Interventions to reduce FGM in African countries. Do they work?

A Campbell Collaboration interview with Rigmor Berg
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In our second interview, Rigmor Berg discusses the Campbell Systematic Review she co-authored with Eva Denison – Interventions to reduce the prevalence of Female Genital Mutilation/Cutting in African countries. The interview is also available on YouTube.

Question 1

The review you wrote with Eva Denison focused on interventions to reduce Female Genital Mutilation (FGM) in Africa. Could you tell us what FGM is and about the scale of this problem?

FGM is the cultural practice of modifying women’s genitalia, in most cases cutting off parts of the external female genitalia.

A recent UNICEF report indicated that around 140 million girls and women alive today have undergone FGM. It’s estimated that about 3 million girls are at risk each year of undergoing the practice.

FGM is concentrated in a band of 27 African countries, stretching from the Atlantic Coast to the Horn of Africa, and to Iraq and Yemen in the Middle East. The prevalence of FGM is particularly high in Somalia, Guinea and Egypt. In those countries, over 90% of all girls and women undergo FGM.

Question 2

What questions did you and Eva set out to address in the review?

Efforts to end FGM have relied on two arguments. The first is that FGM is a violation of women’s human rights. The second is that it involves physical and mental harm. Intervention efforts to reduce the extent of FGM have been initiated in many areas of the African countries where the practice is concentrated.

What we found was that there were no systematic reviews examining the effectiveness of interventions within a perspective of context and explanation of success, or lack of success.

Eva and I decided to conduct a realist review to examine the effectiveness of FGM prevention programmes and identify which factors facilitate and hamper the success of such programmes.
Question 3

What were the key findings of this review?

We identified and included 8 controlled effectiveness studies, and 27 additional studies that could help to explain the relative success of the interventions. Unfortunately, this means that we could only to a small extent conclude how factors related to the abandonment of FGM help to explain the effectiveness of the interventions.

But we found that there were possible advantageous developments as a result of these FGM prevention efforts. We found that all of the interventions were based on a theory that the dissemination of information improves the way people think about FGM, and that the success of these interventions depends on different contextual factors.

We found, for example, that in contexts or areas where FGM and Islam are closely related, the failure to involve religious leaders and base the programme on the receiving community’s needs and wants led to low programme attendance as well as a high drop-out.

Question 4

You noted that there’s a shortage of information and research about FGM interventions. Does that affect the choices policy makers need to make?

Yes. In two ways. On one hand, it means that policy makers who are doing FGM-related work have a tougher time deciding on which intervention programmes to prioritise. If there’s a shortage of high quality data on which to make policy decision, that’s a problem. On the other hand, you could argue that a lack of data is going to encourage policy makers to push for more and better research in this area. I’d argue that, in the long-term, this could lead to the building of a more solid research base for their policy decisions.

Question 5

How does one measure the success of interventions to reduce FGM prevalence? Do interventions need, for example, to take place over a long time in order to detect change? I wondered as well if you could speak about how one can gain the trust of communities practising FGM?

FGM is a challenging subject to research. One reason for this is that it’s a deeply entrenched, highly valued tradition among certain ethnic groups. Girls and families conforming to the practice acquire social status, respect and community membership. Others argue that the practice violates women’s rights and carries too many health risks to be justified.

In other words, while FGM is a centuries-old practice and one that many people wish to continue, it’s also a practice that a lot of people want to see abandoned. When it comes to investigating the effectiveness of abandonment programmes, researchers must consider the ideological contestation of the practice of FGM and must be aware of this.

The most trustworthy evidence that an FGM abandonment programme is effective is that a community has stopped FGM – in other words, that there are fewer or no girls undergoing FGM. If you’re going to measure such a change inside a community, a study is going to have to collect data over many, many years.

“The failure to involve religious leaders and base the programme on the receiving community’s needs and wants led to low programme attendance as well as a high drop-out.”
Evidence of change towards abandonment can also be detected, or at least signalled, by examining people’s intentions to continue the practice and their attitudes towards the practice. Peoples’ intentions and attitudes say something about the likelihood of them behaving in a certain way.

It’s absolutely essential to gain the trust of the communities in which one is seeking change in FGM practice. Firstly, it’s logical that people are going to be more inclined to listen to what you have to say if and when they trust you.

Secondly, in our systematic review we found that the programmes that had project staff – or that were implemented by an organisation that was trusted by the target communities – it was those programmes that were more accepted by communities. The programmes tended to achieve better results compared to those that did not have the trust of communities.

How does one gain trust? There are many possible ways to achieve this, but a precondition of complex health programmes involving behaviour changes is the need to gather appropriate and enough data to inform the development of a programme. One needs to know that a programme fits or matches a target community’s characteristics.

What I’m saying, I guess, is that thorough programme planning is essential if one is going to learn and understand what will create trust. What’s critical for building trust in one community might not be critical in another community.

In our Campbell Systematic Review, we found that a lack of knowledge and understanding of the target groups’ key features or characteristics was related to how much trust was achieved.

Interventions embedded in existing reproductive health projects – for example, those that were implemented by locally trusted agencies that appeared to be ‘neutral’ – it was those interventions that experienced fewer problems and were more successful.

In essence, it’s a researcher’s knowledge of a target community that can help to ensure a good fit between an intervention and the characteristics of the target community. We would argue that ways of establishing trust should be part of a rigorous programme planning phase.

**Question 6**

This review used a ‘realist synthesis’ methodology. What is a realist review and why did you and Eva decide to use this approach when studying the subject of FGM?

A realist synthesis or realist review is a relatively new way of conducting systematic reviews. It’s a theory-driven approach and its working assumption is that a particular intervention triggers particular mechanisms of change. Mechanisms may be more or less effective in producing their intended outcomes, depending on their interaction with various contextual factors.

The interactions are called “context-mechanism-outcome” configurations. In other words, realist reviews seek to answer questions about which mechanisms are causing which outcome under which circumstances.

A realist review has an explanatory focus. It takes context into consideration – and tries to explain – what makes certain programmes work or fail in a specific setting. Reviews based on a realist perspective can use studies based on both qualitative and quantitative data.

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They review the results of previous studies and by doing so, can identify, articulate, test and refine programme theories.

We decided to use this methodology because we believed that the effectiveness of FGM abandonment programmes was likely to be highly context dependent. We also believed that examining the relevance of the interventions would allow us to learn about the conditions needed for FGM abandonment programmes to work.

By arriving at some answers about what factors are important for FGM abandonment programmes to be successful, we also believed that our review would be more useful for other researchers, funders and decision makers.

**Question 7**

**Would you say that you’re positive about what has been achieved so far? Should we be optimistic about what can still be achieved in reducing the prevalence of FGM?**

Change in the practice of FGM is slow. That must be acknowledged. But I’d say that there are reasons to be optimistic that fewer girls will undergo FGM in the next generation.

The issue is gaining international awareness, and there’s also quite a lot of research being conducted. Survey results also indicate a decline in prevalence in some countries. UNICEF’s latest estimates from those countries that have surveyed the prevalence of FGM more than once, show a dramatic decline in prevalence. In the Central African Republic, for instance, FGM prevalence has dropped from 43% in 1994-1995 to 24% in 2010.

FGM prevalence has also declined in countries such as Kenya, Eritrea and Mali. With sustained efforts and appropriate abandonment programmes, I think we’re moving towards a time when fewer girls will be at risk of undergoing FGM.
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