

Global Consultation

on Female Genital Mutilation/Cutting

Technical Report





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Prepared by

Gender, Human Rights and Culture Branch

Technical Division





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List of Abbreviations and Acronyms

AIDOS	Italian Association for Women in Development (Associazione Italiana Donne per lo Sviluppo)
AJM	Malian Women Lawyers' Association (l'Association des Juristes Maliennes)
AMSOPT	Malian Association for Overseeing Directions in Traditional Practices (Association Malienne pour le Suivi et l'Orientation des Pratiques Traditionnelles)
APDF	Association for the Protection and Advancement of the Rights of Malian Women (Association pour Le Progres and La Defense des Droits des Femmes Maliennes)
ARP	Alternative Rite of Passage
CARE	Humanitarian organization fighting global poverty
CBO	Community-based organization
CCE-CC	Community Capacity Enhancement through Community Conversation
CDF	Community Dialogue Facilitator
CEP	Community Empowerment Programme
CEWLA	Centre for Egyptian Women Legal Assistance
CI-AF	Geneva-based Inter-Africa Committee on Traditional Practices affecting women's and children's health
CNLPE	National Committee against FGM/C, Burkina Faso
CONA-CIAF	National Committee of the Fight against Traditional Practices Damaging to Mother and Infant, Inter-Africa Committee on Traditional Practices (Comite national du Comite Inter-Africain de Lutte contre les pratiques traditionnelles nefastes a la femme mere et a l'enfant), Chad, Mali
CPTAFE	Coordination Cell on Traditional Practices Affecting the Health of Women and Infants, Guinea (La Cellule de Coordination sur Les Pratiques Traditionnelles Affectant La Sante des Femmes et des Enfants) (leading organization working to end female genital mutilation in Guinea, affiliate of the Inter-Africa Committee on Traditional Practices)
CRDH	The Centre for Research in Human Development
CST	Country Technical Services Team, UNFPA
CSTAA	Country Technical Services Team, Addis Ababa
DASECA	Division of Arab States, Europe and Central Asia, UNFPA
DHS	Demographic and Health Survey
DWG	Donors Working Group
EDHS	Egyptian Demographic and Health Survey
EGLDAM	Ethiopia Committee on Traditional Practices (Ethiopia Goji Lemadawi Dergitoch Aswegaj Mahber)
FGM/C	Female genital mutilation/cutting
GAMCOTRAP	Fathers' Clubs (Gambia)
GECPD	Galkayo Education Centre for Peace and Development, Somalia-based organization that operates primary and vocational education

GTZ	Development Cooperation of Germany
HIV/AIDS	Human immunodeficiency virus/acquired immunodeficiency syndrome
HUNDEE	Oromo Grass-roots Development Organization, Ethiopia
IAC	Inter-Africa Committee on Traditional Practices
IRC	Innocenti Research Centre, UNICEF
KMG	Kembatta Mentti Gezzima Tope (Woman-focused integrated community development organization)
LHRC	Legal and Human Rights Centre, United Republic of Tanzania
MDG	Millennium Development Goal
MICS	Multiple Indicator Cluster Survey
MYWO	Movement for Women Progress, Kenya (Maendeleo Ya Wanawake Organization)
NAFGEM	Network against FGM/C, United Republic of Tanzania
NGO	Non-governmental organization
NORAD	the Norwegian Agency for Development Cooperation
NPWJ	No Peace without Justice
NUEYS	National Union of Eritrean Youths and Students
ORC Macro	Research, management consulting, and information technology firm
PASAF	Project to Support the Fight against Practices that are Harmful to the Health of Women and Infants (Project d'Appui a la Lutte Contre Les Pratiques Prejudiciables a la Sante de la Femme et de l'Enfant)
PATH	Program for Appropriate Technology and Health
PNLE	National Programme in the Fight against the Practice of Excision (Programme National de Lutte contre la Pratique d'Excision)
REACH	Reproductive Educative and Community Health (Project)
SII	Strategic Impact Inquiry (CARE)
SVRI	Sexual Violence Research Initiative
TBA	Traditional birth attendant
UNCT	United Nations Country Team
UNECA	United Nations Economic Commission for Africa
UNFIP	United Nations Fund for International Partnerships
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNIFEM	United Nations Development Fund for Women
USAID	United States Agency for International Development
WHO	World Health Organization
WOWAP	"Women Wake Up", Tanzanian NGO fighting FGM/C

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Aminata Toure

Chief, Gender, Human Rights and Culture Branch, Technical Division, UNFPA

Foreword

This publication contains rich content on research findings concerning global trends and the prevalence of female genital mutilation/cutting (FGM/C) and its linkages with maternal and newborn health. It describes changing patterns and practices, including medicalization, and analyses the threat FGM/C poses to the achievement of Millennium Development Goals (MDGs) as well as its economic and health costs. It identifies important lessons and discusses in detail case studies as well as the application of theories as a basis for accelerating the abandonment process. It addresses the needs for closing gaps in law enforcement, building capacity for implementers, mobilizing resources and building global partnerships. This extensive knowledge—which was shared by research institutions, foundations, lawyers, medical professionals, religious scholars, development partners and non governmental organizations (NGOs)—is all here, and it would be difficult to find it elsewhere.

Overall, this Technical Report is an excellent resource for a variety of actors involved in the FGM/C abandonment movement. Professional advocates will learn of the latest techniques and challenges in advocating for the acceleration of abandoning FGM/C. Researchers will be able to ascertain the situation of the FGM/C movement globally, including gaps and challenges that need to be addressed. Development partners will gain new insight on where to focus their support. Implementers of FGM/C abandonment interventions, including NGOs, civil society organizations and human rights activists, will be able to use both theory and practice in building capacity. Policy actors and United Nations Country Teams (UNCTs) will gain knowledge about how FGM/C impacts development and the achievement of MDGs and how those teams could address it in their development assistance and plans.

Executive Summary

The World Health Organization (WHO) estimates that about 100-140 million women have been subjected to FGM/C in 28 countries in Africa as well as immigrants in Europe, Australia, Canada, New Zealand and the United States. FGM/C is also practised in some countries in Asia, especially among certain populations in India, Indonesia and Malaysia. The practice has also been reported in Western Asia, particularly in Iraq, southern Jordan, northern Saudi Arabia and Yemen. According to UNICEF, approximately 3 million girls are at risk of being mutilated/cut each year. The prevalence of FGM/C ranges from 90 per cent to as low as 5 per cent in practising countries and among different ethnic groups.

A WHO study in 2006 on FGM/C and obstetric outcomes in six African countries confirmed that, in deliveries, women who had undergone FGM/C were significantly more likely to have Caesarean sections, risks for extensive bleeding, longer hospital stays after delivery, perineal tears, prolonged labour, the need for episiotomies, death, the resuscitation of the infant and low birth weight. Thus, the practice of FGM/C contributed to the high rates of maternal death reported in Africa as well as infant deaths. This practice is not just a health issue; it is also a violation of the human rights of female infants, adolescent girls and women who are either incapable of giving informed consent or coerced into being excised. FGM/C is, therefore, a global concern.

In July 2007, UNFPA brought together global experts and practitioners guided by its commitment to the abandonment of FGM/C, a practice that has caused untold suffering and deaths to millions of women and children through generations. The objective of the meeting was to tell the world that the abandonment of FGM/C is urgent and that commitment and action are needed to accelerate the abandonment of FGM/C within a generation, guided by international conventions and declarations, including the Convention on the Elimination of All Forms of Discrimination against Women, the Convention on the Rights of the Child and the African Union's Protocol on the Rights of Women in Africa (the "Maputo Protocol").

This Technical Report covers deliberations of the global consultation in 13 sessions. Session I is on the rationale for the consultation and process. Session II covers global trends, linkages with maternal and newborn morbidity and mortality and FGM/C-related policies and laws in countries, including their level of implementation or enforcement. Session III is a deeper study of FGM/C practices, including self-enforcing social norms, medicalization and emerging trends to sustain this practice. Session IV covers the link between FGM/C practice and the achievement of MDGs and human rights. Session V looks at the cost implications of FGM/C, including psychological, economic and health costs. Session VI provides an array of field experiences, including the politics of FGM/C, community conversations and operations research. Session VII provides details of strategies that would be considered good practices, including community-led development using social convention theory, a community conversation model, a coordinated strategy for the abandonment of FGM/C, assessment, monitoring and evaluation, including the development of indicators. Session VIII identifies gaps in policies and laws as well as examples of what seems to be working. Session IX provides experiences in culturally sensitive approaches and emerging challenges. Session X concentrates on the critical importance of building capacity for implementers and advocates. Session XI provides details on resource mobilization to scale up FGM/C abandonment interventions. Session XII addresses the critical importance of a global partnership in the abandonment process. The final session, XIII, presents conclusions and the way forward, including the final declaration.

Introduction

Rationale for a Global FGM/C Consultation

UNFPA conceived the idea of bringing together experts and practitioners to a global forum on female genital mutilation/cutting, guided by its commitment to the abandonment of FGM/C, which has created suffering and pain among millions of women through generations. Indeed, this practice causes significant and irreversible damage to the physical, psychological and sexual health of many women and girls and is one of the most devastating human rights violations that are hidden from view. FGM/C violates the human rights of infants, adolescent girls and women who are incapable of giving informed consent due to age or coercion. Recent studies indicate the profound effects of FGM/C on maternal morbidity and mortality and, possibly, on increased infant mortality.

Several declarations call for the abandonment of FGM/C, including the Convention on the Elimination of All Forms of Discrimination against Women and the Maputo Protocol. Indeed, the commitment to the protection of children and women by the international community is critical. In addition, achievement of the MDGs is a global commitment. To achieve goals 4 and 5, aimed at decreasing child mortality and improving maternal health, FGM/C must be addressed and abandoned.

Increasingly, trained health providers—doctors, midwives, nurses and allied health personnel—are carrying out FGM/C. Hospital cleaners and veterinary doctors have also been reported to perform the practice in some communities. With the increasing awareness of negative health consequences of FGM/C, more families—especially the educated and urbanized—are taking their daughters to health facilities and/or to professionals to reduce immediate complications. Health providers often use hospital equipment and drugs (local anaesthesia, antibiotics, anti-tetanus and vitamin K) to reduce the immediate complications of the practice, including bleeding and pain. High

prevalence is therefore maintained as mothers continue to deem the practice “safe” for their daughters. However, the medicalization of FGM/C does not make it right. Therefore, fighting this practice requires that UNFPA, UNICEF, WHO and their partners take a leading role in advocating for the prohibition of medicalization of this practice.

The argument in the last few years has been that so much money has been expended towards the abandonment of FGM/C, yet nothing much has changed over the decades. It is critical to remember that the practice has many tenacious dimensions. It is associated with tradition, spirituality, gender, myths and misconceptions. The money spent towards the abandonment of this practice has not been wasted. Indeed, changes are taking place globally in abandonment and in commitment for greater support. In several countries, including Eritrea, Ethiopia and Kenya, where FGM/C abandonment programmes were sustained over many years, the trend in prevalence is downward. In Africa, 17 countries promulgated laws against FGM/C—Benin, Burkina Faso, Central African Republic, Chad, Cote d’Ivoire, Djibouti, Eritrea, Egypt (in 2008), Ethiopia, Ghana, Guinea, Kenya, Mauritania, Niger, Senegal, Togo and the United Republic of Tanzania. In Nigeria, 12 states enacted laws against the practice. In Uganda, community bylaws against the practice are in place. Developed countries where FGM/C is being practised also enacted laws. In the United States, for example, the law requires that communities and medical professionals be educated about FGM/C.

Despite the increasing number of organizations promoting FGM/C abandonment activities, funding seems to be declining. Therefore, agencies need to share experiences; new findings and lessons learned and critically review what is working and what is not working so as to accelerate the FGM/C abandonment process. Sharing ideas and new thinking will generate new commitments

for funding and programme implementation based on approaches more likely to produce the best results.

To address the issues cited above, UNFPA decided to bring together its partners and its staff to discuss FGM/C abandonment through a Global Consultation which was held from 30 July to 3 August 2007. The specific objectives of the consultation were to:

- (a) Share new research findings, experiences, lessons learned and best practices;
- (b) Identify gaps in laws and policies and consider possible strategies to close those gaps;
- (c) Consider strategies for attracting greater funding for FGM/C abandonment programmes and for developing culturally sensitive approaches to promote community and public understanding, commitment and accountability;
- (d) Propose mechanisms for building the capacity of implementing agencies and organizations to work together in monitoring, evaluating and scaling up FGM/C abandonment interventions;
- (e) Strengthen partnerships for increased attention to FGM/C abandonment activities among professionals, research institutions, funding agencies, NGOs, the private sector, civil society and among other United Nations organizations;
- (f) Build consensus on how to accelerate the abandonment process within a generation.

Preparations

A concept paper was developed to create clarity within UNFPA on the value added of the FGM/C global consultation and to guide pre consultation activities. UNFPA developed a global consultation advocacy brochure that called upon agencies to participate in the global consultation using their own funding sources and supporting others to participate accordingly. Meanwhile, UNFPA committed itself to supporting active NGOs and community-based organizations (CBOs) financially as well as its own senior staff who had demonstrated commitment in FGM/C abandonment. A task force was

created within UNFPA to address both technical and logistics issues.

Participants

More than 86 participants took part in the consultation, drawn from various organizations at global and regional levels (see annex 2 for list of participants). Participants included:

- UNFPA senior staff, including UNFPA Representatives and Programme Officers from country offices, CST directors from Africa and CST Advisers in Africa and the Arab States, Europe and Central Asia Regions; and senior staff of UNFPA Headquarters—Chief of the Gender, Human Rights and Culture Branch; Director, Africa Division; Gender Adviser, Africa Division; and Personal Assistant to the Executive Director
- Parliamentarians and government officials and lawyers from African countries
- Representatives of the United Nations—UNECA, UNICEF, UNIFEM, WHO and the World Bank
- Donor partners and their embassies—Belgium, Irish Aid, the Netherlands, NORAD and USAID
- Foundations, research institutions and international NGOs—Wallace Global Fund, The Population Council, Global Forum for Health Research, No Peace without Justice, CARE, AIDOS and Equality Now
- National NGOs and human rights groups—Inter-Africa Committee on Traditional Practices (IAC); in Geneva, its Regional Office in Addis Ababa and the national branches from selected countries; REACH in Uganda; KMG in Ethiopia; Tostan; and the Sudanese Network on FGM. Religious institutions were also represented.

I. Opening Statements

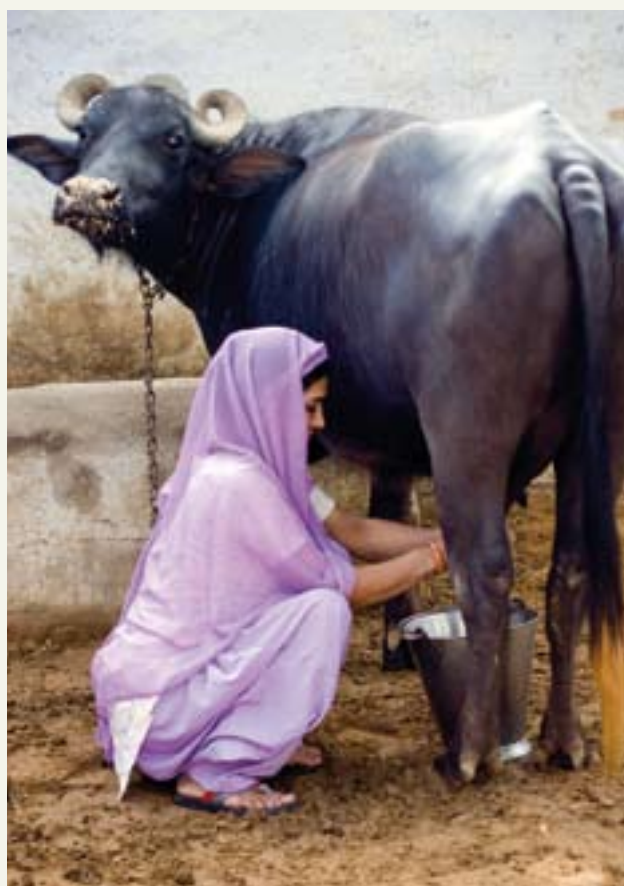


IA. Welcoming Remarks by Mr. Benson Morah, Director, Country Technical Services Team, Addis Ababa

Mr. Benson Morah, Director, CSTAA, on behalf of UNFPA welcomed participants to the global consultation on FGM/C in the beautiful and historic city of Addis Ababa. He noted his appreciation for the presence of colleagues, friends and associates, other United Nations organizations, development partners, governmental institutions and civil society organizations, including religious and traditional organizations from all over the world, coming together to discuss the critical subject of FGM/C. He observed that the level of interest was much more than anticipated, and therefore many people could not be accommodated. He promised to circulate the report as widely as possible to reach those who did not have the opportunity to participate in the consultation. "UNFPA takes this huge expression of interest in the consultation as indicative of the importance of the issue of FGM/C, which is a violation of the fundamental human rights of women and young girls," Mr. Morah said.

Mr. Morah emphasized that the consultation would be devoted primarily to sharing experiences and good practices about what works or does not work so as avoid repeating mistakes and to promote, as quickly as possible, the abandonment of FGM/C in various cultural contexts. In this respect, he observed that UNFPA had established an FGM/C Knowledge Asset. A Knowledge Asset is a web-based living repository of information. The FGM/C Knowledge Asset is therefore an interactive forum for continual sharing of experiences and lessons learned on strategies for accelerating FGM/C abandonment.

Mr. Morah observed that for the repository to remain alive, partnership and interaction were key. Although access to the Knowledge Asset was limited to UNFPA staff, there were plans to open it up to other stakeholders so as to enhance knowledge-sharing. In closing, he emphasized the value of partnerships to make abandonment of the practice faster, while using culturally sensitive approaches in abandonment interventions.



IB. Keynote Address by Ms. Fama Hane Ba, Director, Africa Division, UNFPA

In her opening remarks, Ms. Fama Hane Ba expressed special appreciation on behalf of herself and the Executive Director, whom she was representing, for the overwhelming response to the UNFPA call for dialogue on FGM/C and for partnership in a movement to accelerate the abandonment of FGM/C.

Ms. Ba noted that as many as 140 million women and girls may have been subjected to this practice across the world. She said, "Indeed, our thoughts also go to the 2-3 million women and girls, predominantly from 28 African countries, who would be forced to go through this practice this year in order to conform to this complex and deeply rooted tradition and cultural practice."

She pointed out that even daughters of immigrants from countries where FGM/C was traditionally practised, and living in western countries such as Australia, Canada and the United States as well as Western Europe, are sometimes unable to escape the grip of tradition. Many are operated on within their borders or taken back to Africa to be excised. Various forms of FGM/C are also reported to exist in parts of Asian countries such as India, Indonesia and Malaysia as well as in Jordan, Occupied Palestinian Territory (Gaza), Oman, Yemen and in certain Kurdish communities in Iraq. Therefore, the practice is widespread. Development partners, governments and communities need to recommit themselves to accelerate the abandonment of this practice that violates the basic human rights of women and girls and seriously compromises their health, leaving behind lasting physical and psychological scars.

Until recently, the contributions of FGM/C to maternal and newborn morbidity and mortality and to infertility were known but had not been proved in objective studies. A WHO six-country study confirmed that women who had undergone FGM/C, compared with those who had not, ran a significantly greater risk of requiring a Caesarean section, an episiotomy and an extended stay in hospital, and also of suffering from post partum haemorrhage (annex 1)¹. Moreover, the infants of mothers who had undergone extensive forms of FGM/C, including types II and III, were at an increased risk of dying in childbirth compared with infants of mothers without FGM/C.² Indeed, the more extensive the genital mutilation/cutting, the higher the risk of obstetric complications.

Another study involving 66 infertile women in Khartoum, Sudan, confirmed "after controlling for other risk factors," that women who had undergone the most extensive forms of FGM/C had a significantly higher risk of infertility than did a control group. Many women who had undergone FGM/C delivered without skilled attendants and under unhygienic conditions.³ Therefore, the contribution of FGM/C to maternal and infant morbidity

¹ Female genital mutilation and obstetric outcome: WHO collaborative prospective study in six African countries: WHO study group on female genital mutilation and obstetric outcome, <http://www.who.int/reproductive-health/publications/articles/lanctetfgm.pdf>

² Ibid.

³ Almroth, L.; S. Elmusharaf; N. El Hadi; A. Obeid; M.A. El Sheikh; S. M. Elfadil; and S. Bergström, "Primary infertility after genital mutilation in girlhood in Sudan: a case-control study." Division of International Health, Karolinska Institutet, Stockholm SE-17176, Sweden L.Almroth@telia.com, Journal reference: The Lancet 2005 Jul 30-Aug 5; 366(9483):347-9

ity and mortality, especially in rural and nomadic African settings, cannot be overestimated

A classification of four broad types of FGM/C follows:

Type I — excision of the prepuce, with or without excision of part or the entire clitoris

Type II — excision of the clitoris with partial or total excision of the labia minora

Type III — excision of part or all of the external genitalia and stitching/narrowing of the vaginal opening (infibulation)

Type IV — pricking, piercing or incising of the clitoris and/or labia; stretching of the clitoris and/or labia; cauterization by burning of the clitoris and surrounding tissue; scraping of tissue surrounding the vaginal orifice (*angurya* cuts) or cutting of the vagina (*gishiri* cuts); introduction of corrosive substances or herbs into the vagina to cause bleeding or for the purpose of tightening or narrowing it; and any other procedure that falls under the definition given above.⁴

Over the years, the concerted programming and funding efforts of UNFPA partners have led to some positive results, including:

- (a) Widespread awareness about the harmful health effects of FGM/C and that it violates the rights of women and girls, leading to increased numbers of women, girls and men disapproving of this practice;
- (b) Reduction of the prevalence of FGM/C. In some countries where data were collected in at least two surveys, women aged 15-19 years were less likely to have been subjected to FGM/C than women in older age groups. Prevalence decline was also visible in Eritrea, Kenya, Mali and Nigeria, countries in which anti-FGM/C interventions had been going on for some years. This was good news. However, prevalence seemed to be stagnating in Burkina Faso (one of the

countries with extensive anti-FGM/C programmes), Egypt and the United Republic of Tanzania. This was a concern;

- (c) Laws and policies on anti-FGM/C are also in place. Unfortunately, a study published in 2000 revealed that only 4 of 28 countries in Africa and Western Asia prosecuted violators based on anti-FGM/C or other laws.⁵

Some immigrant populations have continued to practise FGM/C in their host countries. As a consequence, about 13 countries in Western Europe, Australia, Canada, New Zealand and the United States have promulgated anti-FGM/C laws to prohibit immigrants from communities practising FGM/C to continue the practice in host countries.

It is encouraging that many organizations are implementing innovative programmatic strategies combining law enforcement and culturally sensitive approaches to sustain behaviour change. Local organizations are working to have the practice abandoned in many communities and are achieving greater success than formerly because of the realization that dialoguing with communities and their leaders creates a forum in which communities could reflect on this harmful practice and devise solutions.

Ms. Ba observed that community conversation or community dialogue uses a wide range of participatory methodologies and culturally sensitive strategies, such as story telling, active listening and strategic questioning, to generate a deep and complex understanding of the nature of the FGM/C within communities. These approaches are empowering communities to examine and redefine social contracts regarding FGM/C, which had been practised for generations. Through this process, many communities are saying no to FGM/C. This

⁴ World Health Organization, "A Factual Overview of Female Genital Mutilation." *Progress in Sexual and Reproductive Health*, No. 72 (Geneva, WHO, 2006)

⁵ Prevalence of the Practice of Female Genital Mutilation (FGM); Laws Prohibiting FGM and Their Enforcement; Recommendations on How to Best Work to Eliminate FGM, Report by Office of the Senior Coordinator for International Women's Issues, Office of the Under Secretary for Global Affairs, U.S. Department of State, 2001.

“Innovative and effective strategies need to be stepped up in all the practising communities, and zero tolerance to FGM/C must be backed by solid actions.”

approach is being used extensively by Tostan in Burkina Faso, Djibouti, Mali and Senegal as well as by KMG in Ethiopia.

In Kenya and Uganda, communities are supporting alternative rites of passage (ARPs). This approach supports positive aspects of rites-of-passage ceremonies by promoting sexuality education and ushering girls into adulthood without the practice of FGM/C. In Uganda, cultural days and community accountability mechanisms are encouraged.

In Egypt, the positive deviant approach publicizes those families who are role models in abandoning FGM/C within their communities. In Senegal, a community empowerment and education approach is used. It promotes participatory learning and action leading to consensus-building to abandon FGM/C.

Ms. Ba noted that these approaches would be elaborated during the consultation. She emphasized the need to acknowledge the efforts of the international community to protect the rights of women and girls who are being subjected to this cultural practice and to address emerging challenges, especially the following:

- (a) Increasing medicalization of the practice as more and more parents try to minimize the immediate health effects of the practice by having their daughters “cut” by health providers. WHO, UNFPA and UNICEF issued a statement categorically denouncing any form of medicalization and any form of FGM/C;⁶
- (b) Increasing subjection of infants and younger girls to the practice to avoid their ever complaining to law-enforcement agencies, especially in environments

where law-enforcement institutions are vigorously supporting the abandonment of FGM/C;

- (c) A trend towards the lesser cut instead of total abandonment of the practice, which is indicative of shifts in knowledge levels and change of behaviour but, unfortunately, an unacceptable behaviour change because the assault on the bodily integrity of women and girls continues;
- (d) The difficulty in obtaining data on prevalence for monitoring the effectiveness of interventions, as not all countries include FGM/C in their demographic and health surveys (DHSs) and other national surveys.

The international community must increase the tempo of its advocacy against the practice by mobilizing additional resources for the fight against FGM/C. The fruits of grass-roots participatory interventions are demonstrated by the downward trend in prevalence rates and the stagnation in other countries where anti-FGM/C interventions have not been strong.

Innovative and effective strategies need to be stepped up in all the practising communities, and zero tolerance to FGM/C must be backed by solid actions. UNFPA and its partners have pledged to increase their advocacy and support for grass-roots programming and calls for both funding and implementing partners to do their own pledging as well, thereby accelerating not only the abandonment of FGM/C but also the achievement of MDGs.

Noting the diversity and background of the participants in this consultation, Ms. Ba expressed the belief that participants would be able to reflect on the multifaceted aspects of the FGM/C practice and the critical need for a multisectoral approach to hasten change and define key elements for the development of a global road map to accelerate the abandonment of FGM/C.

⁶ Female genital mutilation: a joint WHO / UNICEF / UNFPA statement (Geneva, Switzerland, WHO, 1997), [3], 20 p.

Summary of Presentations and Discussions



II. Prevalence of FGM/C



IIA. Global Trend and Prevalence of FGM/C: Development of Data Analysis Tools for Measuring Changes in FGM/C Practice

Ms. Maria Gabriella De Vita, Child Protection Specialist, Gender Equality and Social Change, Child Protection Section, Programme Division, UNICEF, New York

Current measurement efforts demonstrate the following:

Ms. Maria Gabriella De Vita made a presentation on measurement efforts and the prevailing trend.

1. Magnitude

According to a WHO estimate, between 100 and 140 million women and girls in the world have undergone some form of FGM/C.⁷ UNICEF further estimated that 3 million girls are at risk of being mutilated/cut annually. This estimate is based on:

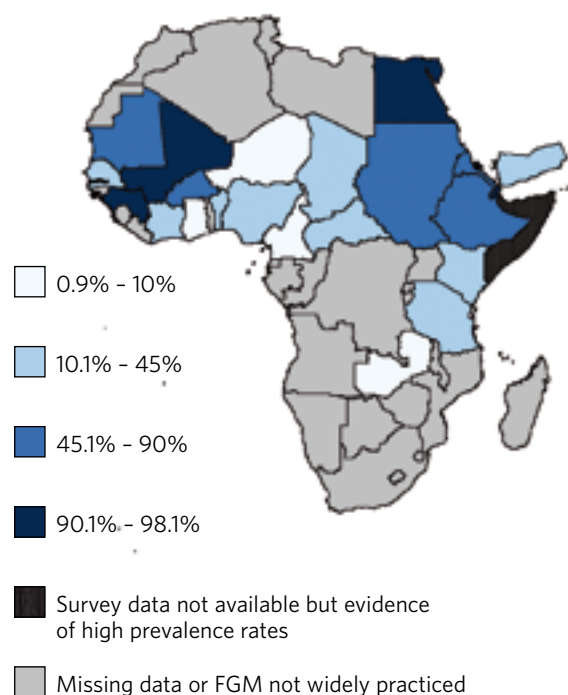
- Number of females born and prevalence of the 15-24-year-old cohort in sub-Saharan Africa, Egypt, Sudan and Yemen
- Loss due to infant mortality
- DHS available data as of 2000

2. Measurement Effort

Two main national household surveys have been used, namely the DHS by ORC Macro and the Multiple Indicators Cluster Survey (MICS) by UNICEF. The FGM/C modules have been harmonized and the data are comparable.

⁷ Progress in Sexual and Reproductive Health Research, World Health Organization, No.72, 2006

FGM/C Prevalence at National Level



Prevalence of FGM/C by DHS

NORTH EAST AFRICA	YEAR	PREVALENCE	SAMPLE
Egypt	1995	97%	14 779
Egypt	2000	97%	15 573
Egypt	2005	96%	19 474
Eritrea	1995	95%	5 054
Eritrea	2002	89%	8 754
Sudan (North)	1990	89%	5 860
Ethiopia	2000	80%	15 367
Ethiopia	2005	74%	14 070
WEST AFRICA NORTH	YEAR	PREVALENCE	SAMPLE
Guinea	1999	99%	6 753
Guinea	2005	96%	7 954
Mali	1996	94%	9 704
Mali	2001	92%	12 849
Mali	2006	Not yet available	14 583
WEST AFRICA NORTH	YEAR	PREVALENCE	SAMPLE
Burkina Faso	1999	72%	6 445
Burkina Faso	2005	77%	124 777
Mauritania	2001	71%	7 728
Senegal	2005	28%	14 602
WEST AFRICA SOUTH	YEAR	PREVALENCE	SAMPLE
Cote d'Ivoire	1994	43%	8 099
Cote d'Ivoire	1999	45%	2 040
Chad	2004	45%	6 087
Central African Republic	1994	43%	5 884
Nigeria	1999	25%	8 206
Nigeria	2003	19%	7 620
Benin	2001	17%	6 219
Ghana	2003	9%	5 691
Niger	1998	5%	7 577
Niger	2005	2%	9 223
EAST AFRICA	YEAR	PREVALENCE	SAMPLE
Cameroon	2004	14%	5 391
Kenya	1998	38%	7 881
Kenya	2003	32%	8 195
U.R. Tanzania	1996	18%	8 120
U.R. Tanzania	2004	15%	10 329

3. Mapping

Survey analysis showed varying patterns of prevalence among regional clusters of countries as well as at subnational levels in each country, especially along ethnic lines, rural/urban differentials and age ranges. FGM/C practice is declining among younger generations, although not as quickly as one would desire. There were lower prevalence rates among daughters of 20-29-year-old mothers as compared with daughters of 30-49-year-old mothers. Daughters of educated mothers also tended to have lower prevalence. The data on FGM/C prevalence was substantiated by mapping at country, subregional and regional levels.

4. Recommendations

Ms. De Vita made the following recommendations:

- FGM/C programming should be multicountry and adapted to reflect regional and ethnic variances
- Detailed desegregation of data by socioeconomic variables and at the subnational level is recommended as it can significantly strengthen the design and impact of programmatic interventions and advocacy efforts at the subnational level
- An in-depth analysis of trends is needed at the local level to identify factors associated with changes in prevalence, the social dynamics that may determine the change and the lessons learned.

Household surveys provide national and subnational prevalence rates and other indicators in a manner that is comparable among countries and regions. They show situations in the past, often 10 or 15 years before the actual implementation of the survey. There is need for a technique to measure prevalence possibly for the age range below 15.

Discussion

Extensive discussion followed this presentation with several suggestions made to use data currently available to celebrate programme successes and disseminate available data for comparative studies within regions and as a basis for advocating for the abandonment of FGM/C.

In addition to research data, a case was made for understanding who and what are the social pillars that support the practice of FGM/C with a view to developing specific interventions to tackle, weaken and dismantle them. These efforts were reported to be hampered significantly by the lack of resources needed to sustain their campaigns and for expanding interventions into more

areas. Several examples from Eritrea, Kenya and the United Republic of Tanzania show that desired change is attainable by providing sustained long-term funding, investing in young people, programming in a holistic manner, anchoring programmes to a human-rights-based approach and engaging the community to own the interventions.

IIB. Linkages of Maternal and Newborn Mortality with FGM/C

Dr. Guyo Jaldesa, Consultant, Obstetrician and Gynaecologist, Principal Investigator, World Health Organization

Dr. Guyo Jaldesa's presentation was based on the WHO collaborative study in six African countries on FGM/C and obstetric outcomes.⁸ He observed that, from previous studies, the known physical complications of FGM/C included: haemorrhage that could lead to death if not controlled; acute infections; urinary retention; injury to the adjacent tissue of the urethra, vagina, perineum and rectum; fracture or dislocation resulting from the forceful holding down of girls and the girls' struggle due to the resultant pain; and failure to heal as a result of wound sepsis. Other known long-term complications associated with FGM/C included multiple keloids of the vulva, cyst and/or abscess, clitoral neuroma, and psychological and sexual complications. No studies link HIV/AIDS and FGM/C directly but haemorrhaging subsequent to the operation, bleeding during sexual intercourse as a result

of lasting damage to the genital area and anal intercourse where infibulations prevent or impede vaginal intercourse are all potential sources of HIV transmission.

Although numerous resolutions and recommendations were made aimed at addressing this situation, large-scale evidence regarding the social, psychosexual and medical consequences of FGM/C was lacking, and this justified the study.

The primary aim of the study was to evaluate the relationship between different types of FGM/C and obstetric complications and to estimate the incidence of obstetric complications among women with a history of FGM/C while giving birth in hospital. The study had a secondary aim of obtaining clinical information relevant to the prevention and treatment of obstetric complications in women with FGM/C.

The study involved 28,393 women at 28 obstetric centres in six countries where FGM/C is common—Burkina Faso, Ghana, Kenya, Nigeria, Senegal and Sudan. The centres varied from relatively isolated rural hospitals to teaching hospitals in capital cities. They were chosen to provide appropriate diversity of types of FGM/C. The

⁸ "Female genital mutilation and obstetric outcome: WHO collaborative prospective study in six African countries: WHO study group on female genital mutilation and obstetric outcome." <http://www.who.int/reproductive-health/publications/articles/lancetfgm.pdf>.

analysis estimated the risk of having specific adverse maternal or infant outcomes among women with different forms of FGM/C.

In the case of Caesarean section, women who had been subjected to the most serious form of FGM/C (Type III) were more likely to have on average 30 per cent more Caesarean sections compared with those who had not undergone any form of FGM/C. Similarly, there was a 70 per cent increase in the numbers of women with FGM/C III who suffered post partum haemorrhage compared with those women without FGM/C. The study also found that FGM/C put the women's babies in substantial danger during childbirth. There was an increased need to resuscitate babies whose mothers had had FGM/C (66 per cent higher in women with FGM/C III). The death rate among babies during and immediately after birth was also much higher for those born to mothers with FGM/C: 15 per cent higher in those with FGM/C I; 32 per cent higher in those with FGM/C II; and 55 per cent higher in those with FGM/C III.

It is estimated that in the African context an additional 10 to 20 babies die per 1,000 deliveries as a result of FGM/C. Although there was no difference in birth weight of the babies among the study population, the differ-

ence in perinatal mortality supports the hypothesis of mechanical problems due to the lack of elasticity in cut/excised tissues. This is evidence of collateral damage to babies as a result of injuries their mothers had suffered earlier in life. This research was carried out in hospitals in which obstetric staffs were used to dealing with women who had undergone FGM/C. The consequences for the countless women and babies who delivered at home without the help of experienced staff were likely to have been even worse.

Dr. Jaldesa observed that, while human rights groups long campaigned against genital cutting as a rights issue, the study provided the first conclusive medical evidence of long-term physical harm. It proved beyond a reasonable doubt that FGM/C was a health issue, a killer of women and children, as well as a human rights issue. Dr. Jaldesa noted that reliable evidence about its harmful effects, especially on reproduction, would greatly help advocates overcome the arguments that genital mutilation is an untouchable cultural practice and contribute to its abandonment. Concerted efforts were needed to encourage abandonment of this harmful practice and ensure that training in maternal and infant health services takes account of this practice.

IIC. Promulgation of Laws

Ms. *Faiza Jama Mohamed, Regional Director Africa, Equality Now*

Ms. Faiza Jama Mohamed observed that FGM/C was a fundamental human rights violation that constituted torture within the meaning of the United Nations Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment. Hence, govern-

ment inaction constituted "official acquiescence" to torture. She noted that the use of the law was critical as an integral part and essential component of the strategies used by different stakeholders to bring an end to FGM/C. Legislation, as a distinct and only strategy, is not effective in ending FGM/C but must be one of the strategies.

She remarked that 16 African countries (Benin, Burkina Faso, Central African Republic, Chad, Cote d'Ivoire, Djibouti, Eritrea, Ethiopia, Ghana, Guinea, Kenya, Mauritania, Niger, Senegal, Togo and the United Republic of Tanzania) had enacted laws against FGM/C which could be analysed in terms of their definitions, scope of culpability and punishments. In addition, several states in the Federal Republic of Nigeria had laws against the practice, and Egypt had in place a ministerial decree that completely forbids anyone, including doctors and nurses, from performing the practice. At the time of writing this report (July 2008), Egypt had promulgated legislation that criminalizes the FGM/C practice nationwide. The law provides for a sentence ranging from three months to a maximum of two years with a penalty of Egyptian pounds 1,000 to 5,000.

Various laws define FGM/C in different ways. The laws of Burkina Faso, Chad, Cote d'Ivoire, Ghana, Niger and Senegal define FGM/C as an assault. In Burkina Faso, Chad, Ghana and Senegal, the laws are part of the criminal laws, whereas in Niger the law is a distinct law on its own. All the laws in other countries penalize the practice of FGM/C and/or excision without defining these terms.

As regards punishment, the laws of Central African Republic, Djibouti, Ethiopia, Ghana, Kenya, Mauritania and the United Republic of Tanzania prescribe general punishments. In Benin, Kenya and Mauritania, the laws criminalize the practice of FGM/C on children (i.e., less than 18 years old), and infractions are punishable by either imprisonment or fine or both. The laws in Burkina Faso, Eritrea, Guinea, Niger and Senegal enhance the punishment for medical or health personnel engaging in the practice of FGM/C, including the suspension of their licenses. The law in Chad mentions culpability for medical personnel, and the law in Togo implies such culpability. In Benin, Burkina Faso, Cote d'Ivoire, Eritrea, Guinea, Niger, Senegal and Togo, stiff punishments apply when the practice results in the death of the victim or, in Ethiopian law, injury to the victim. The Ghanaian law equates the offence to a second-degree felony. The law in the

United Republic of Tanzania provides for compensation of the victim by the perpetrator, to an extent to be determined by the court. Under the laws of Burkina Faso, Eritrea, Senegal and Togo, and in the recently approved bill awaiting presidential assent in Ghana, accomplices are punishable.

None of the laws cited above has taken into consideration the human rights issues around FGM/C in the definition, scope of culpability or even punishment of the practice. Similarly, the implementation of these laws so far is not guided by human rights principles. Several of these laws confine the definition of FGM/C to the context of existing criminal law regimes. This has presented various challenges in implementation, given the sociocultural determinant of the practice, which often exempts certain relations from criminal liability, thereby defeating the application of the law. Also, there is the challenge of procedural regulations to facilitate implementation of the law, as is the case in Guinea. An underlying factor in all this is the failure of several States to translate into national laws the human rights standards contained in the international and regional instruments that they have ratified.

Outside Africa, several countries, including Australia, Canada, Denmark, Norway, Sweden, the United Kingdom and the United States, have enacted laws against FGM/C to curb the practice among immigrant communities from countries of origin where FGM/C is practised. African countries could draw several lessons from the experience of these countries, both in the content of the laws and from their implementation. Ms. Mohamed highlighted five key issues in this regard:

- (a) Unlike countries in Africa, the consent of the victim is not a defence to a charge of FGM/C in these countries;
- (b) The principle of extraterritorial jurisdiction of the law has been used successfully to prosecute parents who, in a bid to evade the law, take their children for excision in countries with no law against FGM/C;

“Ms. Mohamed remarked that, for legislation against the practice of FGM/C to be effective, African governments need to develop comprehensive rights based child-protection frameworks in accordance with universal human rights standards as the basis of all legislation on child rights.”

- (c) Under the laws in Australia, France and Germany, the punishments, compared with those in African countries, are so severe as to serve as an effective deterrent to would-be offenders;
- (d) Prosecutions for FGM/C-related offences in France and Sweden are well integrated into criminal law frameworks and the loopholes presented by the lack of procedural regulations in the African laws do not arise. The laws must be inclusive with no exceptions whatsoever;
- (e) Unlike the non-African countries mentioned above, African countries have minimal public education and, for the most part, FGM/C remains a taboo subject.

Ms. Mohamed remarked that, for legislation against the practice of FGM/C to be effective, African governments need to develop comprehensive rights based child-protection frameworks in accordance with universal human rights standards as the basis of all legislation on child rights. In addition, child rights agencies at national and international levels must take the lead in the inclusive and participatory development of sound child policy frameworks. It is also imperative that African States fulfil their obligations under Article 5 of the African Union’s Protocol on the Rights of Women, which revolve around prohibition of the practice through legislative measures, the provision of comprehensive support to victims and the protection of potential victims.

Further, governments must act on the obligations noted under the protocol using multilateral and bilateral support through an adopted plan of action, whereas NGOs must hold governments accountable when they fail to deliver on their commitments.

In 2000, African activists shared their concerns and frustrations with Equality Now, when it opened its Africa office in Nairobi. Subsequently, Equality Now mobilized resources and created the Fund for Grassroots Activism to End FGM/C, “The FGM/C Fund”, which is supporting campaigns of more than 20 groups in 17 African countries.

With resources guaranteed on a longer term basis, activists are expanding the number of new stakeholders and policy champions advocating for the abandonment of FGM/C and increasing local education and outreach activities aimed at eradicating FGM/C. Two examples provided here show the progress these activists have made in accelerating FGM/C abandonment.

In Morogoro, United Republic of Tanzania, Legal and Human Rights Centre (LHRC) did community sensitization and police training in the FGM/C law and set up a trained team of human rights defenders to sustain the momentum gained. The team was equipped with educational materials, bicycles and mobile telephones, which helped immensely in the efficient implementation of activities. This group played several roles: sensitizing the community and reaching out to more people in the region, monitoring and reporting on FGM/C cases and potential cases and intervening to protect them. This community structure proved a valuable resource not only in facilitating and circulating information but in keeping the debate alive within the community. Girls ran to the centre when at risk and police officials responded to their calls when a threat of FGM/C was reported. As a result of their daily interventions and protective actions, backed by the police, the group succeeded in saving many girls.

The prevalence rate reportedly declined in this region. Nationwide, in the last DHS, a 3 per cent drop in FGM/C prevalence was confirmed. There also appeared to be widespread awareness about the problem and significant public support to end it.

The National Union of Eritrean Youth and Students (NUEYS) targeted future parents—the youth—as they were more receptive to information, including being more impressionable. The union largely concentrated its efforts in two regions, Anseba and Gash Barka, where it set up anti-FGM/C clubs (of 25-30 members) in eight schools to sensitize both the school population (150-200 each school) and the surrounding villages. The Union trained the anti-FGM/C youth clubs and equipped them with necessary tools and information to embark on their campaigns. The clubs engaged school youth through age-friendly sensitization and awareness activities, using strategies such as writing competitions, theatre, music and drama to capture their interest in the issue and to question the stereotypes surrounding the practice of FGM/C. As a result, youth in these two regions became fully aware and able to make informed decisions on their bodily integrity and that of their future children with regard to FGM/C. By the end of 2006, three communities—Asmat, Geleb and Aditekelezan—had openly declared a ban on FGM/C in their villages. This move encouraged the government, which had previously been reluctant, to outlaw the practice in March 2007. Both of the last DHSs showed a decline of 6 per cent in FGM/C prevalence (in each four-year period), and the decline was noted especially among young parents.

The experiences of the partners of the Fund for Grassroots Activism to End FGM/C showed that long-term funding was crucial to sustain anti-FGM/C interventions and gradually bring about the desired change of abandoning FGM/C.

Investing in youth, approaching the problem holistically, anchoring human rights defenders within communities to keep the debate alive, instituting a child-protection

mechanism that was locally run—all these strategies were tried and found effective in gradually dismantling support for the practice.

Plenary Discussions and Recommendations

A number of key ideas discussed during plenary sessions were found to be critical for accelerating FGM/C abandonment, namely: systematically using data to plan interventions; promoting qualitative research to identify misconceptions about FGM/C and sexuality and to understand what sustains the practice; measuring prevalence and incidence in younger generations; and building the capacity of law-enforcement institutions and agents. The government's proactive role was emphasized to demonstrate accountability, especially in allocating budgets to support FGM/C abandonment interventions as well as in enforcing the rule of law.

Several recommendations were made to address the global situation, namely:

- Produce more research (qualitative and quantitative) and analysis of trends at multiple levels—regional, national and subnational—to identify factors associated with changing prevalence, social dynamics and lessons learned
- Develop data collection modules for younger girls before the age of reproduction
- Systematically include and use FGM/C data collected in national surveys such as the DHS
- Increase accountability for FGM/C programmes at all levels—community, national, regional—and among development partners
- Enforce the rule of law as part of government responsibility

III. FGM/C Changing Patterns and Practices



IIIA. Latest Developments in Social Sciences; FGM/C as a Self-enforcing Social Convention: Basic Principles

Ms. Francesca Moneti, Senior Child Rights Officer,
UNICEF Innocenti Research Centre

1. Social processes

Ms. Francesca Moneti observed that the social processes of FGM/C resemble the social dynamics of the self-enforcing social convention theory identified by Thomas Schelling.⁹ Families carry out FGM/C to ensure the marriageability and status of their daughters within the intra-marrying group. For marriage and for status, what one family chooses to do depends on what other families in that community choose to do. No one family can abandon the practice on its own; to do so would ruin the marriageability and status of that family's daughters. To change the convention, it would be necessary to coordinate abandonment by the intra-marrying community as a whole.

To succeed at such mass abandonment, it is not necessary at the outset to gain the support of the entire community. Following the logic of Schelling's social convention theory, if an initial core of families within a larger intra-marrying group decides to abandon FGM/C, it is immediately in the interest of this initial group to recruit other families in the community to abandon cutting. By recruiting other families, the core group that has agreed to abandon cutting increases marriage choices for those within the non-cutting subgroup. Similarly, it is immediately in their interest to persuade others of

the disadvantages. In other words, the knowledge and actions of one family or community can spread to other families or communities through social networks, provided that this process is organized towards coordinated abandonment.

There are two thresholds in the type of convention shift identified by Schelling. First, the initial core group mentioned above must mobilize a sufficient number of people to become self-sustaining (a "critical mass"). Second, the growing core group must, at some point, become a large enough proportion of the intra-marrying group to create a tipping point. Once past the tipping point, a shift to the new convention becomes irreversible for most of the population. After the convention shift, the practice is no longer linked to marriage, and thus there is no reason to return to FGM/C.

Because of the conventional nature of the practice—what one family chooses to do depends on what other families choose to do—it is unlikely that the shift from a convention of cutting to a convention of not cutting would come about spontaneously. After the core group is mobilized, a sufficient proportion (past the tipping point) of families willing to abandon the practice must be enrolled, which would be unlikely in the absence of an organized abandonment effort.

There must also be a moment of social recognition, for example, a public declaration, whereby the ending of the practice is witnessed. This would be a moment of coordinated abandonment when most people are assured

⁹ Thomas C. Schelling, *the Strategy of Conflict* (President and Fellows of Harvard University, 1960, 1980).

“Three assumptions are made: that FGM/C is linked to marriageability, that the typical family or daughter prefers marriageability to non-marriageability and that people always move to the highest possible value among their available choices.”

that most other people are ending the practice. Only then would the marriageability and status of their uncut daughters be assured.

Three assumptions are made: that FGM/C is linked to marriageability, that the typical family or daughter prefers marriageability to non-marriageability and that people always move to the highest possible value among their available choices.

2. Implications for programming

The decision to abandon the practice needs to:

- (a) Be a collective choice of a group that intra-marries or is closely connected in other ways so that no single girl or family is disadvantaged by the decision;
- (b) Facilitate dialogue and make it possible to speak of subjects that are sensitive or taboo;
- (c) Reflect non-coercive and non-judgemental discussion and be empowering, insofar as the discussion is fuelled by new knowledge, including raising aware-

ness of the harm, and derived from an understanding that enables people to find better ways to promote their positive values;

- (d) Overcome unequal gender relations by providing opportunities for girls and women to speak in public, strengthening their voice;
- (e) Rest on a public and explicit affirmation on the part of communities concerning their commitment to abandon FGM/C (for example, as a public declaration) so that everyone can trust that others will follow through with the commitment to abandon FGM/C.

The abandonment movement can spread because of the inherent interest of those who wish or have chosen to abandon FGM/C to convince others to do the same. It can rely on traditional means of information to spread the news of abandonment but also undertake organized diffusion, focusing on nearby communities that the abandoning group decides are most strategic. It also requires an enabling environment to support change, including awareness-raising and dialogue at the national level, with a key role to be played by the media, and the introduction of social and legislative measures and international commitment.

Social convention theory does not provide a full explanation of the social dynamics of the abandonment of harmful practices. It assumes that every individual is identical and will behave in the same way. It also does not explain the factors that lead to the organization of an initial group of individuals who promote change. It is known from ethnographic study that it is possible to have individual families abandon the practice of FGM/C. Such studies lend important insights into the modalities by which this occurs, for example, the abandonment by powerful families in Sudan.



IIIB. The Medicalization of FGM/C: Trends And Global View

Dr. *Elise B. Johansen, Technical Officer, World Health Organization*

Dr. Elise Johansen clarified the concept of medicalization as the performance of FGM/C by professionally trained medical personnel, whether nurses, midwives, medical doctors or health officers in public or private facilities. She said that the practice of re-infibulation should be included in the definition of medicalization. WHO first condemned the medicalization of FGM/C in 1982, and strongly condemned it in a joint statement with UNICEF and UNFPA published in 1997. That statement has been revised to emphasize the need to counteract and insert legal regulations to prevent the medicalization of FGM/C. Other United Nations organizations, medical licensing authorities and professional associations, such as the International Federation of Gynaecology and Obstetrics, passed resolutions against the medicalization of FGM/C.

Despite these numerous declarations, medical professionals are increasingly performing FGM/C. Some governments, NGOs and researchers are also promoting medicalization. It is therefore necessary to intensify the work against medicalization and develop strategies that target health workers. Although the level of medicalization varies from country to country, it is spreading rapidly in many countries. In some countries, more than one third of the women have subjected their daughters to the practice using a trained health professional. Among groups that have immigrated to Europe and North America, reports indicate that re-infibulations are being performed by medical personnel even where the law specifically prohibits it.

Factors that motivate medical professionals to perform FGM/C include prospects of economic gain, pressure and a sense of duty to serve community requests, and personal support of the practice. Some medical personnel may consider medicalization as a harm-reduction strategy, whereas others argue that medicalization is a useful or necessary first step towards total abandonment. However, these reasons are based on undocumented evidence, and serious risks are associated with this practice.

The medicalization of FGM/C may result in the following:

- (a) Legitimize FGM/C. The medicalization of FGM wrongly legitimizes the practice as medically sound or beneficial for girls' and women's health;
- (b) Institutionalize FGM/C. The performance of FGM/C by medical personnel further institutionalizes the procedure. Medical personnel hold power, authority and respect in society, and families take pride in having a medical professional perform the practice and praise the professional's skill;
- (c) Hinder the abandonment of FGM/C. There is no evidence that the medicalization of FGM/C leads to abandonment of the practice. Rather, research suggests that medicalization is more likely to encourage continuation, because it validates the practice;
- (d) Constitute a misuse of the professional role of medical personnel. In countries where FGM/C originates, some medical professionals perform FGM/C as a contribution to uphold their communities' culture and women's value in society while intending to reduce some immediate health risks associated with the practice;

- (e) Foster the spread of FGM/C. In situations of conflict and migration, it has been documented that displaced populations who have no tradition of FGM/C pick up the practice when moving into areas where this practice is a tradition. If the practice is performed by medical personnel, this will further promote the adoption of FGM/C as it can then easily be perceived as a health-promoting practice;
- (f) Confuse the question of human rights. In countries where groups that practise FGM/C have immigrated, medical personnel perform FGM/C in the form of re-infibulations in the name of upholding the right of a patient to choose medical procedures. However, medical personnel are not entitled to respect patients' requests if the act constitutes a human rights violation;

- (g) Not reduce complications associated with FGM/C. That FGM/C is performed by a trained professional does not necessarily mean that the procedure is less severe or that conditions are sanitary. Some reports suggest that they may be even more severe. Some health workers will not use anaesthesia when performing FGM/C in order to uphold the cultural belief that pain is an important part of the experience, and the practice is still often performed in families' homes. Medicalization does not address the documented long-term and obstetrical complications associated with FGM/C.

"It is the mission of the physician to safeguard the health of the people."

—Helsinki Declaration, 1948

IIIC. The Medicalization of FGM/C: Case Study in Egypt

Dr. Mohamed Farid, Project Officer, Reproductive Health Services, Ministry of Health and Population, Egypt

Dr. Mohamed Farid noted that the medicalization of FGM/C is being undertaken by health professionals in clinical settings in the belief that it is safer. More families in Egypt are seeking the advice of medical personnel in an attempt to avoid the dangers of unskilled operations performed in unsanitary conditions. However, the medicalization of FGM/C constitutes wilful damage to healthy organs for non-therapeutic reasons and is unethical. Moreover, the performance of FGM/C by health professionals is a violation of the ethical code governing health practice, which specifically requires that physicians, nurses and midwives "do not harm". WHO, the Inter-

national Council of Nurses, the International Confederation of Midwives and the International Federation of Gynaecologists and Obstetricians; have all declared their opposition to the medicalization of FGM/C and advised that it should not be performed by health professionals or in health establishments under any circumstances.

1. FGM/C status among women of reproductive age (15-49)

According to the Ministry of Health and Population 2005 National Study, the prevalence of FGM/C among girls aged 10-18 years in Egypt was 50.3 per cent. Similarly, the Egyptian Demographic and Health Survey (EDHS) 2005 shows that the prevalence of FGM/C among girls aged 10-17 years was 65.5 per cent. The same study estimates that, over the next decade in Egypt, there will be a

steady decline in the proportions of young adult women who are excised. However, the survey suggests that, in 2015, about 5 in 10 girls will have been excised by their 18th birthday unless further changes occur in attitudes supporting the practice and further actions combating FGM/C are undertaken on the national level.

The proportion of girls excised or expected to be excised decreases with the mother's educational attainment and with wealth status—36 per cent of girls in the highest wealth class and 85 per cent of girls in the lowest wealth class.

2. Reasons for supporting FGM/C

According to EDHS 2005, the following reasons were given for supporting FGM/C among Egyptian families:

- About 70 per cent of ever-married women age 15-49 thought that the husband preferred the wife to be excised
- About 60 per cent of women saw FGM/C as ensuring that a woman would remain faithful to her husband
- Half (50 per cent) of women agreed that FGM/C preserves virginity and prevents adultery
- Less than half (45 per cent) of women did not believe that FGM/C had any adverse consequences on women's health or that it may lead to a girl's death

3. Legal decrees

The Egyptian Ministerial FGM/C Decree of 1959 prohibits FGM/C from being performed in clinics of the Ministry of Health. The second Ministerial Decree (1994) prohibits FGM/C from being performed by non-medical practitioners and in places other than equipped facilities in public and central hospitals. The third decree, in 1996, prohibits FGM/C in any health facility (public or private), except for highly indicated cases that should be approved by the head of Obstetrics and Gynaecology. The fourth decree of 28/6/2007 prohibits any health service providers (physicians and nursing staff) and others (paramedical or related personnel) from performing any excision, deformation or any type of surgical intervention for any natural part of the external female genital

FGM/C Status among Women of Reproductive Age (15-49)

Indicator	1995	2000	2005
Prevalence of FGM/C	97%	97%	96%
Attitudes towards FGM/C (Believe practice should continue)	82%	75%	68%
Mean age of daughter when she was excised	9	9	10
Person who performed FGM/C			
• Trained medical personnel	55%	62%	75%
• Non-medical (TBA / barber)	45%	38%	25%
Place FGM/C performed			
• At home	67%	65%	-
• Private health establishment	33%	35%	-

Source: Dr. Mohamed Farid, Ministry of Health and Population, Egypt.

organs whether in governmental or non-governmental establishments or in any other premises. Those professionals who performed these actions would be considered as having violated the laws and regulations of the ethical code governing the medical profession and would be subjected to penalties and punishment from both the Ministry of Health and the Medical Syndicate.

According to Egyptian criminal law, mutilation of any part of the human body is a crime, whether intended or occurring as a consequence of negligence or ignorance. If the person who performs this operation is not a doctor or a nurse, two crimes have been committed, intentional wound-inflicting and the illegal practice of medicine. Both crimes merit severe punishment (three to seven years in jail) for performing actions resulting in permanent infirmity. A higher committee headed by the First Lady, and including the Ministries of Justice, Health and Interior, was constituted to prepare Egyptian legislation for criminalizing FGM/C. This law was expected to be presented to the Egyptian parliament (People's Assembly) for approval and prompt implementation. This law was passed in June 2008 at the time of writing this report.

IIID. Emerging Community Strategies to Maintain FGM/C Practice: Changing Patterns and Practices – The Kenyan Perspective

Dr. Kemal Mustafa, UNFPA Representative, Kenya

Dr. Kemal Mustafa presented an eight-minute video featuring clips from the Mombasa Muslim Clerics and Scholars Symposium, held in Mombasa in June 2007. The clips highlighted the tensions among symposium participants, especially those of Somali origin, who



expressed fear that the symposium had a hidden agenda of forcing them to renounce their culture and propagating the western ideology of feminism.

Four lessons learned were presented and discussed, namely:

- (a) Working with partners in the same area of intervention strengthens and synergizes activities towards the abandonment of FGM/C.;
- (b) Cultural baggage is a significant barrier to interventions aimed at abandoning FGM/C. This, coupled with suspicion that the campaign towards the abandonment of FGM/C has a hidden agenda to renounce culture or propagate western ideologies of feminism, needs to be addressed;
- (c) Open discussion on FGM/C raises awareness among those unaware of the harmful effects but also raises doubt as to the validity of the practice as an Islamic obligation for women and;
- (d) The use of words such as *Sunnah* may inadvertently validate the practice as a religious obligation among the Muslim faithful.

III.E. Emerging Community Strategies to Maintain FGM/C Practice in Uganda

Dr. Hassan Mohtashami, UNFPA Representative, *a.i.*,
Uganda

Dr. Hassan Mohtashami highlighted key reasons given by community members for carrying out FGM/C, namely: a custom or practice done as a rite of passage from childhood to adulthood; the community's desire to control women's sexuality (virginity, morality and readiness for marriage); a cultural practice that has religious identification; and a source of income for the practitioners who propagate the practice.

The REACH project, a community-based intervention supported by the UNFPA country office for more than 10 years, utilized a number of strategies, namely:

- Advocacy to win over the opposition. Community volunteers were recruited in each sub-county to advocate for a campaign against FGM/C
- Recruitment and mobilization of peer educators
- Grass-roots sensitization and the provision of heifers to reformed "surgeons"
- Annual Culture Day

Dr. Mohtashami emphasized the value of building partnerships in mobilizing and unifying community leaders. In Kapchorwa, the project works with the Sabiny Elders Association, religious leaders, and members of parliament, local government officials, NGOs, CBOs and security forces. As a result, the incidence of FGM/C decreased substantially over the years, especially among the female youth. Dr. Mohtashami pointed out that the factors sustaining FGM/C practice included the lower level of girls' education, remoteness, and inaccessibility creating a closed society.

Plenary Discussions and Recommendations

The plenary emphasized the critical need for building the capacity of medical personnel to manage complications and provide counselling, with the fundamental aim of changing the attitudes and behaviours of medical personnel.

Several recommendations were made:

- Include FGM/C in the medical curriculum
- Enforce laws and regulations against medicalization
- Ensure that FGM/C abandonment interventions address girls and women as primary targets
- Make FGM/C interventions comprehensive by addressing reproductive-health-related issues as well as gender and human rights issues

IV. FGM/C A Threat to Human Rights and to the Achievement of Millennium Development Goals



Ms. Seynabou Tall, Gender Adviser, UNFPA, Country Technical Services Team, Addis Ababa

Ms. Seynabou Tall observed that the Millennium Declaration (September 2000) commits Member States to promote gender equality and the empowerment of women as an effective way to combat poverty, hunger and disease and to stimulate sustainable development. In 2002, this agenda was refined into eight goals establishing measurable targets and indicators of development to be achieved by 2015. Unless FGM/C is abandoned, it is likely to affect the achievement of the first six MDGs.

Goal 1: Eradicate extreme poverty and hunger

Ms. Tall observed that FGM/C was a threat to MDG 1 because important resources are mobilized and spent to treat the consequences of FGM/C. Poverty is not only a shortage of financial resources; it is truly a lack of opportunity and a deprivation of fundamental human rights that can result in the violation of physical and mental integrity.

Goal 2: Achieve universal primary education

FGM/C is a threat to MDG 2 because it compromises the promotion of universal education. The effects of FGM/C on education include disturbances in learning and health problems associated with the practice. The trauma and pain result in absenteeism, drop-outs and poor performance, with some girls dropping out of school to get married.

Goal 3: Achieve gender equality

Gender inequality in every area of life is the major cause of acts of violence committed against women and girls, including FGM/C. Goal 3 challenges discrimination against women and seeks to ensure that girls as well as boys have the chance to go to school.

Goal 4: Reduce child mortality

As already discussed in this consultation, a WHO study provides substantial evidence of the increased risk of stillbirths and neonatal deaths during childbirth among women who are excised.

Goal 5: Improve maternal health

FGM/C is a threat to safe motherhood. Gender inequality and lack of empowerment result in reduced access to information and services and, hence, to adverse reproductive health outcomes, including high maternal mortality. Major health complications of FGM/C are associated with pregnancy, childbirth and the post partum period, making childbirth not only excruciatingly painful but also extremely dangerous as it prolongs labour, obstructs the birth canal and often causes tears, psychological disorder and trauma.

Goal 6: Combat HIV/AIDS

Although there is no documented evidence so far, the use of unsterilized instruments and the tears during sexual intercourse are likely to increase the vulnerability of girls and women to HIV and AIDS.

“Ms. Tall noted that, under international law, States are obligated to prevent, investigate and punish violence against women.”

Regarding human rights aspects, Ms. Tall observed that FGM/C is a manifestation of gender-based human-rights violations aimed at controlling women’s sexuality and autonomy in many cultures. FGM/C is, indeed, one of many forms of social injustice that women suffer worldwide. The abandonment of this practice is considered key to creating societies in which women would be valued as full and equal participants. A human rights perspective sets FGM/C in the context of women’s social and economic powerlessness. Recognizing that civil, political, social, economic and cultural rights are indivisible and interdependent is a starting point for addressing the range of factors that perpetuate the practice. FGM/C is a threat to various human rights such as the right to life, right to health, right to physical and mental integrity, sexual rights, right to choose/decide and right to be free from discrimination. Indeed, the universality of human rights is a key principle in the initiation of a dialogue on FGM/C and its link to human rights.

Ms. Tall noted that, under international law, States are obligated to prevent, investigate and punish violence against women. The United Nations Declaration on the Elimination of Violence against Women provides that:

“States should not invoke any custom, tradition, or religious consideration to avoid their obligation to eliminate violence against women, and ... they must exhibit due diligence in investigating and imposing penalties for violence, and establishing effective protective measures.”

In addition, a number of instruments can be used to advocate with governments to take more responsibility for enforcing the abandonment of FGM/C, including the following:

- Convention on the Elimination of All Forms of Discrimination against Women, 1979 (of the 28 African

countries in which FGM/C is practised, 26 had ratified the Convention)

- Convention on the Rights of the Child, 1989
- African Charter on the Rights and Welfare of the Child, 1990
- United Nations Resolution 56/128 on traditional or customary practices affecting the health of women and girls, 2001
- Additional Protocol to the African Charter on People’s Human Rights on Women’s Rights, 2003
- United Nations conferences: World Conference on Human Rights (Vienna, 1993), International Conference on Population and Development (Cairo, 1994), and the Fourth World Conference on Women (Beijing, 1995)



V. Cost Implications of FGM/C Practice



VA. FGM/C in Relation to Women's and Girls' Rights: Experiences of No Peace Without Justice

Ms. *Alvilda Jablonko, FGM/C Programme, No Peace without Justice*

Ms. Alvilda Jablonko highlighted the efforts made by her organization, No Peace without Justice (NPWJ). She said that the overall objective of the NPWJ FGM/C Programme was to develop a political, legal and social environment contributing to changing attitudes and behaviour favourable to FGM/C abandonment, in the context of promoting and protecting women's and girls' rights.

Specific objectives of NPWJ include:

- (a) Creating a political will in favour of ratification and implementation of the Maputo Protocol in the target countries in recognition of FGM/C as a human rights violation;
- (b) Breaking the culture of silence surrounding FGM/C so as to weaken the self-reinforcing social convention;
- (c) Building the capacity of advocates for FGM/C abandonment within governments and civil society, so as to enable the development of effective FGM/C abandonment strategies;
- (d) Building technical capacity for establishing legislative mechanisms for prohibiting FGM/C and providing legal tools for the protection of women and girls willing to challenge the social convention.

Ms. Jablonko noted that NPWJ has raised awareness and fostered public debate explicitly through political campaigns and the implementation of key programmes, such as international and regional meetings often co-hosted

by and organized with the government of the country in which they were held and the fostering of partnerships among public institutions, NGOs and other actors in society to attain stakeholders' ownership of both the political drive and the results. NPWJ is also undertaking wide ranging technical assistance, through the secondment of legal experts to governments for drafting legislation and for assisting in negotiations on international human rights instruments. Very important, NPWJ has acquired a unique field experience in "conflict mapping" and wide-scale documentation of violations of international humanitarian law in areas affected by conflicts. It is also implementing outreach programmes in conflict and post conflict areas engaging local communities on issues of international criminal justice. In 2007 and 2008, NPWJ is focusing its FGM/C work in Eritrea, Ethiopia and Sudan. NPWJ partners with European and African women's organizations, in particular, with members of the European Network against Harmful Traditional Practices and the relevant ministries of European Union Member States, to facilitate an effective and timely application of FGM/C legislation, such as the Italian law on FGM/C adopted in January 2006.

VB. Denial of Women's Rights and Insights on New Approaches to Gender Equity: "CARE's Strategic Impact Inquiry on Women's Empowerment and FGM/C Abandonment in Awash"

Ms. *Haregewien Admassu, Gender Adviser, CARE Ethiopia*

Ms. Haregewien Admassu made reference to the Strategy Impact Inquiry (SII) launched by CARE USA in 2005. She said that SII aims at determining whether and how CARE programmes around the world have been impacting the underlying causes of poverty and rights denial. The organization's inaugural SII centred on the empowerment of women and the advancement of gender equality.

CARE built its SII around a theory of women's empowerment based on the balance among individuals/agencies, structures and relationships. The conclusion from the SII was that improvements in women's status cannot be realized and sustained without change within the individual. For example, without poor women becoming actors for change or community structures working collectively to change accepted power relationships that perpetuate negative gender stereotypes; improvements in women's status cannot be achieved.

VC. Psychological and Sociocultural Implications

Ms. *Faiza Benhadid, Gender Adviser, UNFPA Country Technical Services Team, Amman*

Ms. Faiza Benhadid observed that FGM/C constitutes a crucial element of ritual initiation ceremonies within certain communities, insofar as they mark the passage of the girl child to adulthood.

The popular belief is that FGM/C controls women's sexuality and guarantees the virginity of women before marriage and their chastity after marriage. FGM/C is also said to constitute barriers to women's sexual desires and any temptation to have premarital sexual experiences or

adulterous relationships. Religion is also a source of traditions and often the reason to maintain the practice. Animists, Catholics, Copts, Jews, Muslims and Protestants practise FGM/C. Within Muslim communities, FGM/C is often practised because of the sincere but erroneous belief that it is mandated by the Koran. However, the Holy Koran does not mention FGM/C. One of the reasons often invoked by mothers to support FGM/C is that, without it, their daughters would not get married. Yet in most societies where this practice is the norm, women's status is subordinated to marriage and, in the same logic, to the number of children they have. Therefore, marriage is of major importance for their societal recognition.

Ms. Benhadid concluded that feminine sexuality covered many domains: physiological, psychological, cultural, social, political and religious. These dimensions of feminine sexuality are also thought and drafted according

to ethical, moral and theological principles. Therefore, it would be incomprehensible in this context to refer to FGM/C without referring to feminine sexuality and its corollaries: masculine sexuality and culture.

VD. Economic and Health Costs

Dr. *Tshiya Subayi-Cuppen, Dr. Khama Rogo and Dr. Gebreselassie Okubagzhi, the World Bank Group*

Dr. Gebreselassie Okubagzhi, presenting a paper on behalf of the World Bank Group, noted that costing FGM/C is important for advocacy purposes. It may be relatively easy to calculate the direct costs related to personal expenditures on treatment of complications—for example, individual or family spending and public expenditures such as spending on facility maintenance, staff salaries and infrastructure. However, it is difficult to cost pain and suffering and identify the social costs related to FGM/C. Furthermore, because most FGM/C activities are expected to be provided in an integrated manner at the facility level, it is an enormous challenge to separate specific costs attributable to FGM/C in integrated services.

Despite the above-mentioned difficulties, economic costs can be calculated and, in particular, costs related to health systems and households. Although detailed FGM/C studies have yet to be conducted by many African countries, studies from other regions reveal that FGM/C leads to a decline in family earnings, limits girls' potential for education, erodes household savings and investment and leads to high cost of treatment, resulting in the accumulation of debts which deepen household poverty.

Thus, an analytic study on FGM/C to compile data on economic cost implications is critical. The results of such

a study would be essential for launching effective community and international advocacy and for designing evidence-based national programmes.

Plenary Discussions and Recommendations

Extensive discussion followed these presentations emphasizing the need to understand the underlying sexual-cultural dynamics of FGM/C; developing positive messages about sexuality (even using religious quotations); involving men to challenge FGM/C practices; developing appropriate strategies to de-link marriage and FGM/C; dealing with the physical and psycho-social consequences of FGM/C; and developing costing methodologies on FGM/C related costs, including psychological, economic, social and health costs. These costs could be used to advocate for more resources to support FGM/C abandonment initiatives.

Recommendations made were that:

- Partners in the movement to abandon FGM/C learn from other health costing exercises, such as malaria and HIV/AIDS costs and undertake similar cost studies on FGM/C especially in Africa
- Holistic programmes to address FGM/C abandonment be developed and implemented
- Appropriate programmes be designed to address patriarchy and male dominance

VI. Experiences/Lessons Learned and Best Practices in the Abandonment of FGM/C



VIA. The Politics of FGM/C, Partnership-Building and Community Accountability Mechanism: Case Study, Kapchorwa District, Uganda

Ms. *Margaret Thuo, Adviser, Behaviour Change and Advocacy, UNFPA/Country Technical Services Team, Addis Ababa*

Ms. Margaret Thuo recounted the experiences of the Sabinu tribe in Kapchorwa District, Uganda, and the efforts to eliminate FGM/C.

The Sabinu traditionally practise FGM/C as a rite of passage to adulthood and to marriage, which is performed bi-annually (in even years) during the month of December. FGM/C affects the education of the girl child. For example, according to the 2002 census, the total net enrolment of children in primary school was 91.8 per cent (92.2 per cent for females) in this district. In secondary school, males and females who completed secondary education and were aged 20+ years were 6.2 per cent. Of all females aged 20+ years, only 3.6 per cent had completed secondary school, compared with 8.8 per cent of males of the same age. Also, 6.1 per cent of girls aged between 12 and 17 years in this district were mothers.

1. The politics of FGM/C

Attempts to eliminate FGM/C were initiated in the 1980s by more enlightened members of the community and religious groups. Heavy opposition from the community was encountered, as this was seen as an external threat to the Sabinu culture. As a result of this resistance, the District Local Government commissioned a study in 1991

on the views of the Sabinu community regarding FGM/C. The majority voted to retain FGM/C. Thus, the District Council passed a resolution to make FGM/C mandatory, which was unfortunately used to force girls to be excised.

Members of the Sabinu Elders Association mobilized some girls to report the matter to parliament, and two ministers flew to Kapchorwa to discuss the implications of the resolution. The District Council apologized and passed a new resolution to make FGM/C optional for females aged 18 years and above. Although this was a positive move, it left loopholes which were used by the pro FGM/C group, who included magistrates, government officers, local government leaders and teachers, to promote excision and to counteract messages by members of the community who advocated for the abandonment of the practice. The pro-FGM/C group contributed enough money to provide gifts, including money, to families that supported excision. By 1998, there was a 36.3 per cent increase in the incidence of FGM/C over the previous period. However, efforts of the pro-FGM/C group to mobilize funding were not sustained.

The politics of FGM/C takes many forms. By 2002, REACH was becoming successful, with many communities saying no to FGM/C. In addition to being seen as those who opposed the continuation of the tradition, they became a threat to politicians and this led to the killing, in December 2002, of the Kapchorwa Chief Dis-

trict Administrative Officer, who was also the signatory of the REACH project. In January 2003, the pro-FGM/C camp also killed the husband of the REACH Coordinator. After the husband's death, the Coordinator was forced to be inherited as a wife by relatives and when she defied the tradition, she lost all her property rights—home and land. Her determination and commitment to fight for women's rights were unequalled.

It was observed that the educated and enlightened few did not allow their daughters to be excised but promoted it in the community. The only explanation for this phenomenon was that this group was bent on sustaining its political power base for generations over the uninformed majority. Unfortunately, some political leaders who saw sense in stopping FGM/C lacked commitment to speak out against FGM/C for fear of losing votes.

Despite these politically motivated problems, REACH has won over the greatest opposition, including Peter Kamuron, who signed the original resolution to continue the FGM/C practice in the district. He later became a human rights activist and started his own Human Rights CBO. Another pro FGM/C activist was Mary Yapkwopei, who later became a councillor and a strong advocate for FGM/C abandonment. By 2006, five subcounties had

registered zero FGM/C prevalence. By 2007, Kapchorwa's senior magistrate, the prosecutor and the police had joined parliamentarians, faith-based organizations, NGOs and the majority of the community in planning together the total abandonment of FGM/C in all subcounties by 2011.

There are still challenges in the opposition stronghold, where FGM/C prevalence rose in four subcounties in 2006.

2. Lessons learned:

- (a) Know your political opponents and their arguments and use their arguments to win them over. This weakens the opposition;
- (b) Work with all stakeholders—parliamentarians, law-enforcement agencies, elders, female “surgeons”, human rights activists and others. They all have an important voice;
- (c) Do not forget boys and girls. Select them carefully and work with them beyond FGM/C issues;
- (d) Remember! Developing awareness within the community is key;
- (e) Encourage and support your staff to keep going when it is really tough.

VIB. Working with Maasai Communities

Ms. *Judith Kunyiha Karogo, Programme Officer, UNFPA Kenya*

The purpose of this presentation was to share the Kenyan experience in working with three Maa speaking communities—the Maasai in Narok District, the Samburu in Samburu District and the Njemps in Baringo District—towards the abandonment of FGM/C. The three com-

munities represent three distinct phases and approaches towards the abandonment of FGM/C.

1. Community mobilization

Community mobilization is being implemented among the Njemps and the Kalenjin-speaking communities through the Catholic Diocese of Nakuru. The communities are engaged in dialogue on the harmful effects of the

practice and possible community-driven interventions towards its abandonment.

2. Alternative rites of passage

Where FGM/C is a rite of passage from childhood into womanhood, the design and implementation of ARPs represents a culturally sensitive approach that accepts and adopts the transition from one stage to another while protecting young girls from excision.

This approach has worked well among the Maasai in Narok. The community designs alternative rites, and the girls who graduate from the process are accepted and acknowledged as women in the society.

3. Rescue Home

The “rescue home” approach, in use among the Maasai in Narok District, was developed in response to the growing need of girls seeking refuge and a safe house to escape FGM/C and early forced marriage. The necessity for these safe houses became clear when internalization of the harmful effects of the FGM/C had been achieved among many. In this respect, different individuals accepted the need to change but remained at risk of being excised forcibly by individuals in the community who had not embraced the change.

Some of the challenges include:



- (a) Sustainability of rescue homes. Girls resident in the houses need basic necessities as well as education, and their numbers continue to increase. Although rescue homes are necessary, they are expensive to maintain;
- (b) Vast geographical areas of coverage in rugged terrain, making intervention and access to communities difficult;
- (c) Cultural “baggage” and fear of moving from tradition;
- (d) Weak law enforcement to prohibit FGM/C.

VIC. The Inter-Africa Committee on Traditional Practices: Programme Strategy

Mr. *Isatou Touray, Secretary General, Inter Africa Committee on Traditional Practices*

Mr. Isatou Touray informed participants that the programme activities of IAC are grounded in empowering people to change their own conditions through advo-

“Mr. Touray observed that the advocacy work had resulted in communities’ recognition of FGM/C as having harmful effects on women’s reproductive health and as being a violation of women’s reproductive rights.”

cacy and through training and information campaigns on harmful traditional practices. IAC uses a rights-based approach focusing on the best interest of the child and works with critical actors, especially religious leaders, local opinion leaders, women, men and youth. Research is a major component of the interventions, and the findings feed into planning and programming of subsequent interventions at different levels.

At the community level, excisers are empowered to understand the harmful effects of FGM/C on women’s and children’s reproductive health and rights. They are supported with alternative employment opportunities based on their choice of small-scale business enterprises that are available in their immediate environment and that are likely to be sustainable.

At the policy level, IAC targets National Assembly members, the judiciary and law-enforcement agencies, educational institutions and civil society.

Mr. Touray observed that the advocacy work had resulted in communities’ recognition of FGM/C as having harmful effects on women’s reproductive health and as being a violation of women’s reproductive rights. This led to the abandonment of FGM/C by many communities. For example, 68 communities and 18 excisers in the Gambia made a public declaration to abandon FGM/C. The effort by IAC paved the way for other organizations such as Tostan to model advocacy on the work already done by national committees in various countries.

VID. Sociocultural Contribution to the Abandonment of FGM/C

Mr. *Ali Hashim Sarag, Sociocultural/Religious Expert, Sudan*

Mr. Ali Hashim Sarag observed the confusion and poor understanding of the word Sunna, which is used as a basis for perpetrating FGM/C. He clarified the concept of Sunna and discussed different types of Sunna as specified in the Hadith. He suggested some changes in terminology that might be acceptable to the Islamic religion, such as female genital violation (FGV) instead of FGM/C. He recommended the following:

- (a) Good understanding of the Koran as a key to advocacy among religious leaders;
- (b) Strategic selection and engagement of traditional and religious leaders in the fight against FGM/C;
- (c) A comprehensive approach that focuses on the rights and violation of rights of women;
- (d) The mainstreaming of human rights principles and education into the school curriculum at all levels.

VIE. Lessons Learned from Operations Research

Ms. *Maryam Sheikh Abdi, Programme Officer, the Population Council, Nairobi*

Ms. Maryam Sheikh Abdi shared with participants important lessons learned from operations research undertaken in some African countries by The Population Council's Frontiers in Reproductive Health Programme. Two key strategies used were single interventions and holistic interventions to encourage FGM/C abandonment. The single-intervention strategy involved addressing excisers and health-care providers whereas the holistic intervention used multiple approaches such as Tostan methods, ARPs and the integration of FGM/C abandonment efforts into community reproductive health.

1. Lessons learned from single interventions

In a single-intervention strategy in 1998, NGOs aimed at converting excisers in Mali through education and alternative revenue. Evaluation showed this strategy as largely ineffective, as those who abandoned FGM/C had already trained a replacement—a daughter or niece—in excision. Some excisers abandoned the practice because of old age or medical reasons, such as blindness. The evaluation also found that excisers had gained social status, and most of them believed that FGM/C is not harmful. Moreover, alternative practitioners could easily be found in other villages and across borders. Therefore, The Population Council recommended that a strategy aimed at reducing demand be put in place rather than trying to reduce the supply.

The strategy for addressing health providers in Mali, in 1998, involved a three-day training course aimed at improving health providers' knowledge and creating positive attitudes towards FGM/C abandonment. Although knowledge improved and some attitudes were changed, providers were still not forthcoming to educate clients.

The Ministry of Health issued a ban on FGM/C in clinics and included it in the training curriculum for providers so as to educate communities about harmful effects of the practice. The lesson learned was the need to address providers' attitudes first, enhance their skills and educate the community about the implications of FGM/C as well.

2. Lessons learned from holistic interventions

The Population Council monitored several holistic interventions, including:

- Basic education programme and public declaration (Tostan)
- Alternative rites of passage—Movement for Women Progress (Maendeleo Ya Wanawake Organization, MYWO)
- The medicalization of FGM/C in Kenya
- The integration of FGM/C into community reproductive health education (CARE)
- Kenya community and clinic interventions
- Burkina Faso interventions with the National Committee against FGM/C (CNLPE) and partners (law+education+multisectoral approach)

Women's education and public declarations. The Tostan approach involves a seven-month literacy programme for the same group of women on such topics as women's health, hygiene and human rights. At the same time, a village-wide discussion on the meaning of "cutting" was held. When the villagers were convinced that there was no more value for FGM/C, they would organize communal pledge ceremonies in public. The scaling up of this approach was tested in different parts of Senegal with the support of Development Cooperation of Germany (GTZ). The replicability of this approach was tested in rural Burkina Faso by various NGOs, also with GTZ support. The long-term impact was also tested with support

“Two key strategies used were single interventions and holistic interventions to encourage FGM/C abandonment.”

of Macro, The Centre for Research in Human Development (CRDH) and UNICEF.

The immediate findings were that the Tostan approach successfully increased knowledge in human rights and reproductive health, decreased negative attitudes and created positive behaviour change within the community, especially in the improvement of hygiene, denunciation of FGM/C and a decreasing percentage of excised girls 0-10 years of age. Through a diffusion system, public declarations of numerous villages were witnessed.

The ARP programme. Supported by The Programme for Appropriate Technology and Health (PATH) and implemented by MYWO, the ARP programme in Kenya involved community-wide education on FGM/C, reproductive health and life-skills education for girls, ARPs from puberty to womanhood and a public ceremony for “graduation”. The assessment found that such alternatives must be preceded or accompanied by community sensitization. ARPs depended upon the meaning of the

practice of FGM/C and the linkage with a rite of passage, for example, among the Meru and Abagusii.

Medicalization. A diagnostic study examined the role of health providers in Kenya’s Abagusii community so as to understand motivations behind the medicalization of FGM/C and to determine the feasibility of using health providers as change agents. The findings showed that criminalization had driven the practice into secrecy and that girls were being cut at younger ages. Medicalization was being preferred due to fear of infection and the preference for professional providers. The health providers’ rationale for cutting was financial (60 per cent), a concern for hygiene and safety, community pressure and cultural demands. It was therefore recommended that laws be disseminated and enforced, that providers be trained in human rights and that the financial motivation for providers be addressed.

Community Education—CARE Integrated Approach. This approach involved the integration of anti FGM/C activities into CARE reproductive health programmes in Ethiopia and in Somali refugee camps in Kenya. It included educational campaigns, public declarations and statements and the involvement of medical personnel. The findings demonstrated increased knowledge about harmful effects of FGM/C—physical, social and psychosexual dimensions. The approach also elicited community debate on the practice, as a result of which 70 local elders in Ethiopia made a public declaration that girls in their villages would no longer be cut.

Kenyan community and clinic interventions: These interventions entailed diagnostic study among the Somali community in Kenya, where Type III is nearly universal. Findings showed that religion was a key rationale for practising FGM/C among the community. An informed intervention addressed the perception of FGM/C as an Islamic



requirement and worked with religious leaders to build consensus on the correct Islamic stand on the practice. It was also found that service provision was poor, and there was a need to strengthen health services by training providers in safe motherhood/reproductive health.

Interventions in Burkina Faso: In Burkina Faso, an evaluation of the CNLPE strategy was undertaken to determine whether FGM/C was declining. CNLPE is a government body composed of 13 institutions, including the army, health, social, defence, communication, and justice institutions. CNLPE strategies consisted of: implementation of the law; a free telephone line for denunciation (SOS excision 80 00 11 12); capacity building and advocacy work and the education of communities on the risks of FGM/C, especially on health consequences and the legal implications if perpetrators were arrested or condemned. The operation of this system was decentralized.

The evaluation found that:

- (a) Four provinces had a prevalence rate of less than 50 per cent;
- (b) Young women cut their daughters less frequently than formerly;
- (c) There was a decrease of the prevalence among young girls less than 10 years of age;
- (d) There was a decrease in the practice in most provinces, even if some areas still had stronger resistance;
- (e) People testified that the abandonment started five to eight years ago at an accelerating pace;
- (f) Christians had abandoned FGM/C earlier than did Muslims;
- (g) There was an increase in the perceived complexity of practising FGM/C because of the law and denunciation;
- (h) There was an increase in the perceived compatibility of not cutting (new cultural environment, migration, education).

3. Common elements in abandonment

Identified factors common to all programmes in speeding up abandonment were as follows:

- (a) Enabling environment: policy (law) and democracy (media);
- (b) Comprehensive, well-structured, holistic interventions;
- (c) Decentralized operating system with a strong coordination mechanism;
- (d) Long-term education of communities (constant and using different channels);
- (e) Organized system of communicating abandonment;
- (f) Involvement of leaders to become key actors;
- (g) Responsibility of communities to maintain the surveillance system.

Plenary Discussions and Key Recommendations

A number of good ideas were drawn from the discussions. The need for accurate analysis of the positions of all stakeholders was stressed, especially concerning opponents' arguments, politicians' games and gatekeepers' power. Reinforcing support to anti-FGM/C activists, particularly those working in strong resistance zones, was determined to be critical. Investing in young people, including out of school youths, and recruiting them to undermine the resistance movement was also proposed. Using the issue of FGM/C as an opportunity to challenge broader gender discrimination and promote women's empowerment in communities was seen as key to furthering gender equality and women's empowerment. Recommendations were to:

- (a) Build partnerships with key stakeholders in various sectors necessary for the success of FGM/C interventions;
- (b) Recognize that the involvement of men and boys is key to programme interventions;
- (c) Adopt a comprehensive approach to programming, including human rights issues and gender and reproductive health and rights, as a necessity for successful programmes;
- (d) Mainstream gender budgeting and analysis into programming and efforts to achieve MDGs;
- (e) Make operations research one component of the programme.

VII. Strategies That Work: Scaling Up and Lobbying for a Global Effort



VIIA. Community-led Developments Using Social Convention Theory, Diffusion Models and Social Networking

Mr. *Malick Diagne, Deputy Director, Tostan*

Mr. Malick Diagne informed participants that Tostan operates as a government-registered NGO in 303 communities in Senegal, 140 communities in Guinea, 42 communities in Somalia and 40 communities in the Gambia. The Tostan Programme was founded in 1991 by Molly Melching, who is also its executive director. She had developed a non formal education programme in Senegal during the 1970s and 1980s, and FGM/C was identified by the community as a special issue to be addressed under the programme, hence the initiation of Tostan.

Over the past 15 years, an emphasis on continual feedback from participants and on external evaluations allowed the Tostan Community Empowerment Programme to evolve and respond to the real needs and priorities of the communities it was serving. Operating in local languages and implemented by Tostan-trained volunteer facilitators from the same ethnic group as the host community, the current version of the Community Empowerment Programme lasts 30 months and uses familiar means of communication, such as discussion, dialogue, song, dance, theatre and poetry.

The programme empowers participants with knowledge, skills and experience in many areas, including democracy, human rights, problem solving, health, hygiene, literacy and numeracy, micro-credit and management skills. In addition, Tostan's innovative "Organized Diffu-

sion Model" exponentially increases programme impact: participants adopt and share programme topics with friends and family members and with the community at large. In turn, each community shares new information and knowledge with surrounding communities. This diffusion of knowledge and action brings about regional and national consensus in areas essential to the respect of human rights, including the abandonment of FGM/C and child marriage.

Positive results from the Community Empowerment Programme include:

- (a) The abandonment of FGM/C and early marriage in more than 1,700 communities in Guinea and Senegal;
- (b) Reduction in infant and maternal mortality;
- (c) School and birth registration campaigns;
- (d) Improved communication among all members of the community;
- (e) Dramatic increases in vaccination rates;
- (f) Increased prenatal and post-natal consultations;
- (g) Increased knowledge about and prevention of HIV/AIDS;
- (h) Promotion of family planning, good nutrition and community health services;
- (i) Regular clean-up activities;
- (j) Active peace committees for conflict resolution.

VII B. Community Conversation Model

Dr. *Bogaletch Gebre, Founder, Kembatta Mentti Gez-zima Tope (KMG), Ethiopia*

Dr. Bogaletch Gebre observed that the international debate on human rights, particularly concerning women and girl children, is always associated with culture. But culture should never be fundamentally at odds with women's human rights. KMG is an indigenous non-governmental, woman focused, integrated community development organization that took steps to harmonize cultural beliefs among communities concerning development, gender equality and women's empowerment. KMG has created programmes on health, livelihood, environment, gender, democracy and human rights. In this respect, KMG works on the assumption that communities have capacities to effect change and sustain it. This is often hampered by information or knowledge gaps and, at times, misconceptions and acts of bad faith.

Few, if any, parents in the world would hurt their children knowingly or deliberately. Therefore, filling the knowledge gap is essential, especially concerning gender concepts, body awareness, civil/legal rights education/information as well as financial, business, economics and environmental literacy.

KMG is based on the principles of respecting and giving dignity to people's way of life, teaching by learning, working with communities and not for them, being transparent and accountable at all times, building trust and understanding, collaboration and cooperation. Its core strategy is to link the practical needs of communities with the strategic needs of women in their communities, thus linking ecological, economic and socio-political systems that hold women and society in congress, thereby making human rights relevant to the reality on the ground.

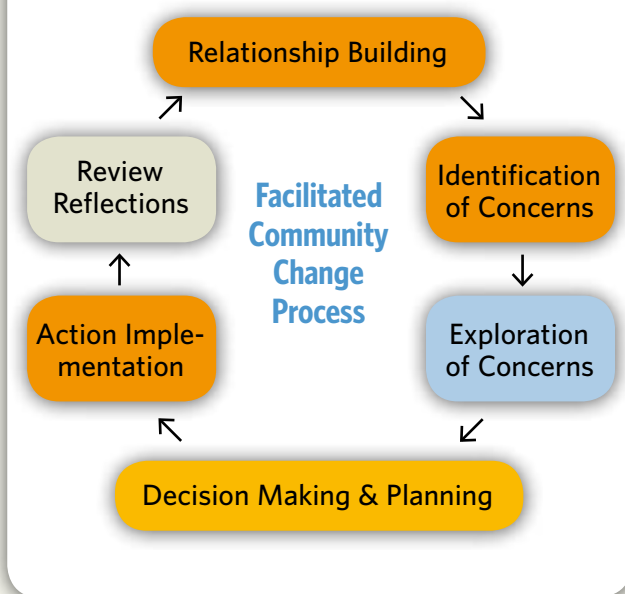
Community Capacity Enhancement - through the Community Conversation (CCE-CC) programme—was introduced by the United Nations Development Programme (UNDP) as a means of expression of the community. By using participatory and transformative tools and skills, Community Conversation provides an opportunity for active and inclusive interaction, dialogue, introspection, reflection and sharing, without fear or discrimination. The programme empowers people to think through how their behaviour, values and practices, and those of their families and neighbours, affect people's lives and to reflect on and discuss these issues with others. It is based on the principle that "the answer lies within" and "transformation is from inside out."

With respect to HIV and AIDS, the aim of Community Conversation is to generate a deep and complex understanding of the nature of the epidemic within individuals and communities, examine social contracts among groups in the community and generate and sustain locally appropriate and effective responses to control the epidemic, thus bringing the voices of the people into the national response.

The principles of Community Conversation are as follows:

- (a) Communities have capacities to identify, generate, own, sustain and transfer changes;
- (b) Facilitation, rather than "expert" intervention;
- (c) Sensitivity to local, family and community experiences;
- (d) Gender sensitivity;
- (e) A focus on the participation and inclusion of women and girls and;
- (f) Mutual learning, mutual trust, respect and teamwork to guide the process.

Community Conversation Methodological Framework



Community Conversation generated collective social learning, a shift in power relations and a strengthening of ownership and responsibility for change as well as the mobilizing of local capacities and resources.

Some major results achieved through this programme were:

- (a) Increased knowledge about HIV and AIDS;
- (b) Increased voluntary counselling and testing among religious leaders, women, men, young boys and girls;
- (c) Decline in practices that are harmful, especially FGM/C;
- (d) Increased care and psychological, financial and material support to members of the community;
- (e) People living with HIV and AIDS coming out openly because of decreased stigma and discrimination;
- (f) Religious leaders, clan leaders and idirs taking action to stop harmful practices that fuel the epidemic;
- (g) The role and position of women improved (as women gain the confidence to talk and raise their voices in

the presence of men, to say no to sex with a guest and to request that their husbands test for HIV);
(h) Resonance effect (sharing information).

In addition, the government structure in Ethiopia accepted Community Conversation as a strategy for its community interventions, especially in social mobilization, agriculture and health extension information and services. Community Conversation also served as an entry point for other developmental activities beyond HIV and AIDS, demonstrating its potential for wider application of the methodology.

Dr. Gebre pointed out that, to be effective Community Conversation requires commitment and a shift in the mindset concerning the way one looks at communities and their capacities. Human rights principles are directed towards ensuring that no one group in society can dominate another by turning another group into oppressed servants and slaves. As in racial apartheid, in which segregation and discrimination exist, women are denied equality in law and under the law, equal rights in marriage and in sexual relations, the right to dignity, the right to life, the integrity and security of the person and the right to equality of opportunities in accessing and controlling resources. Women are lynched, chased, abducted and raped, maimed, mutilated and deformed, abused, used, discarded or shot and killed. As with the fight against racial apartheid, the struggle against the inequality of women must begin with women themselves.

Sadly, Dr. Gebre continued, women have culturally accepted violence as normal, “natural” and a woman’s fate. Women bear the violence and suffer silently. Therefore, for women to lead the struggle and be the principal social agency of change, they themselves must go through transformation from a state of being objects to active citizens.

Unlike racial apartheid where oppressors are located in the northern suburbs, women’s oppressors are within their households—husbands, fathers, sons, uncles, brothers, cousins and other community members. Therefore,

“Unlike racial apartheid where oppressors are located in the northern suburbs, women’s oppressors are within their households—husbands, fathers, sons, uncles, brothers, cousins and other community members.”

women’s struggle for freedom and equality has to begin within the household. Women must be empowered comprehensively—economically, ecologically, socially and politically—to gain their voice within the household.

Women are the first teachers of their children and therefore have a special opportunity to bring cultures of respect, tolerance and the notion of human rights within the household, particularly towards female children. This is where CCE-CC becomes critical as a tool of community social mobilization against gender-based violence,

to build consensus and gain support in their struggle. Women’s struggle for freedom and equality has to be different. It must address “solidarity of humanity” that is committed to the survival and wholeness of the entire people, for the integrity of females and males.

Dr. Gebre concluded by asking participants to work towards the creation of a global coalition against gender apartheid and to secure for women the right to dignity and the right to a healthy life as human beings.

VIIC. Coordinated Strategy for the Abandonment of FGM/C: Main Elements, Goals and Objectives

Ms. *Maria Gabriella De Vita, Child Protection Specialist, Gender Equality and Social Change, Child Protection Section, Programme Division, UNICEF, New York*

Ms. Maria Gabriella De Vita discussed a new approach to programming, the Coordinated Strategy to Abandon Female Genital Mutilation/Cutting in one generation. She described it as human rights based education and adult learning as a way to leverage the emergence of certain social dynamics in communities which could lead to ending FGM/C in a single generation.

The programme was built on the convergence of academic theory and empirical evidence which support an international goal and objectives, including an internationally agreed time for abandonment. The strategic dimensions build upon the main determinants of FGM/C, such as ethnicity, propagation through social networks linked to the potential for marriage of daughters and on factors that perpetuate FGM/C, such as religious commitments. It is a subregional approach that groups countries according to their affinities and similarities.

The new approach utilizes the application by Jeffrey Mackie of game theory.¹⁰ Following this theory, Gerry Mackie views FGM/C as a self-enforcing social convention and assumes that FGM/C is linked mainly to daughters' potential for marriage.¹¹ Thus, in his view, FGM/C is an equilibrium point in a society-wide coordination game linked to marriage. FGM/C is performed on daughters because each family chooses what they think other families will choose. No one family abandons the practice on its own, because to do so would ruin the marriageability and status of the family's daughter. A non-cut daughter would be an outcast and shunned through mechanisms of enforcement that societies put in place. Decision-making is interdependent, and behaviour is contingent on what others do. To abandon the practice, it is necessary to coordinate abandonment collectively, whereby all families abandon daughters' genital mutilation/cutting at the same time through a coordinated decision to do so. This may be facilitated by a public pledge whereby all members of society come together to affirm their intention to abandon. Thus, enforcement mechanisms to continue excision are diminished, and the intention not to excise will be translated into true abandonment.

Utilizing an appropriate social network or networks may facilitate the process. An initial core group of families within an appropriate social network—that is, an intra-marriage group—decides to abandon FGM/C. The core group mobilizes a sufficient number of people to widen their daughters' opportunities for marriage, and the group becomes self-sustaining. At a certain time, there will be a large-enough proportion of the population to create a "tipping point" and the change will be rapid and universal. After the convention shift, FGM/C is no longer linked to a daughter's marriageability and, thus, there is no reason to return to FGM/C. Ms. De Vita noted that empirical evidence demonstrates that human-rights education helps to devalue daughters' genital cut-

ting, thereby accelerating the formation of the first core group, widening it and reaching a tipping point where the convention shifts.

Ms. De Vita remarked that an internationally formulated goal would be presented for wider consensus during the 2007 December session of the General Assembly as a follow-up to the 2002 special session on children. The goal would supersede the goal formulated in 2002, which set 2010 as the year of ending FGM/C. The new goal is "Ending Female Genital Mutilation/Cutting in One Generation (23-25 years), with Demonstrated Successes in Many Countries by 2015". Demonstrated success is intended to be a 40 per cent reduction in prevalence over a period of five to eight years, based on empirical evidence.

Marriageability probably accounts for the universality and persistence of FGM/C. However, Gerry Mackie recognizes that other norms add significance to the practice and contribute to its perpetuation. FGM/C may be perceived as a specific step a girl must take to fulfil religious obligations (Somalia, Sudan); as a step to comply with an honour and modesty code (Somalia, Sudan); as a specific step an adolescent must take to fulfil a rite of passage into adulthood (Kenya); or as a specific step in gaining membership to a secret society (Sierra Leone).



¹⁰ Jeffrey Mackie Mason, *Evolutionary Game Theory* (Washington, American Sociological Association, 1996).

¹¹ Gerry Mackie, *a Harmless Practice?* (American Anthropological Association, June 2003).

“Ms. De Vita remarked that an internationally formulated goal would be presented for wider consensus during the 2007 December session of the General Assembly as a follow-up to the 2002 special session on children.”

The new programmatic approach demands some revision in the classical way of programming. First, it would be necessary to review the timing of programming versus results. A considerable investment in funding and resources would be needed over a multiple-year period when results would not be apparent. The length of this period is variable and cannot be calculated in advance except by referring to existing experience, which suggests three to five years after public acknowledgement. Sudden spontaneous spreading to entire population would be seen in the last phase of the programme.

Communication for programming would aim at achieving a shift in convention through reaching a critical mass, achieving public acknowledgement and reaching a tipping point. The implications of such an approach could be applied to general issues of gender inequality, wherever different standards of living between women and men, and girls and boys, are sanctioned by self-enforcing social conventions.

VIID. Experiences in FGM/C Interventions with Norwegian Support

Dr. Berit Audstveg, Senior Adviser, NORAD

Dr. Berit Audstveg focused on the experience of FGM/C interventions with Norwegian support. Her talk reflected on the main findings from an assessment that documented the support provided by Norwegian international aid for FGM/C efforts in the context of global efforts. The assessment was expected to pave the way for an evaluation to be undertaken between 2008 and 2009.

A 2007 review of projects in Eritrea and Ethiopia demonstrated that the early Norwegian work on FGM/C

(since the 1980s) supported NGOs, especially Norwegian Church Aid, Save the Children, FOKUS and CARE, UNFPA and UNICEF. The focus was on “harmful traditional practices”, using a health approach.

The assessment revealed several trends. There was a substantial reduction in prevalence in Kenya and the United Republic of Tanzania and a more modest decline in Eritrea and Ethiopia. No reduction was recorded in Somalia and Sudan. Eritrea, Ethiopia, Kenya, Sudan and the United Republic of Tanzania had laws that ban FGM/C. The rationale for FGM/C varied among countries (religious, health, cleanliness, beauty etc.) but with some common themes—marriageability and sexual morals.

The prevalence of FGM/C was higher in rural than in urban areas, with the exception of Sudan. The medicalization of FGM/C was not recorded in Eritrea and Ethiopia. Knowledge about the health hazards of FGM/C was increasing. There was a tendency to change from infibulations to less invasive types of FGM/C among Muslims in Eritrea and Ethiopia. Among orthodox Christians in the highlands of Eritrea and Ethiopia, about 90 per cent of girls were excised during their first year of life. In southern Ethiopia, northern Kenya and the United Republic of Tanzania, excision often took place around puberty, but because of medicalization the ages were decreasing. Religious leaders were speaking up and declaring that FGM/C is a cultural and traditional practice and not mandated by religion. This trend has yet to trickle down to religious institutions and individuals' religious thinking.

Some of the shortcomings identified in Norwegian support were that support was given to NGO projects and the United Nations, with little support provided to national authorities. While many projects supported were in Ethiopia, a pilot country for the national Action Plan of 2003, only a few projects were supported in Somalia and Sudan. Emphasis on project purposes was on prevention, with little focus on treatment, rehabilitation and competence-building. The projects were often geographically scattered, with a lack of support to programmes undertaken by central institutions. Projects were only to a small degree integrated into the sector approach of authorities. Many projects lacked baseline data, monitoring and effective evaluation.

NORAD supported a UNFPA-initiated FGM/C project in Eritrea, implemented by the National Union of Eritrean Women. A baseline study was undertaken in Zoba Debub, which has 12 sub-Zobas. An anti-FGM/C committee was established at the sub-Zoba level comprising influential persons in the local communities, administrators, women's activists, teachers, elders, religious leaders, excisers, health workers and youth organizations. Committee members were trained as change agents, and the mapping of excisers (number, age) was under-

taken. FGM/C abandonment campaigns were conducted at the community level in all 12 sub-Zobas where video shows were also used as a medium for communication. The media were also used in the campaign to accelerate the abandonment of FGM/C.

A project review in March 2007 indicated that few adolescents were present at community gatherings, yet youths are an important target group in FGM/C abandonment. In Eritrea, most girls are excised when they are between one week and one month of age, and therefore pregnancy and delivery care providers should participate in the FGM/C campaigns. It was also found that, in addition to large community gatherings, there was a need to plan for smaller groups' discussion forums. Experience with the provision of micro-credit to excisers was not entirely positive. It was recommended that a monitoring system be established. The use of people with authority and power was questioned. It was observed that a legal ban against FGM/C has little effect on the reduction of excision incidences if not complemented by other efforts aimed at attitudinal changes. Also, it was unclear how to tie empowerment and human rights to FGM/C interventions.

The following factors contributed to positive results:

- (a) Using approaches directed towards gender equality and human rights, with a focus on discrimination against women and on FGM/C as violence against women;
- (b) Mobilizing local communities (individuals and groups) and using multisectoral approaches (social sector, legal sector, media and communication through radio and TV);
- (c) Emphasizing the participation of youths;
- (d) Using the Tostan approach, with a common declaration of a FGM/C free zone; the "Kembatta approach", such as marriage with a "declaration on no more FGM/C"; and the use of entry points such as HIV and AIDS, sexual and reproductive health and rights, and community development.

VIIE. FGM/C Abandonment: Mali Experience

Mme. Keita Josephine Traore, Director, National Programme for the Abandonment of FGM/C

Mme. Keita Josephine Traore observed that the prevalence of FGM/C in Mali is 91 per cent in the north and 87 per cent in the south. Certain ethnic groups do not practise FGM/C.

She remarked on the Project to Support the Fight against Practices that are Harmful to the Health of Women and Infants—*Project d'Appui a la Lutte Contre Les Pratiques Prejudiciables a la Sante de la Femme et de l'Enfant* (PASAF). Funded through UNFPA, PASAF was designed after thorough research. The project used three strategies, namely, behaviour change communication in the community, advocacy at national and subnational levels and capacity building.

Human rights were mainstreamed into the FGM/C campaign. Young people participated through school outreach programmes and through the national day on the abandonment of FGM/C, held every year on 6 February. The programme put in place quarterly coordination meetings and established a databank. Mali made impressive strides in the abandonment of the practice, in that 2,100 villages made a declaration against FGM/C, and a 40 per cent reduction in prevalence was achieved.

The main lessons learned for accelerating the abandonment of FGM/C are to empower women and girls who were violated; create a National Programme to Combat FGM/C; and provide a legal framework for action.

VIIF. Monitoring and Evaluation, Including Development Indicators

Ms. Laura Raney, Programme Associate, FRONTIERS, The Population Council, Washington, D.C.

Ms. Laura Raney observed that research is about asking questions, trying to understand situations for which there is no clear logical explanation. Social research is conducted to explore issues in order to become familiar with new issues and persistent phenomena and to

describe situations and events by observing and recounting what is observed. Reporting the frequency of cutting in a community is descriptive; identifying why it is done is explanation.

Ms. Raney observed that basic research generates theory and knowledge. Applied research identifies and offers solutions to problems in the programming process. Both types of research provide programmes with an evidence

base. Furthermore, research provides a programme manager with a clear understanding of the underlying nature of a problem and a sound basis on which to base programme activities. Research can help identify FGM/C issues needing to be addressed; for instance, whether a target community regards the practice as a threat to girls' welfare. Activities based on scientific observation and deduction, not on what someone imagines, is the issue.

Is research necessary all the time? Ms. Raney asked. In answer to this question, she said that some questions and problems cannot be answered by experience or common sense, for example, discrepancies between what is and what should be, or when available literature does not reveal how similar problems are solved. In these instances, research is necessary.

FGM/C-related research helps programme managers understand the practice and its complications, including the prevalence of FGM/C among various age groups; the sociocultural context; social values attributed to the practice; perceptions of different population groups regarding FGM/C; perception and acceptance of anti-FGM/C activities; intention and rationale for continuing the practice; the influence of religion, education and living conditions; and the use and acceptance of different communication channels.

Monitoring—the routine tracking of programme activities to find out whether those activities are being carried out as planned—ensures efficient use of resources. The results of monitoring reveal the extent to which activities are moving towards project goals. Undertaking monitoring helps managers to know where they are starting from, where they want to go and what interim changes they need to achieve.

Indicator-based monitoring is critical. Input indicators measure the resources—human and financial—contributed to the project; process indicators document the challenges encountered at each stage and the lessons learned; output indicators measure quantifiable results

that arise during the project; outcome indicators are longer term and measure social change, the impact of interventions among various community members, changes in women's empowerment and reduction or abandonment of a practice. For example, the intention not to cut is a behaviour change output indicator, whereas prevalence rates are a change in practice (outcome indicator). Indicators should be chosen based on the goal of intervention and what one hopes to achieve.

Plenary Discussions and Recommendations

There was a rich discussion on all presentations. Among the many ideas from the discussion was that communities should be encouraged to establish their own surveillance system on FGM/C abandonment as a measure of communities' responsibility and accountability. It was agreed that comprehensive holistic interventions combine anti-FGM/C programmes with the social and economic empowerment of women, including literacy, hygiene and micro-credit schemes. Strengthening partnership with governments was seen as critical for scaling up promising strategies. Monitoring and evaluation to measure the progress of any FGM/C-abandonment programme was emphasized. Research was seen as critical to help put in place baselines for measuring the effectiveness of FGM/C-abandonment interventions. Research would also help to identify deeply rooted causes, including myths about FGM/C, and this would be a good base for developing arguments towards FGM/C abandonment. Indicators must include the measurement of perceptions among different groups, actual change in mindsets, intention of parents and disapproval rate. Male involvement in FGM/C interventions was seen as crucial, especially for addressing issues of patriarchy and male dominance.

Recommendations made were that:

- (a) The concept of partial rights or partial justice does not exist and, therefore, there should be zero tolerance for FGM/C in any form, because it is a violation of human rights;
- (b) There is need for a multidimensional approach that targets gender equality as an underlying factor.

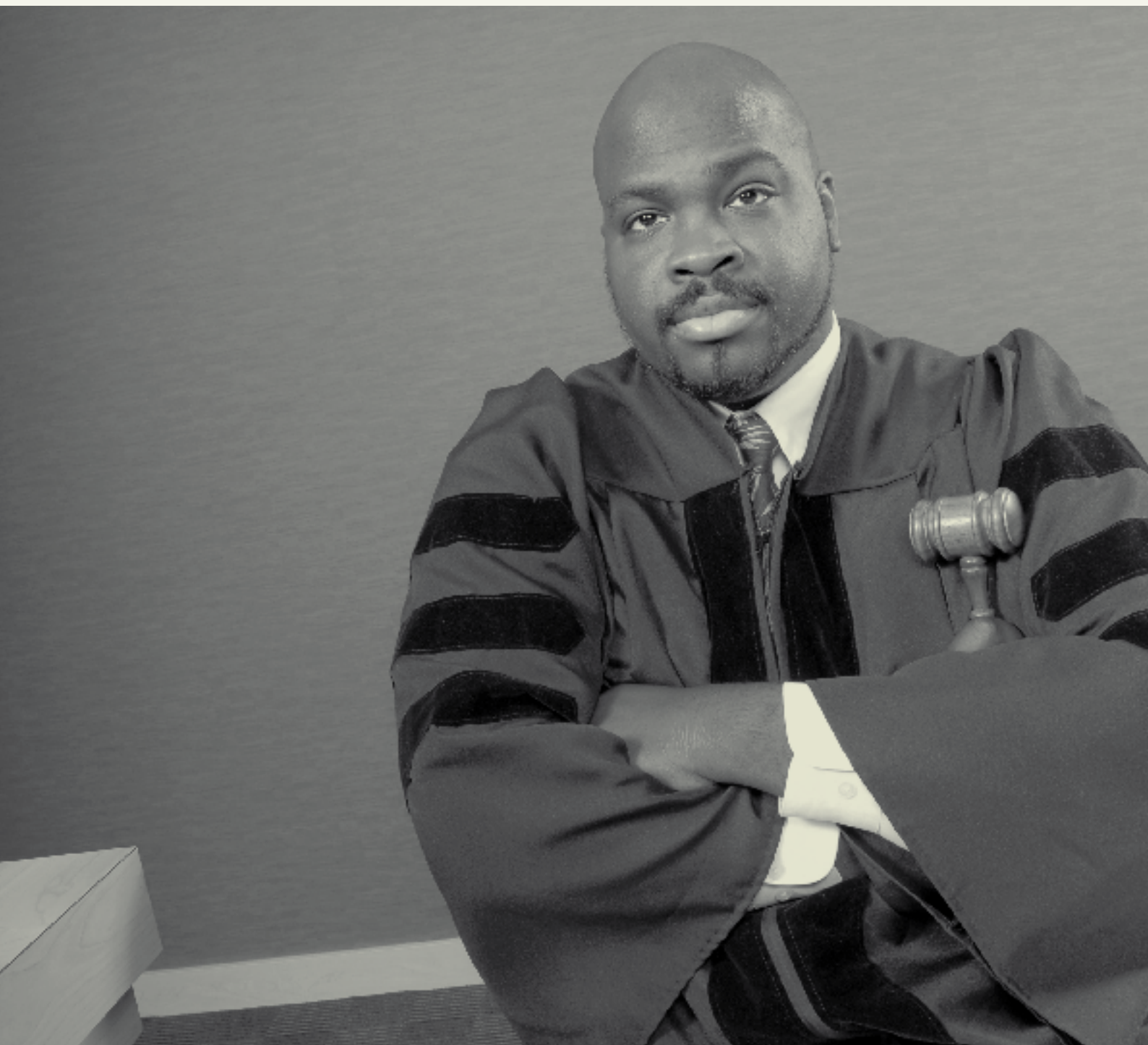
“Among the many ideas from the discussion was that communities should be encouraged to establish their own surveillance system on FGM/C abandonment as a measure of communities’ responsibility and accountability.”

Governments should be in the driving seat in these interventions;

- (c) Research should be conducted especially to provide evidence and identify the magnitude of the problem;
- (d) Positive cultural aspects should be promoted, such as promoting the whole body campaign, which is synonymous with the whole foot campaign held in China;
- (e) Systematic coordination of interventions among actors should be promoted to avoid duplication and strengthen synergies.



VIII. Identification of Gaps in Policies and Laws on FGM/C: Panel Discussion



VIIIA. Support for International Instruments and Harmonization of Traditional/Religious and Statutory Laws

Advocate Ibrahim Lethome Asmani, Kenya High Court

Advocate Ibrahim Lethome Asmani made reference to a number of international Instruments, namely:

- 1948: Universal Declaration of Human Rights
- 1966: International Covenant on Civil and Political Rights
- 1979: Convention on the Elimination of All Forms of Discrimination against Women (Arts. 2f and 5a)
- 1989: Convention on the Rights of the Child (Arts. 19.1, 37 a and 24.3)
- 1993: Vienna Declaration on Human Rights
- 1995: Beijing Platform for Action
- 1997: African Charter on Human and People's Rights (Art. 18 (3))

He observed that Kenyan statutory law does not conflict with Islamic laws in matters relating to FGM/C and other human rights issues. Kenya signed and ratified a number of international instruments, including the Convention on the Elimination of All Forms of Discrimination against Women. The Kenyan penal code criminalizes any act that causes harm to human body. However, there are gaps in these laws and instruments as well as in their enforcement. Some people are ignorant of the relevant legal provisions, while others fear interfering with people's culture and religion. Some law enforcement agencies lack goodwill and hence fail to report offenders due to fear of a parental curse. Also FGM/C is seldom considered a priority in many countries.

Advocate Ibrahim, who is also a consultant with The Population Council, observed that he worked among the predominantly Muslim Somali community where the prevalence of FGM/C is 95 per cent and the community practises the worst form of FGM/C—Type III. The rationale has been that FGM/C is an Islamic religious requirement. There have been many misconceptions about FGM/C in Islam, including that it was practised by Prophet Abraham. Further, the Somali community argues that FGM/C ensures chastity by controlling the sexual desires of women and ensures cleanliness (tohara). Chastity is an Islamic requirement. Nevertheless, Shariah guidelines condemn the practice. Advocate Ibrahim informed participants that Islam has recognized human rights for more than 1,400 years, rights that are similar to human rights in international and statutory laws.

It is therefore critical to argue that FGM/C violates women's human rights, especially: the right to life, right to make a choice in life, right to enjoy sex in marriage, right to safe motherhood, right not to be discriminated against, right to be protected against harmful cultures, right to health and healthy living, right to life free from pain and right to physical and mental integrity.

Positive messages in Islamic law can be used to counter the rationale for the practice. Such messages include: de-linking the practice from Islam by demonstrating that Islamic law condemns anything harmful to the human body, and cutting healthy organs and causing harm is unlawful (Koran: 2: 195). Islam emphasizes the importance of taking expert advice (Koran: 16: 43); Allah con-

demns those who change creation (Koran: 4: 119); Islam emphasizes good upbringing (*tarbiya*) and moral teachings, and no punishment before an offence. In addition, Islam condemns harmful cultural practices, for example, female infanticide (Koran: 81: 8-9). One should not succumb to community pressure at the expense of disobeying Allah, and trust in God does not mean that one does nothing (Koran: 13: 11). Every Muslim has an obligation to correct bad practices (Koran: 3: 110) and especially those in positions of authority.

The above arguments led 11 Somali scholars to declare total change. Instruments and statutes provided a good

legal framework within which to work. In predominantly Muslim areas where FGM/C is practised, Islamic law should be used to de-link the practice from religion, followed by a proof that it is a harmful cultural practice and, hence, prohibited by Islam. To ensure sustainability, available opportunities in the target community should be used, especially religious leaders and elders. Regarding the development of messages and materials, it is critical to demonstrate that Muslim law and international conventions on human rights are in harmony. Finally, the consideration of religious and cultural sensitivities alongside legal literacy should go a long way towards changing the FGM/C practice.

VIIIB. Enforcement of Existing Laws and Policies Pertaining to the Abandonment of FGM/C

His Worship Simon Peter Odo, Senior Magistrate, Kapchorwa, Uganda

His Worship Simon Peter Odo informed participants that FGM/C is practised in five districts among the Sabiny, Pokot and Tepeth communities as an initiation ceremony and a transition to womanhood. In Uganda, both the Constitution and the Penal Code Act provide the legal framework that can be invoked to accelerate the abandonment of FGM/C. This is in addition to other regional and international instruments, such as the African Charter on Human and People's Rights, the International Covenant on Economic, Social and Cultural Rights, the Convention on the Rights of the Child and the Convention on the Elimination of All Forms of Discrimination against Women. These legal regimes, if properly applied, would greatly contribute towards the abandonment of this practice. Also, a number of enforcement mechanisms could be marshalled to fight FGM/C.

Most written constitutions provide procedures by which an aggrieved party can make a petition. For example, the Honourable Dora Byamukama, a member of the East African Legislative Assembly working in human rights activities, made a petition seeking that the custom and practice of FGM/C be declared unconstitutional and, hence, null and void.

In its National Objectives and Directive Principles of State Policy, the Ugandan Constitution provides in paragraph v (ii) that "the State shall guarantee and respect the independence of non governmental organisations, which protect and provide human rights". The 1995 Constitution states in Article 24: "No person shall be subjected to any form of torture or cruel, inhuman or degrading treatment or punishment". Also, Article 33(6) states: "Laws, Cultures, Customs and traditions which are against the dignity, welfare or interest of women or which undermine their status, are prohibited by this Constitution". It is upon the basis of the

foregoing that the Constitution outlaws practices such as FGM/C by stating clearly: "If any other law or any custom is inconsistent with any of the provisions of this Constitution, the Constitution shall prevail, and that other laws or custom shall, to the extent of the inconsistency, be void".

In performing their operations, "surgeons" sometimes cause serious damage to the female's genitalia which constitutes a criminal offence, that of "grievous harm". Grievous harm means:

"any harm which amounts to maim or dangerous harm, or seriously or permanently injures health or which is likely to injure health or which extends to permanent disfigurement or to any permanent or serious injuries to any external or internal organ membrane or sense."

The operation may amount to "harm", which constitutes the criminal offence of assault occasioning actual bodily harm, or it may maim the victim permanently, through the destruction or permanent disability of any external or internal organ, membrane or sense. The surgeon may also commit the criminal offence of wounding her victim.

Another criminal offence is "being an accessory after the fact". This would apply to a person who gives sanctuary to either the "surgeon" or any of the participants who run away from the law after performing an act of FGM/C. This is common and compounded by the porous nature of artificial political boundaries. It is easy to cross from one country to another, and similar tribes are on both sides of national boundaries. Those who hide information after FGM/C has been performed commit the criminal offence of compounding a felony. Most of these criminal offences carry heavy penal sanctions, including life imprisonment.

The magistrate pointed out the need for legal education on FGM/C and related his experience in Kapchorwa, where he addressed so-called surgeons and community leaders. He quoted his own speech:

"I especially informed the surgeons that the Constitution of Uganda doesn't allow FGM/C—any culture that is against

the integrity of a woman is against the law. Sabinu culture contradicts the Constitution. I warned all the surgeons to desist from FGM/C . . . [and] that if anyone is found 'cutting', she would be charged in court or pay a fine of Uganda shillings 200,000 or serve a sentence of seven years."

After both education and threat, mentors and surgeons swore never to participate in FGM/C. During the cutting period, FGM/C declined by 30 per cent because surgeons were on the run for fear of being arrested.

Several challenges, however, remain in the five districts. Political leaders are still reluctant to speak out against FGM/C for fear of losing votes. There are also people willing to do anything to frustrate the campaign, including the use of threats or actual force. In some cases, FGM/C is practised across borders between Uganda and Kenya. Some police are unwilling to protect victims of FGM/C, as they perceive FGM/C to be a cultural practice which they cannot interfere with.

In conclusion, the magistrate said that, despite several challenges facing FGM/C campaigns, there is a wind of change. He quoted Professor Sheme Masaba, a Sabinu, who wrote in the New Vision newspaper that "dialogue will do the trick". A multipronged approach is the key, including community dialogue, legal education, political commitment and enforcement of the law.



VIIIC. Ensuring Public Understanding of the Relevant Legal Provisions (Legal Literacy)

Ms. *Mariam Lamizana, Honorary President, Inter-Africa Committee on Traditional Practices*

Ms. Mariam Lamizana emphasized the importance of a holistic approach in any FGM/C abandonment campaign, which should include law enforcement. The IAC uses an approach with a number of strategies, specifically community mobilization, advocacy and lobbying with leaders, income-generating activities for women and legal education. Burkina Faso enacted a law banning FGM/C, but the law was not enforced. Using the media,

IAC provides legal education to communities, resulting in judges' prosecuting and taking legal actions. There are challenges in prosecution, for example, putting excisers in prison, dealing with immigrants from Cote d'Ivoire who practise FGM/C and female politicians who keep silent about the practice. IAC has also trained magistrates, lawyers and law-enforcement officers on FGM/C issues. As a result, police officers are promoting the campaign against FGM/C. Ms. Lamizana recommended that partnership building with all stakeholders be a major strategy to accelerate FGM/C abandonment.

VIIID. Advocating for Political and Community Accountability in the Abandonment of FGM/C

I *mam Afiz Ambekema, Benin*

Imam Afiz Ambekema observed that FGM/C is a male-dominated approach to control women's sexuality. Prophet Mohammed's only daughter who survived him, Fatma, was never excised. Therefore, religion has a large part to play in promoting the abandonment of FGM/C and in preserving the dignity of women. Chapter 30, verse, 32 of the Koran says: "God created a woman for peace and enjoyment that man can have". A woman is a partner to a man; she is not an object. The Koran also says: "The key to paradise of a man is a woman". God created a man in

his own image. So who is man to amputate others so as to recreate them the way he wants? Similarly, restructuring the clitoris is wrong because the clitoris is an organ that God created for a specific function. God did not give anyone permission to perform FGM/C (restructuring the clitoris), which destroys a woman's integrity. The covenant made in the book of Genesis for Abraham to remove his foreskin was never made with Sarah, his wife.

Religious leaders have great influence on society and should be careful about what they tell their followers. God wants religious leaders to protect the welfare of women and from this obnoxious act. Honesty is one of the chal-

lenges that religious leaders face. They are accountable for the wrong information they give to people. Religious scholars need to challenge one another and come up with a statement that is clear. Some Imams carry cultural baggage with them. Therefore, activists need to select religious leaders who freely provide facts to audiences and in a polite manner. Imam Afiz called upon religious leaders to speak with intellect so that they are not be swayed by taboos and customs.

Plenary Discussion and Recommendations

Important ideas came from plenary. Participants observed that cutting female genitalia was of no practical value; it only hurts and maims innocent women in the name of culture. It was noted that change was also painful. Thus, the pillars that sustain the continuation of FGM/C must be weakened. Most Muslim leaders do not know what excision is or its gravity because the act of sexual intercourse occurs in total darkness as far as Muslim culture is concerned. Therefore, more education is needed among religious leaders because they are responsible for guiding their people. In predominantly Muslim communities in which a rights-based approach has been used, the abandonment of FGM/C has been witnessed. Consequently, advocacy should be aimed at religious leaders' networks so that religious leaders are motivated to address the FGM/C issue in their institutions and religious gatherings.

Specific recommendations made were that:

- (a) In the next FGM/C consultation, Christian and Jewish scholars be represented so as to get their perspectives on FGM/C;
- (b) Public and private discourse between fathers and mothers on FGM/C should be supported. In addition, lobbying with regional and subregional institutions was seen as critical towards promulgating cross-border laws on FGM/C;
- (c) Messages and materials on FGM/C should be informed by science, Islamic law based on the Koran and Christian canon law based on the Bible. The messages should demonstrate that these laws are in

harmony with the abandonment of the practice and, therefore, clearly de-link the practice from religion. Similarly, such messages must prove that FGM/C is harmful, and all messages be harmonized among stakeholders to ensure consistency;

- (d) Legal literacy activities should be undertaken. Where laws do not exist, civil action/litigation within the country's constitution should be used. Often, law-enforcement officials and institutions have insufficient knowledge of the law, and it is crucial to orient them accordingly. Other groups that should be oriented in the existing legal framework include religious leaders and the media. Inter-border laws which define the conduct of border populations and those crossing from one country to another as well as programmes should be put in place. In promoting legal literacy, activists should make gender and human rights central;
- (e) Networks should be established to sustain dialogue and debate among religious leaders at the country level and among medical professionals and media. Governments should lead coordinated efforts.

IX. Culturally Sensitive Approaches for Sustainable Abandonment of FGM/C: Panel Discussion



IXA. Culturally Sensitive Communication: Approaches to Support Shifts in FGM/C Related Social Norms

Ms. *Tabeyin Gedlu, Programme Communication Officer, UNICEF Ethiopia*

Ms. Tabeyin Gedlu noted that traditional practices, harmful or beneficial, are widespread among the crop producing peasantry of Ethiopia's highland communities as well as lowland pastoralists. FGM/C and early marriage are not considered harmful by communities that practise them.

1. Reasons for the practice

Most ethnic societies are patriarchal, and male dominance regulates gender relations. To ensure respectability in the male line, the societies place a high value on women's premarital chastity and marital fidelity. Sexual freedom for females carries more serious consequences than it would for a male. These communities institute harsh measures for safeguarding virginity and fidelity through cutting the erogenous parts of female organs and marrying girls off at a pre-adolescent age. Having little or no education, women take FGM/C and early marriage for granted.

Progress towards ending FGM/C through awareness creation has been slow. Therefore, in 2003, community dialogue was launched as a new venture to create space and give a voice to the voiceless so that all could be involved in a community dialogue led by trained facilitators. In most communities of Ethiopia, dialogue is used for conflict resolution. Therefore, Community Dialogue Facilitators (CDFs) use this traditional approach to conduct discussions. Prayer is

always the first item on the agenda and is used to initiate sessions.

Community dialogue assists communities in discussing FGM/C and early marriage practices freely and openly at their own pace. When they are convinced that these practices are harmful, they reach a consensus to abandon them. It has also been found that facilitators recruited and trained from the community are more effective than those recruited from the administrative structure. Also, communities more readily implement decisions and pledges reached at village/community levels than those reached at district or higher levels. The will of the community is imposed on the individual.

The knowledge that FGM/C and early marriage have no religious basis has relieved many community members from fear of violating religious obligations.

2. Lessons learned

- (a) Community dialogue should be neither too long nor too short but allow enough time to attain insight and to act. Prolonged community dialogue has been found to be less manageable, repetitive and leading to declining motivation;
- (b) Traditional enforcement mechanisms employed at the community level are more effective in abandoning harmful traditional practices than legal measures would be;
- (c) Films on FGM/C and flip-chart presentations on basic simple anatomy and the functions of female reproductive organs are useful in helping commu-

- nity understanding and in accelerating changes in attitude;
- (d) Consistent monitoring and backstopping of CDFs contribute to the success of dialogue, leading towards change;
 - (e) Community-based follow-up mechanisms sustain results and prevent relapse. The replication of expe-

- rience in abandoning FGM/C from one village community to another would permit coverage of a larger area in a reasonably short time;
- (f) Community-led interventions and community capacity-building are absolutely essential for the gradual reduction and abandonment of FGM/C.

IXB. Five Dimensional Approaches in Community Mobilization: Ethiopia's Experience

Mr. *Abebe Kebede, Executive Director, Ethiopia Committee on Traditional Practices (EGLDAM)*

Mr. Abebe Kebede reported that, in Ethiopia, FGM/C prevalence is highest in the Afar, Harari, Oromia and Somali regions. Most communities, especially men, support FGM/C for religious reasons and promote the removal of the prepuce. However, women are the primary demanders and practitioners of FGM/C, because of extreme gender inequality, lack of information and education, and the lack of intra-familial and community dialogue.

A project entitled "Expanding the Role of Women and Community Leaders to Eliminate Female Genital Mutilation/Cutting in Harari, Somali and Oromia Regions" was developed to reduce demand for the practice by bridging the knowledge gap of women in the reproductive age group. The project, supported by community leaders, introduced and implemented a five-dimensional approach during 2005 and 2006 in selected sites (rural villages/Kebeles) in the three regions and among target groups. The five dimensions were: health, law and human rights, gender, religion and information.

A training-of-trainers manual based on the five dimensions was developed, along with a booklet, audio, video

and CD-ROM materials for community mobilization. Training sessions were carried out at various levels for regional and community leaders. Community mobilization was followed by a public hearing to announce community leaders' decisions and community rules against FGM/C. A national forum of religious leaders was held to advocate for a unanimous ban on FGM/C.

Results of the project included the following:

- (a) A total of 525 community members were mobilized through community conversation, with equal participation of fathers, mothers, unmarried women and unmarried men;
- (b) Anti-FGM/C rules and penalties were written and publicly declared at three sites (Jijiga, Manna district and Awumer Farmers Association), and FGM/C was publicly banned by religious/political leaders at two sites (Harar and Burqa Farmers Association);
- (c) Anti-FGM/C poems were written at each site, and anti-FGM/C dramas and musical shows, prepared by young men and women, were presented to more than 300 spectators in Jijiga and 700 spectators at the Awumer Farmers Association. Jijiga was also the site of a public rally against FGM/C.

- (d) A total of 21 non-excised girls publicly proclaimed that they were lucky and proud to be non-excised;
- (e) A total of 83 prominent Muslim and Christian religious leaders from the highest national and regional institutions unanimously banned FGM/C;
- (f) Religious leaders/Imams of all 13 mosques of Jijiga made anti-FGM/C religious proclamations in Friday prayers;
- (g) FGM/C was included on the crime list by mobilized police officers of the Jimma zonal police force, who organized and led an anti-FGM/C public declaration that gathered 522 community members in Manna district;
- (h) Seven famous excisers and traditional birth attendants (TBAs) who had practised FGM/C for the past 15-31 years publicly promised to stop FGM/C.

IXC. Regional Experiences

Ms. *Faiza Jama Mohamed, Regional Director Africa, Equality Now*

Ms. Faiza Mohamed informed participants that when Equality Now opened its Africa Regional Office in Nairobi, Kenya, in 2000, it consulted with African women's rights organizations to learn about their priorities. One of the main issues that came up was FGM/C and the concern that local organizations were not sufficiently resourced to work at influencing communities and transforming the attitudes and practices of community members.

Equality Now mobilized resources and launched the Fund for Grass-roots Activism to End FGM/C ("the FGM/C Fund"). The new and long-term funding opportunity that the FGM/C Fund offered the organizations greatly contributed to sustaining interventions for a longer period of time. This brief presentation attempts to capture the campaign experiences of the organizations that form part of an African movement to end FGM/C.

Obviously, before designing interventions towards ending FGM/C, it is important to analyse what sustains continuation of the practice. Ms. Mohamed used the analogy of an inverted triangle that cannot stand on its tip unless there are pillars that sustain its existence. To address the

centuries old practice of FGM/C, there was need to identify the pillars that support it and to come up with tailor-made interventions for weakening and dismantling each pillar. African activists who were fighting the practice in their communities knew well who and what these pillars were—governments, cultures, excisers, men, women, girls, boys, religious leaders, etc.—and why they supported the practice (ignorance, economic gain, gender-power relations, fear of rocking the boat, etc.). These activists over the years adopted various strategies to get rid of those supports. However, their efforts had been hampered by the lack of sufficient resources to sustain their campaigns and to expand their interventions to more areas.

FGM/C Fund partners undertook various interventions in their efforts to dismantle the pillars that sustain FGM/C. They successfully engaged diverse community members in their activities to end FGM/C, and their campaign work led to increased awareness of the issues and public participation in the search for solutions. Some of their strategies are described below.

1. Targeting communities

In addition to engaging women and girls, it was found that ending the practice of FGM/C required reaching out

“Among the many ideas from the discussion was that communities should be encouraged to establish their own surveillance system on FGM/C abandonment as a measure of communities’ responsibility and accountability.”

to all actors or stakeholders throughout society, including excisers, religious leaders, policymakers, law enforcement, fathers and youth. The importance of this inclusive approach was evidenced in part by the increasing number of excisers who were abandoning the practice in Guinea, Kenya, Mali and the United Republic of Tanzania, among others. For example, in Mali, two groups in Dangassa and Kansamana were engaged in pottery-making on a full-time basis, having received training from the Malian Association for Overseeing Directions in Traditional Practices (AMSOPT) on how to manage their business and donkey carts to transport their pots to the market. During the rainy season, when they could not produce the pots, the donkey carts were being used to earn income by transporting people across impassable village roads. Another group in Bamako undertook, in addition to soap-making and fabric dyeing, sensitization activities among practising excisers and succeeded in getting several women out of the practice. Those women then became part of the association engaged in soap making and fabric-dyeing.

FGM/C Fund partners succeeded in engaging their community members through the establishment of “fathers clubs” in the Gambia; anti-FGM/C clubs in schools, such as NUEYS, in Eritrea; and community human rights defenders such as LHRC, in the United Republic of Tanzania, to name a few.

The Coordination Cell on Traditional Practices Affecting the Health of Women and Infants (CPTAFE), the leading organization working to end FGM/C in Guinea and affiliate of the IAC, held advocacy forums aimed at various levels of decision makers, public sensitization campaigns and workshops for youth, lawyers, health personnel, religious experts and excisers. Many of these groups

were using community radios, including “Women, Wake Up” (WOWAP), in the United Republic of Tanzania; the Centre for Egyptian Women Legal Assistance (CEWLA), in Egypt; the Oromo Grass-roots Development Organization (HUNDEE), in Ethiopia; CPTAFE, in Guinea; the National Union of Djibouti Women, in Djibouti; and the Sudan Development Authority, in Sudan.

Other organizations were using community media to disseminate information about FGM/C and advocacy tools to end the practice, including the Association for the Protection and Advancement of the Rights of Malian Women (APDF) in Mali; Galkayo Education Centre for Peace and Development (GECPD), a Somalia-based organization that operates primary and vocational education; the Network against FGM/C (NAFGEM), in the United Republic of Tanzania; the Marakwet Girls and Women Project, in Kenya; and Voice of Women, in Burkina Faso.

2. Targeting youth

Beyond engaging community actors, abandoning FGM/C will also require sensitizing today’s youth so that the next and future generations discontinue the practice. A number of groups, including CEWLA, NAFGEM and NUEYS, engaged youth in the anti FGM/C movement. In Egypt, CEWLA targeted one of the marginalized communities where FGM/C was a taboo subject. In Eritrea, the elders of three villages publicly declared a ban against FGM/C as a result of youth’s outreach campaign; and this move further inspired the government to pass a law against the practice in February 2007.

3. Targeting law and law enforcement

Many organizations have used legal channels to address the abandonment of FGM/C, such as CEWLA, the Gambia Committee against Traditional Practices

(GAMCOTRAP), Voice of Women and LHRC. Where no laws exist, they must be created, and where they do exist, they must be enforced. Although using the law cannot be the sole tool through which to abandon FGM/C, it is a critical tool. FGM/C is frequently seen by police and other actors as a private issue mandated by tradition, culture and/or religion. Police intervention would not occur in the absence of those laws. Ongoing sensitization must be undertaken with law enforcement agencies on the issue, and continued efforts are required to make progress. In Mali, where an anti FGM/C law does not exist, Equality Now partnered with AMSOPT, the coordinator of the Social Development and Health coalition in Mali and APDF. Both organizations were working towards getting a law enacted. AMSOPT worked in collaboration with the Malian Women Lawyers' Association (AJM) and the National Committee for the Abolishment of FGM/C, which hosted a regional workshop bringing together organizations from several countries.

4. Lessons learned

Employ a holistic approach. Analysis of the pillars that sustain FGM/C and the experiences of Fund partners show that a holistic approach is necessary to realize abandonment of FGM/C. This means not only employing many approaches and strategies but also being as inclusive as possible in engaging all the stakeholders that have a role, including the excisers.

Hold regular debates. It is important to sustain discussion on the issue of FGM/C involving all stakeholders. In so doing, the communities internalize the issues around the practice of FGM/C and begin to question the practice in relation to their experiences. Information-sharing and sensitization activities should be sustained and not be an on and off event.

Utilize existing community support structures. Activists and other anti-FGM/C campaigners are often stretched in terms of human and other resources. This makes it difficult to maintain the momentum envisaged above. It is imperative to have in place a community support group,

composed of people who are committed to end FGM/C, and pass on the information they have gained in order to extend the reach as widely as possible. Community supervisory structures have proved valuable resources in facilitating and disseminating information and in keeping the debate alive within the community. They also become guardians to whom girls could turn when at risk of FGM/C.

Put in place a protection mechanism involving law enforcers and social workers. It has been seen that the existence of the laws without a corresponding implementation strategy renders the laws of no consequence. It is imperative that the laws are situated within a child-protection framework that recognizes the role of the law enforcement officers, who as state agents are obliged to protect children. This would effectively shift the burden of reporting and providing evidence of mutilation to the community in general rather than the present situation in which this rests on the child.

Invest in youth. Youth are the leaders and parents of the future. Investing in youth through age-friendly sensitization activities using strategies such as writing competitions, theatre, music and drama not only captures their interest in the issue but also enables them to question the stereotypes surrounding the practice of FGM/C. In future, they will be able to make informed decisions on their bodily integrity and that of their children with regard to FGM/C.

Ensure long-term funding. Long-term funding to support local organizations is critical if real change is to take place in a single generation. The presence of these organizations and their campaigns over several years in the same community/communities would help to bring about that change.

IXD. UNFPA Perspectives on Culturally Sensitive Approaches

Ms. *Miriam Jato, Senior Gender Adviser, Africa Division, UNFPA*

Ms. Miriam Jato's presentation dealt with elements of culturally sensitive approaches that UNFPA has identified, including the following: understanding the cultural context in which interventions are implemented, promoting recognized human rights in ways that enable communities to own them, creating a positive environment for policy dialogue with partners and stakeholders, being patient, respecting the cultures of others and honouring commitments.

In 2002, UNFPA launched an initiative to systematically mainstream culturally sensitive approaches into programming efforts. On the ground, this demanded a greater emphasis on working with communities and local change agents, engaging in dialogue, listening, sharing knowledge and insights, and jointly planning the way to move ahead.

UNFPA learned that it needs to identify, engage and partner with local power structures and religious institutions to strengthen alliances and partnerships. There are many reasons for working with religious and faith-based organizations. They have access to people, they live in the community, have legitimacy and credibility among the people who listen to them and seek their advice and counsel, have strong structures and outreach programmes, and have institutional, human and financial resources.

UNFPA developed and is promoting "the culture lens" programming tool to enhance strong community acceptance and ownership of programmes. The "culture lens" is an analytical and programming tool that helps policy-

makers and development practitioners analyse, understand and utilize positive cultural values, assets and structures in their planning and programming, so as to reduce resistance, strengthen programme effectiveness and create conditions for ownership and sustainability.

The "culture lens" enables development practitioners to:

- (a) Understand the context and realities of societies in which interventions are implemented;
- (b) Identify influential local power structures and pressure groups (religious, cultural, political, legal and professional, etc.) that can be potential allies or adversaries to development programming;
- (c) Develop context-specific culturally acceptable language and "negotiation and communication tools";
- (d) Understand social practices that are harmful to people and hinder their enjoyment of human rights;
- (e) Identify internal cultural tensions and aspirations of the various subcultures;
- (f) Develop skills for dealing with individuals, communities and interest groups living in a specific cultural context;
- (g) Achieve the goals of development programming more effectively and efficiently, with stronger community acceptance and ownership.

In the processes of using these culturally sensitive approaches in programming, UNFPA learned important lessons, namely:

- (a) Encouraging communities to incorporate universally recognized human rights into their own realities can be done through an exploration of how human rights and gender issues contribute to the well-being of men, women, children and families;

- (b) Promoting behaviour change often begins by identifying individuals who have the capacity and legitimacy to motivate and mobilize communities. Partnering with local “agents of change” became an invaluable strategy in gaining wider acceptance and ownership of programmes;
- (c) Gaining the support of local change agents and power structures is necessary before engaging effectively with communities. One way to do this is to present evidence-based data on issues of concern to the community, such as the health of mothers and children, the impact of violence against women and the prevalence of HIV/AIDS. Such information helps to defuse potential tensions by focusing on the shared goal of people’s well-being. Once trust develops, discussions can be expanded to more sensitive issues;
- (d) Negotiating effectively requires an understanding of the interests of diverse stakeholders—from political leaders to civil society organizations, cultural leaders and the private sector. Until their interests are clearly understood, it is often difficult to find common grounds for effective programming;
- (e) Avoiding value-laden language can help create neutral ground in which understanding and support for programme objectives become possible;
- (f) Developing advocacy campaigns and closely tailoring them to the cultural context in which they are launched can make it easier to deal with sensitive subjects. These campaigns should reflect a clear understanding of the views of both allies and potential adversaries, and draw from sources that are popular within a given culture. In Uganda, for example, the use of African music, poetry and drama has proved effective in reaching a wide audience. In Muslim contexts, using Islamic references in advocacy campaigns helped to dispel suspicions and promoted local ownership.

IXE. The Face of FGM/C in Southern and Central Africa

Ms. *Safiatu Singhateh, Gender, Population and Development Adviser, UNFPA Country Technical Services Team, Harare*

Ms. Safiatu Singhateh observed that FGM/C in southern Africa presents itself in different ways. These practices are described by WHO as Type IV. Stretching of the clitoris and/or the labia using various means is one of the practices. The elongation of the clitoris and the labia minora is common in central and southern African regions. The manner in which this is done varies from country to country, some of which are equally hazardous to health.

Another practice is the introduction of corrosive substances or herbs into the vagina with the aim of tightening or narrowing. This may or may not be a rite of passage, but it is common throughout the African region. This is done by women themselves, not for their own pleasure but for that of their male partners. Another form is making patterns of deep cuttings around the inner and outer parts of the thighs and the buttocks to create scarred contours. This is a form of rites of passage. It is performed on the girl child before puberty. The scarred contours are believed to create some sensation for the male partner as he caresses the buttocks and inner thighs of his partner before and during intercourse.

“In plenary discussions, participants identified community dialogue as empowering and critical for accelerating abandonment. Therefore, building the capacity of implementers and managers in employing culturally sensitive approaches is critical.”

Another rite of passage is the Reed dance in Swazi culture; every girl goes through this cultural practice. A principal requirement for participating is that the girl must be a virgin. Thus, the maidens go through a dancing ritual with exposed breasts and very short tasselled skirts, which also expose their nakedness. Virginity testing of girls is common in Swaziland as well as in the Kwa-zulu Natal province in South Africa. Such testing is carried out by traditional female Sangomas. Girls who pass this test command respect and stand greater chances of marriage. On the other hand, they may easily fall prey to rape.

The Moon Light Dance is a rite of passage, practised among a few tribes in certain parts of the United Republic of Tanzania and also by immigrants in some southern African countries. During this period, girls between 8 and 12 years of age are introduced to young men 15 to 18 years of age. The young men are required to pair up with the girls, dilate their vagina with special lubricating oil and then penetrate them, marking the climax of the rite of passage of girls to adulthood. This rite occurs before puberty to prevent pregnancy, but the health risks are obvious.

Approaches that have worked in eliminating harmful practices associated with the female genitalia are the following:

- (a) Raising awareness of the existence and implications of the practices;
- (b) Building partnerships and alliances with the community and ensuring that awareness-raising and prevention programmes are designed through participatory processes;
- (c) Involving significant stakeholders, such as religious and traditional leaders, men, youths, influential women and media professionals, in all processes;
- (d) Assessing and incorporating positive cultural values into programme interventions;
- (e) Supporting and celebrating positive social and cultural aspects and meanings while addressing basic sexual and reproductive health issues;
- (f) Ensuring that all behaviour change communication messages and materials are explicit but also gender- and culturally sensitive and that they are pre-tested with the target audiences and other critical stakeholders;
- (g) Establishing alliances among health practitioners, human rights activists and women and youth groups at district and national levels to advocate for and rally around issues of culture and religion that interfere with female sexuality.

Ms. Singhateh emphasized the critical importance of building the capacity of NGOs and CBOs and women’s associations to scale up actions against gender discriminatory practices. She recommended lobbying governments to establish community-level mechanisms for child protection, counselling those affected and establishing monitoring and reporting mechanisms for all interventions.

Plenary Discussions and Recommendations

In plenary discussions, participants identified community dialogue as empowering and critical for accelerating abandonment. Therefore, building the capacity of implementers and managers in employing culturally sensitive approaches is critical. Community interventions need external stimuli as catalysts for facilitating debates. Communities should be encouraged to dia-

logue on human rights issues within their own culture. Participants noted that it is difficult to separate FGM/C from female subjugation and sexuality. They observed that reference to traditional practices that are no longer practised could be used as a springboard. Communities should be encouraged to put in place traditional sanctions as an accountability mechanism.

The main recommendations were that:

- (a) Through dialogue, communities should be empowered to weaken the pillars that sustain FGM/C as this is critical for accelerating its abandonment;
- (b) Further research should be undertaken on Type IV FGM/C and other practices observed in southern Africa as a basis for interventions;
- (c) Advocacy should be continued to sustain support by development partners, stakeholders and communities.

X. Panel Discussion: Building the Capacity for Planning, Implementing, Evaluating Interventions



Capacity of Managers and Implementers Scaling Up FGM/C Innovative

Contributors:

Dr. Magdi Hemy, Director, Health Programmes, CARITAS, Egypt; Ms. Beatrice Chelangat, Coordinator, REACH, Uganda; Ms. Safia Elmi Djinril, Director of Mother and Child Health, Djibouti; Ms. Fatma Abdel Fattal, Executive Director, Sudanese Network on FGM/C

Contributors to this panel discussion emphasized capacity-building and development as critical towards a sustained acceleration of FGM/C abandonment. Several categories of capacity building were shared and discussed.

1. Institutional capacity-building at central and local levels

Specific capacities mentioned included technical writing, strategic planning and networking to enhance the capacity for resource mobilization, planning and implementation of FGM/C interventions. Training on human rights, sexual and reproductive health and other related development issues was emphasized as a package to be integrated into the programme. Also included in this category was the training of media personnel to ensure accurate and pertinent FGM/C information to their audience.

2. Advocacy, lobbying and campaign activities

Implementers need capacity to conduct campaign activities among the medical and legal communities, media personnel, relevant government ministries, universities and youths in schools. Comprehensive media campaigns with unified messages were depicted as crucial to avoid

confusing audiences. The mechanism of networking was described as effective in ensuring involvement of all stakeholders and partners, in promoting the sharing of experience and information on emerging issues or trends in the abandonment of FGM/C and in fostering coordination of FGM/C initiatives.

3. Situation analysis, monitoring, reporting and evaluation

The capacity to undertake situation analyses, monitoring, reporting and evaluation was viewed as another critical development area. Implementers should appreciate the essence of evaluation and be involved in internal evaluations. Improved capacity in this area would help implementing institutions to conduct village profiles, undertake daily monitoring of local activities or regular field visits by the central team. Capacity in periodical, technical and financial reporting would ensure that implementers keep all stakeholders informed of the results being achieved.

XI. Panel Discussion: Resource Mobilization for Scaling Up FGM/C Abandonment Efforts Globally



XIA. Guiding Principles for Resource Mobilization

Ms. *Fama Hane Ba, Director, Africa Division, UNFPA*

Ms. Fama Hane Ba introduced this session by listing important guiding principles in resource mobilization. They included clarity on the desired outcomes within a specific time frame; how FGM/C would be integrated into existing programme strategies; mechanisms for ensuring community ownership of a programme; and mechanisms for monitoring and evaluation to ensure

accountability. Human resources, institutional resources, knowledge resources and financial resources are required to achieve the desired outcomes. Resources should be mobilized internally and externally, including from within communities, central and local governments, non-profit and for-profit organizations and from external resources—bilateral and multilateral organizations, the United Nations and regional development banks. Funding provided should be tied to results for mutual accountability.

XIB. Belgium's Contribution to the Abandonment of Harmful Practices, Including FGM/C

Ms. *Cecile Charot, Deputy Adviser, Ministry of Foreign Affairs and Development Cooperation, Belgium*

Ms. Cecile Charot observed that Belgium, through its policy of international cooperation, supported the abandonment of FGM/C in developing countries as an integral part of sexual and reproductive rights. Moreover, in April 2007, upon a parliamentary resolution, a strategic note to frame more accurately activities in sexual and reproductive health and rights was designed in full collaboration with Belgian civil society. This support was key to the achievement of all the MDGs, and more particularly towards reduction of poverty. Through political dialogue, Belgium would continue to encourage its partner countries to integrate health and reproductive and

sexual rights into their national strategies for poverty reduction and their sectoral plans.

Ms. Charot noted that Belgium encouraged its partners to take into consideration the multiple and disastrous effects of FGM/C on women's lives and their communities. Women and girls must be considered and treated as full-fledged citizens, in the same way that men and boys are, and enjoy the same rights, opportunities and responsibilities in all areas of life. Governments must guarantee that these rights are protected and that women have access to information about these rights and the power to make use of them. In this regard, Belgium would support the initiatives of its partner countries aimed at guaranteeing girls universal access to education; strengthening the economic and political power of women within their

communities and societies; developing and promoting preventive measures for sexually transmitted infections by providing microbicides; and supporting contraceptive commodities such as the female condom.

The Belgian Government would also support initiatives designed to increase participation, behaviour change and assumption of responsibility by men and boys in promoting gender equality, preventing and combating sexual violence and harmful practices, and ensuring care for and non-discrimination of victims.

Belgium would also continue to support its partner countries' policies of increasing the financial, geographical and cultural accessibility of public health care. To this end, and working with other donors, it would use available resources in an effective and coordinated manner—making use, for example, of “vertical” funds. The goal would be to enhance the quality and accessibility of health care, of which sexual and reproductive health is a part. The Government would continue to support improvements in the quality of medical staff and to enhance their professional skills through training, retraining and incentives, with particular attention to teaching communication techniques that respect the right to privacy and confidentiality of information.

As part of the political dialogue with those partner countries where FGM/C is still practised on a large scale,

Belgium would ensure that special attention is given to compliance with the terms of the Maputo Protocol, which these countries signed and which most of them also ratified. Belgium would support civil society and local organizations that have acquired experience with regard to this issue as well as actions promoting a community approach that supports abandoning FGM/C through dialogue with the traditional authorities. It would support national and regional behaviour change campaigns in local communities.

Belgium would use its diplomatic resources to encourage those African States that have not yet ratified the Maputo Protocol to do so and support governments that have signed the Maputo action plan in carrying it out. In this regard, emphasis would be given to women's right to dignity, integrity and security, the abandonment of discrimination and harmful practices like FGM/C, the protection of women and girls during armed conflicts, and the right to reproductive and sexual health and related care. Belgium would work closely with the European Commission and the international community to empower women and enhance the rights of women, to combat all forms of violence such as FGM/C, and to promote sexual and reproductive health and rights. As a non-permanent member of the Security Council of the United Nations, Belgium would ensure that sexual and reproductive health and rights are taken into consideration.

XIC. The Case for Investing in the Abandonment of FGM/C

Ms. *Layla Shaaban, Programme Analyst, Office of Population and Reproductive Health, USAID*

In her presentation, Ms. Layla Shaaban observed that, unlike many other issues of concern, the case still needs to be made that abandoning FGM/C is an important and

worthwhile investment. Ms. Shaaban highlighted the following tips for effective resource mobilization.

1. Messages that maximize limited resources and keep FGM/C abandonment on the agenda

Strong arguments for abandonment need to be created so as to keep the issue on the agenda of donors. Messages that make sense to various audiences with varying priorities need to be developed, clearly articulating how FGM/C abandonment is important and what it means to development and the lives of women and the community. NGOs and advocates need to:

- (a) Demonstrate its relationship to other issues, for example, education, health and human rights, and use these links to advocate for funding and sharing examples of successful linkages and programmes;
- (b) Integrate FGM/C messages into existing national and organizational strategies to sustain support;
- (c) Identify opportunities that make it easier for new donors to get involved;
- (d) Draw and share lessons from the last 20 years to create messages for partners in 2007.

2. Resources to address funding challenges

Ms. Shaaban noted that the process of abandonment has been slow and complex. Therefore, donors need to adjust their expectations and funding accordingly. FGM/C abandonment should be framed as a long-term but not an indefinite investment that requires continued support until abandonment is sustained. Donors should invest in longer term projects that allow flexibility. Many donors, however, are constrained by short-term funding cycles and results-oriented programming. Therefore, it is important for NGOs to make the most of these resources by evaluating programmes to demonstrate successes and needs. They can make the case for further funding and for supporting activities that would build on or support existing efforts to maximize impact.

3. Networks and partnerships

Ms. Shaaban pointed out the need to build and maintain networks of stakeholders to share information at

national, regional and international levels. She said it is essential that information be shared at the country level to avoid overlap and to complement the messages of related interventions. It is also important that information flow upward to the regional level and to the global level to drive resource mobilization efforts. There is a need to look for opportunities with existing networks and associations to draw attention to the issue. Also needed are the identification and support of “champions” of the issue—within governments, NGOs, donor agencies—and the regular sharing of ideas and strategies for resource mobilization.

4. Strategies for resource mobilization

National, regional and global strategies and partnerships allow for better information-sharing and coordination, which are essential for increasing resources. Identifying where partners are working and the comparative advantages of each organization would help to identify progress and gaps to make the case for additional resources. In this regard, it is important to:

- (a) Identify what resources are needed for donor outreach and the comparative advantages of each partner;
- (b) Define roles for each organization and develop a clear plan of action with a timeline on how to move the agenda forward;
- (c) Share evaluations on effective programming to strengthen arguments for funding;
- (d) Develop a plan for communication and advocacy using existing opportunities at national, regional and global levels to raise awareness and to bring more champions to the issue;
- (e) Link these strategies to maximize impact.

XID. Norway's Interventions Concerning FGM/C

Dr. *Berit Audstveg, Senior Adviser, NORAD*

Dr. Berit Audstveg informed participants that Norway initiated its support to FGM/C interventions led by the United Nations and NGOs in the 1980s, when Norway began to receive immigrants from countries where FGM/C was, and still is, common. The issue of legality of the cutting was taken up in Norway. The then Director General of Health concluded that performing FGM/C would be punishable under the general Criminal Code, which forbid harming another person's body, and under the Child Protection Act.

Early in the 1990s, lawyers argued that there might be a need for a separate act against FGM/C because of two situations not covered under the general law—a case in which the cutting took place outside the borders of the country and another in which the woman asked for the cutting herself (including re-stitching after delivery). After some public debate, parliament adopted a separate law, which came into force in 1995.

Some medical practitioners felt that there was need for guidelines for health personnel. However, the ministry that dealt with health (then called the Ministry of Social Affairs) went against this, arguing that it would be redundant, as there was a law that “took care of the problem” and, besides, the matter was too sensitive for politicians to be involved. Nevertheless, the Director General of Health supported the development of guidelines.

In 1999, a tabloid TV channel broadcast, in prime time, a programme showing an authentic cutting. People were shocked and outraged, and the media and politicians became deeply involved. A week after the first programme, another programme was shown in which a young Somali girl met with some religious and spiritual

leaders (men), recording the meetings with a camera hidden in her clothes. The men advised her to be excised. It was clear that the tapes had been cut and edited. Somali men were portrayed as cruel, and women were either helpless victims or strong and brave opponents of a brutal tradition. Nevertheless, the general anger and despair among the population found direction. Politicians, including members of parliament, accepted that when the law was passed, they had no idea that FGM/C was an issue in Norway. Within weeks, the country had an action plan against the “tradition”. An international Action Plan followed in 2003. The domestic action plan gave space for much good work, including the building up of a network of change agents who used culturally sensitive dialogue as a method.

The call for punishment was steady, and even some liberal politicians questioned the dialogue method, calling it “softness” and lack of proper will. Even the provision of health care and rehabilitation for women who had undergone cutting was being seen as softness, downplaying the seriousness of FGM/C. Despite this, it was possible to build up health services for the rehabilitation of excised women, and such services were established throughout the country. Obstetricians and gynaecologists, together with midwives and public health nurses, took a special interest in FGM/C and initiated health services to manage and treat FGM/C-related conditions.

A new strategy on gender issues, under Norway's development assistance, was launched in March 2007. It has four areas, with sexual and reproductive health and rights as one of the four. Fresh funds were brought in, and the work against FGM/C was expected to benefit from this. The mainstream broadcasting cooperation aired a report from a trip to Somalia with interviews of excisers, who confirmed that they had, altogether, cut 184 girls with permanent residence in Norway who had

gone to Somalia during their vacation. The correctness of the number was questioned, but it became clear that Somali women and girls residing in Norway were still undergoing mutilation. The call for punishment was renewed, and even moderate politicians claimed again that there had been “enough dialogue”. Compulsory, regular checking of girls’ genitals was being seriously discussed. The Norwegian Medical Association and the Norwegian Nursing Association warned strongly against compulsory examination on ethical grounds, implying that the fundamental principle of voluntarism in health care would be violated and access to health care could be hindered, and also because it would be impossible to implement. The two cases in which health care was compulsory were tuberculosis screening and the use of force in certain cases in psychiatry, both of which were regulated by law. There was already an obligation for health personnel, who otherwise were bound by professional secrecy, to inform the relevant authority—police or child-protection authorities—to protect a girl from being excised and for securing necessary treatment.

In her concluding remarks, Dr. Audstveg said that it seemed like a paradox that a country with such a good track record in sexual and reproductive health and rights, including gender, had not managed to handle FGM/C among immigrants in a better way. On the other hand, the outrage led to securing funds, so that it is possible to do a lot of good technical work. It is also a paradox that Norwegians may have to use human rights in their own country to prevent new assaults on immigrant women and girls.

Plenary Discussion and Recommendations

During the plenary discussion, the topic of resource mobilization was reiterated from various perspectives. A call for the integration of FGM/C programming within the context of sexual and reproductive health and gender equality, to provide a direct linkage with the achievement of MDGs, was emphasized. Recommendations were made to develop programmes to increase the participation of men and boys and their assump-

tion of responsibilities in promoting gender equality, preventing sexual violence and harmful practices, and ensuring care for victims without discrimination. For effective resource mobilization, consensus was reached that an accurate assessment of needs, including costs and budgets for results, is necessary. Also deemed necessary were the identification of potential partners and sources and the harnessing of resources available at grass-roots levels in communities as well as those at national, regional and international levels and the private sector.

The following specific recommendations were made:

- (a) Collectively design messages that maximize limited resources and keep FGM/C abandonment on the government and public agenda to sustain support;
- (b) Mobilize resources to effectively address funding;
- (c) Create networks and partnerships at national, regional and international levels to share information with all stakeholders;
- (d) Develop regional strategies for resource mobilization.



XII. Global Partnership-building for the Abandonment for FGM/C



XIIA. Fostering Joint Programming to Accelerate Change: Example of the UNFPA UNICEF Joint Programme and Trust Fund

Ms. *Aminata Toure, Chief, Gender, Human Rights and Culture Branch, UNFPA*

Ms. Aminata Toure briefly described the UNFPA UNICEF Joint Programme and Trust Fund: “Female Genital Mutilation/Cutting: Accelerating Change”. The goal is to decrease by 40 per cent FGM/C prevalence in 17 countries within five years. The initiatives have nine planned outcomes, as described below.

1. Planned outcomes

- (a) The process of enacting, revising and enforcing legislation in countries of prevalence would be accelerated;
- (b) New knowledge and understanding concerning the social dynamics of the abandonment of FGM/C would be generated, communicated and applied at the community level;
- (c) In collaboration with key global development partners, a common framework for the abandonment of FGM/C would be fully developed, explicitly agreed to and applied worldwide;
- (d) Existing theories on the functioning of harmful social norms would be further developed in collaboration with the academic community and practitioners, with a view to making them applicable to specific realities of FGM/C;
- (e) National and subnational data on FGM/C would be analysed based on available DHS and MICS data to increase understanding of this social norm and inform policy and programming;

- (f) Existing partnerships with organizations and institutions committed to the human rights of girls and women would be consolidated and new partnerships identified and fostered;
- (g) Networks of religious leaders supporting and advocating for the abandonment of FGM/C would be expanded;
- (h) Partnering with the media would be expanded, including local media to keep FGM/C on the public agenda and foster behaviour change;
- (i) The capacity of the health system would be developed, particularly reproductive health services to address FGM/C.

2. Segmentation criteria

UNFPA and UNICEF jointly developed segmentation criteria which go beyond national boundaries, namely:

- (a) Status of the practice: Type/severity of practice; prevalence of FGM/C; number of population practising; location in the DHS regions;
- (b) Attitude: Discrepancy between attitude towards the practice (opposition) and practising behaviours, according to DHS/MICS;
- (c) History of abandonment: Previous demonstrations of abandonment in country/ vicinity;
- (d) Regional/ethnic connections: Shared practising ethnic groups with neighbouring countries; shared ethnic groups with neighbouring countries that abandoned the practice; influence on other countries via ethnic group; shared languages;

Ms. Aminata Toure briefly described the UNFPA UNICEF Joint Programme and Trust Fund: “Female Genital Mutilation/Cutting: Accelerating Change”. The goal is to decrease by 40 per cent FGM/C prevalence in 17 countries within five years.

- (e) Enabling environment;
- (f) Attitudes of communities, governments and policy-makers at national and local levels, and of international organizations, NGOs and CBOs (commitment towards abandonment); attitudes of the traditional and religious leadership and the intellectual/educational community; the media environment and the presence of potentially supportive actors and resources.

3. Blocks of countries

Six subregions/blocks of countries were identified against the above-mentioned criteria, as follows:

Region/Block 1. The Gambia, Guinea-Bissau, Guinea Conakry, Mali, Mauritania and Senegal were identified as countries where abandonment is accelerating at a large scale. The Senegal experience of public declaration towards abandonment is being replicated in the Gambia, Guinea and Mauritania using the local context.

Region/Block 2. Burkina Faso and northern Ghana, where there is increasingly widespread opposition to the practice, as well as effective law enforcement.

Region/Block 3. Eritrea has increasingly widespread opposition to the practice. A law prohibiting FGM/C was enacted on 20 March 2007. A large discrepancy exists between the rate of prevalence, 89 per cent, and opposition to the practice, at 49 per cent (DHS 2002). This is a high-priority country because there is a likelihood of an accelerated process of abandonment.

Region/Block 4. Djibouti, Ethiopia (Afar and Somali regions), Kenya (Somali), Somalia and Sudan, identified along ethnic lines and sharing additional perpetrating

factors. A religious movement is unfolding in Sudan to “de-link” FGM/C from religious teachings, which may have an overall impact in the eastern African region and on this block of countries in particular.

Region/Block 5. Egypt, due to its history of abandonment and high prevalence. The 2005 EDHS reports a decrease in the number of adolescent girls subjected to FGM/C, indicated by a 77 per cent prevalence for girls aged 15–17 versus 96 per cent for ever-married women aged 15–49. This is an indication of change unfolding in Egypt. Support for the practice decreased by 14 points according to 2005 DHS data as compared with 1995 DHS data.

Region/Block 6. Kenya (non-Somali), Uganda and the United Republic of Tanzania have a history of abandonment and medium/low prevalence. In non-Somali Kenya, as in other countries with FGM/C prevalence below 40 per cent, the younger age groups consistently showed lower prevalence rates. It would be possible to address certain weaknesses of the rite-of-passage approach and transform it in a powerful abandonment movement across these three countries.

The stakeholders that have been identified as critical in the abandonment process include: communities; traditional, religious and government leaders, such as parliamentarians, governments, NGOs and donors; and the media and research institutions.

4. Monitoring and evaluation

Baseline surveys to be conducted in selected localities would help in the final assessment and evaluation of programme results (end line surveys). Indicators selected include:

- (a) Attitudes of men and women, community leaders (formal and informal) vis-a-vis FGM/C (opposition to or support for the practice);
- (b) Status of daughters (cut or not cut);
- (c) Women's empowerment (women speaking in public, women seeking reproductive health services);
- (d) Public pledges by communities to abandon FGM/C;
- (e) Existence and enforcement of legislation, national plan of action and resources allocated for FGM/C prevention activities;
- (f) Prevalence rate.

XIIB. Inter-agency Group on FGM/C

Ms. *Bintou Sanogoh, Director, UNFPA Country Technical Services Team, Dakar, and Dr. Morissanda Kouyate, Director of Operations, Inter-Africa Committee on Traditional Practices, Addis Ababa*

Ms. Bintou Sanogoh summarized the role of the Inter-agency Group on FGM/C, which was established to contribute to the abandonment of FGM/C. The four main agencies in the Inter-agency Group are: CI-AF Geneva, the Inter-Africa Committee on Traditional Practices affecting women's and children's health; UNFPA, UNICEF and WHO. The members developed a Memorandum of Understanding within which to operate. The specific objectives of the group are to: reinforce capacities and interventions in countries; support NGO efforts; exchange information, tools and strategies and contribute to creating databases on FGM/C; reinforce advocacy; and support the development of implementation, monitoring and evaluation mechanisms.

Each organization has specific responsibilities: UNFPA to lead in research and information dissemination; WHO to build and reinforce capacities of institutions and NGOs; CI-AF to undertake advocacy and community mobilization; and UNICEF to take responsibility for monitoring and evaluation.

A Plan of Action for 2007-2011 was developed to guide the group in the following ways:

- (a) Promote research to ensure the use of existing research findings and lessons learned, develop a research culture and stimulate new research to fill the gaps;
- (b) Promote partnerships. The plan of action is expected to promote partnership-building and lobbying for the incorporation of FGM/C modules in primary, secondary and university education;
- (c) Reinforce capacities of thematic groups of UNCTs and orient bilateral and development agencies on FGM/C;
- (d) Monitor and evaluate interventions. Establish a system of monitoring and evaluating FGM/C interventions. Develop a culture of evaluation and continual monitoring at the country level and promote the use of the 10 indicators adopted by UNICEF and the indicators of CI-AF. It is critical to take stock of the status of FGM/C during annual meetings of every agency and to institutionalize bi-annual consultations on FGM/C at the inter-country level;
- (e) Advocate and lobby with policy actors especially through opportunities provided at international and African Union forums; similarly, the Inter-agency Group and its partners would advocate and lobby with First Ladies, national parliamentarians and religious

and traditional leaders using all channels, including modern and traditional media;

- (f) Disseminate the Memorandum of Understanding to governments, to UNCTs, NGOs and other partners in development;
- (g) Collaborate among agencies to ensure the incorporation of FGM/C issues in ongoing programmes on sexual and reproductive health, HIV and AIDS and maternal and newborn care as well as in all human rights activities.

Planned Contribution by Each Agency

Intervention	SUM (USD)	%	Leading Agency
Research and information dissemination	343 000	11.61	UNFPA
Training and strengthening capacities	1 100 000	37.24	WHO
Advocacy and communication	455 500	15.42	CI-AF
Documentation	330 000	11.17	CI-AF
Monitoring and evaluation	585 000	19.80	UNICEF
Collaboration and partnership	140 000	4.74	Inter-Agency Task Force
Total	2 953 500	100%	

XIIC. Donors' Working Group on the Elaboration of a Common Framework for the Abandonment of FGM/C

Ms. *Francesca Moneti, Senior Child Rights Officer, UNICEF Innocenti Research Centre*

Ms. Francesca Moneti observed that the Donors Working Group (DWG) included the United Nations Fund for International Partnerships (UNFIP), UNFPA, UNICEF, WHO, the European Commission, the World Bank, GTZ, Finland, Italy, the Swedish International Development Cooperation Agency, the United Kingdom's Department for International Development and USAID, the Ford Foundation, the Public Welfare Foundation and the Wallace Global Fund.

During its 2006 meeting, the DWG agreed to promote a coordinated global strategy under the umbrella of the

United Nations to intensify efforts of the international community to promote the abandonment of FGM/C by 2015. This included expanding partnerships, broadening political will and mobilizing resources. It also included elaborating a common framework for the abandonment of FGM/C.

The emerging common framework is consistent with the United Nations Inter-agency Statement on FGM/C. It has endorsed the approach that has been found to successfully promote abandonment of FGM/C—a systemic approach that stimulates and supports large-scale social transformation benefiting children and women. The development of a common framework aimed at promoting explicit partnerships with the large number of actors

that are not United Nations organizations and that play a central role in efforts to end FGM/C.

The approach aims at encouraging communities to raise problems and define solutions themselves on a variety of concerns, including sensitive ones such as FGM/C, without feeling coerced or judged, thus stimulating a process of positive social change. It is based on:

- (a) Empowering education—literacy, education in health and reproductive health, and management that provides new knowledge and skills;
- (b) Participatory communication—no-directive dialogue that may be organized among women, with men or across generations;
- (c) The promotion of human rights principles, including gender equality.

Beyond communities, the approach is based on:

- (a) Engaging traditional, religious and government leaders, including parliamentarians;

- (b) Stimulating and supporting dialogue at the national level in partnership with strategic allies in government and civil society and working with national and local media;
- (c) Undertaking the review and reform of policies and legislation;
- (d) Developing child-protection frameworks that bring together legislative, welfare and social services, police and justice systems and basic service providers with local leaders and civil society to provide a holistic mechanism of protection.

The approach reflected in the common framework calls for different types and levels of resources at different stages of the abandonment process. Based on knowledge from programme experience and social science, UNICEF estimates that \$US 24 million a year over 10 years could lead to a major reduction in the prevalence of FGM/C in 16 countries in sub-Saharan Africa with a high and medium prevalence.

XIID. Global Collaboration in Monitoring and Evaluation of FGM/C

Ms. *Ann P. McCauley, Ph.D., Senior Reproductive Health Technical Adviser/Programme Officer, USAID/East Africa Mission*

Ms. Ann P. McCauley reiterated that DHSs and MICSS have been used extensively to measure national data on FGM/C. Common population indicators used are: prevalence by age, FGM/C status of daughters, percentage of “closed” and “open” procedures, performer of FGM/C,

and support of, or opposition to, FGM by age and sex. Through such measurements, it has been observed that in several countries women are more supportive of FGM/C than men are.

Common programme indicators include public statements of intent, community monitoring mechanisms and decline in prevalence. FGM/C may also be linked to other measures of gender equity. For example, excised

women are more likely than un-excised women to lack education, agree that wife beating is justified in some cases and believe that men should make decisions.

Trend data are measures that are repeated over time, for example, trends towards medicalization, decreasing age at which FGM/C is performed or changes in types of FGM/C. It is important for implementers to decide which measures of gender equity or human rights are important to FGM/C. Each element of the road map should also have clear indicators.

Support for FGM/C (in percentages)

Country Survey	Women	Men
Benin 2001	5	5
Burkina Faso 1998-99	21	17
Côte d'Ivoire 1998-99	30	23
Eritrea 1995	57	46
Guinea 1999	68	52
Mali 2001	80	73
Mauritania 2000-01	64	37
Niger 1998	32	14

Source: Country Demographic and Health Surveys (DHSs).

XIIE. Research on Emerging Issues: Towards a Global Research Strategy for the Abandonment of FGM/C

Dr. Mary Anne Burke, Health Analyst/Statistician, Global Forum for Health Research

The Global Forum for Health Research is an independent international foundation in Switzerland working since 1998 to focus global research efforts on the health of poor and marginalized populations (www.globalforumhealth.org). Dr. Mary Anne Burke explained that its work is informed by principles of equity, human rights and gender equality and that it is committed to improving global health and achieving health equity. As such, the Global Forum is committed to the abandonment of FGM/C and encourages research towards that end.

As part of its work, the Global Forum has hosted a number of research networks and initiatives. One of these networks is the Sexual Violence Research Initiative

(SVRI), which was launched in 2003 to create a network of committed researchers, policymakers, donors and activists to ensure that the many aspects of sexual violence are addressed. As of 2007, it had close to 1,000 members from more than 80 countries, guided by a coordinating group of research experts from around the world and hosted by the Medical Research Council of South Africa.

The SVRI research agenda includes a specific focus on the following:

- Investigation of the nature, extent and social context of FGM/C in various cultural settings, using standardized instruments and methodologies;
- Description of the medical, social, psychological and economic impact of FGM/C;

(c) Development and evaluation of empirically based programmes aimed at the abandonment of FGM/C in various cultural settings.

(c) Emphasize the measurement of trends, including trends towards medicalization and emerging types of FGM/C.

A number of strategic opportunities and mechanisms could be built upon in developing a research agenda on FGM/C, including the following:

(a) The proposed Global Research Strategy, which would explore opportunities to engage with ministers of health, education and science and technology; donors; researchers in government, industry and academia; NGOs; and activists. The strategy could also guide FGM/C research towards the Global Ministerial Forum on Research for Health, to be held in Bamako, Mali, 17-19 November 2008;¹²

The network for SVRI could promote SVRI list-serve activities, websites, research discussion groups and workshops; and the sharing of technical expertise, skills and knowledge with other SVRI researchers.

Plenary Discussion and Recommendations

Many key ideas were discussed in the plenary, including emphasis on using parliamentary channels to mobilize resources from international partners, strengthening relationships with civil society and initiating results-based interventions that should be evaluated externally. Linking FGM/C to the achievement of MDGs, such as girls' education, was seen as key to lobbying for greater commitment by governments. Donors were also urged to maintain long-term commitments. Key recommendations made in the plenary were to:

(a) Develop indicators that measure gender equality and human rights;

(b) Use indicators developed in the road map or framework for the implementation of programmes aimed at accelerating the abandonment of FGM/C;

¹² <http://bamako2008.org/en/index.shtml>

XIII. Final Conclusions and Recommendations



XIIIA. The Way Forward

Participants reflected on the proceedings during the one-week consultation, analysed key ideas and built a consensus on critical steps for moving the FGM/C abandonment agenda forward, namely:

- (a) Develop an operational and practical road map that lays out challenges, opportunities and working strategies for accelerating the abandonment of FGM/C within a generation (25 years). The purpose of the document would be to guide global, regional and national advocacy and provide practical guidance for programming;
- (b) Create an electronic network based on this consultation to continue sharing good practices, new research

findings and working models. UNFPA could host a website, which could be linked to the FGM/C Knowledge Asset;

- (c) Publish experiences from the consultation, including summaries of the presentations;
- (d) Include in the content of the road map: where we are, where we should be in the next 25 years and how to get there;
- (e) Keep members of the network informed of the progress, share the draft for input, finalize the document and prepare a plan of action to lobby for adaptation.

XIIIB. Final Declaration of Participants

Participants made the following Declaration:

We, participants of the Global Consultation on Female Genital Mutilation/Cutting (FGM/C), organized by UNFPA from 30 July to 3 August 2007 in Addis Ababa, Ethiopia:

Welcome this important forum as a space that facilitated experience-sharing, review of strategies and analysis of new challenges and opportunities to accelerate the abandonment of FGM/C;

Support the development of a global road map to accelerate the abandonment of FGM/C in consultation with national partners, civil society organizations and development partners;

Reaffirm our zero tolerance of FGM/C as it is an intolerable practice that is harmful to the health and well-being of women and girls and a clear violation of women's and girls' rights and cannot be justified under any circumstance;

Note with concern the slow pace of progress despite decades of interventions to end the practice and the continued unnecessary suffering of millions of women and girls and;

Call upon medical professionals to uphold medical ethics and bring to an end any form of medicalization of FGM/C practice.

Therefore, we, the participants, call on:

- Governments to increase their commitment to:
 - (a) Accelerate the abandonment of FGM/C in line with existing international instruments that protect the health and rights of women and children, including the Convention on the Elimination of All Forms of Discrimination against Women, the Convention on the Rights of the Child, the African Charter on Human and People's Rights, and others, by enacting and enforcing laws banning any form of FGM/C, including when performed by health providers;
 - (b) Build a broad partnership and networks at national, regional and international levels and implement culturally sensitive approaches for sustainable behaviour change;
 - (c) Give highest priority to the health and human rights of women and girls and call upon men to support the abandonment of FGM/C;
 - (d) Uphold the rights of female children who are also victims of this practice;
 - (e) Mainstream FGM/C in human rights and reproductive health issues;
 - (f) Provide adequate resources to scale up FGM/C abandonment programmes in the context of effective gender equity, equality and women's empowerment policies and programmes;
 - (g) Build national capacity, including law enforcement institutions and health providers, in counselling and the management of complications associated with FGM/C;
 - (h) Empower communities and their leaders through sensitization programmes to educate them on the gravity of FGM/C and on legal literacy;
 - (i) Implement a well-funded, coordinated and integrated response to accelerate the abandonment of FGM/C;
 - (j) Set appropriate mechanisms that involve all stakeholders to monitor progress towards the abandonment of FGM/C;

- (k) Demonstrate accountability by making abandonment of FGM/C a national development agenda item and using the report on the Convention for the Elimination of All Forms of Discrimination against Women as a platform for monitoring FGM/C abandonment.

We also call on:

- Religious and traditional leaders to
 - (a) Dispel the continuing myths and misconceptions within cultures and religious communities that are used to justify the continuation of this practice;
 - (b) Educate their constituencies on the rights of women and girls to bodily integrity and their right to enjoy a healthy sexual and reproductive life and widely spread the position of all religions banning any form of FGM/C and;

Finally, we recommend to:

- Development partners to
 - (a) Increase their technical and funding support to countries (governments, civil society organizations, faith-based organizations and community-based organizations);
 - (b) Support continuing research, promote solidarity in the abandonment of FGM/C and mobilize adequate resources towards national ownership and sustainability.
 - (c) Promote gender equality.

Addis Ababa, 3 August 2007

XIIIC. Closing Remarks

Ms. *Fama Hane Ba, Director, Africa Division, UNFPA, closed the global consultation, remarking that the consultation had been enriched by the global diversity and community of purpose. She said:*

“We have learned and indeed we are ready now to scale up what has been working very well. We need to mobilize resources and move forward with a sense of urgency. UNFPA is committed to moving forward, and the Executive Director is committed and will be briefed. UNFPA, UNICEF and WHO commit themselves to moving forward.”

Annexes



Annex 1

List of Participants Global Consultation on FGM/C

30 July - 3 August 2007 Addis Ababa, Ethiopia

Representatives of Governments

Mrs. Safia Elmi Djinril	Director of Mother and Child Health, Ministry of Health	Djibouti
Dr. Mohamed Farid	Project Officer, Reproductive Health Services, Ministry of Health and Population	Egypt
His Worship Simon Peter Odoo	Magistrate	Kapchorwa, Uganda
Ms. Brehane Assefa	Ministry of Health	Ethiopia

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Ms. Alvilda Jablonko	FGM Programme Coordinator	No Peace without Justice (NPWJ)
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Dr. Tekle-ab Mekbib	Senior Consultant	The Population Council (Ethiopia)
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Ms. Haregewien Admassu	Gender Adviser	CARE (Ethiopia)
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Ms. Tabeyin Gedlu	Programme Communication Officer	UNICEF (Ethiopia)
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Dr. Guyo Jaldesa	Consultant, Obstetrician and Gynaecologist, Principal Investigator	WHO (Nairobi)
Dr. Abonesh Haile Mariam	Family Health Programme Officer	WHO/Ethiopia Country Office
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Independent Religious Leader and Consultant

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Country Technical Services Teams (CSTs)

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Mr. Michel Rosalie	Specialist Pop.& Development	CSTAA
Mr. Osaretin Adonri	Consultant	CSTAA

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Annex 2

Female Genital Mutilation and Obstetric Outcome: WHO Collaborative Prospective Study in Six African Countries*

WHO Study Group on Female Genital Mutilation and Obstetric Outcome

Summary

Background Reliable evidence about the effect of female genital mutilation (FGM) on obstetric outcome is scarce. This study examines the effect of different types of FGM on obstetric outcome.

Methods 28 393 women attending for singleton delivery between November, 2001, and March, 2003, at 28 obstetric centres in Burkina Faso, Ghana, Kenya, Nigeria, Senegal, and Sudan were examined before delivery to ascertain whether or not they had undergone FGM, and were classified according to the WHO system: FGM I, removal of the prepuce or clitoris, or both; FGM II, removal of clitoris and labia minora; and FGM III, removal of part or all of the external genitalia with stitching or narrowing of the vaginal opening. Prospective information on demographic, health, and reproductive factors was gathered. Participants and their infants were followed up until maternal discharge from hospital.

Findings Compared with women without FGM, the adjusted relative risks of certain obstetric complications

were, in women with FGM I, II, and III, respectively: caesarean section 1.03 (95% CI 0.88–1.21), 1.29 (1.09–1.52), 1.31 (1.01–1.70); postpartum haemorrhage 1.03 (0.87–1.21), 1.21 (1.01–1.43), 1.69 (1.34–2.12); extended maternal hospital stay 1.15 (0.97–1.35), 1.51 (1.29–1.76), 1.98 (1.54–2.54); infant resuscitation 1.11 (0.95–1.28), 1.28 (1.10–1.49), 1.66 (1.31–2.10), stillbirth or early neonatal death 1.15 (0.94–1.41), 1.32 (1.08–1.62), 1.55 (1.12–2.16), and low birthweight 0.94 (0.82–1.07), 1.03 (0.89–1.18), 0.91 (0.74–1.11). Parity did not significantly affect these relative risks. FGM is estimated to lead to an extra one to two perinatal deaths per 100 deliveries.

Interpretation Women with FGM are significantly more likely than those without FGM to have adverse obstetric outcomes. Risks seem to be greater with more extensive FGM.

* Full Report: <http://www.who.int/reproductive-health/publications/articles/lancetfgm.pdf>



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