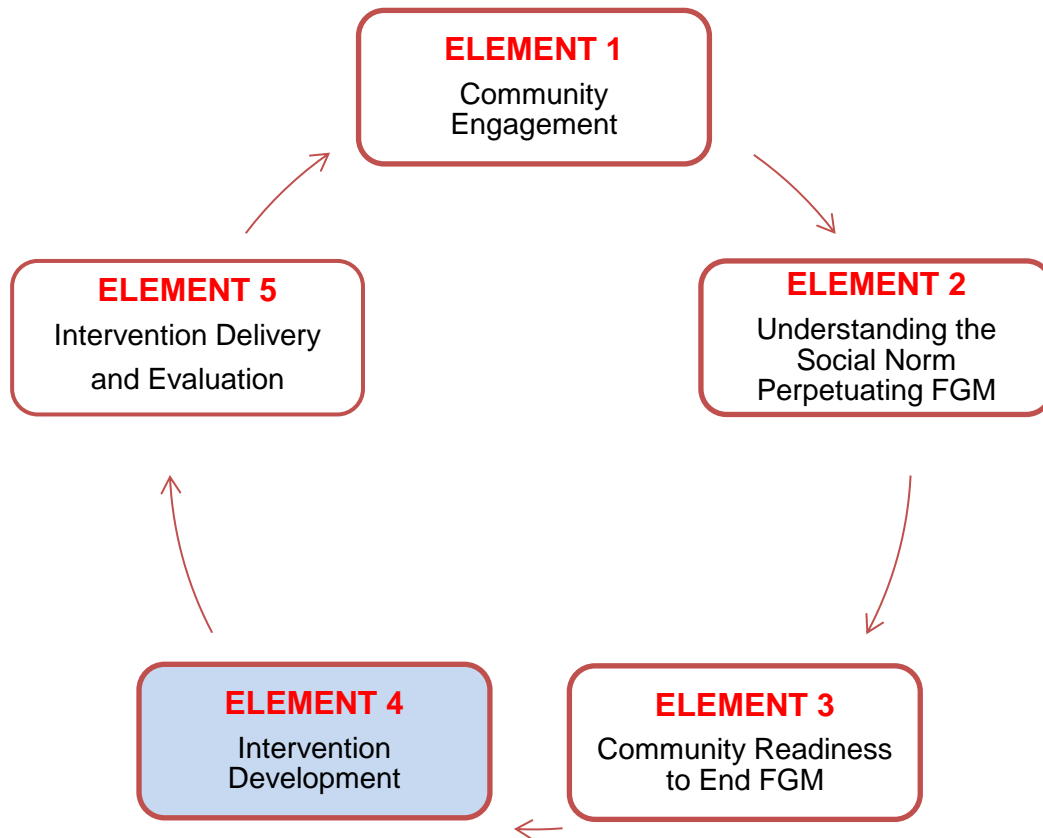
Source: REPLACE

6.0   Introduction

Intervention development can begin once a core group of community members are engaged on the project, when there is a good understanding of the beliefs and social norms influencing FGM and a baseline community readiness to end FGM assessment has been completed (see sections 3, 4 and 5 above outlining Elements 1, 2 and 3 of the REPLACE Cyclic Framework). The first step in intervention development draws on the outcomes from the work completed in Elements 2 and 3, and success is dependent on the buy-in achieved through community engagement (Element 1).

6.1 Step 1: Identify a target intervention action (or actions)

Community Peer Group Champions or others from the FGM affected community need to work together to identify a target intervention action or actions. To do this, they should draw on what has been learnt in Elements 1, 2 and 3 and what they know about the community so far in relation to FGM. They need to think about the Community Readiness assessment covered in the previous section (section 5). They need to consider the types of actions and activities that the peer champions could engage in; it is important that community members themselves generate ideas, as they need to be actions that they feel would be feasible and

acceptable in their local context. Table 6.1 might provide the basis of some ideas. It gives suggestions generated by REPLACE for the early stages (1-4) of Community Readiness (see accompanying toolkit section 6 for suggestions relating to later stages). These suggestions could be starting points for the community, but detail and specifics will need to be added, so the community should use its own knowledge and insights as a guide. A target action can be anything that has the potential to engage more people on the issue and persuade more people that ending FGM should happen.

6.2 Step 2: Consider the norms and enforcing mechanisms important within the community and use this to specify the target action further

In addition to identifying an intervention action or actions with community members for them to engage in, it is important to consider what is known about the social norms and enforcing mechanisms that support perpetuation of FGM within the community. These might include religious beliefs that support the continuation of FGM (e.g. 'little sunna' is required by Islam'), beliefs that relate to health outcomes of FGM (e.g. 'cutting is good for women's health and there are no severe consequences of FGM type I or type II'), the role of women in the community (e.g. 'women are viewed as subordinate to men'), the role of community elders (e.g. 'community elders are respected and listened to') and the acceptability of communicating about the issue of FGM by community members (e.g. 'it's difficult to talk openly about FGM') (see REPLACE Toolkit Section 4 for detailed account of these amongst REPLACE partner communities). Table 6.2 shows the selected intervention actions and content focus chosen by members of the FGM affected communities who were involved in the REPLACE Project; along with the stage of community readiness for that community at the outset of the project in 2013.

Table 6.1: The first 4 stages of readiness to change as applied to FGM affected communities in the EU with example intervention actions generated during REPLACE [1]

Stage number	Stage name	Suggested intervention actions
1	**No Community Awareness** FGM practice is a social norm	• Visits and discussions with community leaders, community elders and other community members about FGM. • Visit existing and established small groups to inform them of the issue. • Raising the issue with friends and potential supporters.
2	**Community Denial/Resistance** Community members recognise FGM is an issue	• Continue visits and discussions and encourage those you have talked with to assist. • Discuss local anecdotal evidence of harms of FGM. • Approach and engage local education/health outreach programmes to assist efforts • Identify the issue at local parent/teacher association meetings or to the board of school governors at local schools and ask that the school act as a focal point for community engagement on the issue – mothers can do this at their own children's school • Present information to community groups. • Organise opportunities for community members to get together to discuss the issue and their concerns.
3	**Vague Community Awareness** Many have concerns about FGM but no community motivation to change	• Identify important evidence to support claims and arguments about why FGM should end • Present information at local community events and to unrelated community groups, with community leaders if possible. • Discuss and identify ways to preserve positive cultural values that do not involve FGM (e.g. mothers teaching daughters about preserving traditional values relating to chastity to replace the need to cut girls) • Begin to initiate events (e.g. community women's health events etc.) to present information on the issue of FGM. • Provide 'safe' opportunities to allow people to talk openly about FGM e.g. at specially organised events
4	**Preplanning** Community recognition that something must be done about FGM, but efforts lack focus	• Introduce more formal information about the FGM through presentations and local media. • Develop support from community leaders and peer group champions.. • Review existing efforts in the community to tackle FGM and determine who it targets and what the degree of success has been.

Source: REPLACE

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[1] NB Some of these target actions may be taking place in some affected communities already, but where they are led by or initiated by those outside of the community they can't be considered as evidence of the community being in that stage – the community must generate the activity from within. They can be supported to do this by others.

Table 6.2: REPLACE Intervention actions and content focus identified by participating communities, listed by stage of community readiness to end FGM assessment

FGM affected community	Intervention action	Focus of main messages based on evidence about FGM perpetuation in each community	Stage of community readiness to end FGM at outset of REPLACE2
Dutch Somali	Koranic school teachers delivering a Koranic school lesson focussing on challenging beliefs that FGM required by Islam	'Little Sunna' or FGM is not a requirement of Islam.	3 – Vague awareness but approaching 4 - Preplanning
British Sudanese	Organisation of a community event to present sessions on the health consequences of FGM types I and II and challenge the belief that FGM is required by Islam and have break-out discussions in three languages	'Little Sunna' or FGM is not a requirement of Islam. Women with FGM types I and II are four times more likely to have health problems than women with no FGM	3 – Vague awareness
Spanish Gambian and Senegalese	Organisation of a set of community sessions focussing on attitudes towards European culture including FGM and health, religion, the law, and gender equality and allowing opportunity for discussion	Link between gender inequality and economic development and between gender inequality and FGM Development of capabilities and opportunities for intergenerational communication about FGM	2 - Denial
Portuguese Guinea Bissauan	Organisation of a set of community sessions focussing on attitudes towards European culture including FGM and health, religion, the law, and gender equality and allowing opportunity for discussion	Link between gender inequality and economic development and between gender inequality and FGM Development of capabilities and opportunities for intergenerational communication about FGM	2 - Denial
Sicilian Eritrean and Ethiopian (Habesha)	Organisation of a set of community sessions to bring community members together	Providing people with a greater sense of community and belonging and better understanding of western values as this is a transient community not ready to address FGM	1 - No awareness to 2 – Denial

Source: REPLACE

6.3 Step 3: Understanding what needs to change for Community Peer Group Champions

Having identified a target intervention action or actions, it is important to understand factors that may prevent Community Peer Group Champions from engaging in the identified intervention activities. The COM-B model (Michie *et al.*, 2011; 2014) supports this and is shown in Figure 6.1.

Figure 6.1: The COM-B model (Michie *et al.*, 2011; 2014)
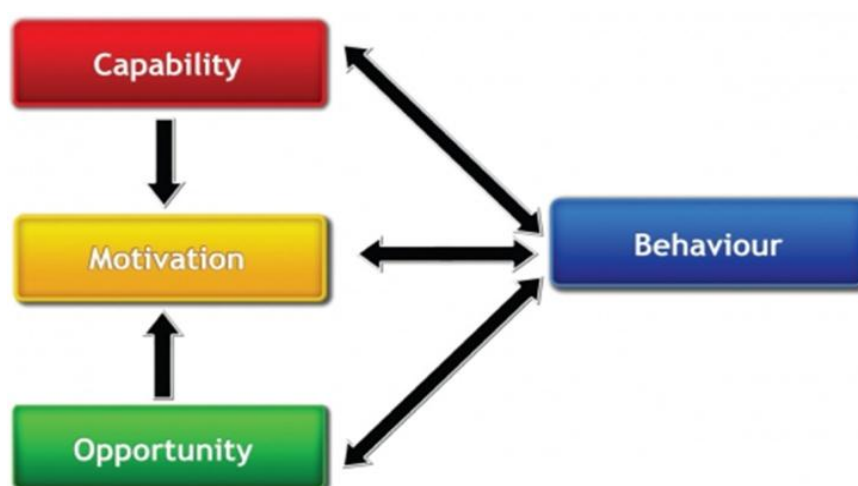
The model proposes that for any behaviour (or target intervention action) to be enacted the three components on the left hand side of the figure must be present. People must be capable of performing the behaviour, they must be motivated (or want) to perform the behaviour, and they must have the opportunity to perform the behaviour. These three components are further subdivided as follows:

- Capability
- Psychological capability – includes knowledge, skills, aptitude, understanding, ability to self-regulate behaviour
- Physical capability – includes physical ability to carry out the behaviour
- Motivation
- Automatic (passive) motivation – includes wanting to do something out of habit or because it makes you feel good without using effortful thought
- Reflective (active) motivation – includes positive evaluations of performing the behaviour through effortful thought
- Opportunity
- Social opportunity – includes opportunities created by the interaction of peers, family, and other networks and the influence of social norms including culture and subculture to support the behaviour
- Environmental opportunity – includes opportunities created by the physical environment; objects, services, resources and locations that promote the behaviour

Community peer champions and others from the community can work together to identify where they may need support to take action effectively. The assessment questionnaire shown in Figure 6.2 can be used individually or in groups to identify what is needed. Download this from the REPLACE website at www.replacefgm2.eu

Figure 6.2: COM-B assessment questions (adapted from Michie *et al.,* 2014)

In order for you to do or be involved in *[insert target intervention action]*, what do you think it would take for you to do it?		
Capability		Tick here if important to your group/community and add any notes or details
I need to know more about why it was important to end FGM and/or engage in this action	e.g. arguments about why FGM not required for Islam; or how it causes health problems	
I need to know more about how to do it	e.g. how to organise a community event, or stand up and present to an audience	
I need to have better mental skills	e.g. learn how to present arguments about FGM more effectively	
I need to have more mental strength	e.g. be able to resist the urge to leave taking action to someone else	
I need to overcome physical limitations	e.g. get around problems of disability or illness	
I need to overcome mental obstacles	e.g. Overcome feeling of it's easier to take no action	
I need to have more physical stamina	e.g. develop greater capacity to maintain physical effort	
I need to have more mental stamina	e.g. develop greater capacity to maintain mental effort	

Opportunity		Tick here if important to your group/community and add any notes or details
I need to have more time to do it	e.g. find dedicated time and re-organise other things in my life	
I need to have more money to do it	e.g. apply for and win funding to do it	
I need to have more materials or resources to do it	e.g. access to presentation tools, and the internet, or support to plan a talk	
I need to have access to facilities	e.g. find somewhere to host an event	
I need to have more people around me also doing this	e.g. be part of a group who are doing this together	
I need to have more triggers to prompt me	e.g. have reminders to raise the topic for discussion when needed with family or friends	
I need to have more support from others	e.g. family and friends would need to support me	
Motivation		Tick here if important to your group/community and add any notes or details
I need to feel that I want to do it more	e.g. feel more of a sense of pleasure or satisfaction from doing it	
I need to feel that I need to do it more	e.g. care more about the negative consequences of not doing it	
I need to believe it would be a good thing to do	e.g. have a stronger sense that this is something I should do	
I need to develop better plans for doing it	e.g. have a clearer and better developed plan for how to achieve it	

I need to develop a habit for doing it	e.g. get into a pattern of doing it without needing to think much about it	
I need to feel that I am able to do it	e.g. feel that I am fully capable and confident of doing it	
Anything else (give details)		

6.4 Step 4: Understanding how to change things to support Community Peer Group Champions

Table 6.3 provides a list of behaviour change techniques (BCTs) that have been identified by Michie *et al*. (2014) as useful ways to improve capability, motivation and opportunity. These have been specially selected by the REPLACE team from the all current identified BCTs, as ones particularly relevant to the issue of FGM and likely to be most relevant to supporting community members or peer group champions in carrying out target intervention actions. Most BCTs can be used to support more than one of the three components necessary to engage in the target action (i.e. may support two or more of capability, motivation and opportunity) and ticks in the relevant columns show how they can be applied.

Not every BCT will be relevant but REPLACE recommend considering each one in relation to the support the team of community peer group champions give each other and the training and resources that may be developed for community members/peer group champions through NGOs or other organisations. Example interventions that incorporate these techniques from the REPLACE Project are on the REPLACE website at www.replacefgm2.eu to illustrate how they may be applied.

Table 6.3: Behaviour Change Techniques identified as useful for supporting community peer group champions to engage effectively in target intervention activities

Behaviour Change Techniques	FGM relevant example	Capability	Opportunity	Motivation
Action planning Prompt detailed planning of performance of the behaviour (must include at least one of context, frequency, duration and intensity). Context may be environmental (physical or social) or internal (physical, emotional or cognitive) (includes 'Implementation Intentions').	Encourage formation of a detailed plan about exactly how to deliver on agreed goal of organising community events. Prompt planning the performance of raising the topic of FGM with peers at a particular time (e.g. at a pre-arranged social gathering) on a certain day of the week (e.g. next Wednesday).	✓	✓	✓
Adding objects to the environment Add objects to the environment in order to facilitate performance of the behaviour.	Provide special passport size documents (such as those available in Netherlands and UK) for families to take abroad which explain the illegality of FGM in the UK or other EU nations to their families living in Africa (or other FGM affected region).	✓	✓	✓
Anticipated regret Induce or raise awareness of expectations of future regret about performance of the unwanted behaviour.	Ask the person to assess the degree of regret they will feel if they do not take action in their community to tackle FGM. Or if they found out a local girl or woman had died as a result of FGM.	✓	✓	✓★
Behavioural practice/rehearsal (Unique to capability) Prompt practice or rehearsal of the performance	Practice giving a presentation OR raising the issue of FGM with peers.	✓	NA	NA

of the behaviour one or more times in a context or at a time when the performance may not be necessary, in order to increase habit and skill.				
Commitment Ask the person to affirm or reaffirm statements indicating commitment to change the behaviour.	Ask the person to use an "I will" statement to affirm or reaffirm a strong commitment (i.e. using the words "strongly", "committed" or "high priority") to start, continue or restart the attempt to have conversations with peers about ending FGM.	✓	✓	✓
Credible source Present verbal or visual communication from a credible source in favour of ending the behaviour.	Present a speech or other information from respected community member, Imam or other high status individual in favour of ending FGM.	NA	NA	✓★
Demonstration of the behaviour Provide an observable sample of the performance of the behaviour, directly in person or indirectly e.g. via film, pictures, for the person to aspire to or imitate (includes 'Modelling').	Demonstrate to person or group how to raise the issue of ending FGM in the community with their peers via a role-play exercise. Show an example of raising the issue and having a conversation about it with a filmed conversation.	✓	✓	✓★
Discrepancy between current behaviour and goal Draw attention to discrepancies between a person's current behaviour (in terms of the form, frequency, duration, or intensity of that behaviour) and the person's previously set outcome goals, behavioural goals or action plans (goes beyond self-monitoring of behaviour).	Point out that a person has only achieved communication with two of their peers and not five as planned.	✓	✓	✓

Feedback on the behaviour Monitor and provide informative or evaluative feedback on performance of the behaviour (e.g. form, frequency, duration, intensity).	Inform the person of how many arguments they presented about ending FGM, how well they could be heard, how clear and confident the delivery was etc (can include praise, but this would also be a type of social reward).	✓	NA	✓
Focus on past success Advise to think about or list previous successes in performing the behaviour (or parts of it).	Advise to describe or list the occasions on which the person successfully raised the issue of FGM with peers.	✓	✓	✓
Framing/reframing Suggest the deliberate adoption of a perspective or new perspective on behaviour (e.g. its purpose) in order to change cognitions or emotions about performing the behaviour (includes 'Cognitive structuring').	Suggest that the person might think of ending FGM not as ending an important part of their culture but as ending the part that is bad, and maintaining what is good, and thus improving the cultural norms for future generations (or similar types of argument).	✓	✓	✓★
Goal setting (behaviour) Set or agree on a goal defined in terms of the behaviour to be achieved.	Agree to organise a set number of community events addressing FGM over the next six months. Agree to raise the issue of FGM with five members of your peer group over the next six weeks.	✓	✓	✓
Goal setting (outcome) Set or agree on a goal defined in terms of a positive outcome of wanted behaviour.	Set a goal for number of people reached with the anti-FGM message over next six weeks (e.g. number of people attending a community meeting).	✓	✓	✓
Habit formation (Unique to capability)	Consistently working at skill of discussing FGM or organising events where the issue is discussed will support habit	✓	NA	NA

Prompt rehearsal and repetition of the behaviour in the same context repeatedly so that the context elicits the behaviour.	formation.			
Identification of self as role model Inform that one's own behaviour may be an example to others.	Inform the person that if they stand up against FGM, that may be a good example for their children.	✓	✓	✓★
Identity associated with changed behaviour Advise the person to construct a new self-identity as someone who 'used to engage with the unwanted behaviour'.	Ask the person to articulate their new identity as openly anti-FGM.	✓	✓	✓★
Incompatible beliefs Draw attention to discrepancies between current or past behaviour and self-image, in order to create discomfort (includes 'Cognitive Dissonance').	Draw attention to a community or person's use of FGM which involves physical harm and self-identification as caring about children (may be difficult if audience still sees the benefit as outweighing harm).	✓	✓	✓★
Information about emotional consequences Provide information (e.g. written, verbal, visual) about emotional consequences of performing the behaviour.	Explain that FGM can affect mental health and wellbeing of those affected; but again make this commensurate with level of experience of the audience. Personal emotional responses of the individual or group may also be relevant to comment on e.g. positive emotions/empowerment gained through taking action.	✓	NA	✓★
Information about health consequences	Explain the physical and mental health consequences of	✓	NA	✓★

Provide information (e.g. written, verbal, visual) about health consequences of performing the behaviour.	FGM, but wherever possible attempt to tailor this information to the audience and the likely type experienced/ common in that community. If FGM type 1 or IV common do not focus overly on health consequences likely from FGM type III (infibulation). Might focus on pain, blood loss etc as appropriate.		
Information about approval from others Provide information about what other people think about the behaviour. The information clarifies whether others will like, approve or disapprove of what the person is doing or will do.	Tell people that other community members approve of their event organisation actions or arrange for community members to tell people that. The approval of influential and respected community leaders may be particularly important so their approval of ending FGM should also be made really clear.	✓	NA	✓★
Information about social and environmental consequences Provide information (e.g. written, verbal, visual) about social and environmental consequences of performing the behaviour.	Tell person/group that most community members disapprove of FGM. Tell person that their actions/behaviour promoting change can have a real positive impact and provide examples (e.g. a girl saved from FGM locally).	✓	NA	✓★
Instruction on how to perform behaviour (Unique to capability) Advise or agree on how to perform the behaviour	Advise the person how to deliver a session to a community group (includes communication skills training and providing a lesson plan).	✓	NA	NA

(includes 'Skills training').	Advise them on how to notify authorities or seek help in preventing a girl being taken out of the country for FGM. Advise them on successful strategies for raising the issue of FGM with a family member, peer or community leader.			
Monitoring of behaviour by others without evidence of feedback (Unique to motivation) Observe or record behaviour with the person's knowledge as part of a behaviour change strategy.	Watch person give presentation, have a conversation or deliver an argument about FGM and make notes about content, reaction to content, style etc.	NA	NA	✓
Monitoring outcome of behaviour by others without evidence of feedback (Unique to motivation) Observe or record outcomes of behaviour with the person's knowledge as part of a behaviour change strategy.	Record data about number of people contacting anti-FGM organisation and citing an event they attended, or count number of people at the event.	NA	NA	✓
Problem solving Analyse , or prompt the person to analyse, factors influencing the behaviour and generate or select strategies that include overcoming barriers and/or increasing facilitators (includes 'Relapse Prevention' and 'Coping Planning').	Identify the particular barriers to raising the issue with your peer group and discuss strategies that could be used to raise the issue and ways to start the conversation. Identify the reasons for resistance to host the community event at the mosque and generate ideas for addressing that resistance/making the event more acceptable.	✓	✓	✓★

Re-attribution Elicit perceived causes of behaviour and suggest alternative explanations (e.g. external or internal and stable or unstable).	Elicit any beliefs that a person or group has that may lead them to favour continuation of FGM and provide alternative world views or counter-arguments e.g. it is required by religion could be counter-argued by citing evidence from Koran or Islamic scholar which argues that it is not.	✓	NA	✓★
Restructuring the physical environment Change, or advise to change the physical environment in order to facilitate performance of the wanted behaviour or create barriers to the unwanted behaviour (other than prompts/cues, rewards and punishments).	Change or advise to change anything in the physical environment that may make it easier for FGM to be carried out (e.g. breaking community silence to the authorities when they know an excisor has been brought into the community).	NA	✓	NA
Restructuring the social environment Change, or advise to change the social environment in order to facilitate performance of the wanted behaviour or create barriers to the unwanted behaviour (other than prompts/cues, rewards and punishments).	Advise to minimise time spent with community members who may try to persuade you to have your daughter cut (possible in EU context in a way that may not be possible back in African context).	✓	✓	✓★
Material incentive (behaviour) Inform that money, vouchers or other valued objects will be delivered if and only if there has been effort and/or progress in performing the behaviour (includes 'Positive reinforcement').	Community organisation are informed that they will gain more funding for projects if they engage in hosting events designed to support the anti-FGM agenda and can demonstrate through evaluation they are making progress.	NA	NA	✓
Material reward (behaviour) Arrange for the delivery of money, vouchers or other valued objects if and only if there has been	Arrange for the community organisation to receive money if and only if they have held successful community events with the anti-FGM campaign agenda incorporated.	NA	NA	✓

effort and/or progress in performing the behaviour (includes 'Positive reinforcement').		NA	NA	
Non-specific reward Arrange delivery of a reward if and only if there has been effort and/or progress in performing the behaviour (includes 'Positive reinforcement').	Identify something (e.g. an activity such as a visit to the cinema) that the person values and arrange for this to be delivered if and only if they have raised the issue of ending FGM with their peers.	NA	NA	✓
Social reward Arrange verbal or non-verbal reward if and only if there has been effort and/or progress in performing the behaviour (includes 'Positive reinforcement').	Congratulate the person for each occasion they successfully raise the issue of ending FGM with a peer in the affected community.	NA	NA	✓
Social incentive Inform that a verbal or non-verbal reward will be delivered if and only if there has been effort and/or progress in performing the behaviour (includes 'Positive reinforcement').	Inform that they will be congratulated for each attempt to raise this issue of ending FGM with a peer.	NA	NA	✓
Non-specific incentive Inform that a reward will be delivered if and only if there has been effort and/or progress in performing the behaviour (includes 'Positive reinforcement').	Identify an activity that the person values and inform them that this will happen if and only if they work towards organising the community event(s).	NA	NA	✓
Self-incentive Plan to reward self in future if and only if there	Encourage to provide self with material (e.g., new clothes) or other valued objects if and only if they have tried to and/or made progress with organising the community event or	NA	NA	✓

has been effort and/or progress in performing the behaviour.	raising the issue of ending FGM with peers in the community.			
Incentive (outcome) Inform that a reward will be delivered if and only if there has been effort and/or progress in achieving the behavioural outcome (includes 'Positive reinforcement').	Inform the community organisation they will receive money if and only if a certain number of people are reached with an anti-FGM message through events hosted by them.	NA	NA	✓
Self-reward Prompt self-praise or self-reward if and only if there has been effort and/or progress in performing the behaviour.	Encourage to reward self with material (e.g., new clothes) or other valued objects if and only if they have raised the issue of ending FGM with a number of peers in the community.	NA	NA	✓
Reward (outcome) Arrange for the delivery of a reward if and only if there has been effort and/or progress in achieving the behavioural outcome (includes 'Positive reinforcement').	Arrange for the community organisation to receive money if and only if a certain number of events have been hosted and number of people reached.	NA	NA	✓
Salience of consequences Use methods specifically designed to emphasise the consequences of performing the behaviour with the aim of making them more memorable (goes beyond informing about consequences).	This might involve showing images or film of consequences but this is not likely to be appropriate in many cases and should always be coupled with a BCT designed to support overcoming any emotional response to such images otherwise response may be negative rather than positive. Might involve a personal story to make it more memorable/salient.	✓	✓	✓★
Social support (emotional)	Ask the person to take a friend along to a presentation or event they are giving or organising OR help them identify	✓	✓	✓★

Advise on, arrange, or provide emotional social support (e.g. from friends, relatives, colleagues, 'buddies' or staff) for performance of the behaviour.	someone they can get emotional support from if their efforts raise emotional issues related to their own experiences of FGM.				
Social support (practical) Advise on, arrange, or provide practical help (e.g. from friends, relatives, colleagues, 'buddies' or staff) for performance of the behaviour.	Ask the partner or peers of the person to help them transport materials to a community event in their car OR help them learn how to use a new technology that will help them carry out planned activities.	✓	✓	✓★	
Social support (unspecified) Advise on, arrange or provide social support (e.g. from friends, relatives, colleagues,' buddies' or staff) or non-contingent praise or reward for performance of the behaviour. It includes encouragement and counselling, but only when it is directed at the behaviour .	Provide and suggest forums for social support, such as creating a what's app network. Advise people to make contact with support network when experiencing difficulties in delivering planned activities or target behaviours.	✓	✓	✓★	
Valued self-identity Advise the person to write or complete rating scales about a cherished value or personal strength as a means of affirming the person's identity as part of a behaviour change strategy (includes 'Self-affirmation').	Advise the person to write about their personal strengths before they receive a message advocating the behaviour change.	✓	✓	✓	

Verbal persuasion about capability (Opportunity and motivation only) Tell the person that they can successfully perform the wanted behaviour, arguing against self-doubts and asserting that they can and will succeed.	Tell the person that they can successfully take the anti FGM message back to their community/stand up to the grandparent who favours the practice.	NA	✓	✓★

Important additional note

If the target intervention action involves peer group champions going out to communicate in some way with others in the community (and most actions will) then pay particular attention to how the BCTs relevant to improving MOTIVATION can be used within that communication. E.g. embed motivation BCTs in a presentation or session plan for a communication event to increase the likelihood that the message will be persuasive and engage others in the community to get involved and take action. The BCTs likely to be most useful for this have been marked with a star★ in the motivation column in Table 6.3. but any could be considered – it will depend on the nature of the communication activity as to what is most likely to work best.

For instance, during a communication session at a community event, community peer group champions may provide **information about health consequences** of FGM, from a **credible source** (e.g. Doctor from a local FGM clinic and research comparing uncircumcised women in Africa with those subject to type I and type II FGM). They may increase the **salience of health consequences** to the audience by providing personal stories from affected community members, and highlight the **incompatible beliefs** that relate to wanting what is best for their child and putting them at risk of health consequences.

Ethics: ethical considerations are outlined at the end of the next section (Section 7). They relate specifically to evaluation of interventions but since evaluation should be planned alongside development of your intervention it is important to READ the NEXT section before any intervention development work commences and consider the ethical considerations simultaneously.
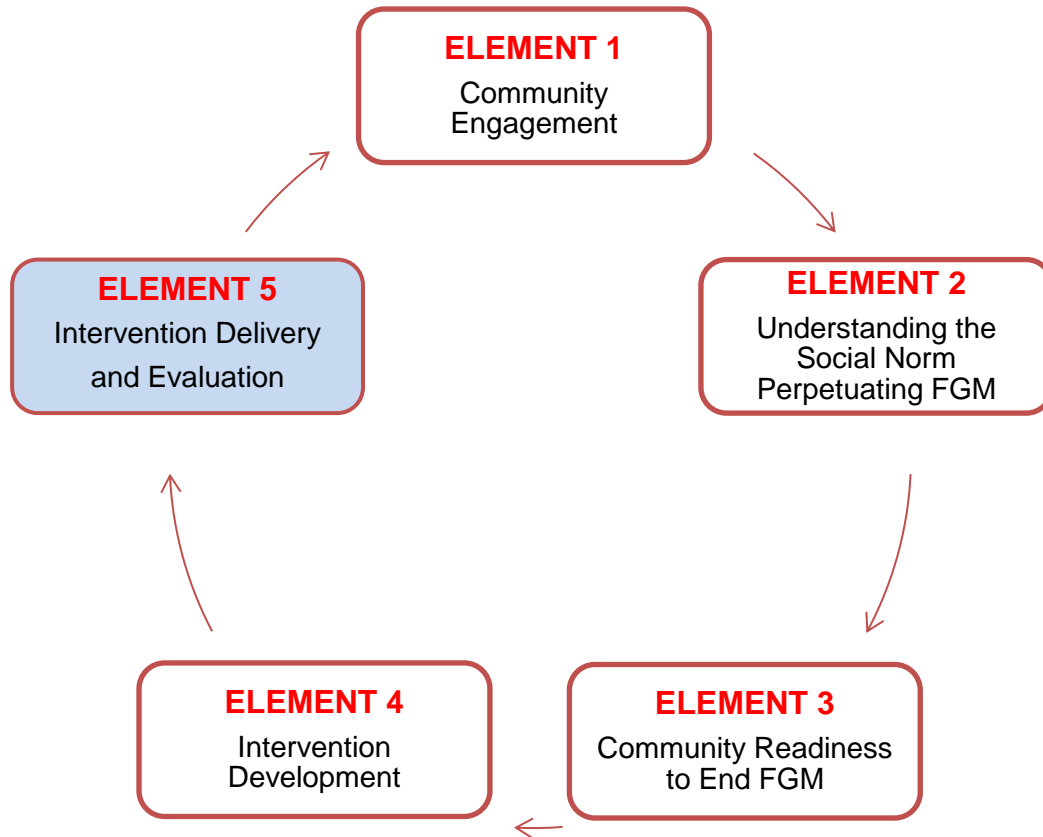
6.5 Summary

Section Number	Aim/Objectives of Section	Tools and Techniques
Section 6: **Element 4:** **Intervention** **Development**	To identify and develop a community activity/intervention designed to change attitudes and behaviour concerning FGM	Community Peer Group Champions to work with the community to identify a target activity/intervention consistent with the community's stage of readiness to end FGM. Undertake a Capability, Opportunity, Motivation and Behaviour (COM-B) assessment of the Peer Group Champions and others involved in developing and delivering the activity/intervention. Using appropriate Behaviour Change Techniques (BCTs) train/mentor Peer Group Champions and others involved in developing and delivering the activity/intervention in the aspects of COM-B that they show weaknesses in. .

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

ELEMENT 1
Community Engagement

ELEMENT 2
Understanding the Social Norm Perpetuating FGM

ELEMENT 3
Community Readiness to End FGM

ELEMENT 4
Intervention Development

ELEMENT 5
Intervention Delivery and Evaluation

Source: REPLACE

7.0 Introduction

The purpose of this section of the community handbook is to provide a 'how to' guide for developing an evaluation methodology and associated materials to assess the effect of the intervention on community peer group champions and/or other members of an FGM affected community as the intervention is delivered.

Exactly how the intervention is delivered will depend on what has been devised to meet the needs of the specific community. For REPLACE, some partners and communities held a series of workshops over a number of weeks, covering a range of issues. Another partner held a single one off 'starter' event and then community peer group champions followed that up with lower key communications about FGM in the community. Another, devised a Koranic school lesson and delivered it a number of times at different Koranic schools. The challenges of setting up and organising such intervention target actions need to be

considered as part of the COM-B analysis (see Element 4 in Section 6 above). Appropriate support and resources for intervention delivery need to be planned for alongside intervention development.

With regards evaluation planning, it is recommended that Sections 7.1 and 7.2 of the accompanying REPLACE Toolkit are read. This explains in more detail that the purpose of evaluation is to decide what it is that needs to change as a result of the intervention, designing an intervention that is aimed at bringing about that change and assessing or measuring in some way throughout the process, whether or not the expected changes occurred, in the way that was expected.

Evaluation provides evidence of wanted or expected change as a result of activities/interventions and when things do not change as expected, there is an opportunity to understand why and adjust future activities accordingly.

In the accompanying REPLACE Toolkit we recommend that the following components are included in your evaluation activities:

7.1 REPLACE Community Readiness to End FGM assessment

REPLACE Community Readiness to End FGM assessment should be conducted at the outset of working with a community and a repeated assessment carried out after intervention delivery (and potentially repeated again at later dates to continue to assess shifts at the community level) as part of evaluation efforts. This involves conducting qualitative interviews or focus groups based on dimensions of change which then translate to a stage of community readiness to end FGM. This method assesses community level change. Section 5 of this Community Handbook has already provided detail on how to carry out a Community Readiness to end FGM assessment.

7.2 Focus groups and interviews

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

Detailed guidance on how to conduct a focus group and one-to-one interviews is available on the REPLACE on-line resources which can be accessed for free through the REPLACE website www.replacefgm2.eu. This also provides guidance on how to manage the information and analyse it to identify themes which represent the major content and meaning of what people have said.

The key materials needed to conduct an interview or focus group include an interview or focus group schedule, which contains the major questions you have for people to answer and ideas about prompts to keep discussions moving or to get people to elaborate what they have said. For the purposes of evaluation your interview or focus group schedule should ask questions about peoples' experiences of being involved in the intervention, and what they perceive the impact or the effect to have been. In particular you want them to comment on how they perceive the intervention to have influenced their own thinking and behaviour in relation to FGM, and how they perceive the thinking and behaviour of others has been influenced. Box 7.1 below provides an example evaluation focus group schedule from the REPLACE Project and further examples are available from the REPLACE website www.replacefgm2.eu.

Box 7.1 Example of a REPLACE focus group schedule for qualitative evaluation of intervention activities

REPLACE – Focus Group/Interview evaluation schedule for community peer group champions

Assessing the experience of being involved in the activity/intervention and perceptions of community change

1. Please explain what your involvement was in the Koranic school teachers lesson delivery work?

2. What has that experience been like? Anything particularly good or bad about the experience? Please elaborate.

3. How have your friends and family responded to you working with FSAN on this project?

4. How did you feel about FGM before this project?

5. Have your beliefs and understanding changed as a consequence of being involved? If so how?

6. What impact has being involved had on your life? Give examples.

7. What impact has being involved had on other important people in your life? Give examples.

8. What impact do you think the project has had within the community?

9. How have things changed with regard to attitudes towards FGM?

10. What else needs to happen in your opinion to progress your community towards the goal of ending FGM?

11. Do you want to talk about anything else relating to FGM or this work within your community?

Source: REPLACE

7.3 Questionnaires (pre and post) and including comparator groups if possible

Questionnaires should be completed before and after interventions with those who have participated. They should always be anonymous; do not ask people to put their name on them. Where possible people should complete these privately as self-reported questionnaires, but there may be times when it is more appropriate to sit down with people and complete the questions with them. Questionnaires can include numerical rating scales to assess things like specific beliefs as well as open-ended (qualitative) response items to gain richer information about the nature of any changes. This method assesses individual level change, and using numeric rating scales means it is possible to assess using statistical techniques whether, on average, groups of individuals shift their thinking and beliefs.

The value of questionnaires is that they can be designed to specifically measure what the intervention targeted for change. They can be used with:

a) community peer group champions to assess whether they improved on capability and motivation to engage in the identified intervention action, and to what extent they have managed to put what they have learnt into practice in the community (i.e. changed their behaviour)

b) other community members who have been exposed to or received intervention messages or materials (e.g. at a community event) to assess the impact on their beliefs about FGM and attitude towards its continuation.

Asking people to complete the same measures before and after the intervention allows assessment of whether things changed because of the intervention. Of course there may have been other things that influenced peoples responses, so we cannot be sure changes detected were only due to the intervention.

One way to be more certain the intervention was the cause of any changes is to collect questionnaire data from control or comparison groups at the same time who did not receive your intervention, or who have not received it yet. Using a control or comparator group is more robust, but time and resources do not always allow for this.

Critically, if you want to allow data to be analysed for statistical significance you need to be able to match up questionnaires completed by the same individual at two or more time points. To do this without asking for names it is recommended that you ask people to self-generate a code on each questionnaire that they will not need to remember. For example, you could ask people to provide their house/flat number and the last three letters of their given name. For example for Katherine Brown who lives at house number 32, this code would be: 32INE. Any combination of numbers or letters can work as long as it is easy to generate and does not allow someone to be identified.

Figure 7.1 gives some examples of numerically scaled questionnaire items. A selection of example questionnaires is available on the REPLACE website (www.replacefgm2.eu). Please note the ethical considerations box (Box 7.2). When collecting data for research or

evaluation purposes it is vital that people and the information they provide are treated ethically.

Figure 7.1 Examples of numerical questionnaire items

Measure of perceived capability to communicate with others about FGM:

1. Thinking about your own abilities, how able do you feel right now, to talk to other **people in your community** about ending FGM/female circumcision?

7	6	5	4	3	2	1
Very able	Able	A little able	Neither able nor unable	A little unable	Unable	Not at all able

Measure of motivation to communicate with others about FGM:

2. How much do you want to talk to other **people in your community** about ending FGM/female circumcision?

7	6	5	4	3	2	1
Very much	A lot	Quite a lot	A fair amount	A little	Not really	Not at all

Measure of belief that Islam requires FGM:

3. To what extent do you believe that female circumcision/FGM is a requirement of Islam?

7	6	5	4	3	2	1
Absolute require-ment	Strongly recomm-ended	Somewhat recomm-ended	Could be recomm-ended but not necessary	Not really a requireme nt	Not at all necessary	Should not be considered part of Islam

Quantitative or numerical data from questionnaires should be entered into spread sheets such as Microsoft Excel in the following format:

Participants	code	age	gender	Q1	Q2	Q3	Q4	Q1 Time2	Q2 Time2	Q3 Time2	Q3 Time4
participant1	32INE	32	2	1	4	2	1	5	3	5	6
participant2	56LAN	45	2	2	2	2	2	6	4	6	7

participant3	89TER	67	2	3	3	2	3	4	5	5	5
participant4	23SIF	28	1	2	4	4	2	6	6	6	7
participant5	16ANA	19	1	3	1	3	2	5	4	5	6

Each row should represent a single person, and each column should represent an item of information on the questionnaire. For gender code 1=female and 2=male.

Excel can be used to do some types of statistical analysis, and most other statistical software packages will translate information from excel. It is beyond the scope of this guide to cover how to do statistical analysis but youtube is always a good place to access tutorials if you are keen to learn. Alternatively, although we cannot promise to analyse data for everyone, the REPLACE team may be able to offer support if you have followed our guidance. Contact us via the website www.replacefgm2.eu

If you collect qualitative, open-ended responses as part of questionnaires, then this information can be analysed in a similar way to focus group or interview data, by identifying common themes or ways of grouping responses for their common meaning (see www.replacefgm2.eu).

7.4 Objective assessments of reach of the intervention activity

Records of the instances of intervention activities, include the number of community events that are held and the number of people who attended, or the number of people a community member has reached with their one-to-one or small group activities. This method assesses both individual and community level change, since every individual instance of someone attending an event or engaging in discussion about FGM that they would not have done before the intervention represents some change. If over time it is possible to show increasing engagement and participation in anti-FGM activities by community members then there is evidence of community development and change.

It is recommended that groups or organisations collate this information within an excel spread sheet so that over time a record of events and attendance is maintained and evidence of reach and expanding engagement can be evidenced.

Box 7.2 Ethical considerations when undertaking evaluations

Informed consent – provide people with a Participant Information Sheet (PIS) (see Section 2 of this Handbook) so that they can make an informed decision about whether they want to participate. For focus groups and interviews ask people to sign a Consent Form (see Section 2 of this Handbook).

Time to consider participation and ask questions – give people enough time to make a decision about their participation without feeling pressured and give them the opportunity to ask questions and get answers. If possible tell them about the data collection in advance so they time to consider participation.

Right to say no and right to withdraw – make sure people know they are under no obligation to take part, that it will not effect their rights to do things like access services (e.g.

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if recruiting a service) and that they can change their mind at any time without giving a reason.

Right to know what will happen to the data and how it will be stored – tell people how their information will be stored and how you will keep it safe – include this on your PIS

Anonymity and confidentiality – never collect identifiable information. Assure people that although data will be used to report the outcomes of the evaluation, this will be done anonymously.

Right to access findings – provide people with contact details of those using this information so they can get access to the evaluation, or tell them where the evaluation will be reported.

Right to complain if unhappy – give people someone to complain to if they feel unhappy about their experience. Provide these contact details on the PIS.

7.5 Summary

Section Number	Aim/Objectives of the Section	Tools and Techniques
Section 7: **Element 5: Intervention Delivery and Evaluation**	To effectively deliver the intervention/activity developed in Element 4.	Deliver the intervention/activity according to: the nature of the intervention; the stage of community readiness to end FGM; and the COM-B of the Community Peer group Champions and others delivering the intervention/activity.
	To evaluate the impact of the intervention/activity on the community and individual attitudes and behaviour towards FGM.	Develop an evaluation strategy to include: REPLACE Community Readiness to End FGM Model; focus group discussions and interviews; questionnaires; and objective assessments of the reach of the intervention/activity. Review the results of the evaluation. Use the results of the evaluation to inform the next cycle of the REPLACE Cyclic Framework for Social Norm Transformation.

Section 8:

Conclusion

The REPLACE team implemented the REPLACE Approach in five EU countries with a range of migrant African communities over three years, and learnt a lot about the challenges of engaging on this issue and of implementing the Approach. Although it was known at the outset how important it is to engage with affected communities in a genuine and honest way; the amount of time and resources needed to do this cannot be underestimated. REPLACE partners with greater experience of engaging with FGM affected communities in the UK and the Netherlands (FORWARD and FSAN) were in a much stronger position to move quickly on engagement because of their long histories of working in the field. It was more challenging for the Southern European partners (APF, CESIE and GES) who were working with newer migrant communities and who as organisations had only recently begun working with them on the issue of FGM.

The evaluation of the interventions developed and delivered by the five REPLACE partners indicated that there had been a change in attitudes towards FGM. In some communities it was evident that both community and individuals were shifting their views of FGM, in others there was some indication that communities were beginning to challenge the social norm supporting the practice of FGM, but that individuals felt they lacked the power to question the status quo. However all these shifts, however small, are moves in the right direction and are taking these communities towards the goal of ending FGM.

Other aspects of REPLACE learning relate to the absolute importance and value there is in placing FGM affected communities in the EU at the heart of tackling the issue of bringing the practice to an end. REPLACE viewed this as highly important, but through the delivery of the REPLACE project have truly understood how critical this is. In Southern European communities in particular, this was the first time these communities had been consulted directly on the issue, and the power of providing the community with their own voice is immense. It is itself a highly motivating part of the REPLACE activities that communities could talk openly and honestly about their views concerning FGM without being judged.

It is really useful to understand how other organisations and communities are getting to grips with the challenge of using the REPLACE Approach, and so it is suggested that those implementing the REPLACE Approach identify themselves as part of the REPLACE Approach community so that they can be known to one another and can provide opportunities (e.g. through an online forum on the REPLACE website) to share learning and challenges.

We wish you well in applying the REPLACE Approach.

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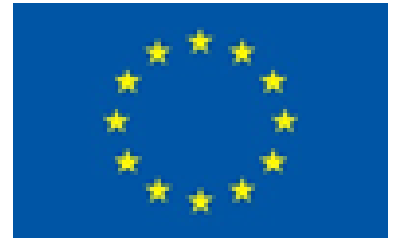
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