Conference report:
« Preventing Female Genital Mutilation in hard to reach communities »

Friday 26th of April 2019 – Brussels

There are many stereotypes concerning FGM, often seen as an act only practice by the Sub-Saharan communities, Muslim communities or communities with low social status.

As an actor in the fight against FGM, it's important to **deconstruct these stereotypes** in order to show that we are all concerned by this issue, no matter where we live. Indeed, everyone can be caused to be in contact with persons concerned by FGM. In this sense, it's important to ask ourselves:

⇨ *Are we inclusive enough? Are we making efforts to reach the unrepresented communities?*

Because it's up to us to go meet these communities in order to have **a global and inclusive approach**, hence the implementation of this project to **improve our practices** and **work with all communities concerned** by FGM. The aim of this conference was precisely to **overcome barriers** between communities and support services (psycho-social-medical) to improve FGM prevention and care:

- What do we mean by 'Hard to reach'? What barriers do some communities face in accessing services?
- What are the consequences of not working with certain communities affected by FGM?
- Understanding FGM in different contexts: examples on Iraqi Kurdistan, the Bohra community (India), and Egypt.
- Sharing good practices on current work with FGM affected communities, such as:
    - People who are temporarily in the country (transmigrants)
    - People who speak languages for which there are no accessible translators
    - People from communities who are not known by specialized services

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Panel 1. What defines 'Hard to reach'? / Which are the barriers for reaching communities affected by FGM?

Today, it's necessary to take the necessary measures so that no girls are at risk of FGM. Since FGM is a **global practice** not limited to one country or religion, it is necessary to work with **all communities affected** by this practice.

The purpose of this first panel was to discuss of "hard-to-reach" communities, and of limits faced to approaching them.

⇨ *What do we mean by « hard to reach »? Are we the ones who fail to establish the necessary communication with communities? Are we the ones who are not doing enough or are there real obstacles to reaching certain communities?*

1. Is the term « hard to reach » appropriate?

Language is not only a means of communication: it also creates new realities. Thus, we have to be careful of the language used to talk about communities affected by FGM. The term "hard to reach" has a **negative connotation**, and by using this term, we label them and marginalize them even more. Moreover, it is not the communities that are "hard to reach". In reality, it is the associations and actors on the ground who don't know how to find them. In this sense, it is preferable to speak of "marginalized", "forgotten", or "disadvantaged".

2. What barriers are interfering between actors on the ground and communities affected by FGM?

- The main obstacle is **linguistic.** Indeed, how to approach communities who don't speak the same language? How to free speech and create a relationship of trust? This has many consequences: for example, in the medical setting, **their access to care, and the quality of care provided is lower** (misunderstanding of the dosage of the medicine, difficult to diagnose, transplants refused, chronic disease follow-up difficult, etc.).); in the context of social support, building a relationship based on trust is more difficult.

- The **cultural barrier** is also an issue. It can lead to **misunderstandings**, even **prejudice** and **discrimination**. For example, confusions may be related to nodding (yes / no), which does not mean the same thing depending on the culture. Similarly, the place of women and gender roles differ depending on the societies, and power relations and family structures can be diverse (for example, in-laws sometimes play a key role). The cultural barrier is sometimes so important that there is a stigma internalized by cultural norms.

- The third obstacle is the **social barrier**. These communities often have **low socio-economic status** (although it should not be forgotten that FGM is also practiced in communities with a high social level), and they are already **marginalized and oppressed**. Because of this status, FGM is not necessarily a priority for them (their asylum application, enrolling their children in school, their status is a priority), and FGM "can wait".

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In addition to these main barriers, there are also others, such as age or gender (men are "hard to reach").

3. How can we overcome these barriers?

- **Go to meet communities** where they are and **build a relationship of trust**, give them the floor. We must not wait for the communities to come to us, it's up to us to go to them.
- **Collaborate with interpreters** from the same communities to facilitate exchanges
- **Sensitize** communities and professionals to cultural differences
- **Allocate more capacity and resources** and make existing services more visible
- **Persevere**!

4. Examples of good practices to overcome these barriers

» Focus on a human rights organization: (Solomie Teshome, Finnish League for Human Rights, Finland): It's necessary to reach communities where they are (in churches for example) accompanied by an interpreter from these communities. In order to establish a **relationship of trust**, the way to approach them is essential: it is preferable to adopt an **individual approach**, i.e. to start an individual discussion in order to understand their priorities, their culture and their context. **Be receptive** to the person and **be accepted** is essential to open the discussion. Once this relationship of trust is established, it is better to start the discussion with **topics related to health in general** (since FGM is often not their priority), and then gradually address FGM. Group discussions are then set up, with the presence of a key person from their community.

» Focus on a medical institution (Isabelle Coune, FPS Public Health): In order to overcome these barriers, the FPS Public Health of Belgium funded the presence of **intercultural mediators** and coordinators of intercultural mediation in general and psychiatric hospitals. In 80% of cases, their role is to provide **linguistic interpretation** to facilitate communication between the patient and the practitioner, but they may also be required to **facilitate** and **defend the patient's right**. In this sense, they will solve misunderstandings, do "brokerage culture", encourage the patient to ask questions, defend him in case of discrimination (only with the agreement of his manager), etc. The mediators come from the communities for which they translate, so they understand their culture and language.

⇨ What we need to keep in mind is not the "hard to reach" label, but rather the importance of addressing FGM as a **global issue**, while focusing on **eliminating obstacles** to the fight against FGM.

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Panel 2. Understanding different contexts on FGM and how to work alongside with communities

The purpose of this second panel was to understanding FGM in different contexts, especially in 'hard-to-reach' communities.

1. The context of the Kurdish community

The Kurdish context is unique and difficult, because they lived under fascist regimes and dictatorships, they have experienced **political violence**, and following the Kurdish uprising in 1991, **state violence** reached the homes: honor killings, FGM, other acts of violence. As a result, society wasn't homogeneous and they were divided for a very long time. There were struggles for **recognition and independence**, but the struggle for **recognition of women's rights** was not part of any program. It was not a priority.

Since 2003, the issue of **women's rights** emerges gradually. This was primarily a fight against all types of violence (FGM, honor killings), and **giving women voices**. A shift in attitude has gradually taken place and Kurdish society is now open to debate. The difficulty is that women don't feel listened to, or don't have the language to talk about it.

The Kurdish community in Europe has a different life experience. Once organizations reach them, **trust can be built**. So it is up to organizations to make efforts to reach them.

The context is therefore different in a **society in conflict** than in a western "democracy" with a stable political regime and a rule of law. People are divided and **violence against women** is forgotten. As a result, FGM is not even addressed.

2. The context of the Bohra community

The Bohra community is a small community that is mainly present in India, but whose origin is related to Egypt and Yemen. It is quite different from the Muslim community. Men are dressed in white, while women wear colorful headgear. Women are often more educated than men who take care of the family business (doctor, lawyer ...), while women are the entrepreneurs of the family structure. They enjoy a **privileged position in education and employment.**

It is therefore a high-level social community, but FGM is practiced there at the age of 7, mostly in a medicalized way, and almost all girls undergo it. In most cases, the clitoris is cut (type I). FGM is considered as a **religious practice**, but it is also practiced for hygienic reasons, and to control the sexual desire of women.

WeSpeakOut call for FGM to be banned in India, but the problem is that there is the **agreement of the religious community, as well as the expatriates** who voted against the implementation of a law.

A case was recently argued by WeSpeakOut to the Indian Supreme Court, but the Bohra community **denies the practice** of FGM. In their eyes, they don't practice excision but another intervention: «a symbolic khatna» (note that the term used in India is not excision but female circumcision).

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3. The context of Middle East

FGM is practiced in Kurdistan, but it remains in the private sphere. In the public sphere, this is considered a myth. Religious clergy, village structures, and even **international institutions denied the practice of FGM in Kurdistan**. Important research has been conducted in Kurdistan to prove that it is real.

In recent years, studies have also been conducted on the prevalence of FGM in the Middle East. It shows that FGM is also practiced **in Iran, Afghanistan, Indonesia, Sri Lanka, Malaysia**, in fact wherever research is conducted, which is overwhelming.

Even international institutions deny the existence of FGM, so it is easier for governments to deny it as well. This denial poses many problems: risks of carrying out research, no legislation in the matter, etc.

What strategy for better engagement of these communities?

- **Adopting a strategy adapted to the context** and the community: a European approach will not necessarily work for a Kurdish question for example (example of a hotline that didn't work). Understand the religious, social and political context of communities, **identify key people** and do awareness work. For example, FGM is not a religious practice, but religious leaders may have a role to play; the grandmother often has an important role in the absence of the man.

- **Translate all available literature** into the language of the communities, as well as into Arabic, to facilitate the dissemination of information (indeed, how to know that FGM is not a good practice if information is not available in their language?).

- **Field work** is essential: at the local level, we have to go in districts and villages to discuss with women and men; at the national level, it is necessary to talk about it through the schools (so that the children can then share the information to their parents) : train teachers, distribute brochures, put up posters => **raise awareness**

- **Involve men and older women to change attitudes**, because they are part of the system, and change must come from within.

- **Deconstruct religious beliefs** and try to convince religious clergy to fight against FGM. Show that the Quran does not provide that.

- **Promote dialogue and exchange of knowledge**, especially between the diaspora and the community of origin who have to work in tandem.

- **Establish legislation**, even if it is not enough, and have a very strong position.

- **Be careful about the language used** in order not to label: do not use the same vocabulary as our oppressors

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» Focus on a Middle East NGO (Isis Elgibali, WADI): After seeing the existence of FGM, a campaign was launched with people from different fields (media, schools, villages, other NGOs, network of women lawyers, NGOs specialized on domestic violence) in order to start the discussion. The goal was to motivate people to **take ownership** of the issue and **identify with it**. A petition was also launched, collecting tens of thousands of signatures, and a bill was submitted to the Kurdish government, approved in 2011. Following the failure of the hotline, they started a dialogue with women and practitioners ("excisers"): conclusion of an agreement with payment of a reward for stopping the practice, which worked well.

» Focus on a India NGO (Jaria Hussain-Lala, WeSpeakOut): The use of the mobile phone is widespread. Messages are spread through **digital platforms** (Skype, FB and WhatsApp), but also in **community events** where the Bohra communities are (schools, universities). Dialogue between peers is very important for social change (discussion between friends, families, daily conversations).

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Panel 3. Sharing good practices on current work with FGM-affected communities

» Focus on a project between two NGOs in Brussels (Carolina Neira Vianello - GAMS Be, and Céline Glorie - Doctors of the World): The objective of this project is to promoting access to healthcare for precarious and migrant populations, especially **transmigrating women** in the humanitarian hub of the North Station. **Permanent reception with volunteer midwives** on the days the hub is open. This is a **safe space reserved for women** (so there are not necessarily consultations). It can be proposed to women to talk more, and individually, in the hub (psychological support, social and legal support), but also in the GAMS where the follow-up is adapted to each person (psychological and psycho-social support, multidisciplinary activities) in order to perform a real **work of support and sensitization** (especially at the generational level to prevent the excision of their children). This is a particular public, since they will take every opportunity to go to England, at the expense of other appointments. Support work must therefore be carried out very quickly.

» Focus on an NGO in Spain (Asha Ismail, Save a Girl Save a Generation): After identifying the **difficulties faced by newly arrived women** in Spain (translation in immigration and police offices, during medical visits, poor treatment of women who have undergone FGM, etc.), Save a Girl Save a Generation has been created. Its goal is to help these women (travel, Spanish classes ...), to enable them to understand the context of their host country, to e**mpower them** and to allow them to **regain their power**, to be actresses of their lives. Partnerships with the police and hospitals have been established. No condescension or taboo. Only **support and trust**.

How do we dare to address sensitive issues?

- **Don't be afraid** to ask questions, while **respecting the limits** of the person
- Communicate through **artistic activities** such as dance.
- Topics related to self-esteem, love, self-confidence are highly appreciated and bring together many women, thus avoiding always focusing on FGM
- Need to **train professionals** to strengthen their awareness of the realities experienced by their public, in order to develop their knowledge of FGM and gender-based violence, but also to ensure that the themes of sexual health and gender-based violence are **routinely and mechanically integrated** during consultations and animations.

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Final recommendations

- The use of the term "hard to reach" should be avoided. Let's use the term "key community" or "EndFGMForAll".
- Importance of **overcoming stereotypes** related to FGM: this is not practiced only in Africa, within the Muslim community, or in low-level social groups. FGM is not a religious or cultural practice.
- Don't working *for* the communities, but **with the communities**
- **Liberate women's voices** often forced to live in silence, so that they can claim what they have been through and regain power
- Establishing a **relationship of trust** is the key to discussing FGM and breaking the taboo
- **Integrate FGM into school curricula** and **strengthen professional practices** through training
- It is important to give voice to young activists, because they can be a stepping stone to creating a movement and influencing society.
- It's important to **allow young activist to express their views** because they can be a springboard for influence society.
- Importance of **policy support** (legislation and funding).

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