Literature Review:
Best Practice Approaches to the Prevention and Abandonment of Female Genital Mutilation/Cutting

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Introduction

What is FGM/C?

Female genital mutilation/cutting (FGM/C) is internationally defined as comprising 'all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons' (WHO, UNICEF, UNFPA 1997).

An estimated 100 to 140 million women and girls worldwide have undergone some form of the practice and 3 million girls are estimated to be at risk of undergoing FGM/C every year (WHO 2008). FGM/C is mostly carried out on young girls between 0 and 15 years of age. However, it is occasionally performed on adult women.

The WHO/UNICEF/UNFPA Joint Statement made in 1997 classified female genital mutilation into four broad categories which distinguished different types or degrees of the procedure and can be summarised as: Type I (clitoridectomy); Type II (excision); Type III (infibulation); and Type IV involving other harmful procedures to the female genitalia for non-medical purposes (WHO 2008). For the purposes of this review, FGM/C will refer to all types unless otherwise stated.

FGM/C has no health benefits. On the contrary, it has immediate, short and long-term health consequences that are harmful to girls and women. Beyond the pain and trauma of the event itself, procedures can cause immediate health complications including shock, severe bleeding, septicaemia, bacterial infections and death. Long-term associated health problems can include the recurrence of urinary and kidney infections; an increased risk of childbirth complications; mother and newborn deaths; chronic pain and decreased sexual enjoyment. FGM/C can also have adverse long-term effects on mental health and wellbeing.

The practice of FGM/C violates the human rights of girls and women and is embedded in a complex set of traditional rituals and cultural and social values. In countries where the practice is prevalent, it is often connected to girls' marriageability, chastity, the preservation of virginity and social acceptance amongst family and community members (UNICEF 2013). While the practice is inherently violent, it is not carried out with a primary intention of violence. It is, rather, a self-enforcing social convention (UNICEF 2010). Families and individuals may perceive strong social pressure to practise FGM/C, and may closely connect it to personal and social identity. For diaspora communities, this connection may also be negatively experienced as stigma in their country of migration.

The practice of FGM/C has been documented in 28 countries in Africa and several countries in Asia and the Middle East (WHO 2008). Forms of FGM/C have also been reported in Central and South America. In other countries where there is no established or widespread cultural precedent for FGM/C, such as Australia, New Zealand, Canada, Europe, the United Kingdom and the United States, immigrants from practising communities are sometimes known to practise FGM/C and are thought to be at risk.

Legal Status of FGM/C in Australia

FGM/C is a crime under state-based law in every state and territory in Australia. These legislative measures are supported by community education, health and allied health services and women's health support programs. Programs are underway in most Australian states and territories to work with communities impacted by FGM/C, as well as with health practitioners, health educators, community and settlement workers and the general community. They aim to promote awareness, increase knowledge and provide information to support the abandonment of the practice. Many of these programs are community-based and conducted by women from the communities most affected by FGM/C, some for over 16 years. Programs also work with men, youth and key community members to mobilise them against FGM/C. However, there has been limited opportunity or resourcing to share expertise across Australia or allow for a nationally coordinated approach.

A Note on Terminology

Female Genital Mutilation (FGM) can be an emotionally and politically loaded term, which has generated debate about whether it accurately and appropriately describes the practice. The term 'FGM' is used in the 1997 Joint Statement made by WHO, UNICEF and UNFPA as well as in Australian legislation. Using the word 'mutilation' highlights the seriousness of the harm done by the practice to women and girls (WHO 2008) and to avoid drawing parallels to male circumcision. However, if it is being discussed in English, it is preferable to use the term 'female genital cutting' or 'female circumcision' or 'excision' because it carries less judgement (UNICEF 2013).

This paper uses the term 'FGM/C': female genital mutilation/cutting to reflect the importance of using meaningful, non-judgemental and respectful language towards practising communities. Using this term also avoids confusion with procedures like female genital cosmetic surgery, which is currently conducted in Australia, and with the medicalisation of the practice in some countries. Using the term cutting is not an attempt to excuse or trivialise the gravity of the practice, but to acknowledge the diversity of ways women might identify FGM/C for themselves or interpret their experience.

Literature Review

Purpose

This review was undertaken as part of the National Education Toolkit for FGM/C Awareness (NETFA) project (2013-2014) led by the Multicultural Centre for Women's Health (MCWH), with partners representing FGM/C programs in every Australian state and territory. The NETFA project was one of fifteen projects funded by the Australian Department of Health to support the abandonment of FGM/C among immigrant communities and to ensure the practice is not being continued in Australia.

The purpose of the NETFA project is to increase understanding of FGM/C and its consequences by creating a national network of FGM/C service providers working at the front-line of community awareness and education, to share their expertise and develop culturally appropriate, cost-effective, nationally adaptable and accessible resources. While programs to support the elimination of FGM/C have been active in Australia for over 30 years, they have been state based and there has been little opportunity to share information or to develop a cohesive, national approach. The Northern Territory, for example, currently has no funding for programs, and poses a significant gap in developing comprehensive health education and awareness for immigrant communities.

One key component of the NETFA project is to develop a national best practice guide for current and emerging FGM/C service providers involved in community awareness and education. By sharing best practice models and approaches across states and territories, the NETFA project aims to increase national awareness efforts among communities and to promote and share effective approaches to community engagement.

Aims

The aims of the literature review were to:

- inform the NETFA Best Practice Guide in relation to best practice models and approaches, with a particular focus on migrant and refugee contexts;
- identify accepted best practice and lessons learned in relation to community-based approaches in health promotion and education;
- identify challenges and gaps; and
- assist the international community to access information about FGM/C abandonment programs and strategies relevant to destination or receiving countries, particularly in relation to Australia.

Scope and Methodology

As part of this review a wide range of literature was consulted including academic papers, program and project reports, and documented studies of immigrant community attitudes to FGM/C. Significant material outlining best practice approaches and strategies already exists in relation to international efforts to address FGM/C in countries where FGM/C is known to be prevalent, with a

focus on countries on the African continent. In this review, attention is given to community program models and initiatives relating to the specific challenges encountered within immigrant and refugee contexts similar to that of Australia. We have been opportunistic in collecting material through desktop searches and in consultation with our national partners. This review does not present a comprehensive survey of every program or organisation providing FGM/C awareness and education; literature reviewed was largely selected according to its availability and accessibility and searches were limited to English language material.

Much of the available literature relating to the abandonment of the practice presents a high-level, multi-agency strategy or national action plan, which does not directly detail the nature of community-directed programs. For the purposes of this review, legislation and policy related to FGM/C is not addressed directly, nor are practices related to protection, prosecution or punishment, education to health professionals, or approaches to FGM/C in a clinical setting. While these issues are fundamentally important, they are being addressed through complementary projects being developed as part of the Australian government's wider commitment to eliminate the practice of FGM/C in Australia.

Limitations

A significant limitation of the review in identifying effective programs is the lack of rigorous program documentation and evaluation. Although there has been a decline in the practice, the rate of decline has been slow, which might suggest that interventions have been ineffective in their outcome (WHO 2011).

Although there have been numerous FGM/C interventions developed and implemented by a vast number of agencies worldwide, very few of these are adequately documented or evaluated, which makes it difficult to assess which interventions work and which do not (WHO 2011; Johansen et al 2013). In a systematic review of interventions in 2012, only eight were found with sufficient evaluation to be included (Berg & Denison 2012). However, there have been a number of common approaches, including community-led approaches, which have undergone some form of evaluation (Johansen et al 2013).

The review also found a lack of comprehensive research on the prevention and eradication of FGM/C in migration countries. The disparity between research and program development in migration countries is highlighted in a recent report about the perceptions of immigrants in Hamburg in relation to FGM/C (Behrendt 2011). The report also points out that campaigns and activities are mostly based on anecdotal evidence and are often carried out without the involvement of main stakeholders of immigrant communities.

'Best Practice'

For the purpose of this review, 'best practice' has been informed by the available evidence and recommendations of successful international programs and interventions, as well as the lessons and experiences of health service providers and other professionals working with communities around the issue of FGM/C in Australia. As such, the review focussed on gathering the most culturally appropriate and relevant elements in research and practice for working with immigrant and refugee communities.

Issues Particular to Migration Countries

The importance of raising awareness about the harms of FGM/C has become a global issue with increasing migration of communities from countries where FGM/C is or has been practised. The possible reach of the practice is said to have extended from 28 countries in Africa and others in Southern Asia and the Middle East to include Europe, North and South America, Canada, Australia, New Zealand and the United Kingdom (UNFPA 2006). In addition to 26 countries in Africa and the Middle East that have prohibited FGM/C by law or constitutional decree, legislation has also been adopted in 33 countries around the world, mostly to protect children with origins in practising countries (UNICEF 2013: 8). However, reliable data on the prevalence of FGM/C in destination or receiving countries are rare and often based on estimation or anecdotal evidence. The 'Study to map the current situation and trends of female genital mutilation in 27 EU Member States and Croatia' put together by the European Institute for Gender Equality in 2012 highlights the fact that prevalence figures are often based on extrapolation from minor studies and census data (EIGE 2012).

Australia

It is impossible to speculate on the incidence of FGM/C in Australia or to estimate the number of girls and women who have undergone the practice before migration or who may be at risk. There is currently limited evidence to suggest that the practice is being continued by immigrant communities in Australia, outside a number of isolated cases. However, migrants from practising countries may have already undergone the procedure or may be considered at greater risk of undergoing or practising FGM/C. Although some estimates have been based on country of birth, such an indicator fails to account for the diversity of practices within cultures and ethnicities. Given the lack of data, women should not be unduly stereotyped or discriminated against based solely on country of birth. The increased migration to Australia of populations from countries where FGM/C is known to occur means that effective strategies must be in place to ensure that newly arrived communities are supported to abandon the practice. Two separate incidents resulting in arrests in 2012 suggest that ongoing community awareness and education are needed. To date, there have been no prosecutions of FGM/C under Australian laws.

Settlement Issues

Migrant communities often face barriers to successful settlement due to a lack of relevant health services, cultural stigmatisation and/or discrimination. Equally, FGM/C and its attendant consequences can impede women's and girls' mental, physical, cultural and social well-being, making it more difficult for them to successfully adjust to and participate in the life of their destination country (IOM 2008).

Allotey, Manderson and Grover note that women in countries where the practice is culturally sanctioned belong to a mainstream culture where both debate and change involve the wider community. In contrast, in displaced communities, particularly among immigrants and refugees living in Western countries, women from these countries are the visible minority, and the focus and implementation of legislation and related health policy relating to FGM/C risk creating or increasing inequalities (Allotey, Manderson & Grover 2001: 189).

In countries like Australia with diverse migrant populations, community engagement presents some different challenges and opportunities for service providers. As the International Organisation for

Migration affirms, strategies addressing FGM/C must be adapted to the specificities of the migration context in order to be effective (IOM 2008). Moving to another country can be an isolating experience for families and the need to preserve cultural traditions can become even more important to communities as a way of maintaining their cultural identity and history.

While there is evidence to suggest that migrant attitudes to FGM/C may change depending on the length of time people have lived in a destination country and the age they arrived, attitudes do not necessarily change simply because an individual lives in a country where FGM/C is not a cultural expectation and/or illegal.

A study of the attitudes of Somalis in London found that there was support for the continuation of FGM/C among both women (18%) and men (43%). The study further showed that older generations, new arrivals and those unable to participate in the broader community are more likely to hold traditional views (Morison et al 1998). Similarly, a study of Sub-Saharan immigrants in Hamburg found that most (80%) advocated for abandonment, while the remaining 20% supported the continuation of the practice or reported uncertainty (Behrendt 2011). The proportion of supporters was higher (32%) among practising families than among non-practising families (7%).

Other studies from the UK (FORWARD 2010) and Sweden (Johnsdotter et al 2009) have suggested that attitudes to FGM/C can change significantly due to migration and acculturation. A qualitative study among Ethiopian and Eritrean families in Sweden found widespread rejection of any form of upholding the practice (Johnsdotter et al 2009). However, these studies did not measure participants' level of exposure to education or community engagement strategies promoting the abandonment of FGM/C.

As the UNFPA notes, policy makers in countries receiving immigrants from countries where FGM/C is practised face the challenge of establishing culturally sensitive approaches designed to halt the practice (UNFPA, 2006). In particular, Western countries need to ensure that prevention efforts are not perceived as judgemental or morally offensive, as this could lead to negative reactions in migrant communities. Many lessons can and have been learned from programs implemented in countries where FGM/C prevalence was high and cultural acceptance of the practice has declined. Many of the current government action plans developed in parts of the world with relevant immigrant populations reflect the recommendations of WHO and the UNICEF/UNFPA Joint Program of FGM/C which began in 2008. These recommendations include supportive legislation, community engagement, and education of health practitioners.

Human Rights: a Framework for Social Justice

"FGM/C is recognised as a violation of the human rights of girls and women. It is an act of violence that harms women and girls in many ways, limiting their potential for full development, and a major obstacle to the achievement of gender equality. Families and communities that support FGM/C believe that it is a necessary requirement for raising girls to become 'proper' women. It is a practice deeply rooted in tradition and persists because it is a social convention upheld by underlying gender structures and power relations."

(UNICEF 2010)

Internationally FGM/C is recognised as a form of gender-based violence (and in countries with appropriate legislation in place, it is also a criminalised issue). As such, FGM/C is formally recognised by the United Nations as a human rights violation that is supported by a number of international instruments, including the Convention on the Elimination of all forms of Discrimination against Women (CEDAW) and the Convention on the Rights of the Child. Addressing FGM/C within a human rights framework is a crucial means by which to develop a social justice approach (Rahman and Toubia 2000).

As the International Office of Migration suggests, a comprehensive and human rights approach to FGM/C may be particularly important in addressing the unique challenges around community engagement in migration countries with no cultural precedence of the practice. The IOM (2008) outlines three key benefits of adopting a human rights approach in this context. Firstly, it moves the practice out of the private sphere and makes governments responsible for ensuring that women's and girls' rights are respected. Secondly, the universality of human rights de-legitimises claims for the continuation of FGM/C for cultural reasons. Finally, the human rights approach provides a framework and vocabulary as well as practical guidelines for programs against FGM/C which prevents the 'medicalisation' of the practice (IOM 2008).

Common Elements of the Social Dynamics of Change

A significant finding of the review highlights the mismatch between changes in individual attitudes and actual behaviour change. Survey data have shown that in many countries, the numbers who oppose and want to end the practice are greater than those who have abandoned the practice. Trend reports also reveal that diminishing support tends to precede an actual decline in the practice and that the most commonly reported reason for carrying out FGM/C is social obligation (UNICEF 2013 : 117).

This finding highlights and confirms that the decision-making processes surrounding FGM/C are complex, relational and deeply embedded in power structures. The key to transformational change cannot only reside with individual preferences, but depends also on reciprocal expectations (UNICEF 2013; UNICEF 2010; WHO 2008).

Although there is a notable lack of rigorous evaluations, the most recent reviews of FGM/C interventions and programs provides sufficient information about which interventions do or do not work. Analysis of experiences also show that there a number of common elements that create the necessary conditions for the abandonment of FGM/C (UNICEF 2010). The review commissioned by WHO on 'what works and what doesn't' found, that despite the lack of evaluations, most agencies could identify the factors which led to the success of their intervention. In reviewing the most common approaches that have undergone some type of evaluation, the study conducted by Johansen et al (2013) also provides information about successes and challenges. Elements of successful and promising approaches identified in all these reviews have been summarised below.[1]

In addition to the diversity of approaches, it is useful to know that approaches are carried out at four levels—community, national, regional and international—and that actions at each level need to be

[1] As the review focusses on prevention and abandonment in a migration context, 'conversion of excisers' as an approach is not included.

complementary and mutually reinforcing. The approaches and interventions summarised here have been developed by a vast array of agencies, operating at the different levels, worldwide.

Programmatic Approaches to FGM/C

Prioritisation of Women's Empowerment

> **"…within each community in one country, leadership should always be for women from the country and the community. This basic principle does not only contribute to a justifiable "rights" approach but has proven to be more effective when applied. For women to feel strong enough to stand up and demand their rights, they must be given the tools for self-empowerment."**
>
> **(Rahman & Toubia 2000 : 75)**

The literature highlights the importance of understanding FGM/C as a form of gendered-based violence and as a manifestation of gender inequality. As a matter of human rights and in keeping with principles of social justice, it is essential that women, as those most affected by and who will benefit the most from the elimination of FGM/C, should lead the change (Rahman & Toubia 2000).

In many of the successful initiatives, women affected by FGM/C are placed at the centre of programs: as the group most directly impacted by the practice, they are potentially the best agents to bring about its demise (MCWH 2012; Toubia & Sharief 2003).

Within this approach, interventions can range from broader, long-term strategies to improve women's social and economic development to participatory education programs that include health literacy training and sexual and reproductive health education.

The success of a woman-centred approach has been most evident in the Tostan Project, more commonly known as the Community Empowerment Program. The Program uses a community education approach for women based on human rights principles and has resulted in the organised abandonment of FGM/C in 7,000 communities across Africa (Tostan 2013).

It is also important to note that women do not and cannot stand alone in ending FGM/C and must be supported by allies from all levels of community and governments who can help strengthen women's leadership and advocacy efforts.

Health Risk Approaches

"Concern over health consequences of FGM is one of the most significant motivations for abandonment of the practice. However, to be effective, it has to be reliable and communicated in a way that can be absorbed and integrated into a wider health information package."

(Johansen et al 2013)

Providing information to community members about the health risks of FGM/C has been the most popular and oldest approach to preventing FGM/C. This approach is underpinned by the belief that individuals will abandon the practice if they are well informed of the harmful consequences. However, the advantages of this approach (such as increased knowledge; reflection and critical thinking) have been mitigated by evidence that suggests health information can also lead to other undesirable outcomes, rather than abandonment. Health information about complications, for example, has led to health providers performing more FGM/C procedures and has also led to changes in the type of FGM/C performed instead of total abandonment.

Programs that only supply or use information, education and communication (IEC) as an independent intervention are insufficient because they don't attempt to change the social belief model in which FGM/C is deeply rooted (WHO 2011.). There has now been a shift from IEC interventions to behaviour change interventions (BCI), which work on understanding and changing the shared codes of behaviour and learned knowledge amongst members of a particular community. This change in communication necessarily involves working at the community level to assess, build on, and develop positive community values that underpin FGM/C, while at the same time trying to eliminate the practice.

Recent community-based prevention work conducted in the UK found that discussion and debate around FGM/C amongst affected migrant communities are becoming more sophisticated and require culturally sensitive and respectful messaging (Options UK 2013).

Community–led Approaches

"Programs are best led by communities in a participatory way, supporting the communities to define problems and solutions themselves. Programs that have demonstrated success in promoting abandonment of FGM build on human rights and gender equality and are nonjudgmental and non-coercive. They focus on encouraging a collective choice to abandon FGM."

(WHO 2011)

Community-led programs have been found to be essential in the abandonment of FGM/C. Individuals from FGM/C affected backgrounds play a crucial role in the strategic development of prevention programs and can help to assess the best messages and approaches to prevention and abandonment for their community.

The most successful programs engaged respected community members to promote change. Engagement and recruitment of religious leaders; representatives of women's and youth community groups; and role models (also called the positive deviant approach) to facilitate transformation (UNICEF 2010).

Non-governmental organisations working at the community level are considered to be most effective in developing and undertaking education and awareness programs (Bentze & Talle 2007: Centre for Reproductive Matters 2006).

Public Statements

> **"Depending on the stage of readiness for change and processes running prior to the public statements, they can mark a final decision already made to abandon FGM in some communities, whereas in others they are a milestone that signifies readiness for change, and further support is needed to sustain and accelerate the process."**
>
> **(Johansen et al 2013)**

Public statements are an important element in mobilising communities and can be effective in making evident declining social support. Recent findings from UNICEF (2013) highlight the need to make more visible the hidden attitudes favouring the abandonment of the practice, to help accelerate actual behaviour change.

Local and trusted media can also have a role to play in facilitating informed discussion and disseminating information. Best practice suggests that the media's role is more effective when they complement these strategies—facilitation and dissemination—at the community level with policy measures at the national level (UNICEF 2010).

Capacity Building of Relevant Professionals

> **"The ability of health professionals to translate training into action both requires structural support…in the form of resources and time allocated, and techniques, encouragement and empowerment strategies."**
>
> **(Johansen et al 2013)**

There have been several interventions targeting health professionals to build their capacity to identify, treat complications and recruit them as change agents. Health providers play a key role in providing community outreach such as school programs and public health education programs. Although healthcare training for treating FGM/C complications was found to be poor (WHO 2011), evaluations conducted with health professionals after FGM/C training showed increased knowledge about the topic and a willingness to conduct community outreach to stop the practice (Johansen et al 2013).

The main activities of the 'chain approach', a prevention program conducted in the Netherlands (EIGE 2013) included the training of professionals and key persons from at-risk communities to promote their skills in conducting outreach and information sessions. The rationale behind the program was that if a chain approach is organised, all actors from prevention to prosecution should be trained and there should be no gap in the chain. The pilots implemented for the program invested heavily in building the capacity of professionals, which resulted in healthcare professionals reaching the target group.

The main challenge in this area is the quality of training and education materials. Training reviews of curricula submitted by program staff and health providers suggest that training programs need to provide specific and tailored FGM/C information that could be understood by communities with whom they work with (WHO 2011.).

Legal Measures

"Debate on the efficacy of legislation banning FGM/C has been largely overtaken by a growing consensus that laws should be one set of interventions by governments to support a social movement towards its elimination."

(UNICEF 2013)

Legal measures can create an enabling platform for advocacy to decrease support.

Twenty-four of the 29 countries where FGM/C is concentrated (mainly countries in the African continent and the Middle East, and excluding South Africa and Zambia) have prohibited FGM/C by law or constitutional decree. Legislation prohibiting FGM/C has also been adopted in 33 countries to protect children from practising countries (UNICEF 2013). In Australia, FGM/C is a crime under state-based law in every state and territory.

Legal measures can act to discourage FGM/C. However, especially in communities that have broad support for FGM/C, the practice may encourage some to go underground. If health complications do arise as a result of illegal practice, there may be fear of seeking healthcare. To guard against such scenarios, measures should be viewed broadly and include reforms necessary to promote women's rights and that will complement efforts in other social spheres (UNICEF 2013; Centre for Reproductive Rights 2006; Rahman & Toubia 2000).

One of the key findings of the Program for Appropriate Technology in Health (PATH) review was anti-FGM legislation, which acted as an important support for project activities (Muteshi & Sass 2005). Importantly for the Australian context, the review noted that loop holes and poor enforcement

could erode the effect of legislation and pave the way for the medicalisation of FGM/C. The ongoing ambiguity between the legal practice of female genital cosmetic surgery in Australia and the illegal practice of FGM/C is one area that requires further attention.

Alternative Rituals

> **"Alternative rites have been found to be effective to the extent that they foster a process of social change by engaging the community at large, as well as girl, in activities that lead to changing beliefs…"**
>
> **(WHO 2008)**

The development and implementation of alternative rituals or rites of passage across parts of Africa have shown promising results. Community-based interventions in Kenya resulted in girls' increased knowledge of reproductive health and decreased support for the practice (Johansen et al 2013). The intervention involved a period of secluded training aimed at empowering young girls to take charge of their sexual and reproductive health and concluded in a public celebration.

In a migration context, the importance of alternative rituals as an approach can reinforce the cultural dignity of the community because FGM/C is strongly linked to culture and preservation of ethnic and cultural identity. The promotion of alternative rituals should therefore be seen as part of a collective effort to eliminate FGM/C that treats women who have undergone the procedure with respect and provided with the support and resources needed for cultural change. Failure to acknowledge the role that alternative rituals can play may further stigmatise women who have been subjected to FGM/C.

Summary of Findings

Current literature suggests that addressing FGM/C is a long-term process and no single approach can eliminate the practice. Although there are many ways of approaching FGM/C, addressing the issue within a human rights frameworks should ensure greater government and community involvement in the protection of girls' and women's rights. However, despite the diversity and specificity of efforts across various levels, there are some approaches that are better received within practising communities than others. Community-based approaches to the elimination of FGM/C, which are grounded in culturally informed dialogue with the communities involved have shown to have the most promising results (see Appendix: Summary of Relevant Literature).

Globally, the evidence also points to the significance and efficacy of approaches that place women's empowerment at the centre of advocacy and prevention efforts. FGM/C needs to be understood as a human rights and women's health issue. Prevention education should be delivered in a holistic, community-based, culturally sensitive, sexual and reproductive health context, rather than one of violence against women and girls.

With regard to community level strategies, best practice elements and approaches[2] to the prevention and abandonment of FGM/C include:

1. **Community engagement and leadership**: aiming for permanent social and cultural transformation by encouraging community engagement and ownership of the issues, involving all members of the community across all ages, and including men. Specific strategies include the employment of professional peer educators.

2. **Women's empowerment**: prioritising the self-empowerment of women and girls through investment in awareness raising and increased decision-making power for women, including improved access to formal education and economic empowerment, combined with building broader community consensus for women's and girls' rights.

3. **Holistic and integrated education**: promoting elimination through a sexual and reproductive rights agenda, which addresses FGM/C as part of a holistic approach to improving girls' and women's health and wellbeing. Specific strategies include the use of peer health educators to ensure a gendered, cultural and/or generational understanding of the issues.

4. **Cultural dignity**: promoting 'change from within' through a holistic, culturally sensitive, participative approach that avoids stigmatising communities. This includes the recognition that maintaining rites of passage is important in immigrant and refugee communities.

5. **Collaboration**: taking a coordinated approach to information sharing about differences among population groups within and across national borders is essential.

6. **Capacity- building of relevant professionals:** building the capacity of health professionals and other key personnel to respond appropriately and act proactively to FGM/C.

7. **Research and Evaluation**: developing comprehensive evaluation frameworks and documenting and distributing the results can increase the reach and effectiveness of resources and best practice initiatives.

2 The implications of these on health promotion and education for FGM/C affected communities can be found in Chen, J. & Quiazon, R. (2014) 'National Education Toolkit for FGM/C Awareness (NETFA): Best Practice Guide for Working with Communities Affected by FGM/C', MCWH: Melbourne.

Bibliography

International

Amnesty International Ireland (2013) 'End FGM European Campaign', Accessed 6th November http://www.endfgm.eu/content/assets/ENDFGM_Where_do_we_standinEurope_June2013_light_with_links.pdf

Barret, H., Brown, K., Beecham, D., Otoo-Oyortey, N., and Nalie, Z. (2011) *Pilot Toolkit for Replacing Approaches to Ending FGM in the EU: Implementing Behaviour Change with Practising Communities,* Coventry University (REPLACE), Coventry.

Bentzen, T. and Talle, A. (2007) The Norwegian International Effort Against Female Genital Mutilation, Norad, Norway.

Bodiang, C. (2001) *Female Genital Mutilation an issue for Swiss Agency for Development and Cooperation, (SDC)* SDC, Basel.

Behrendt, A. (2011) Listening to African Voices: Female Genital Mutilation/Cutting among Immigrants in Hamburg: Knowledge, Attitudes and Practice, Plan (February).

Centre for Reproductive Rights (2006) *Female Genital Mutilation A Matter of Human Rights: An Advocates' Guide to Action,* Centre for Reproductive Rights, N.Y.

The Donors Working Group (2010) Platform for Action towards the abandonment of Female Genital Mutliation/Cutting (FGM/C): A matter of gender equality

European Institute for Gender Equality (2013) *Female Genital Mutilation in the European Union and Croatia—Report*, EIGE, Luxembourg.

European Institute for Gender Equality (2013) *Good Practices in Combating Female Genital Mutilation,* EIGE, Luxembourg.

Foundation for Women's Health Research and Development (FORWARD) (2010) *Women's Experiences, Perceptions and Attitudes of Female Genital Mutilation—the Bristol Peer Study,* Forward, UK.

International Organisation for Migration (2008) Supporting the Abandonment of Female Genital Mutilation in the Context of Migration.

IPU, IOM, IACTP, AHWC, DIG (2009) How to put an end to the practice of Female Genital Mutilation (FGM) Panel discussion report (6 February 2008).

Leye, E., Bauwens, S. and Bjälkander (2005) *Behavior Change towards Female Genital Mutilation: Lessons Learned from Africa and Europe,* EuroNet-FGM .

Momoh, C. (*2005*). FGM and issues of gender and human rights of women. In *Comfort Momoh* (ed), Female Genital Mutilation, Radcliffe Publishing Ltd, Oxford.

Muteshi J. and Sass J. (2005) *Female Genital Mutilation in Africa: An Analysis of Current Abandonment Approaches*, PATH, Nairobi.

Options UK (2013) *Tackling Female Genital Mutilation in the UK: What Works in Community-based prevention work—Report,* Options UK, London.

The Public Policy Advisory Network on Female Genital Surgeries in Africa (2012) 'Seven Things to Know about Female Genital Surgeries in Africa', *Hastings Centre Report*, no.6, pp. 19-27.

Tostan (2013) *Tostan: Community-Led Development*, Brochure, Tostan, Senegal.

UN Commission on Human Rights (1994) 'Plan of action for the Elimination of Harmful Traditional Practices affecting the Health of Women and Children', U.N. Doc. E/CN.4/Sub.2/1994/10/Add1, July 22, Accessed June 10, 2009, paras 9-12 http://www.unhchr.ch/Huridocda/Huridoca.nsf/(Symbol)/E.CN.4.Sub.2.1994.10.Add.1En?Opendocument

UNICEF (2013) *Female Genital Mutilation/Cutting: A statistical overview and exploration of the dynamics of change*, UNICEF, NY.

UNFPA (2011) Global Consultation on Female Genital Mutilation/Cutting—Technical Report, UNFPA: N.Y.

UNFPA-UNICEF (2012) Joint Program on Female Genital Mutilation-Cutting: Accelerating Change Annual Report 2012, UNFPA-UNICEF.

UNICEF (2008) Changing a Harmful Social Convention: Female Genital Mutilation/Cutting, UNICEF, Florence.

World Health Organisation (2011) Female Genital Mutilation Programs to date: what works and what doesn't—Policy Brief, WHO/RHR/11.36, WHO, Geneva.

World Health Organisation (2014) Female Genital Mutilation: Fact Sheet No. 241 (updated February 2014), WHO, Geneva.

World Health Organisation (2011) An Update on WHO's Work on Female Genital Mutilation: Progress Report, WHO, Geneva.

World Health Organisation (2008) Eliminating Female Genital Mutilation: An Interagency Statement UNAIDS, UNDP, UNESCO, UNFPA, UNHCHR, UNHCR, UNICEF, UNIFEM, WHO, World Health Organisation, Geneva.

National

George, L. (2011) *Bilingual Community Workers Training November –December 2010—Report,* North Parramatta, New South Wales Education Program on FGM.

Momoh, C. (2013) *A Report on the National Female Genital Mutilation Summit*, Accessed 6th November 2013 http://www.health.gov.au/internet/main/publishing.nsf/Content/report-fgms

Multicultural Centre for Women's Health (2013) *Female Genital Mutilation/Cutting*, Position Paper, MCWH, Melbourne.

Multicultural Centre for Women's Health (2012) *Elimination of FGM: what works,* Fact Sheet 1, MCWH, Melbourne.

Vaughan, C., White, N., Keogh, L. Tobin, J., Ha, B., Ibrahim, M. & Bayly, C. (2014) *Listening to North Yarra Communities about Female Genital Cutting*, The University of Melbourne, Melbourne.

Academic

Allotey, P., Manderson, L. and S. Grover (2001) 'The Politics of Female Genital Surgery in Displaced Communities', *Critical Public Health*, 13 (3), pp. 189-201.

Berg, R. and Denison, E. (2012) 'Effectiveness of Interventions Designed to Prevent Female Genital Mutilation/Cutting (FGM/C): A Systematic Review Of The Best Available Evidence', *Studies in Family Planning*, 43(2), pp. 135–146.

Brown, K., Beecham, D., and Barrett, H. (2013) 'The Applicability of Behaviour Change in Intervention Programs Targeted at Ending Female Genital Mutilation in the EU: Integrating Social Cognitive and Community Level Approaches', *Obstetrics and Gynaecology International*, 2013, Article ID 324362, 12 pages.

Elgaali, M., Strevens, H. and Mårdh, P. (2005) 'Female genital mutilation-an exported medical hazard', *European J. of Contraception and Reproductive Healthcare*, 10.2, pp. 93-97.

Essen, B. and Johnsdotter, S. (2004) 'Female Genital Mutilation in the West: Traditional Circumcision versus Genital Cosmetic Surgery', *Acta Obstatrica et Gynecologica Scandinavica*, Vol. 83, pp.611-613.

Gunning, I. (1992) 'Arrogant Perception, World-Travelling and Multicultural Feminism: The Case of Female Genital Surgeries, *Columbia Human Rights Law Review,* 23 pp. 189-248.

Johansen, R.E.B., Nafissatou, J.D., Laverack, G. and Leye, E. (2013) 'What works and What Does Not: A Discussion of Popular Approaches for the Abandonment of Female Genital Mutilation', *Obstetrics and Gynecology International,* 2013, Article ID 348248, pp. 1-10.

Johansen, R.E.B., Diop, N.J., Laverack, G. and Leye, E. (2012) 'What works and What Does Not: A Discussion of Interventions for the Abandonment of Female Genital Mutilation', *Community Medicine and Health Education*, 2:5.

Johnsdotter, S. and Essén, B. (2010) 'Genitals and Ethnicity: the politics of genital modifications', *Reproductive Health Matters*, 18 (35), pp.29-37.

Johnsdotter, S., Moussa K., Carlbom A., Aregai R., Essén B. (2009) 'Never My Daughters: A Qualitative Study Regarding Attitude Change Toward Female Genital Cutting Among Ethiopian and Eritrean Families in Sweden', *Health Care for Women International*, 30.1-2, pp. 114-133

Knight, R., Hotchin, A., Bayly, C. & Grover, S. (1999) 'Female Genital Mutilation-Experience of The Royal Women's Hospital, Melbourne', *Australian and New Zealand journal of obstetrics and gynaecology,* 39.1, pp. 50-54.

Mathew, B. (2011) 'Female Genital Mutilation: Australian Law, Policy and Practical Challenges for Doctors, *Medical Journal of Australia*, Vol. 194 (3), pp. 139-141. Accessed 10th December 2012. https://www.mja.com.au/journal/2011/194/3/female-genital-mutilation-australian-law-policy-and-practical-challenges-doctors

Morison, L.A, Dirir, A., Elmi S., Warsame, J. & Dirir, S. (2004) 'How Experiences and attitudes relating to female circumcision vary according to age on arrival in Britain: a study among young Somalis in London', *Ethnicity and Health*, 9:1, 75-100.

Ní Mhórda, M. (2007a) *Female Genital Cutting, Human Rights and Resistance: A Study of Efforts to End the 'Circumcision' of the Women in Africa,* Working Paper No.21 , Research School of Pacific and Asian Studies, The Australian National University.

Ní Mhórda, M. (2007b) *Female Genital Cutting: traditional practice or human rights violation? An exploration of interpretations of FGC and its implications for development in Africa*, Participatory Development Working Papers No 07/01, January, The Australian National University.

Toubia, N.F.F. and Sharief, E.H. (2003) 'Female Genital Mutilation: have we made progress?', *International Journal of Gynecology and Obstetrics,* pp. 251-261.

Rahman, A. and Toubia, N. (2000), Female Genital Mutilation: Guide to Laws and Policies Worldwide, Zed Books publishing Ltd., UK.

Thierfelder, C., Tanner, M. and Bodiang, C. (2005) 'Female genital mutilation in the context of migration: experience of African women with the Swiss health care system', *The European Journal of Public Health*, 15.1, pp. 86-90.

Appendices

Appendix: Summary of Relevant Literature

Title	Summary	Key Findings, Lessons Learnt and/or Best Practices	Geographic Coverage	Related Links / Documents
Behrendt (2011): Listening to African Voices—FGM/C among Immigrants in Hamburg: Knowledge, Attitudes and Practice	This Plan Germany publication reports on research conducted with immigrants from Sub-Saharan Africa living in Germany The research sought to gather first-hand information on how the immigrant populations feel about and deal with FGM/C.	• Priority should be given to immigrants with a strong need for intervention • Integration of networking and advocacy activities can the increase impact of interventions • Consult, work with or invite community associations to take the lead on implementation of community activities • Community activities can be directed through information exchange hubs (e.g. ethno-specific shops, restaurants, hairdressers etc.)	Hamburg, Germany	Listening to African Voices—FGM/C among Immigrants in Hamburg: Knowledge, Attitudes and Practice
Bentzen and Talle (2007): The Norwegian Government's Action Plan for Combating FGM	This report presents an overview of the Norwegian Government's efforts to support the abandonment of FGM/C in six partner countries. The study, conducted by the Norwegian Agency for Development Cooperation	• Include a rights-based focus • Community-based or integrated socioeconomic development approaches are the most effective • Adopt a holistic approach • Involve communities to instil ownership	Eritrea, Ethiopia, Kenya, Somalia/Somaliland Sudan and Tanzania	The Norwegian International Effort Against FGM Report

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	(Norad), outlines means and ways of support; important actors and activities; lessons learned and knowledge gaps.	• Activities must be voluntary and participatory		
Centre for Reproductive Rights (2006): FGM A Matter of Human Rights—An Advocate's Guide to Action	This practical guide, which is based on the book 'FGM: A Guide to Laws and Policies Worldwide', is aimed at assisting advocates to engage their governments. It includes recommendations for governments of both African and receiving countries.	• Invoking human rights standards can hold governments accountable • NGOs working at the community level are the most effective in undertaking awareness and outreach programs • Governments should work with community-based immigrant NGOs in creating and implementing education programs • Governments should ensure that immigrant women are able to make informed choices about their own bodies	Global	FGM A Matter of Human Rights—An Advocate's Guide to Action Female Genital Mutilation: A Guide to Laws and Policies Worldwide, Rahman and Toubia (eds), Zed Books: UK (2000)

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European Institute for Gender Equality (EIGE): Good Practices in Combating FGM (2013)	This publication presents good practices identified during the implementation of the 'Study to Map the Current Situation and Trends of FGM in 27 EU Member States and Croatia' conducted by the EIGE. Practices identified are presented according to: prevalence; prevention; protection; prosecution; provision of services and partnerships.	In relation to prevention: • Adopt a cross-sectoral, collaborative, integrated approach ('the chain approach') • Involve migrants form FGM/C practising communities • Train professionals and key personnel from relevant communities • Pilot test activity Remunerate well key personnel to prevent high staff turnover	27 European Union Members States and Croatia (Note: the 'prevention' case study was conducted in the Netherlands)	Good Practices in Combating FGM FGM in 27 EU Member States and Croatia Report
Foundation for Women's Health Research and Development (FORWARD) (2010): Women's Experiences, Perceptions and Attitudes of FGM—The Bristol PEER Study	This report outlines research conducted in 2008 with women from countries with high FGM/C prevalence rates living in Bristol, UK. The research was conducted through a Participatory Ethnographic Evaluation and Research (PEER) method.	• Encourage women's self-empowerment, including the provision of a safe space for dialogue • Ensure community support to any efforts being carried out • Raise awareness through 'community champions' and engaging with men	U.K	Women's Experiences, Perceptions and Attitudes of FGM—The Bristol PEER Study

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Title	Summary	Key Findings, Lessons Learnt and/or Best Practices	Geographic Coverage	Related Links / Documents
		• Listen to community needs and find meaningful and constructive forms of engagement		

Johansen et al (2013) Review Article:
 	
What Works and What Does Not: A Discussion of Popular Approaches for the Abandonment of FGM
	This article discusses seven of the most common approaches that have undergone some form of evaluation.	• Community-based empowerment models are best, which should be informed by, or include the following:
		  ○ Sufficient planning and adjustment to local context;
		  ○ Well-trained individuals
		  ○ A comprehensive education package and a supportive context;
		  ○ Interventions have to be long-term
		  ○ Interventions are broad-based and integrated
			Global	What Works and What Does Not: A Discussion of Popular Approaches for the Abandonment of FGM
				
				What Works and What Does Not: A Discussion of Interventions for the Abandonment of FGM
				
				FGM programs to date: what works and what doesn't—WHO Policy Brief (WHO/RHR/11.36)

Leye, Bauwens and Bjalkander (2005): Behaviour Change Towards FGM: Lessons Learned from Africa and Europe	This report, written in collaboration with the European Network for the Prevention of FGM/C (EuroNet-FGM), examines information, education, and communication	• A process of listening and dialogue ('intergenerational dialogue') is crucial to enable personal and cultural development	Africa and Europe	Behaviour Change Towards FGM: lessons learned from Africa and Europe

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	(IEC) activities conducted in Africa and Europe. Research conducted for the report found that well-designed IEC activities, although essential steps to abandonment, do not by themselves stop the practice of FGM/C. The report presents best practices and essential elements of community based interventions that have been successful in changing behaviour.	• Work at the community level is critical to reach sustainable behaviour • An integrated approach within a broader program of community empowerment (e.g. sexual and reproductive health) is likely to be more successful • Appropriate and fully-trained personnel is vital • Include monitoring bodies at the community level to ensure ownership and maintain sustainability		
Options UK (2013) Evaluation Report: Tackling FGM in the UK: What Works in Community-based Prevention Work	This report presents the findings of the FGM Initiative established by three independent charitable organisations: Trust for London; the Esmée Fairbairn Foundation and Rosa, the UK Fund for Women and Girls.	• Rejection of FGM/C increases with community-based prevention work • Working with younger women could be more effective • Religious leaders should be used to confront misconceptions • Prevention requires multiple stakeholders	UK	Options UK (2013) Evaluation Report: Tackling FGM in the UK: What Works in Community-based Prevention Work

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	The first phase (2010-2012) invested approximately £1 million in community-based organisations across the UK. The second phase began in 2013 (to 2016).	• A coordinated, integrated and resourced local response is essential when working with community groups		
Anika Rahman and Nahid Toubia (2000): Female Genital Mutilation: A Guide to Laws and Policies Worldwide	This book is a report on the use of law and policy to address FGM/C in 41 countries. It reports on the prevalence and governmental measures for eradication in each country, including Australia.	• FGM/C should be characterised as a violation of the human rights of women and girls • Activities should be guided by an awareness of lessons learned thus far • Governments must adopt a multi-strategy approach	Global	Female Genital Mutilation: A Guide to Laws and Policies Worldwide FGM A Matter of Human Rights—An Advocate's Guide to Action
REACH (the Reproductive, Educative and Community Health) Project	This UNFPA-supported project has been carried out in partnership with the Sabiny Elders Association since 1996. An evaluation conducted 15 months after the project was launched found that cutting had been reduced by 36%. In 2002, out of 12,000 potential	• Involve local communities in project design and to instil a sense of ownership • Reinforce cultural dignity of the community • Recruit an 'ally group' such as peer educators and local project managers • Use a non-prescriptive approach	Uganda	UNFPA Lessons from the Field: Culturally Sensitive Approaches

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Title	Summary	Key Findings, Lessons Learnt and/or Best Practices	Geographic Coverage	Related Links / Documents
	candidates, just over 5% were subjected to cutting in a district that once had a by-law making FGM/C compulsory for all women.	• Provide evidence-based information to enable informed choice • Publicise successes		
Tostan Community Empowerment Program	This 3-year, UNICEF-supported education program includes community-led outreach strategies that engage program participants. Since its inception in 1991, over 6,500 communities from eight countries have publicly declared abandonment of FGC/C and child/forced marriage.	• Adopt a community-led approach to social change • Deliver a holistic, human-rights based education program • Implement an 'organised diffusion' strategy to encourage participants to use their existing social networks • Engage in regular dialogue with communities • Use local radio programs in-language to accelerate the spread of information	Offered in 22 languages in eight African countries: Djibouti, Guinea, Guinea-Bissau, Mali, Mauritania, Senegal, Somalia and The Gambia	Tostan Website
UNFPA Global Consultation on FGM—Technical Report (2008)	This report outlines the findings of consultations conducted with global experts and practitioners in 2007. It includes global trends,	• Integrate activities into community reproductive health education • Adopt a comprehensive approach to programming, including reproductive health rights	Global	Global Consultation on FGM—Technical Report

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Title	Summary	Key Findings, Lessons Learnt and/or Best Practices	Geographic Coverage	Related Links / Documents
	changing patterns and practices, and identifies lessons learned and best practices in abandonment of FGM/C.	• Use approaches directed towards gender equality and human rights • Work on facilitation rather than 'expert' intervention • Promote positive cultural aspects • Work and build partnerships with all stakeholders • Engage boys and men • Focus on participation of women and girls • Emphasise participation of youth • Support staff • Conduct research		
UNFPA-UNICEF Joint Program on Female Genital Mutilation-Cutting (2012)	Since 2008, this program has worked towards ending FGM/C in one generation in partnership with other UN Agencies, cooperation/development partners and NGOs.	• Adopt a holistic, human rights-based approach • Engage local communities • Design activities to empower communities, girls and women • Identify and foster new and existing partnerships with religious groups and other organisations and institutions	Burkina Faso, Djibouti, Egypt, Eritrea, Ethiopia, The Gambia, Guinea, Guinea Bissau, Kenya, Mali, Mauritania, Senegal, Somalia Sudan and Uganda	UNFPA-UNICEF Joint Program on Female Genital Mutilation-Cutting: Accelerating Change Annual Report 2012

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Title	Summary	Key Findings, Lessons Learnt and/or Best Practices	Geographic Coverage	Related Links / Documents
		• Integrate and expand abandonment into reproductive health policies, planning and programming		
UNICEF—Female Genital Mutilation: A Statistical Overview and Exploration of the Dynamics of Change (2013)	This report provides a comprehensive statistical overview of practice prevalence. Analysis of the data is informed by policy, programmatic and theoretical evidence.	• National plans need to consider the diversity and specificity of ethnicity or other characteristics • Shifts in individual attitudes do not automatically lead to behaviour change • A collective, community approach is required to shift social norms • Facilitate dialogue between and within girls and boys, women and men to increase engagement at all levels of society Frame abandonment as a way to attain positive values (not as a criticism of local culture)	29 countries where the practice is concentrated	Female Genital Mutilation: A Statistical Overview and Exploration of the Dynamics of Change
UNICEF—The Dynamics of Social Change:	This research report by UNICEF Innocenti Research Centre examines the social dynamics of the abandonment of FGM/C in	• Address FGM/C within broader framework of human rights, social justice and community development	Egypt, Ethiopia, Kenya, Senegal and Sudan	The Dynamics of Social Change: Towards the Abandonment of Female Genital Mutilation/Cutting in Five African Countries

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Towards the Abandonment of FGM in Five African Countries (2010)	five African countries and seeks to inform policies and programs aimed at ending the practice, including in countries of migration.	• The role of communities and expanded networks needs to be the main focus of analysis • Engage respected community members • Provide communities with information from credible sources • Provide communities with possibilities to reflect and discuss • Reinforce positive aspects of local culture • Engage the media to promote social change • National responses are most effective when tailored to grass-roots level efforts • Legislation reform must be part of a broader reform process • Develop links beyond national borders		Changing a Harmful Social Convention: FGM (2008)
Vaughan et al (2014) Listening to North Yarra Communities About FGC	This report summarises the findings from a community-based research project conducted by the University of	• Need to recognise, and community-led change	Victoria, Australia	Listening to North Yarra Communities About FGC Report

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	Melbourne, the Royal Women's Hospital and North Yarra Community Health, in conjunction with members of the Ertirean, Hararian, Oromo, Somali and Sudanese communities.	• Public discussion of FGC should reflect the complexity and diversity of the issues • Highlight the importance of community workers to community engagement		
WHO: Eliminating FGM—An Interagency Statement	This is an updated statement of the 1997 Joint Statement on FGM issued by UNFPA, UNICEF and UNFPA. The statement aims to support advocacy for the abandonment of FGM/C and is based on new evidence and lessons learnt over the past decade	• Multisectoral, multilevel action is needed • Sustained action is essential to lasting impact • Programs should be community-led • Build programs on human rights and gender equality • Empowerment of girls and women is of key importance • Strategies should be non-judgmental and non-coercive	Global	WHO: Eliminating FGM—An Interagency Statement An Update on WHO's Work on FGM—A Progress Report 2011
WHO Policy Brief (2011) FGM programs to date: what works and what doesn't	The brief reports on results from a review of FGM/C Programs in WHO countries within the African and Mediterranean Regions,	• Coordination between NGOs and governments is crucial • Behavioural change interventions (as opposed to awareness raising) at the community level are successful	African and Mediterranean Regions	FGM programs to date: what works and what doesn't—WHO Policy Brief (WHO/RHR/11.36)

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	which was conducted in three phases: i) a literature review of all anti-FGM program documents; ii) development and distribution of a questionnaire to 365 organisations (102 were completed); and iii) five country assessments of strong, well-established programs.	• Training should be provided at all levels of the intervention • Consistent post-evaluation programs (internal and external) need to be in place • Research on effective interventions needs to be conducted	(The final phase of the review included five country assessments: Burkina Faso, Egypt, Ethiopia, Mali and Uganda)	

Appendix: Best Practice Map