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Innocenti Research Centre

Innocenti Digest

CHANGING A HARMFUL SOCIAL CONVENTION: FEMALE GENITAL MUTILATION/CUTTING

For every child
Health, Education, Equality, Protection
ADVANCE HUMANITY

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Mona Omar, social worker in an awareness raising session on FGM, holding a poster that says "from the medical perspective, FGM is the most harmful practice".
Nazlet Ebeed district in Menya, Upper Egypt at Better Life Association
UNICEF/Egypt/2005/838/Pirozzi

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Every year, three million girls and women are subjected to genital mutilation/cutting, a dangerous and potentially life-threatening procedure that causes unspeakable pain and suffering. This practice violates girls' and women's basic human rights, denying them of their physical and mental integrity, their right to freedom from violence and discrimination, and in the most extreme case, of their life.

Female genital mutilation/cutting (FGM/C) is a global concern. Not only is it practiced among communities in Africa and the Middle East, but also in immigrant communities throughout the world. Moreover, recent data reveal that it occurs on a much larger scale than previously thought. It continues to be one of the most persistent, pervasive and silently endured human rights violations.

This *Innocenti Digest* examines the social dynamics of FGM/C. In communities where it is practiced, FGM/C is an important part of girls' and women's cultural gender identity. The procedure imparts a sense of pride, of coming of age and a feeling of community membership. Moreover, not conforming to the practice stigmatizes and isolates girls and their families, resulting in the loss of their social status. This deeply entrenched social convention is so powerful that parents are willing to have their daughters cut because they want the best for their children and because of social pressure within their community. The social expectations surrounding FGM/C represent a major obstacle to families who might otherwise wish to abandon the practice.

Taking this as its point of departure, the *Digest* presents some of the most promising strategies to support communities to abandon FGM/C. These approaches recognize that the decision to abandon the practice must come from communities themselves, and must reflect a collective choice, reinforced publicly and grounded on a firm human rights foundation. Greater understanding of human rights provides communities with the tools to direct their own social transformation. The explicitly collective dimension empowers individual families, while liberating them from having to make the difficult choice of breaking with tradition.

This *Innocenti Digest* is a contribution to a growing movement to end the practice of FGM/C around the world. As early as 1952, the UN Commission on Human Rights adopted a resolution on the issue. The 1979 Convention on the Elimination of All Forms of Discrimination Against Women was an important milestone in recognizing the human rights implications of FGM/C. With the 1989 Convention on the Rights of the Child, the procedure has been identified as both a harmful traditional practice that compromises a child's right to the highest attainable standard of health and a form of violence. The issue has received consistent attention from the Committee on the Rights of the Child and from other treaty bodies and human rights mechanisms.

International commitment to address FGM/C continues to grow. The Millennium Development Goals establish measurable targets and indicators of development that are of direct relevance to ending FGM/C – namely to promote gender equality and empower women, to reduce child mortality and to improve maternal health. *A World Fit for Children*, the outcome document of the 2002 UN General Assembly Special Session for Children, explicitly calls for an end to "harmful traditional or customary practices, such as

early and forced marriage and female genital mutilation". Some countries may be able to achieve this target if adequate resources are provided, while others can make significant advances towards that aim. The current UN Special Studies in Violence against Children and Violence Against Women offer new and important opportunities to draw attention to the issue and generate action to transform this goal into a reality.

Never before has the global community had such a refined understanding of why FGM/C persists and encouraging evidence from innovative programmes. There is good reason to be optimistic that by applying this knowledge, FGM/C can become unacceptable from any point of view and in any form, and that the practice can be ended within a single generation.

Marta Santos Pais
Director Innocenti Research Centre

1 INTRODUCTION

There are an estimated 130 million girls and women alive today whose human rights have been violated by female genital mutilation/cutting (FGM/C). This harmful practice not only affects girls and women in Africa and the Middle East, where it has been traditionally carried out, but also touches the lives of girls and women living in migrant communities in industrialized countries. Although concerted advocacy work over recent decades has generated widespread commitment to end this practice, success in eliminating FGM/C has been limited – with some significant exceptions.

This *Innocenti Digest* meets a pressing need to take stock of progress to date, identify persistent challenges, and highlight the most effective approaches to end FGM/C. In the context of human rights, it integrates concrete field experience with academic theory to provide the global community with a greater understanding of why FGM/C persists. This harmful practice is a deeply entrenched social convention: when it is practiced, girls and their families acquire social status and respect. Failure to perform FGM/C brings shame and exclusion. Understanding how and why FGM/C persists is crucial for developing strategies that are most likely to lead to the abandonment of the practice.

This *Innocenti Digest* is intended to serve as a practical tool to bring about positive change for girls and women. It:

- analyses the most current data to illustrate the geographic distribution of FGM/C and outlines key trends;
- identifies the principal ways in which FGM/C violates a girl's or woman's human rights, including the serious physical, psychological and social implications of this harmful practice;
- examines the factors that contribute to perpetuating FGM/C; and
- outlines effective and complementary action at the community, national and international levels to support the abandonment of FGM/C.

On the basis of analysis conducted, there is good reason to be optimistic that, with the appropriate support, FGM/C can be ended in many practicing communities within a single generation.

What is FGM/C?

Female genital mutilation/cutting includes "a range of practices involving the complete or partial removal or alteration of the external genitalia for nonmedical reasons".[1] This procedure may involve the use of unsterilised, makeshift or rudimentary tools.

The terminology applied to this procedure has undergone a number of important evolutions. When the practice first came to be known beyond the societies in which it was traditionally carried out, it was generally referred to as "female circumcision". This term, however, draws a direct parallel with male circumcision and, as a result, creates confusion between these two distinct practices. In the case of girls and women, the phenomenon is a manifestation of deep-rooted gender inequality that assigns them an inferior position in society and has profound physical and social consequences.[2] This is not the case for male circumcision, which may help to prevent the transmission of HIV/AIDS.[3]

The expression "female genital mutilation" (FGM) gained growing support in the late 1970s. The word "mutilation" not only establishes a clear linguistic

distinction with male circumcision, but also, due to its strong negative connotations, emphasizes the gravity of the act. In 1990, this term was adopted at the third conference of the Inter African Committee on Traditional Practices Affecting the Health of Women and Children (IAC) in Addis Ababa.[4] In 1991, WHO recommended that the United Nations adopt this terminology and subsequently, it has been widely used in UN documents.

The use of the word "mutilation" reinforces the idea that this practice is a violation of girls' and women's human rights, and thereby helps promote national and international advocacy towards its abandonment. At the community level, however, the term can be problematic. Local languages generally use the less judgmental "cutting" to describe the practice; parents understandably resent the suggestion that they are "mutilating" their daughters. In this spirit, in 1999, the UN Special Rapporteur on Traditional Practices called for tact and patience regarding activities in this area and drew attention to the risk of "demonizing" certain cultures, religions and communities.[5] As a result, the term "cutting" has increasingly come to be used to avoid alienating communities.

To capture the significance of the term "mutilation" at the policy level and, at the same time, in recognition of the importance of employing non-judgmental terminology with practicing communities, the expression "female genital mutilation/cutting" (FGM/C) is used throughout this *Digest*.

Box 1 - Classification of FGM/C types

The specific form that FGM/C takes can vary widely from one community to another. WHO is currently reviewing the 1997 classification of types of FGM/C[6] in collaboration with UNICEF, the United Nations Population Fund (UNFPA) and the United Nations Development Fund for Women (UNIFEM). The new version identifies five types of FGM/C.[7]

There are difficulties associated with any classification. Girls and women may not always be certain of which procedure was performed on them. In cases where they were cut at an early age, girls may not even recall undergoing FGM/C. Moreover, there may be significant variation in the extent of cutting, because the procedure is commonly carried out without anaesthetic in poorly lit conditions, and girls often struggle to resist.

Notes

1 Shell-Duncan, Bettina and Ylva Hernlund, eds, (2000), *Female "Circumcision" in Africa: Culture, Controversy and Change*, Lynne Rienner Publisher, London. WHO also offers a definition of FGM/C, however this is under revision at the time of writing. See WHO/UNFPA/UNICEF (1997), *Female genital mutilation. A Joint WHO/UNICEF/UNFPA statement*, World Health Organization, Geneva.

2 Yoder, P. Stanley, Noureddine Abderrahim and Arlinda Zhuzhuni, *Female Genital Cutting in the Demographic and Health Surveys: A Critical and Comparative Analysis*, DHS Comparative Reports No. 7, September 2004, ORC Macro.

3 Reynolds SJ, Sheperd ME, Risbud AR, Gangakhedkar RR, Brookmeyer RS, Divekar AD, Mehendale SM, Bollinger RC (2004) "Male circumcision and risk of HIV-1 and other sexually transmitted infections in India", *The Lancet*, Mar 27, 2004; 363(9414); 1039-40.

4 Shell-Duncan, Bettina and Ylva Hernlund, eds, (2000), *Female "Circumcision" in Africa: Culture, Controversy and Change*, Lynne Rienner Publisher, London.

5 "Third report on the situation regarding the elimination of traditional practices affecting the health of women and the girl child, produced by Mrs. Halima Embarek Warzazi pursuant to Sub-Commission resolution 1998/16", Commission on Human Rights, Sub-Commission on Prevention of Discrimination and Protection of Minorities, E/CN.4/Sub.2/1999/14, 9 July 1999.

6 WHO/UNFPA/UNICEF (1997), *Female genital mutilation. A Joint WHO/UNICEF/UNFPA statement*, World Health Organization, Geneva.

7 In its current draft form, Type I refers to excision of the prepuce with partial or total excision of the clitoris (clitoridectomy); Type II refers to partial or total excision of the labia minora, including the stitching or sealing of it, with or without the excision of part or all of the clitoris; Type III indicates excision of part or most of the external genitalia and stitching/narrowing or sealing of the labia majora - often referred to as "infibulation"; Type IV makes specific reference to a range of miscellaneous or unclassified practices, including stretching of the clitoris and/or labia, cauterization by burning of the clitoris and surrounding tissues, scraping (angurya cuts) of the vaginal orifice or cutting (gishiri cuts) of the vagina, and introduction of corrosive substances or herbs into the vagina to cause bleeding or for the purposes of tightening or narrowing it; Type V refers to symbolic practices that involve the nicking or pricking of the clitoris to release a few drops of blood.

2

MAGNITUDE, ASSESSMENT AND MEASUREMENT

According to a WHO estimate, between 100 and 140 million women and girls in the world have undergone some form of FGM/C.[1] Although overall figures are difficult to estimate, they do indicate the massive scale of this human rights violation. FGM/C affects far more women than previously thought. Recent analysis reveals that some three million girls and women are cut each year on the African continent (Sub-Saharan Africa, Egypt and Sudan).[2] Of these, nearly half are from two countries: Egypt and Ethiopia. Although this figure is significantly higher than the previous estimate of two million, this new figure does not reflect increased incidence, but is a more accurate estimate drawn from a greater availability of data. Effective efforts to end this practice require a more detailed picture of this situation.

Where is FGM/C practiced?

The majority of girls and women at risk of undergoing FGM/C live in some 28 countries in Africa and the Middle East (see map 1). In Africa, these countries form a broad band from Senegal in the west to Somalia in the east. Some communities on the Red Sea coast of Yemen are also known to practice FGM/C, and there are reports, but no clear evidence, of a limited incidence in Jordan, Oman, the Occupied Palestinian Territories (Gaza) and in certain Kurdish communities in Iraq. The practice has also been reported among certain populations in India, Indonesia, and Malaysia.[3]

The most reliable and extensive data on prevalence and nature of FGM/C are provided by Demographic and Health Surveys (DHS) and Multiple Indicator Cluster Surveys (MICS) (see box 2). Prevalence is defined as the percentage of women aged 15 to 49 who have undergone some form of FGM/C. Obtaining data on FGM/C prevalence among girls under 15 years of age poses a number of methodological challenges, not least of which includes ascertaining if and how the procedure was carried out.

Currently DHS and MICS data on FGM/C prevalence are available for 18 countries (see map 1). The most current data from these sources, summarized in table 1, indicate that the prevalence of FGM/C varies significantly from one country to another – from as low as 5 per cent in Niger to as much as 99 per cent in Guinea.[4] Countries in which FGM/C is practiced but for which there are not, as yet, DHS or MICS data are Cameroon[5], the Democratic Republic of Congo, Djibouti, Gambia, Guinea Bissau, Liberia, Senegal, Sierra Leone, Somalia, Togo, and Uganda. The latter countries also demonstrate a wide range of prevalence: the Democratic Republic of Congo is thought to have less than 5 per cent prevalence, while both Djibouti and Somalia are estimated to have prevalence around or above 90 per cent.

Patterns of FGM/C prevalence emerge when countries are grouped by region. For example, in the countries of northeast Africa (Egypt, Eritrea, Ethiopia, and Sudan), it ranges from 80 to 97 per cent, while in East Africa (Kenya and Tanzania) it is markedly lower and ranges from 18 to 32 per cent.[6] Care is required, however, when interpreting these figures, since they represent national averages and do not reflect the often marked variation in prevalence in different parts of a given country. In Nigeria, for example, national prevalence is 19 per cent; prevalence in the southern regions reaches almost 60 per cent, while in the north it is between zero and 2 per cent.

Map 1 - Countries in which FGM/C is practiced

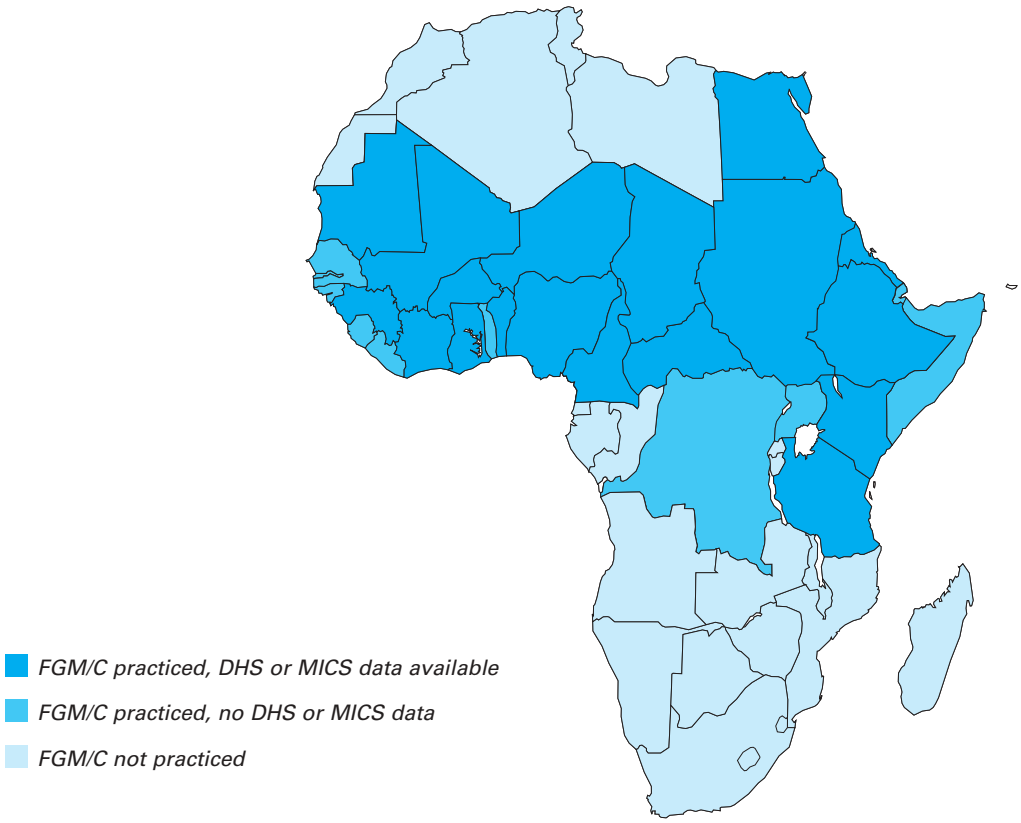


Table 1 - FGM/C prevalence among women aged 15 to 49 by country[7]

Country	Survey type and date	National prevalence FGM/C %
Benin	DHS 2001	17
Burkina Faso	DHS 2003	77
Central African Republic	MICS 2000	36
Chad (provisional)	DHS 2004	45
Côte d'Ivoire	DHS 1998-9	45
Egypt *	DHS 2003	97
Eritrea	DHS 2002	89
Ethiopia	DHS 2000	80
Ghana	DHS 2003	5
Guinea	DHS 1999	99
Kenya	DHS 2003	32
Mali	DHS 2001	92
Mauritania	DHS 2000-1	71
Niger	DHS 1998	5
Nigeria	DHS 2003	19
Sudan* +	MICS 2000	90
Tanzania	DHS 1996	18
Yemen*	DHS 1997	23

* Sample consisted of ever-married women
\+ Surveys were conducted in northern Sudan.

The practice of FGM/C is no longer restricted to countries in which it has been traditionally practiced. Migration from Africa to industrialized countries has been an enduring characteristic of the post World War II period, and many of the migrants come from countries that practice FGM/C. Beyond economic factors, migratory patterns have frequently reflected links established in the colonial past. For instance, citizens from Benin, Chad, Guinea, Mali, Niger and Senegal have often chosen France as their destination, while many Kenyan, Nigerian and Ugandan citizens have migrated to the United Kingdom.

In the 1970s, war, civil unrest and drought in a number of African states, including Eritrea, Ethiopia and Somalia, resulted in an influx of refugees to Western Europe, where some countries, such as Norway and Sweden, had been relatively unaffected by migration up to that point. Beyond Western Europe, Canada and the USA in North America, and Australia and New Zealand in Australasia also host women and children who have been subjected to FGM/C, and are home to others who are at risk of undergoing this procedure.

Data on the prevalence and characteristics of FGM/C in industrialized countries are rare and extrapolations are sometimes used to gain insights on the extent of the practice. By combining data from the office of migration with data on prevalence from countries of origin, the Swiss National Committee for UNICEF estimated that, in Switzerland, some 6,700 girls and women have either undergone FGM/C, or are at risk of undergoing the procedure. Of these, more than one third are of Somali origin. This number does not include women and girls holding a Swiss passport.

Box 2 - Demographic and Health Surveys and Multiple Indicator Cluster Surveys

The principal source of data and data analysis on FGM/C is provided by MEASURE DHS+, which assists developing countries worldwide in the collection and use of data to monitor and evaluate population, health, and nutrition programmes. Demographic and Health Surveys provide national and sub-national data on family planning, maternal and child health, child survival, HIV/AIDS/sexually transmitted infections, infectious diseases, reproductive health and nutrition.[8] Additional optional modules address women's status, domestic violence, HIV/AIDS and FGM/C.

A module on FGM/C was first included in a survey of northern Sudan in 1989-90, and by the end of 2003, a total of 17 countries (16 in Africa, plus Yemen) had included questions on FGM/C in their surveys.[9] This module represents an important tool for standardizing reporting, monitoring progress and establishing goals in countries where FGM/C remains a challenge. Although the form and emphasis of the questions asked in the surveys have evolved over time, they have generally sought to establish if a woman has undergone FGM/C and, if so, the age of the woman at the time of the procedure, the type of surgery and by whom it was performed. Additional questions also determine whether the respondent's daughter has undergone the operation and, again, the circumstances of this event (generally this refers to the proportion of women aged 15-49 with at least one circumcised daughter, although several studies capture the status of the oldest daughter only). Finally, a number of questions have helped to establish the respondent's attitude towards the practice. Since the survey population is women aged 15-49,[10] in communities where girls undergo cutting at a very young age, the picture presented by DHS data does not necessarily reflect current prevalence. Data on a girl cut at age five, for example, would be recorded ten years later.

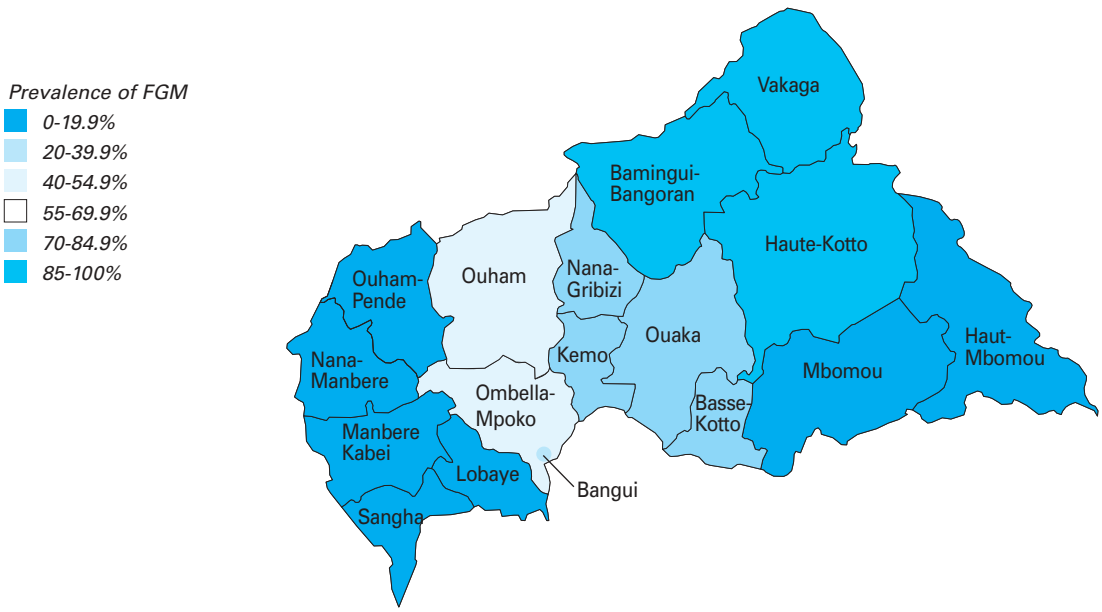
DHS data are complemented by UNICEF Multiple Indicator Cluster Surveys (MICS). These have a similar structure to DHS surveys and are designed to provide an affordable, fast and reliable household survey system in situations where there are no other reliable sources of data. The first round of MICS was conducted as part of the review of progress made in achieving the goals of the World Summit for Children in 1990 and the second (MICS2) as end decade surveys in 66 countries. The latter were used to inform the UN General Assembly Special Session on Children, held in New York in 2002. MICS, with a module on FGM/C, were carried out in the Central African Republic, Chad and Sudan in 2000, and a new round – MICS3 – is planned for 2005.

Disaggregated data[11]

Both DHS and MICS permit national level data to be disaggregated by age group, urban-rural residence and region or province. Many surveys also show differences in prevalence by ethnicity and religion. The possibility of analysing disaggregated data on prevalence is of crucial importance since national averages can disguise significant in-country variations. This is less the case in countries where the prevalence of FGM/C is very high, such as Egypt, Guinea and Sudan, with prevalence rates of 90 per cent or over. However, in countries where a significant proportion of the population does not pursue the practice, disaggregation can significantly enhance understanding of the phenomenon and inform programmatic interventions to support its abandonment.

The value of disaggregation by region or province is illustrated by the case of the Central African Republic (map 2), where data from MICS2 indicate that, at the national level, 36 per cent of women aged 15 to 49 have undergone FGM/C. Looking at the situation from a sub-national perspective reveals significant geographic variations. In five prefectures in the west of the country and two in the east, FGM/C prevalence

Map 2 - Central African Republic, 2000



is between 0 and 19.9 per cent, while in three prefectures in the north of the country, the prevalence is between 85 and 100 per cent.[12]

The variation is largely explained by the presence of diverse ethnic communities with differing attitudes and practices regarding FGM/C. In the Central African Republic, countrywide FGM/C prevalence ranges from 5 per cent among the Mboum and Zande-N'zakara to 75 per cent among the Banda, one of the largest ethnic groups in the country. Among the Gbaya, the largest ethnic group, the prevalence rate is 24 per cent. DHS analysts point out that data vary far more by ethnicity than by any other social or demographic variable. In other words, ethnic identity and the practice of FGM/C are closely linked. Some groups rarely or never practice FGM/C, while in others, virtually all women have been cut.

Data on ethnicity are available for only a limited number of countries, and when analysing them, at least three important issues need to be considered. First, ethnic groupings rarely correspond to clearly defined national administrative divisions, and groups that practice FGM/C may be present in a number of provinces or districts. Second, even in a relatively detailed survey, the ethnic groups listed may in fact be an ethnic category consisting of many subgroups with differing practices. Finally, while the disaggregation of FGM/C prevalence by ethnicity is useful for informing programmatic action, these data should be interpreted with care to avoid stigmatization.

Urban development has been considered as a possible factor influencing prevalence, although the link between urbanization and prevalence is not unequivocal. Of the 18 countries covered by DHS or MICS, 12 demonstrate a higher prevalence of FGM/C in rural areas than in urban areas, although in certain cases the difference is very small. In two cases (Ethiopia and Guinea), urban and rural rates were both found to be identical or near identical, while in four cases (Burkina Faso, Nigeria, Sudan and Yemen), prevalence in urban areas is higher than in rural parts of the country, a phenomenon most likely explained by the confounding effect of ethnicity.

Education, especially of women, can play an important role in safeguarding the human rights of both women themselves, and those of their children. Overall, daughters of mothers who are more highly educated are less likely to have undergone FGM/C than daughters of mothers with little or no education.[13] This is illustrated by the data in table 2. Only in Guinea does no relationship appear between the FGM/C status of daughters and a mother's level of education, a finding which can largely be explained by the very small proportion of women in this country with secondary schooling or above. Table 2 also shows that although there is a statistical difference between women with secondary education and those with no education, FGM/C is still practiced by women with higher education. In other words, women's education may contribute to a reduction of the practice, but alone it is not sufficient to lead to its abandonment.

Table 2 - Prevalence (per cent) of FGM/C among daughters, by mother's education[14]

Survey	No education	Primary	Secondary	Total
Benin (2001)	11.1	2.5	0.7	8.2
Egypt (2000)	64.7	62.6	21.2	49.5
Eritrea (2002)	67.5	59.4	40.0	62.5
Ethiopia (2000)	55.7	35.4	25.4	51.8
Guinea (1999)	54.7	44.0	55.1	53.9
Mali (2001)	73.1	73.9	64.8	72.8
Mauritania (2000-01)	77.4	60.6	41.1	70.9
Yemen (1997)	41.4	23.9	29.0	38.3

The circumstances surrounding FGM/C

DHS and MICS provide valuable information regarding the circumstances surrounding the act of FGM/C, including the age at which a girl or woman is subjected to the practice, the type of cutting involved and the practitioner who carried it out. These surveys reveal notable variations in both the form and meaning of FGM/C – variations which largely occur between different groups rather than within groups.

The age at which large proportions of girls are cut varies greatly from one country to another. About 90 per cent of girls in Egypt are cut between the ages of 5 and 14 years,[15] while in Ethiopia, Mali and Mauritania, 60 per cent or more of girls surveyed underwent the procedure before their fifth birthday.[16] In Yemen, the Demographic and Health Survey carried out in 1997 found that as many as 76 per cent of girls underwent FGM/C in their first two weeks of life. In-country variations are also apparent, often reflecting the distribution of ethnic groups. In Sudan, a cohort study in 2004 found that at least 75 per cent of girls had undergone FGM/C by the age of 9 to 10 in South Darfur, a state which has a predominantly Fur and Arab population, while in Kassala, which has a predominantly Beja population, 75 per cent of girls had already been cut by the age of 4 to 5.[17]

Information regarding the type of FGM/C performed is useful in helping to anticipate the extent of the physical consequences of the practice. There are, however, certain challenges in obtaining these data, including ascertaining whether survey respondents understood what was meant when asked about which type of FGM/C they had undergone. In the majority of countries where DHS or MICS included a question regarding type of FGM/C, the "lightest" form[18] was found to be most common. Only in Burkina Faso was the more extensive procedure, involving excision of the labia minora, most frequently carried

out (accounting for 56 per cent of all cutting[19]). Infibulation – cutting followed by stitching or narrowing – was found to affect large proportions of women in two countries: Sudan, where the MICS2 survey in 2000 estimated that as many as 74 per cent of women who had been cut had undergone this procedure; and Eritrea, where the DHS survey in 2002 estimated that 39 per cent had been subjected to infibulation. This procedure is also known to be widely practiced in Djibouti and Somalia.

The large majority of girls and women are cut by a traditional practitioner, a category which includes local specialists (cutters or *exciseuses*), traditional birth attendants and, generally, older members of the community, usually women. This is true for over 80 percent of the girls who undergo the practice in Benin, Burkina Faso, Côte d'Ivoire, Eritrea, Ethiopia, Guinea, Mali, Niger, Tanzania and Yemen. In most countries, medical personnel, including doctors, nurses and certified midwives, are not widely involved in the practice. Egypt offers a clear exception: in 2000, it was estimated that in 61 per cent of cases, FGM/C had been carried out by medical personnel. The share of FGM/C carried out by medical personnel has also been found to be relatively high in Sudan[20] (36 per cent) and Kenya (34 per cent).

FGM/C and changes over time

FGM/C is an evolving practice, and its characteristics and distribution have changed over time. In Yemen, for instance, the practice only emerged in the course of the 20th century as a result of contacts with practicing communities in the Horn of Africa.

Evidence of changes in the prevalence of FGM/C can be obtained by comparing the experiences of women in different age groups in a given country. Using this method, 9 of the 16 countries in which DHS has collected data demonstrate a marked decrease in prevalence in the younger age groups (15 to 25 years of age): Benin, Burkina Faso, Central African Republic, Eritrea, Ethiopia, Kenya, Nigeria, Tanzania and Yemen. In the remaining seven countries (Côte d'Ivoire, Egypt, Guinea, Mali, Mauritania, Niger and Sudan[21]) prevalence is at roughly the same level for all age groups, suggesting that rates of FGM/C in these cases have remained relatively stable over recent decades. Of the four countries that demonstrate the highest rates of prevalence (Egypt, Guinea, Mali and Sudan[22]) – none have shown any evidence of change in prevalence over time.

Changes in prevalence can also be assessed in a number of countries where two surveys have been carried out, thus enabling a comparison of results at different points in time. Table 3 indicates that of the seven countries where this type of comparison is currently possible, there has been a clear decrease in overall prevalence in Eritrea, Kenya and Nigeria.

The data provide grounds for cautious optimism. Asked if they think that FGM/C should continue, younger women are generally less likely to agree than older women. This difference was highest for the DHS survey in Eritrea in 2002, which found that 63 per cent of women between 45 and 49 years of age supported FGM/C compared to only 36 per cent of women between 15 and 19 years of age. While these findings are encouraging, attitudes may shift with age. Moreover, field experience indicates that a lack of support for FGM/C (i.e. a change of attitude towards the practice) is not always translated into a change in behaviour.

Table 3 - FGM/C prevalence in countries where two DHS surveys have been conducted[23]

Country	Survey Date	FGM/C Prevalence (%)
Burkina Faso	1998-99	71.6
Burkina Faso	2003	76.6
Côte d'Ivoire	1994	42.7
Côte d'Ivoire	1998-99	44.5
Egypt	1995	97.0
Egypt	2000	97.3
Eritrea	1995	94.5
Eritrea	2002	88.7
Kenya	1998	37.6
Kenya	2003	33.7
Mali	1995-96	93.7
Mali	2001	91.6
Nigeria	1999	25.1
Nigeria	2003	19.0

In addition to changes in prevalence, there are three significant trends which are emerging in a number of countries where FGM/C is practiced.[24]

- *The average age at which a girl is subjected to cutting is decreasing in some countries*. Of the 16 countries surveyed by DHS, the median age at the time FGM/C was performed has dropped substantially in Burkina Faso, Côte d'Ivoire, Egypt, Kenya and Mali. Reasons for this may include the effect of national legislation to prohibit FGM/C, which has encouraged the practice to be carried out at an early age when it can be more easily hidden from the authorities. It is also possible that the trend is influenced by a desire on the part of those who support or perform the practice to minimise the resistance of the girls themselves.
- *The "medicalization" of FGM/C, whereby girls are cut by trained personnel rather than by traditional practitioners, is on the rise*. This trend may reflect the impact of campaigns that emphasise the health risks associated with the practice, but fail to address the underlying motivations for its perpetuation. Analysing survey data by age group reveals that in Egypt, Guinea and Mali, the medicalization of FGM/C has increased dramatically in recent years.
- *The importance of the ceremonial aspects associated with FGM/C is declining in many communities*. This trend may also be related, in part, to the existence of legislation to prohibit FGM/C that discourages public manifestations of the practice.

Standardizing indicators for situation analysis and monitoring progress

The information contained in this section represents only a brief introduction to the data on FGM/C available from DHS and MICS. The questions posed in these surveys enable a range of inter- and intra-country comparisons to be carried out. The potential for comparison is further enhanced as these surveys move towards a set of standardised indicators for situation analysis and monitoring progress towards ending FGM/C. In November 2003, international agreement was reached on appropriate indicators for these purposes at a UNICEF Global Consultation on Indicators.[25] At this consultation, five standard indicators for situation analysis were established.

1. *Prevalence of FGM/C by age cohorts 15-49.* This is the most important indicator. Age cohorts are 15-19, 20-24, 25-29, 30-34, 35-39, 40-44 and 45-49.
2. *FGM/C status of all daughters.* This indicator refers to FGM/C prevalence for all daughters of mothers aged 15 to 49 years. It is recommended to collect data on the current age of daughters as well as on the age at which they were cut.
3. *Percentage of "closed" FGM/C (infibulation, sealing) and "open" FGM/C (excision).* This simplified category is introduced to help overcome the difficulty of identifying the specific type of FGM/C a woman or her daughter has undergone.
4. *Performer of FGM/C.*
5. *Support of, or opposition to FGM/C by women and men age 15-49.*

The Global Consultation also sought to extend the collection of data on prevalence to girls aged 5 to 14. It may be possible to obtain these data through local surveys, although these do not yield prevalence data at national levels.

To assess the effectiveness of programmes promoting the abandonment of FGM/C, three indicators were agreed upon.

- *Public declaration of intent.* The questions should capture the stated intent of individuals, communities and villages to abandon FGM/C. Forms of public declarations may vary from one community to another.
- *Community-based monitoring mechanisms to follow up on girls at risk of FGM/C.* Information should be gathered from the community through the health and school systems and from youth groups, along with other community-selected monitoring mechanisms. Information might include the number of girls who have or have not been cut, the age at which the practice is carried out (and any changes in this age), the number of men who would marry women who have not undergone FGM/C, and the dissemination of messages by community members and former practitioners.
- *Drop in prevalence.* This is the ultimate quantitative measure that demonstrates progress towards the abandonment of FGM/C and hence the effectiveness of programmes in place. It can be obtained though household surveys organized with international support (MICS or DHS) or locally.

Data measuring these indicators can be derived from smaller community studies and programme monitoring and evaluation. Communities should be involved throughout any evaluation process in order to identify indicators and information that reflect their own perception of progress.

Notes

1 See, for example, WHO (2000), *Female Genital Mutilation*. Fact sheet no. 241, World Health Organization, Geneva.
2 It has been calculated that in 2000, approximately 3,050,000 were girls cut on the African continent. Figure courtesy of Stan Yoder, Measure DHS, ORC Macro. This figure is derived by taking the number of females born in 2000 in these countries, calculating a loss due to infant mortality, and multiplying the resulting figure by the prevalence of FGM/C among the 15-24 year old cohort in each of the countries where FGM/C is performed. The resulting figure is approximate, in part because there are no figures for prevalence among girls of less than 15 years of age, and in part because there is uncertainty over FGM/C prevalence in a number of countries (DRC, The Gambia, Liberia, Senegal, Sierra Leone and southern Sudan).
3 Amnesty International (1998), "Section 1: What is Female Genital Mutilation", Female Genital Mutilation – A Human Rights Information Pack, www.amnesty.org/ailib/intcam/femgen/fgm1.htm#a3, accessed 10.2.2005.
4 Demographic and Health Survey, Niger, 1998: Women aged 15-49, and Demographic and Health Survey, Guinea, 1999: Women aged 15-49.
5 Provisional 2004 DHS data indicates a prevalence of approximately 1% in Cameroon.
6 Yoder, P. Stanley, Noureddine Abderrahim and Arlinda Zhuzhuni, *Female Genital Cutting in the Demographic and Health Surveys: A Critical and Comparative Analysis*, DHS Comparative Reports No. 7, September 2004, ORC Macro. See also UNICEF (2004), *The State of the World's Children 2005*, The United Nations Children's Fund, New York, Table 9.
7 Table compiled by the UNICEF Strategic Information Section, Division of Policy and Planning. *Data for Egypt, Yemen, and Sudan are based on a sample of ever-married women. It is assumed that FGM/C prevalence rate is no different among non-married women.
8 For more information on Demographic and Health Surveys, see www.measuredhs.com.
9 There are currently 25 Demographic and Health Surveys that contain data on FGM/C (another two contain figures that are still provisional), including countries in which 2 surveys have been carried out.
10 In most countries, the survey includes all women in the 15-49 cohort, however in DHS surveys for Egypt and Yemen, the sample includes only ever-married women in this age group.
11 For a more detailed discussion of the issues introduced in this section, see Yoder, P. Stanley, Noureddine Abderrahim and Arlinda Zhuzhuni, *Female Genital Cutting in the Demographic and Health Surveys: A Critical and Comparative Analysis*, DHS Comparative Reports No. 7, September 2004, ORC Macro.
12 All data from Multiple Indicator Cluster Survey 2, Central African Republic, 2000.
13 Yoder, P. Stanley, Noureddine Abderrahim and Arlinda Zhuzhuni, *Female Genital Cutting in the Demographic and Health Surveys: A Critical and Comparative Analysis*, DHS Comparative Reports No. 7, September 2004, ORC Macro. Considering the education level of a woman who has been cut is not helpful, since cutting nearly always takes place before a girls' education is complete, and in some cases, even before it begins.
14 Table based on Demographic and Health Survey data, from Yoder, P. Stanley, Noureddine Abderrahim and Arlinda Zhuzhuni, *Female Genital Cutting in the Demographic and Health Surveys: A Critical and Comparative Analysis*, DHS Comparative Reports No. 7, September 2004, ORC Macro.
15 Demographic and Health Survey, Egypt, 1995 and 2000.
16 Demographic and Health Survey, Ethiopia, 2000; Mali, 2001; Mauritania, 2000-01.
17 Bayoumi, Ahmed (2003), *Baseline Survey on FGM Prevalence and Cohort Group Assembly in Three CFCI Focus States*, UNICEF Sudan Country Office, Khartoum.
18 Excision of the prepuce, with or without excision of part or all of the clitoris. This refers to the original WHO classification, currently under review.
19 Demographic and Health Survey, Burkina Faso, 1998-99.
20 Surveys were conducted in northern Sudan.
21 Surveys were conducted in northern Sudan.
22 Surveys were conducted in northern Sudan.
23 Yoder, P. Stanley, Noureddine Abderrahim and Arlinda Zhuzhuni, *Female Genital Cutting in the Demographic and Health Surveys: A Critical and Comparative Analysis*, DHS Comparative Reports No. 7, September 2004, ORC Macro.
24 Yoder, P. Stanley, Noureddine Abderrahim and Arlinda Zhuzhuni, *Female Genital Cutting in the Demographic and Health Surveys: A Critical and Comparative Analysis*, DHS Comparative Reports No. 7, September 2004, ORC Macro.
25 UNICEF (2004), "UNICEF Global Consultation on Indicators, November 11-13, 2004, NYHQ. Child Protection Indicators Framework. Female Genital Mutilation and Cutting", New York, USA, 12 July, 2004 revision.

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3

THE SOCIAL DYNAMICS OF FGM/C

In every society in which it is practiced, FGM/C is a manifestation of gender inequality that is deeply entrenched in social, economic and political structures. In practice, however, this dimension is not explicitly addressed and may not even be recognised by those who support and perpetuate FGM/C.

Researchers seeking to understand how and why the practice of FGM/C persists are confronted with what appears to be a paradox: in many cases, parents and other family members are perpetuating a tradition that they know can bring harm, both physical and psychological, to their daughters. The explanation lies in the social dynamics among individuals in communities that practice FGM/C. Mothers organize the cutting of their daughters because they consider that this is part of what they must do to raise a girl properly[1] and to prepare her for adulthood and marriage. In discussions about FGM/C, Maninka women in central Guinea explained that parents have a threefold obligation to their daughters: to educate them properly, cut them, and find them a husband.[2] This obligation can be understood as a social convention to which parents conform, even if the practice inflicts harm. From this perspective, not conforming would bring greater harm, since it would lead to shame and social exclusion.

Social convention is so powerful that girls themselves may desire to be cut, as a result of the social pressure from peers and because of fear – not without reason – of stigmatisation and rejection by their own communities if they do not follow the tradition.[3]

FGM/C is an important part of girls' and women's cultural gender identity and the procedure may also impart a sense of pride, of coming of age and a feeling of community membership. Girls who undergo the procedure are provided with rewards, including celebrations, public recognition and gifts. Moreover, in communities where FGM/C is almost universally practiced, not conforming to the practice can result in stigmatization, social isolation and difficulty in finding a husband. Girls and women living in immigrant communities may also value the procedure because it can play a role in reinforcing their cultural identity in a foreign context.

Understanding FGM/C as a social convention provides insight as to why women who have themselves been cut and suffer the health consequences favour its continuation.[4] They resist initiatives to end FGM/C, not because they are unaware of its harmful aspects, but because its abandonment is perceived to entail loss of status and protection. This also helps to explain why individual families that voice a desire to abandon the practice nonetheless submit their daughters to the procedure. The convention can only be changed if a significant number of families within a community make a collective and coordinated choice to abandon the practice so that no single girl or family is disadvantaged by the decision.[5]

Mechanisms that reinforce the social convention

The justifications offered for the practice of FGM/C are numerous and, in their specific context, compelling. While these justifications may vary among communities, they follow a number of common themes: FGM/C ensures a girl's or woman's status, marriageability, chastity, health, beauty and family honour. In some cases they are presented positively to emphasise the advantages of undergoing FGM/C,

Box 3 - FGM/C and footbinding: a path to marriage and improved social status

Important and instructive parallels exist between FGM/C and the well-documented practice of footbinding in China, which help to explain how such harmful social conventions first developed. FGM/C, like footbinding, is thought to have evolved in the context of a highly stratified empire, in which the emperor and his elite used the practice to control the fidelity of their many female consorts. With time, these practices came to be adopted by families in lower strata of society to enable their daughters to marry into higher strata. Footbinding and FGM/C eventually became essential signs of marriageability throughout the respective empires and in all but the poorest groups in society. In this way, the practices became social conventions that had to be observed if a girl was to find a husband – conventions that persisted after the original imperial conditions faded.[6]

The hypothesis that, like footbinding, FGM/C is linked to marriageability is applicable in many practicing communities of Africa and the Middle East. Evidence suggests that FGM/C is broadly linked to the social status, respectability and honour of girls and their families. In Sierra Leone, for example, failure to join one of the country's cross-group secret societies that require FGM/C, leads to exclusion from society in general. In all cases parents cannot choose to abandon the practice without depriving their daughters, and perhaps the entire family, of the opportunity to become full and recognized members of the community. Parents who submit their daughters to the practice do so because they are honourable members of society who want the best for their children.

while in others they point to the consequences of not undergoing the procedure.[7]

> "Why do you think people here in the village support the practice?"
> *"It is a norm that has to be fulfilled. The girl must be circumcised to protect her honour and the family's honour, especially that now girls go to universities outside the village and may be exposed to lots of intimidating situations."*
> Interview with woman from Abu Hashem village, Upper Egypt.[8]

Among groups that practice FGM/C, cutting constitutes a social, ethnic and physical mark of distinction.[9] FGM/C assigns status and value both to the girl or woman herself and to her family. Among the Chagga of Arusha in Tanzania, the link between FGM/C and the value of girls is explicit: the bride price for a girl who has undergone the practice is much higher than that for one who has not.[10]

FGM/C is also practiced on the grounds that it preserves a girl's virginity, making the procedure a prerequisite for marriage. In part of Nigeria, for instance, FGM/C serves the purpose of allowing the future mother-in-law to verify the virginity of the bride.[11] Similarly, FGM/C is often justified on the grounds that it protects girls from excessive sexual emotions and therefore, helps to preserve their morality, chastity and fidelity. FGM/C may additionally be associated with bodily cleanliness and beauty. For instance, in Somalia and Sudan, infibulation is carried out with the express purpose of making girls physically "clean".

Religious justifications are also given for the practice. Often communities that cite a religious motivation consider the practice a requirement to make a girl spiritually pure. Among the Bambara in Mali, for example, excision is called *Seli ji*, meaning ablution or ceremonial washing.[12]

FGM/C is not prescribed by any religion. This is not, however, the general perception, especially regarding Islam. Although there is a theological branch of Islam that supports FGM/C of the *sunna* type, the Koran contains no text that requires the cutting of the female external genitalia (see Box 4), and it is widely accepted that the practice was current in Sudanese or Nubian populations before Islam.[13] Moreover, the majority of Muslims around the world do not practice FGM/C. There is no evidence of the practice in Saudi Arabia and it is not found in several North African Muslim countries, including Algeria, Libya, Morocco and Tunisia.

Box 4 - Statements from Islamic and Coptic church leaders

"Islamic Shari'a protects children and safeguards their rights. Those who fail to give rights to their children commit a major sin. […] FGM is a medical issue, what doctors say we heed and obey. There is no text in Shari'a, in the Koran, in the prophetic Sunna addressing FGM."
The Grand Imam, Sheikh Mohammed Sayed Tantawi, Sheikh of Al-Azhar.[14]

"It has been proven to us with authenticated religious evidence that there is no rightful Shariat evidence on which to base the legitimacy of any form of FGM/C. Moreover any type has associated harm, as stated by trusted doctors."
Signed statement by 30 Sheikhs from the eight largest Sufist groups in Sudan, 2004

" […] from the Christian perspective – this practice has no religious grounds whatsoever. Further, it is medically, morally and practically groundless. […] When God created the human being, he made everything in him/her good: each organ has its function and role. So, why do we allow the disfiguring of God's good creation? There is not a single verse in the Bible or the Old or New Testaments, nor is there anything in Judaism or Christianity – not one single verse speaks of female circumcision."
Bishop Moussa, Bishop for Youth of the Coptic Orthodox Church and Representative of Pope Shenouda III.[15]

Whether they are religious, aesthetic, hygienic or moral, the justifications given for FGM/C are all mechanisms that maintain the social convention of cutting girls and women and contribute to the perpetuation of the practice. Information regarding the validity of these justifications helps to change attitudes towards FGM/C, but real and lasting change in behaviour is most likely to result from transforming the social convention itself.

Changing the social convention: towards the abandonment of FGM/C

As with any self-enforcing social convention, the choice of an individual – in the case of FGM/C, a single family's choice of whether or not to cut its daughter or daughters – is conditioned by the choice of others. This social pressure tends to perpetuate the practice. It can also be the key to promote rapid collective abandonment. The practice of footbinding in China, for example, which lasted some 1000 years, was abandoned in little more than a generation.

To understand how a social convention might be transformed, it is helpful to use a simple metaphor. A group has a convention whereby audiences (at the cinema, at plays, at recitals) stand up rather than sit down. An outsider comes along and explains that elsewhere audiences sit. After the shock of surprise wears off, some people begin to think that sitting might be better. If only one person sits, that person can't see anything on the stage. However, if a critical mass of people in the audience can be organized to sit, even a group of people who are less than the majority, they realize that they can sit comfortably and have a clear view of the stage.[16]

Similarly, in communities where cutting is a prerequisite for marriage, if only one family abandons FGM/C, its daughter doesn't get married. A critical mass is needed to bring about change. Once enough individuals are willing to abandon FGM/C, they will work to convince others to follow suit because this will reduce the social stigma associated with not cutting. The critical mass need not be a majority, but simply a sufficient number of individuals to demonstrate to others the relative benefits of *not* practicing FGM/C.

Individuals within the group who have opted to abandon the practice will still face social pressure to cut their daughters, as illustrated by the challenges faced by a mother in Sudan (see Box 5). For this pressure to disappear, the number of people who have expressed their intention to abandon the practice must reach a "tipping point". At this point, those who still consider following the practice recognise that the status and honour it brings to a girl and her family no longer outweigh the risks involved.

Once the new convention of valuing a girl's physical integrity is established, it becomes, like the old convention, self-enforcing. For those who have abandoned FGM/C, there is no incentive to revert to the practice, while the few individuals who continue to support FGM/C will face the disapproval of the community.

Abandoning FGM/C: six key elements for change

Concrete field experience, together with insights from academic theory and lessons learned from the experience of footbinding in China suggest that six key elements can contribute to transforming the social convention of cutting girls and encourage the rapid and mass abandonment of the practice.

1. *A non-coercive and non-judgmental approach whose primary focus is the fulfilment of human rights and the empowerment of girls and women.* Communities tend to raise the issue of FGM/C when they increase their awareness and understanding of human rights and make progress toward the realisation of those they consider to be of immediate concern, such as health and education. Despite taboos regarding the discussion of FGM/C, the issue emerges because group members are aware that the practice causes harm. Community discussion and debate contribute to a new understanding that girls would be better off if everyone abandoned the practice.
2. *An awareness on the part of a community of the harm caused by the practice.* Through non-judgmental, non-directive public discussion and reflection, the costs of FGM/C tend to become more evident as women – and men – share their experiences and those of their daughters.
3. *The decision to abandon the practice as a collective choice of a group that intramarries or is closely connected in other ways.* FGM/C is a communi-

Box 5 - A mother's story: Challenges faced by those who begin the process of change

Khadija is a devout Ansar Sunna Muslim from the Beni Amer tribal group in Eastern Sudan. She lives with her extended family. When she leaves the house, she covers herself in a black *abaya* (garment) and face veil to be properly modest. As a girl, she underwent infibulation, known in Sudan as "pharaonic" cutting, according to Beni Amer tradition.

Now she has a six-year-old daughter who has not yet been cut. Khadija attended a program about harmful traditional practices, where she learned about the health complications associated with FGM/C. Along with other women, she registered her daughter with the group of uncircumcised girls. Yet Khadija is troubled. Although she doesn't want her daughter to suffer from the health complications she heard about, she knows that men favour the practice for religious reasons. She also expects that her mother-in-law will have something to say about it. "If I don't cut her, there won't be anyone to marry her," says Khadija. "I wish I didn't have daughters, because I am so worried about them."[17]

ty practice and, consequently, is most effectively given up by the community acting together rather than by individuals acting on their own. Successful transformation of the social convention ultimately rests with the ability of members of the group to organize and take collective action.

4. *An explicit, public affirmation on the part of communities of their collective commitment to abandon FGM/C.* It is necessary, but not sufficient, that most members of a community favor abandonment. A successful shift requires that they manifest – as a community – the will to abandon. This may take various forms, including a joint public declaration in a large public gathering or an authoritative written statement of the collective commitment to abandon.

5. *A process of organized diffusion to ensure that the decision to abandon FGM/C spreads rapidly from one community to another and is sustained.* Communities must engage neighbouring villages so that the decision to abandon FGM/C can be spread and sustained. It is particularly important to engage those communities that exercise a strong influence. When the decision to abandon becomes sufficiently diffused, the social dynamics that originally perpetuated the practice can serve to accelerate and sustain its abandonment. Where previously there was social pressure to perform FGM/C, there will be social pressure to abandon the practice. When the process of abandonment reaches this point, the social convention of not cutting becomes self-enforcing and abandonment continues swiftly and spontaneously.

6. *An environment that enables and supports change.* Success in promoting the abandonment of FGM/C also depends on the commitment of government, at all levels, to introduce appropriate social measures and legislation, complemented by effective advocacy and awareness efforts. Civil society forms an integral part of this enabling environment. In particular, the media have a key role in facilitating the diffusion process.

Notes

1 Gruenbaum, Ellen (2001), *The Female Circumcision Controversy: An anthropological perspective*, University of Pennsylvania Press, Philadelphia.

2 Yoder, P. Stanley, Papa Ousmane Camara, and Baba Soumaoro (1999), *Female genital cutting and coming of age in Guinea*, Macro International Inc., Calverton, MD.

3 A number of observers have noted the power of peer pressure on girls and young women as regards FGM/C. See chapters 7, 9, 12 and 14 of Shell-Duncan, Bettina and Ylva Hernlund, eds, (2000), *Female "Circumcision" in Africa: Culture, Controversy and Change*, Lynne Rienner Publisher, London.

4 Carr, Dara (1997), *Female Genital Cutting: Findings form the Demographic and Health Surveys Program*, Macro International Inc, Calverton MD.

5 For more on the social convention of FGM/C, see Mackie, Gerry (1996), "Ending Footbinding and Infibulation: A Convention Account", *American Sociological Review*, vol. 61, no. 6, December 1996.

6 For more on the similarities between FGM/C and footbinding, see Mackie, Gerry (1996), "Ending Footbinding and Infibulation: A Convention Account", *American Sociological Review*, vol. 61, no. 6, December 1996.

7 For example, the Taguana from Côte d'Ivoire are among a number of groups who believe that women who have not undergone the procedure are unable to have children, see Dorkenoo, Efua and Scilla Elworthy (1992), *Female genital mutilation : proposals for change,* London, Series: MRG report ; no. 92/3. In some communities it is said that a woman's external genitalia have the power to blind anyone attending her during childbirth or to cause the death of her newborn if the child's head touches the mother's clitoris during delivery. Others believe that a woman who has not been cut may become physically deformed or mad, or may cause the death of her husband. See WHO (2001), *FGM. Integrating the Prevention and Management of the Health Complications into the Curricula of Nursing and Midwifery. A Teacher's Guide*, World Health Organisation, Geneva.

8 Bradford, Quiana and Kimberly Mc Clure (2003), "Qualitative Analysis of the Role of Human Rights Language in Efforts to Stop Female Genital Mutilation (FGM) in Egypt", policy analysis exercise for the Population Council, Office of West Asia and North Africa, Cairo, Egypt and The Carr Center for Human Rights Policy, John F. Kennedy School of Government, Harvard University.

9 Gachiri, Ephigenia W. (2000), *Female Circumcision. With reference to the Agikuyo of Kenya*, Paulines Publication, Nairobi.

10 Information provided by Ananilea Nkya, director of the Tanzanian Media Women's Association, 21 June 2004.

11 Dorkenoo, Efua and Scilla Elworthy (1992), *Female genital mutilation : proposals for change,* London, Series: MRG report; no. 92/3.

12 Dorkenoo, Efua and Scilla Elworthy (1992), *Female genital mutilation : proposals for change,* London, Series: MRG report; no. 92/3.

13 Carla Pasquinelli (2004), "Anthropology of Female Genital Mutilation" in *Legal Tools for the Prevention of Female Genital Mutilation*, proceedings of the Afro-Arab expert consultation, Cairo, Egypt, 21-23 June 2003 Non c'è pace senza giustizia, special supplement to periodical 1/2004. For further discussion of FGM/C and Islamic theology see, for example, Johnsdotter, S. (2003), "Somali Woman in Western Exile: Reassessing Female Circumcision in the Light of Islamic Teachings", *Journal of Muslim Minority Affairs*, vol. 23, no. 2, October 2003.

14 Statement made on the occasion of the Afro-Arab expert consultation on "Legal Tools for the prevention of Female Genital Mutilation, Cairo 21-23 June 2003", reported in *Legal Tools for the Prevention of Female Genital Mutilation*, proceedings of the Afro-Arab expert consultation, Cairo, Egypt, 21-23 June 2003 Non c'è pace senza giustizia, special supplement to periodical 1/2004.

15 Statement made on the occasion of the Afro-Arab expert consultation on "Legal Tools for the prevention of Female Genital Mutilation, Cairo 21-23 June 2003", reported in *Legal Tools for the Prevention of Female Genital Mutilation*, proceedings of the Afro-Arab expert consultation, Cairo, Egypt, 21-23 June 2003 Non c'è pace senza giustizia, special supplement to periodical 1/2004.

16 Mackie, Gerry (2000), "Female Genital Cutting: the Beginning of the End" in Shell-Duncan, Bettina and Ylva Hernlund, eds, (2000), *Female "Circumcision" in Africa: Culture, Controversy and Change*, Lynne Rienner Publisher, London.

17 From Gruenbaum, Ellen (2004), "FGM in Sudan: Knowledge, Attitudes and Practices. Qualitative Research on Female Genital Mutilation/Cutting (FGM/FGC) in West Kardofan and Kassala States", UNICEF Sudan Country Office, Khartoum.

4

FGM/C AND HUMAN RIGHTS

As a harmful "customary" or "traditional" practice, FGM/C is addressed under two important legally-binding international human rights instruments: the 1979 Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) and the 1989 Convention on the Rights of the Child (CRC). CEDAW addresses FGM/C and other cultural practices in the context of unequal gender relations and calls upon States Parties to (article 5):

> *[…] take all appropriate measures: […] To modify the social and cultural patterns of conduct of men and women, with a view to achieving the elimination of prejudices and customary and all other practices which are based on the idea of the inferiority or the superiority of either of the sexes or on stereotyped roles for men and women.*

The Convention on the Rights of the Child, ratified by 192 countries,[1] makes explicit reference to "harmful traditional practices" in the context of the child's right to the highest attainable standard of health. This broad category includes, among others, FGM/C, early marriage (See *Innocenti Digest* No. 7) and preferential care of male children.[2] In addition, Article 19 of the Convention calls upon States Parties to "take all appropriate […] measures to protect the child from all forms of physical or mental violence, injury or abuse […] while in the care of parent(s), legal guardian(s) or any other person who has the care of the child."

International human rights instruments promote the right of an individual to participate in cultural life, but they do not uphold traditional practices that violate individual rights. Therefore, social and cultural claims cannot be evoked to justify FGM/C. In deciding to abandon FGM/C, a community is not rejecting their cultural values, but rather a practice that causes harm to girls and women and reinforces gender inequalities.

FGM/C and the rights of the child

The impact of all types of FGM/C on girls and women is wide-ranging, and the practice compromises the enjoyment of human rights including the right to life, the right to physical integrity, the right to the highest attainable standard of health (including, with maturity, reproductive and sexual health), as well as the right to freedom from physical or mental violence, injury or abuse. The practice is also a violation of the rights of the child to development, protection and participation. FGM/C has often been raised as a matter of concern by the Committee on the Rights of the Child, which, in the light of the CRC, has called upon States Parties to "take all effective and appropriate measures" with a view to abolishing such practices.

Best interests of the child and the right of the child to respect for his or her views

One of the guiding principles of the CRC is the "best interests of the child". It is recognised in Article 3, which calls for the best interests of the child to be taken as a primary consideration "in all actions concerning children". This principle is of decisive relevance within the family context. Indeed, "[…] Parents

Box 6 - The emergence of FGM/C as a human rights issue

Today, FGM/C is widely perceived as a violation of human rights, but this perception evolved over time. For many years, FGM/C was regarded as a "private" act carried out by individuals rather than by state actors. There was also a reluctance to "impose" universal values on what was widely perceived to be a cultural tradition and one that contributed to the collective identity of the communities who practiced it.[3]

The earliest United Nations initiatives to place the practice on the international agenda date back to the early 1950s, when the issue was addressed within the UN Commission on Human Rights. In 1958, the UN Economic and Social Council invited the World Health Organisation to undertake a study on the persistence of customs subjecting girls to ritual operations.[4] While these initiatives were significant in bringing international attention to the issue, their impact remained limited.

The 1960s and 1970s were marked by an increasing awareness of women's rights in many parts of the world and women's organizations began to lead campaigns to raise awareness of the harmful effects of FGM/C on the health of girls and women. These efforts form part of an important current in the history of the movement to end FGM/C. The first regional seminar on Harmful Traditional Practices Affecting the Health of Women, organized by WHO in Khartoum, Sudan in 1979, sounded a historic call to condemn the practice in all its forms, including when it is performed under appropriate medical or hygienic conditions. Moreover, it made a recommendation for the establishment of the Inter-African Committee on Traditional Practices Affecting the Health of Women and Children. The Committee has since played a major role at international level in ensuring that the practice is raised at international conferences and addressed by legal instruments relating to girls and women.

The 1980s and 1990s were critical decades for the recognition of FGM/C as a violation of girl's and women's human rights. The 1979 Convention on the Elimination of All Forms of Discrimination Against Women was a significant milestone in promoting this perspective.[5] The human rights dimension of FGM/C has subsequently been reinforced at a number of important international conferences, including the UN World Conference on Human Rights in Vienna, Austria (1993)[6], the International Conference on Population and Development in Cairo, Egypt (1994)[7] and the Fourth World Conference on Women in Beijing, China (1995)[8], as well as its follow-up events, Beijing +5 and Beijing +10 held in New York, USA in 2000 and 2005 respectively.

or, as the case may be, legal guardians, have the primary responsibility for the upbringing and development of the child. The best interests of the child will be their basic concern"[9] (article 18 CRC).

Parents who take the decision to submit their daughter to FGM/C perceive this procedure to be in the child's best interests. In fulfilling a social and cultural expectation that girls should be cut, parents are promoting the status and acceptance of their daughters in the community. Although they – and especially mothers and other female relatives – may be aware of the potentially serious physical and psychological implications of FGM/C, there is the perception that the benefits to be gained from the procedure outweigh the risks involved. These perceptions should not in any case justify the violation of girls' and women's rights.[10] As discussed in other sections of this digest, there are effective ways to resolve this tension and to work with parents, families and communities to promote an approach that is consistent with human rights and promotes the abandonment of FGM/C.

As in many other situations, in the context of FGM/C, the consideration of the child's views has particular relevance. As stressed by the CRC (article 12), "States Parties shall assure to the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child." In the majority of cases, FGM/C is performed on a girl against her will. In cases where a girl is in apparent agreement, it is hard to argue that her consent is truly informed and meaningful. In reality, it is strongly subject to tradition and culture, community expectations and peer pressure – including songs and poems that deride girls who have not been cut[11] – and conditioned by the girl's own aspirations to be accepted as a full member of her community. All of these dimensions are compelling motivations for a girl or woman to submit to the procedure.[12]

The rights to life and to the highest attainable standard of health

FGM/C irreversibly compromises a girl or woman's physical integrity. The damage caused by this procedure can pose a serious risk to her health and well-being.[13]

In extreme cases, FGM/C can also violate a girl or woman's right to life. Fatalities are often due to severe and uncontrolled bleeding or to infection after the procedure.[14] Moreover, FGM/C may be a contributory or causal factor in maternal death.[15] The mortality rate of girls and women undergoing FGM/C is not known, since few records are kept and deaths due to FGM/C are rarely reported as such.[16] Medical records are also of limited use in determining morbidity due to FGM/C because complications resulting from the practice, including subsequent difficulties in childbirth, are often not recognised or reported as such and may be attributed to other causes. In some cases, these assigned causes may be medical in nature, but in others, they may reflect traditional beliefs or be attributed to supernatural causes. As a result, many girls who experience complications are treated with traditional medicines or cures and are not referred to health centres.

Until recently, information on the physical complications associated with FGM/C has tended to be based on case history reports from hospitals. Moreover, there have been few comparisons with uncut women to establish the relative frequency of these complications.[17] In recognition of the need for better data, WHO has now developed research protocols on FGM/C with a network of collaborating research institutions as well as biomedical and social science researchers with linkages to communities concerned.[18]

The specific impact of FGM/C on the health of a girl or woman depends on a number of factors, including the extent and type of the cutting, the skill of the operator, the cleanliness of the tools and of the environment, and the physical condition of the girl or woman.[19] Severe pain and bleeding are the most common immediate consequences of all forms of FGM/C. As the great majority of procedures are carried out without anaesthetic, the pain and trauma experienced can leave a girl in a state of medical shock. In some cases, bleeding can be protracted and girls may be left with long-term anaemia.

Infection is another common consequence, particularly when the procedure is carried out in unhygienic conditions or using unsterilised instruments. The type and degree of infections vary widely and include potentially fatal septicaemia and tetanus. Sometimes the risk of infection is increased by traditional practices, such as binding of the legs after infibulation or applying traditional medicines to the wound. Urine retention is another frequent complication, especially when skin is stitched over the urethra. All these elements may contribute to the wound failing to heal quickly, as may other factors affecting a girl's general health, including anaemia and malnutrition.[20]

FGM/C can result in long-term physical effects. Slow or incomplete healing leaves abscesses, painful cysts and thick, raised scars called keloids. These in turn can cause problems in later stages, including in pregnancy and childbirth. Deinfibulation - the procedure to re-open the orifice after it has been stitched or narrowed - and reinfibulation - to re-stitch the vagina - may be performed at each birth. Both procedures seriously compromise the health of women.

FGM/C also jeopardises the health and survival of the children of women who have undergone the procedure. A recently completed WHO study investigated the effects of FGM/C on a range of maternal and infant outcomes during and immediately following delivery. These include caesarean section, length of labour, postpartum haemorrhage, perineal injury, low birth weight, low Agpar score[21] and perinatal death. Initial analysis of the data from some 28,000 women in Burkina Faso, Ghana, Kenya, Nigeria, Senegal and Sudan indicates a relationship between some maternal and infant outcomes and FGM/C, especially in its more severe forms.

Concern has been raised at the possible link between FGM/C and HIV transmission. To date, no concrete evidence for this link exists, and rates of HIV infection in Africa are generally lower in the 28 countries where FGM/C is practiced. This may, however, be due to factors that prevail over the additional risk factor of FGM/C, including cultural and religious attitudes to sexual life. A community-based study in rural Gambia in 1999 identified a significantly higher prevalence of herpes simplex virus 2 among women who had been subjected to FGM/C, a finding which suggests that these women may also be at increased risk of HIV infection.[22]

Some of the early advocacy efforts aimed at stopping FGM/C placed a very strong emphasis on the health consequences of this practice. While these initiatives have been important in raising public awareness of the health risks involved, an overemphasis on the health implications of FGM/C outside the context of a holistic human rights approach, has inadvertent-

Box 7 - The trend towards medicalization and "symbolic" interventions

In some countries, FGM/C is performed in hospitals and health clinics by medical professionals who use surgical instruments, anaesthetics and antiseptics. Data from DHS demonstrate this trend towards "medicalization" in a number of countries, including Guinea and Mali in West Africa and Egypt in Northeast Africa, where most anti FGM/C efforts over the past 20 years have emphasised the procedures' health risks. In the case of Guinea, for example, 21.8 per cent of girls and women aged 15 to 19 years were found to have undergone FGM/C at the hands of a medical professional, while this was estimated to be the case for less than 1 per cent of women between the ages of 45 and 49.[24]

The fact that certain medical professionals or health workers are known to be involved in the practice may contribute to a general misconception that FGM/C is somehow acceptable. In reality, the medical profession has widely condemned the medicalization of the practice. WHO has stated unequivocally that, "FGM of any form should not be practiced by health professionals in any setting - including hospitals or other health establishments,"[25] and, as early as 1993, the World Medical Association explicitly condemned the practice of FGM/C as well as the participation of physicians in its execution.[26] From a human rights perspective, medicalization does not in any way make the practice more acceptable. FGM/C remains a gender-based act of violence that compromises a girl's or woman's physical integrity.

The same critique applies to symbolic forms of FGM/C, such as anaesthetized pricking of the clitoris, which have been proposed in recent years, within migrant communities in industrialized countries.[27] Advocates of such "alternatives" argue that they reduce the harm to girls. In fact, a symbolic gesture is not guaranteed to satisfy the expectation that FGM/C involves the removal of flesh. This leaves girls vulnerable to "traditional" FGM/C at a later date, for example, in preparation for marriage. More fundamentally, "symbolic" interventions do not address the gender-based inequality that drives the demand for this service and may actually inhibit progress toward abandonment of the practice.

ly contributed to the phenomena of "medicalization" and "symbolic interventions" (Box 7). Partly as a result of campaigns that have focussed exclusively on the health risks associated with FGM/C, a growing number of parents have preferred to have the operation performed on their daughters in hygienic conditions where pain is minimised and the risk to the girl's health is reduced. Medicalization is also partially supported by those health workers for whom FGM/C represents a source of income.[23]

Freedom from physical or mental violence, injury or abuse

For many girls and women, FGM/C is an acutely traumatic experience that leaves a lasting psychological mark and may adversely affect their full emotional development. Here too, scientific research is limited, but the anecdotal evidence from girls and women who have undergone the practice is testament to the impact it has had on their lives. Girls are generally conscious when the operation is performed, and for many, it is a shocking experience marked not only by acute pain, but also by fear and confusion. In cases where there has been some preparation for the operation, girls are often expected to suppress such feelings and collaborate in the proceedings. The experience of FGM/C has also been related to a range of psychological and psychosomatic disorders such as disturbances in eating and sleeping habits, moods and cognition. Symptoms of these include sleeplessness, recurring nightmares, loss of appetite, weight loss or excessive weight gain, as well as panic attacks, difficulties in concentrating and learning, and other symptoms of post-traumatic stress.[28]

The physical damage resulting from FGM/C, together with the psychological trauma and pain associated with it, can compromise an adult woman's normal sexual life. Moreover, women who have been infibulated may be deinfibulated upon marriage, a process that is a source of both pain and, potentially, further psychological trauma.[29] Marital problems can arise and eventually lead to divorce[30] which, in turn, may jeopardise women's social and economic status and that of their children.

In many cases, women and girls who have been traumatized by FGM/C remain silent about their experience. In some cultures they have no socially acceptable means of expressing their feelings of psychological unease or distress. In cases where they cannot or will not speak openly about a psychosocial difficulty, individual women or girls may present it in terms of a physical complaint. Some evidence of the psychological effects of FGM/C is also emerging among immigrant communities in Europe, America, Australia and New Zealand. Migrant women who have undergone FGM/C often face an additional psychological burden, since both the values associated with FGM/C and its physical and psychological impact are poorly understood in their host country.[31]

The practice of FGM/C can compromise other human rights, including the right to education. States Parties to the CRC are required to take measures to promote universal access to quality education, encourage regular attendance at schools and reduce drop-out rates, while promoting the child's development to reach his or her fullest potential. FGM/C is increasingly indicated as a factor in school drop-out rates for girls.[32] The health problems, pain and trauma experienced by girls concerned can lead to absenteeism, poor concentration, low performance and loss of interest. In certain parts of sub-Saharan Africa, such as Kenya and Tanzania, FGM/C is performed on the occasion of ceremonies and rites that require long preparations, making it difficult for girls to follow classes. Moreover, in many cultures girls who undergo the procedure are considered to have become adults ready for marriage and, as a consequence, they may be removed from school. This not only has a serious impact on a girl's personal development, but also on her community, since girls' education and informed participation in social life is a key to reducing discrimination and promoting development and social progress.

State obligations

Upon ratification of the CRC and other relevant human rights instruments, States Parties undertake legal obligations to prevent the practice of FGM/C among their citizens and others under their jurisdiction.[33] These measures are relevant and needed at the national and sub- national levels, and call for the involvement and mobilization of a wide range of partners, including community leaders and grassroot organizations. Article 24(3) of the CRC calls upon States Parties to "take all effective and appropriate measures with a view to abolishing traditional practices prejudicial to the health of children." These measures include promoting awareness-raising and education campaigns, developing mechanisms to protect children from these practices, introducing legislation to prevent them and ensuring the provision of health care and health information.[34]

The Committee on the Rights of the Child is mandated to monitor the implementation of the Convention and assess the progress made by States Parties to ensure the realization of children's rights. Upon the examination of States Parties' reports on the implementation of the CRC, the Committee has often expressed concern on FGM/C and issued recommendations to prevent its continuation (see Box 8). In 1995, the Committee held a general discussion about the girl child in the run-up to the Fourth World Conference on Women in Beijing. This discussion emphasised the importance of the promotion and protection of the rights of girls in breaking the cycle of harmful traditions and prejudices against women and drew attention to the importance of education for giving children the necessary confidence and skills to make free choices in their lives.

Like the Committee on the Rights of the Child, the Committee that monitors the 1979 Convention on the

Box 8 - Some recent concluding observations from the Committee on the Rights of the Child regarding FGM/C

Burkina Faso, CRC/C/15/Add.193, 9 October 2002

3. The Committee notes with appreciation: [...]

(e) The prohibition of female genital mutilation under the new Penal Code and the establishment of the National Committee to Combat Female Circumcision [...].

45. The Committee urges the State party to continue its efforts to end the practice of female genital mutilation [...], inter alia, through enforcement of legislation and implementation of programmes sensitizing the population to their harmful effects.

Egypt. 21/02/2001. CRC/C/15/Add.145.

45. Taking note of the Government's 1996 decision to prohibit female genital mutilation and the 1997 ministerial decree banning this practice in Ministry of Health service outlets, as well as various efforts to educate the public about the harm caused by this practice, including campaigns in the media and in the curricula, the Committee is concerned that the practice is still widespread.

46. The Committee [...] recommends that the State party address the issue of female genital mutilation as a matter of priority. In addition, the State party is urged to design and implement effective education campaigns to combat traditional and family pressures in favour of this practice, particularly among those who are illiterate.

Netherlands. 26/10/99.

18. The Committee welcomes the efforts made and understands the difficulties faced by the State party in protecting girls within its jurisdiction from female genital mutilation carried out outside its territory. Nevertheless, the Committee urges the State party to undertake strong and effectively targeted information campaigns to combat this phenomenon, and to consider adopting legislation with extraterritorial reach which could improve the protection of children within its jurisdiction from such harmful traditional practices.

Sierra Leone. 24/02/2000. CRC/C/15/Add.116.

61. The Committee is very concerned at the widespread practice of female genital mutilation.

62. In the light of article 24.3 of the Convention, the Committee urges the State party to pass legislation prohibiting practices of female genital mutilation, to ensure that such legislation is enforced in practice and to undertake preventive information campaigns.

Elimination of All Forms of Discrimination Against Women (CEDAW) has made specific reference to the obligations of States Parties with respect to FGM/C. In its 1990 General Recommendation (no. 14), the Committee recommended that States Parties "take appropriate and effective measures with a view to eradicating the practice of female circumcision". The Recommendation also proposes that States Parties "include in their national health policies appropriate strategies aimed at eradicating female circumcision in public health care. Such strategies should include the special responsibility of health personnel, including traditional birth attendants to explain the harmful consequences of female circumcision."[35] More recently, the Committee has issued a General Recommendation on Woman and Health that calls upon States parties to ensure that laws are enacted and enforced to prohibit female genital mutilation.

The 2001 Resolution of the UN General Assembly on traditional or customary practices affecting the health of women and girls reaffirms the obligation of all States to promote and protect human rights and calls upon them *inter alia* to collect and disseminate data regarding FGM/C and other practices, adopt and implement legislation, provide support services for victims, address the training of health workers and other personnel, empower women and strengthen their economic independence, mobilize public opinion, address traditional practices in education curricula, promote men's understanding of their roles and responsibilities and work with communities to prevent the practice.[36]

The breadth of the measures proposed in this Resolution indicates that the promotion and protection of human rights must be supported through the commitment of governments. It is their duty to adopt a wide range of measures, including an effective legal framework, as well as to promote awareness-raising and education campaigns. The Resolution also indicates that action needs to be taken and sustained at the local level.

Many non-governmental actors have also adopted a human rights framework to address FGM/C.

A recent major review of the methods used to sensitize communities to abandon the practice, carried out by the NGO RAINBO, confirms that the human rights approach is especially effective in empowering girls and women, transforming their status and building community consensus.[37]

Providing opportunities for all members of local communities to learn about human rights and to participate in discussions on how these rights relate to their own situation is an essential element in the development of a protective environment for children[38] and a key factor in accelerating the societal transformation necessary for the abandonment of FGM/C.

Notes

1 Only two countries are not yet party to the CRC – Somalia and the United States of America.
2 In addition to the CRC and CEDAW, a range of other important human rights instruments contain articles relevant to FGM/C. International instruments include the 1948 Universal Declaration of Human Rights (articles 2 and 3), the 1966 International Covenant on Civil and Political Rights (articles 7 and 24) and the 1966 International Covenant on Economic, Social and Cultural Rights (article 12). The UN Committee on Economic, Social and Cultural Rights has stated in its general comments on the right to health (article 12) that it is important to undertake action to protect women and children from the impact of harmful traditional practices that affect their health.
3 Amnesty International, "Section 4: A Human Rights Issue", *Female Genital Mutilation – A Human Rights Information Pack*, 1998, www.amnesty.org/ailib/intcam/femgen/fgm4.htm, accessed 10.2.2005.
4 Office of the United Nations High Commissioner for Human Rights (1997), "Harmful Traditional Practices Affecting the Health of Women and Children", UNOHCHR, fact sheet no 23.
5 Some states in which FGM/C is practiced – including Somalia and Sudan – are not signatories to CEDAW. The United States of America, where certain immigrant populations are known to practice FGM/C is also not a signatory.
6 See paragraphs 49 and 224 of Declaration and Programme of Action of UN World Conference on Human Rights, Vienna, 1993.
7 See paragraphs 4.22, 5.5 and 7.6 of Programme of Action of the International Conference on Population and Development, Cairo, 1994.
8 See paragraphs 108, 125 and 232 of Declaration and Platform for Action of the Fourth World Conference on Women, Beijing, 1995.
9 The principle of the child's best interests is established under article 3 of the CRC.
10 See, for example, Wheeler, Patricia (2003), "Eliminating FGM: The role of the law", *The International Journal of Children's Rights*, 11, 2003, pp. 257-71.
11 WHO (1999) *Female genital mutilation - Programmes to date: What works and what doesn't - A review*, World Health Organization, Geneva.
12 For a fuller discussion of meaningful consent in the context of FGM/C, see Mackie, Gerry (2004), "Ending Harmful Conventions: Liberal Responses to Female Genital Cutting", prepared for Yale University Political Science Department.
13 For a fuller review of health complications deriving from FGM/C see: World Health Organization (2000), "A Systematic review of the Health complications of Female Genital Mutilation including Sequelae in Childbirth", WHO, Geneva.
14 WHO (2000), *Female Genital Mutilation*, Fact sheet no. 241, World Health Organization, Geneva.
15 WHO (2001), "Management of pregnancy, childbirth and the postpartum period in the presence of female genital mutilation", report of WHO Technical Consultation, Geneva, 15-17 October 1997.
16 WHO (1996), *Female Genital Mutilation: Information Pack*, World Health Organization, Geneva.
17 Obermeyer, C. (1999), "Female genital surgeries: The known, the unknown, and the unknowable", *Medical Anthropology Quarterly*, 13(1), cited in Jaldesa, Guyo W., Ian Askew, Carolyne Njue, Monica Wanjiru (2005), "Female Genital Cutting among the Somali of Kenya and Management of its Complications", USAID.
18 WHO (2000), *Female Genital Mutilation*. Fact sheet no. 241, World Health Organization, Geneva.
19 WHO (1995), "Female Genital Mutilation. Report of WHO Technical Working group, Geneva, 17-19 July", World Health Organization, Geneva.
20 See Jones, Heather, Nafissatou Diop, Ian Askew and Inoussa Kabore (1999), "Female genital cutting practices in Burkina Faso and Mali and their negative health outcomes", *Studies in Family Planning*, September 1999, 30(3) pp 219-30.
21 Agpar is an acronym from the five indicators employed to derive the score: activity, grimace, pulse, appearance and respiration.
22 Morison, Linda, Caroline Sherf, Gloria Ekpo, Katie Paine, Beryl West, Rosalind Coleman and Gijs Walraven (2001), "The long-term reproductive health consequences of female genital cutting in rural Gambia: a community-based survey", *Tropical Medicine and International Health*, vol. 6, no. 8, August 2001, pp. 643-53.
23 WHO (1999), *Female genital mutilation - Programmes to date: What works and what doesn't - A review*, World Health Organization, Geneva.
24 Yoder, P. Stanley, Noureddine Abderrahim and Arlinda Zhuzhuni, *Female Genital Cutting in the Demographic and Health Surveys: A Critical and Comparative Analysis*, DHS Comparative Reports No. 7, September 2004, ORC Macro.
25 WHO/UNFPA/UNICEF (1997), Joint Statement, World Health Organization, Geneva.
26 World Medical Association Statement on Condemnation of Female Genital Mutilation, adopted by the 45th World Medical Assembly, Budapest, Hungary, October 1993.
27 For further details see Shell-Duncan, Bettina and Ylva Hernlund, eds, (2000), *Female "Circumcision" in Africa: Culture, Controversy and Change*, Lynne Rienner Publisher, London.
28 Frontiers in Reproductive Health and Population Council (2002), *Using Operation Research to Strengthen Programs for Encouraging Abandonment of Female Genital Cutting*. Report of the Consultative Meeting on Methodological Issues for FGC Research, April 9 – 11, 2002, Nairobi, Kenya.
29 Stewart, Holley, Linda Morison and Richard White (2002), "Determinants of Coital Frequency among Married Women in Central African Republic: the Role of Female Genital Cutting", *Journal of Biosocial Science*, 34(4), pp. 525-39.
30 The link between FGM/C, marital problems and divorce emerged clearly during fieldwork and interviews carried out in September 2004 in the UNICEF-funded ACDA projects in Assiut, Egypt.
31 The conflictual feelings experienced by migrant women are

described in Johnsdotter, Sara and Birgitta Essen (2004), "Sexual Health Among Young Somali Women in Sweden: Living with conflicting culturally determined sexual ideologies", paper presented at the conference "Advancing Knowledge on Psychosexual Effects of FGM/C: assessing the evidence", Alexandria, Egypt, 10-12 October, 2004.

32 See, for example, "Basic Education and Female Genital Mutilation", GTZ Topics, www2.gtz.de/fgm/downloads/eng_basic_education.pdf, accessed 4.5.2005.

33 See Wheeler, Patricia (2003), "Eliminating FGM: The role of the law", *The International Journal of Children's Rights*, 11, 2003, pp. 257-71.

34 For an extensive list of State obligations as regards traditional practices affecting the health of women and girls see UN General Assembly Resolution A/RES/54/133, 7 February 2000.

35 Committee on the Elimination of Discrimination Against Women, General Recommendation 14, 1990, HRI/GEN/1/Rev.5.

36 UN General Assembly Resolution A/RES/56/128, 7 December 2001.

37 Toubia, Nahid and Eiman Sharief (2003), "Female Genital Mutilation: have we made progress?", *International Journal of Gynecology and Obstetrics*, 82 (2003), pp. 251-61. Based on this review RAINBO has developed the Women's Empowerment and Community Consensus model (WECC) for the improved design, evaluation and monitoring of FGM/C projects. The model has two principal dimensions. The first is the promotion of women's self-empowerment – including economic empowerment - through raising their awareness and increasing their decision making abilities. This allows women to redefine their identity and social status in terms that do not include FGM/C. The second dimension is the building of community consensus around the protection of women's and children's rights and the advancement of social change through the negotiation of support from the hierarchy of power holders such as men, religious and civic leaders, health professionals and others.

38 UNICEF identifies eight key elements in a protective environment for children: government recognition of child protection abuses and commitment to promote the protection of children; legislation to protect children and to sanction those who abuse or exploit them; attitudes, customs, behaviour and practices that support, value and protect children; open discussion on child protection issues, with the full participation of civil society and the media; the life-skills, knowledge and participation of children themselves in issues affecting them; awareness in the community, complemented by the adequate capacity of those in contact with children (eg. family, health workers, law enforcement officials); the provision of essential services and rehabilitation for victims of abuse or exploitation; and a system of monitoring and reporting.

A man from the Beni amir ethnic group for eastern Sudan holds his daughter while attending a workshop on FGM , Idimair, Kassala State.
UNICEF/Sudan/2004/1139/Ellen Gruenbaum

5

COMMUNITY-BASED ACTIONS

The most successful community-based initiatives take human rights as the basis for action and incorporate the key elements for change (See page 13).

Changing the social convention: from theory to practice

A number of programmes, working at the community level, are protecting girls from FGM/C. The most successful are participatory in nature and generally guide communities to define the problems and solutions themselves. They harness positive village traditions to encourage people to speak out and engage in discussion. They equip families with knowledge on human rights and responsibilities. They encourage communities who have made the decision to abandon the practice to spread their message to their neighbours. All these elements help to bring about the social change needed to protect girls and women from FGM/C.

In Senegal, Tostan, an international NGO specializing in non-formal education, has developed and refined an approach that is based on the promotion of human rights. It embodies key elements necessary to change a social convention at the community level, including collective action, public declaration and organized diffusion. Tostan's Community Empowerment Program is a participatory, non-formal, education programme that lasts 30 months. With the support of UNICEF and in collaboration with the government, it has been implemented in over 1,500 communities in 11 regions of the country.

At the outset of the programme, a community establishes a management committee to coordinate activities and ensure sustainability. This committee develops, implements, manages, and evaluates small projects to address community-identified needs, oversees classroom activities and serves as a link between Tostan and the community.

Tostan's education programme typically establishes two classes in each community: one of 25 adults and another of 25 adolescents, mainly women and girls. Programme modules cover democracy and human rights, problem-solving, hygiene and health, literacy, math and management skills. These themes are reinforced using interactive literacy workbooks. The programme is carefully planned to ensure that sessions are inter-related and build upon previous learning. Classroom sessions actively engage participants with little or no formal schooling through a combination of approaches including sharing of personal experiences, the use of written and pictorial materials, theatre, poetry and song. The programme helps develop key skills and promote the reflection necessary for social change. Classes promote consensus and unity through activities that bring together diverse members of the community, including men and women, youth and elders and members of all ethnic groups.

Information and lessons learned are shared with family, friends, relatives, and other communities through a process of organized diffusion. Following a practice that is common in Wolof society, participants in the classes adopt a friend or family member with whom to share programme information. Villages reach out to neighbouring villages – an effort that engages surrounding communities in change at a larger scale. (Box 9)

Tostan's Community Empowerment Program has

achieved notable results in the communities in which it has been implemented, including increased enrolment of girls in school, systematic birth registration, and a significant increase in vaccination rates. One of the most significant outcomes has been the grassroots movement for the abandonment of FGM/C, which is spreading across Senegal. The opportunity to understand human rights and explore their direct relevance in the village setting creates confidence, especially among girls and women. It also increases the capacity of the group to tackle more challenging issues and prepares the ground for community members to take the decision to abandon FGM/C. In turn, communities share this information and experience with other intramarrying groups. Motivated communities host inter-village meetings to reach consensus on abandoning this practice that affects their common future. As of December 2004, these meetings have led to 18 public declarations by 1,527 communities, or approximately 30 per cent of the population estimated to practice FGM/C in Senegal in 1997.[1]

Extensive media coverage of these public declarations helps to introduce the alternative of abandonment to communities that continue the practice. It also contributes to creating a supportive environment for change at the national level. Since 1977, the programme has reached some 700,000 people and continues to expand.

An independent evaluation of the Tostan Community Empowerment Program, recently completed by the Population Council, compared the knowledge, attitudes and behaviour of women and men living in 20 villages in which Tostan had been active to 20 similar villages in which it had not. The evaluation found that the programme significantly increased women and men's awareness of human rights, gender-based violence, reproductive health and the consequences of FGM/C. There was also a notable decrease in approval of FGM/C among both women and men living in the intervention villages, although 16 per cent of the women who participated in the programme did not change their attitude. Of those women who voiced their disapproval of FGM/C, 85 per cent said that they had come to this position since participating in the Tostan programme. Immediately before the programme began, 7 out of 10 women stated that they wished to have their daughters cut. At the end of the programme, this proportion had fallen to approximately 1 in 10 among women who had participated in the programme, and 2 in 10 among women who had not participated directly, but lived in the same village.[2] MACRO International, the Population Council and UNICEF will support a further study of the social dynamics that lead to positive change in villages covered by the Tostan programme. The study will complement the DHS survey planned for 2005.[3]

In Burkino Faso, the NGO Mwangaza Action has adapted and applied the Tostan Community Empowerment Program in 23 villages.[4] Efforts are also currently under way to adapt the approach in Guinea and Sudan. Prior to 2002, the Sudanese Programme for Accelerated Social Transformation (PFAST) had focused on providing information about the health consequences of FGM/C and on disassociating the practice from Islam. As it became apparent that this alone was insufficient to promote the abandonment of FGM/C, the programme began to shift its focus to the empowerment of women and the promotion and safeguard of human rights. There is evidence that this shift has initiated a process of change: reformers and resisters of FGM/C have appeared in the selected communities, suggesting that a social dynamic has been set in motion; traditional beliefs about honour, shame, virginity and marriageability are being debated; and there are indications that many community members, including leaders, are questioning their deeply-held convictions and exploring alternative behaviour. Operating primarily in the states of Kassala, West Kordofan, South Darfur and Al Gadarif, PFAST covers some 120 selected communities, representing a population of approximately 6,000,000. It is creating a social environment in which people can respond to the messages about the consequences of FGM/C that they have received in recent years.

Activities carried out by the Coptic Evangelical Organization for Social Services (CEOSS) and the Centre for Education, Development and Population Activities (CEDPA) in Egypt also point to the effectiveness of a holistic, human rights-based approach that enables communities to discuss and subsequently abandon FGM/C.

CEOSS strategies – the result of more than 50 years of experience – place particular emphasis on improving the status of women and identifying patterns of effective partnerships with male and female community leaders. Village-level activities support a

Box 9 - Organized diffusion begins in Senegal

When the women of Malicounda Bambara declared that they would abandon FGM/C on 31 July, 1997, the news attracted interest from many neighbouring villages. Demba Diawara, a 70-year- old religious leader and Tostan participant from nearby Keur Simbara realized that it would be impossible for his village alone to abandon FGM/C because the people of his village intermarry with twelve neighbouring communities. Since all these communities considered FGM/C necessary for the acceptance, respectability and marriage of their daughters, Diawara decided to lead community-to-community family discussions to achieve consensus on the issue.

After several months of information sharing and intense debate in all thirteen villages, members of the intramarrying group decided to make a public declaration to abandon FGM/C as a united extended family seeking to improve the health and wellbeing of their girls and women. Religious leaders as well as traditional and government authorities supported their decision. The Diabougou Declaration inspired other Tostan participants to organize intercommunity public declarations as a means to end FGM/C. The media coverage generated by these events led to open debate of this formerly taboo subject at a national level for the first time.

variety of development projects aimed at empowering communities and individuals in all aspects of life including education, health, income-generation, agriculture and environmental protection. Specific activities promoting the abandonment of FGM/C include: establishing local women's committees; raising awareness of harmful traditional practices; providing training to local community members, teachers, health workers and the media; making home visits to families with girls who are identified as being at risk of undergoing the practice; and supporting the establishment of local NGOs to ensure both relevancy and a sense of community ownership.[5]

The experience in the village of Deir el Barsha, in the governorate of Minya in Upper Egypt, demonstrates that change is possible. An external evaluation conducted in 1997-8[6] found a clear change in both attitudes and behaviour towards FGM/C in the village, with the proportion of uncut girls reaching 50 per cent (DHS indicates that national prevalence in Egypt in 1995 was 97 per cent). According to the evaluation, a number of factors contributed to this result including: gender-based development activities carried out in the village over more than two decades; temporary male labour migration abroad that permitted women more decision-making power in the community;[7] and the role played by the clerical order in providing information on FGM/C and socializing people against the practice.[8] In 1991, after nearly a decade of CEOSS activity directed at FGM/C, traditional practitioners, including barbers and midwives, publicly signed a document in which they pledged to abandon the practice.

Also in Egypt, the experience of CEDPA points to the importance of providing support to those members of the community who have already chosen to abandon the practice of FGM/C. This support both reinforces their decision and enables them to initiate discussions on the issue with others.

CEDPA has been engaged in promoting the abandonment of FGM/C since 1988, using the "Positive Deviance Approach". Its FGM Abandonment Program is based on participatory community mobilization, relies on local knowledge and aims to build on solutions that already exist within communities. It identifies community members who have chosen to oppose the practice of FGM/C and supports these individuals to recruit others to this position. Internal assessments have indicated that this is potentially an effective strategy and have encouraged CEDPA to undertake a systematic scaling-up of the programme.[9] However, the longer term impact of the approach in the promotion of behaviour change still needs to be evaluated.

In partnership with CEDPA, UNICEF supports non-governmental organizations that have organized peer educators and advocates in four governorates of Upper Egypt (Assiut, Sohag, Quena and Minya) and who, with the assistance of religious leaders, lead discussion groups and make house-to-house visits to raise awareness within communities.[10] These peer educators, which include women and men of different backgrounds and ages, demonstrate a high level of commitment and also have extensive reach within the community. The potential of these individuals to engage their neighbours on the subject of FGM/C is enhanced by their deep understanding of the internal dynamics of their communities and the trust they enjoy among fellow villagers. As with other programmes that have demonstrated success, the approach adopted is both respectful and non-judgmental. When interviewed, peer educators emphasised the importance of offering information on FGM/C in a non-directive manner.

By providing support to those who have chosen to abandon FGM/C and promoting community-based discussions, CEOSS and CEDPA initiatives have contributed to changes in attitude and behaviour toward FGM/C. Replication of the approaches to additional villages, however, has been limited.

Facilitating dialogue and non-judgmental discussion

Creating appropriate spaces and opportunities in the community for discussion – spaces in which individuals feel safe and confident to share their views – enables community members to be active agents who control their own development rather than passive recipients of communication messages. They also provide an opportunity to those who would nor-

Box 10 - Communication for social change[11]

Delivering messages on the health consequences of FGM/C may raise awareness of the risks associated with the procedure and even change attitudes toward the practice, but it does not necessarily produce behaviour change. The most effective communication initiatives for behaviour change engage community members as active agents who control their own development.

Using communication as a means to empower communities involves a series of shifts from traditional communication strategies:

- from designing and delivering messages to facilitating and encouraging dialogue, which implies sharing ideas rather than making judgmental statements or labelling practices as "wrong";
- from focusing on individual behaviour to focusing on collective social change;
- from focusing on social problems to appreciating cultural richness and facilitating a process of cultural change;
- from expert-driven solutions to community-driven solutions, which involves engaging communities in the identification of existing structures and appropriate solutions.

mally be voiceless to express their opinions. In the case of FGM/C this is often women and girls themselves, but it may also include men who do not always have the opportunity to discuss this issue.

Through non-judgmental, non-directive public discussion and reflection, the previously hidden costs of FGM/C tend to emerge, as women and men share their own experiences and those of their daughters. At the same time, individuals wanting to end the practice join hands with others similarly committed, and spread the message to other members of the community.

The German Agency for Technical Cooperation (GTZ) has applied these principles to the issue of FGM/C in Guinea through its "listening and dialogue approach". The organizers of this project suggest that it turned out to be their most effective intervention. The opportunity to express views in a respectful and non-judgmental setting enabled women and men to share their ambivalences regarding the practice of FGM/C and introduced a new discourse and behavioural options for the community.

This approach to communication is also sensitive to the use of images and messages that communities may perceive to be inappropriate and in some cases offensive. The experience of GTZ in the Kolda region of Senegal illustrates the importance of using a non-judgmental and respectful approach that stimulates discussion and reflection (see Box 11).

Alternative rites of passage

In contexts where the practice of FGM/C is associated with initiation rites or coming of age ceremonies that mark transition to adulthood, such as in certain communities in Gambia, Kenya, Tanzania and Uganda, action has often focused on developing alternative rites of passage. These alternative rites preserve the positive socio-cultural aspects of the ritual, but do not require girls to undergo FGM/C. The potential of this strategy is limited to communities that associate FGM/C with such rites or ceremonies. It is further limited by the trend among many of these communities towards cutting girls at a younger age and with less associated ritual.[12]

Alternative rites have enjoyed varying degrees of success in promoting the abandonment of FGM/C. In isolation, they have limited impact since they do not address the underlying social values associated with FGM/C and therefore, provide little assurance that a girl will not be cut at a later date. However, as indicated by the experience of Maendeleo Ya Wanawake (MYWO), a Kenyan women's organisation, alternative ceremonies are well received and contribute to a reduction in the incidence of FGM/C when they are accompanied by community awareness and discussion.[13] MYWO, with technical assistance from the Program for Appropriate Technology in Health, has developed a programme that begins with community-level awareness raising activities to recruit participants, introduces family life education for girls, and culminates in a public event modelled on a community's traditional ceremony to mark the passage to adulthood. The education component builds on the traditional knowledge imparted to girls prior to these ceremonies, often during a period of seclusion, and is enhanced with additional information on sexual and reproductive health.

According to a study carried out by the Population Council in 2000,[14] the work of MYWO had an impact on both attitudes and behaviour associated with FGM/C. It was found to be more effective, however, when other institutions and socio-cultural developments contributed to changing attitudes toward FGM/C and when the groundwork was laid through awareness-raising activities. It is too early to know whether this initial success can be sustained over time and what kinds of rituals work best.[15]

Alternative employment opportunities for traditional excisers

In a number of countries, including Burkina Faso, Ethiopia, Gambia, Kenya, Mali, Sudan and, Uganda, there have been initiatives to educate those who perform FGM/C about the health risks associated with the practice and to provide them with opportunities for alternative income. Projects usually combine education on the harmful effects of FGM/C with the development of new skills and provision of loans or other incentives to find an alternative source of livelihood. In some cases, this training is followed by a public or private ceremony, which may involve the excisers denouncing the practice and symbolically surrendering their instruments or making an oath on the Koran to stop their activities. Although these initiatives have succeeded in supporting cutters in ending their involvement in the practice, they do not change the social convention that creates the

Box 11 - Nantoondiral: using film to stimulate discussion

In villages of the Kolda region in Senegal, a film entitled *Nantoondiral* ("consensus" in Pulaar) is used to promote the abandonment of FGM/C. The film, produced by the GTZ Fankanta project covers broad themes including the medical and social consequences of FGM/C, the Islamic perspective on the practice, and traditional social values regarding women and girls. Before the film is screened, an introductory message prepares the audience for the sensitive nature of the material. After the screening, the audience is encouraged to ask questions that stimulate discussion. Information on health structures is provided and guidance is offered for further reflection. *Nantoondiral* was produced in response to the negative audience reaction towards an earlier film, *La duperie* ("Deception"). This film contained scenes and images that were considered by many to be shocking, and provoked concern among audiences that the filmmakers had set out to criticise their culture.

demand for their services, and families continue to seek out individuals who are willing to perform the practice.[16] Providing opportunities for alternative income for excisers may complement approaches that address demand for the practice, but alone it does not have the elements necessary to end FGM/C.

Working with migrant communities in industrialised countries

The fact that many migrant communities continue to practice FGM/C in their new countries of residence is evidence of the strength of social convention. The key elements necessary to address the issue among migrant communities in countries where FGM/C is not traditionally practiced are essentially the same as those in countries with higher prevalence.

> *"Due to our migration and the passing of time, we have come to think differently, and we now see the harm caused by our tradition. However, our parents could not have acted otherwise and it is out of the question to suggest any kind of abuse. They wanted the best for us, their children. After all, we all looked forward to the day we were able to announce in the school playground that we had been circumcised too.*
>
> *We are now able to express the sadness and pain in our history and that the genital mutilation of girls is no longer appropriate in this day and age. We want to give our daughters a happy future, a future in which they can fully develop emotionally, and a future in which they can be allowed to play and feel protected."*
> *Somali woman, Netherlands*

The work of Pharos, an NGO active in the field of health care for refugees, and the Federation of Somali Associations in the Netherlands illustrates the importance of adopting a respectful and culturally-sensitive approach, working with groups rather than individuals, facilitating discussion and raising awareness rather than imposing solutions, and investing the time necessary for communities to reach their own decisions regarding the practice.

FGM/C first became a major issue in the Netherlands during the 1990s with the arrival of women refugees from Somalia. Although the practice was prohibited under general criminal injury law in 1993, girls continue to be subjected to the procedure. In 2000, with funding from the Ministry of Health, Welfare and Sport, Pharos and the Federation of Somali Associations established a collaborative project with the aims of empowering the Somali community to discuss FGM/C and of promoting expertise in FGM/C in the health sector.

Recognizing that dialogue within a community on FGM/C must be lead by the community itself, project partners established tailored educational sessions, led by trained "educators" and "key figures" drawn from Somali communities. These are individuals who enjoy the trust and respect of their own communities, who can facilitate discussion, and who are familiar with Dutch institutions. Most of the sessions are held on weekends, when participants have free time. Sometimes men, women and youth meet separately: men may meet in mosques after Friday prayers, while women may meet in community centres or at their homes in the evening. One of the important achievements of the project to date, however, has been a series of meetings in which women and men have come together to discuss the issue. These sessions have served as a catalyst for more widespread discussion of FGM/C in the community. At the same time, the sessions have demonstrated that there are still many Somali parents who intend to have their daughters cut. The most recent assessment of the project emphasizes that awareness of the issue is increasing, but that continuity is necessary to achieve behavioural change.[17]

Among migrant groups, the convention of cutting girls is often reinforced by the social and cultural link the practice establishes with their communities of origin. A recent development of the Tostan programme, discussed at the start of this section, has the potential to use these same links as a means to reach and influence practicing groups in industrialised countries. In May 2005, representatives from 44 villages in the Kolda region of Senegal gathered in the village of Marahkissa to make a public declaration of their communal decision to abandon the practices of FGM/C and child marriage. This decision had been reached after a period of meetings and discussions not only among participating villages, but also with wider kinship networks in the main cities of Senegal and, significantly, in the Gambia and USA. Delegations from these countries attended the declaration, the first to directly involve emigrant relatives in the decision to abandon FGM/C. The declaration was an opportunity for migrant members of Diola communities to affirm their rejection of FGM/C while reinforcing positive aspects of their culture.

> *"It is a wonderful day for all of us Diolas living in the United States. We now can send our daughters home to the village during vacation so they can know their family and our positive Diola traditions without worrying that they will undergo this cutting practice."*
> Son of the Village Chief of Marakissa, now living in Houston, USA

Notes

1 *UNICEF estimated that some 5000 villages practiced FGM/C in Senegal in 1997.*
2 *Diop, Nafissatou J., Modou Mbacke Faye, Amadou Moreau, Jacqueline Cabral, Hélène Benga, Fatou Cissé, Babacar Mané, Inge Baumgarten and Molly Melching (2004), The TOSTAN Program. Evaluation of a Community Based Education Program in Senegal, FRONTIERS Final Report, Population Council, Washington DC.*
3 *To date, neither a DHS nor a MICS survey has been undertaken to determine prevalence of FGM/C in Senegal. Preliminary results of the DHS survey are expected in July 2005.*
4 *For more information regarding the activity of Tostan in Burkina Faso see Ouoba, Djingri, Zakari Congo, Nafissatou J. Diop, Molly Melching, Baya Banza, Georges Guiella and Inge Baumgarten (2004), Experience from a Community Based Education Program in Burkina Faso. The Tostan Program, FRONTIERS Final Report, Population Council, Washington, DC.*
5 *Members of the women's committee make visits to families in which girls are considered to be at risk of FGM/C or early marriage until the girls are considered to have passed this stage. In particular, their efforts are oriented toward mothers in order to raise their awareness of the harmful consequences of these practices. During the follow-up period, other committees, together with informal leaders and religious figures work to change the position of other family members, especially men. CEOSS (2003), Empowerment: From theory into practice, Ceopress, Cairo.*
6 *Hadi, Amal Abdel (1998), We are Decided. Struggle of an Egyptian village to eradicate female circumcision, Cairo Institute for Human Rights Studies, Cairo.*
7 *The evaluation shows a lower percentage of FGM/C among the daughters of men who had migrated abroad than among daughters of men who had not migrated. In-depth interviews indicated that male migration abroad had an important influence on the status of women within the village of Deir el Barsha, giving them more responsibility and opportunity for decision making beyond traditional domains.*
8 *For more information on the impact of these different factors see Hadi, Amal Abdel (1998), We are Decided. Struggle of an Egyptian village to eradicate female circumcision, Cairo Institute for Human Rights Studies, Cairo.*
9 *CEDPA (2004), "Female Genital Mutilation Abandonment Program- Implementation results June 2003-June 2004".The CEDPA abandonment programme consists of five sequential phases: 1. Orientation activities and identification of individuals termed "positive deviants"; 2. Community mobilization through awareness raising activities to increase knowledge, engagement of leaders and creation of community support for abandonment of the practice; 3. Training of a team to promote the abandonment of FGM/C in the community; 4. Direct family approach. Every two weeks the team visits families with a girl identified as being at imminent risk of FGM/C until each family publicly manifests its firm intention not to subject their daughters to FGM/C on their daughters; 5. Monitoring and evaluation activities. Less frequent home visits continue until a girl is married, at which time she is no longer considered at risk of undergoing FGM/C.*
10 *UNICEF Egypt, (2004), "Campaigning against Female Genital Mutilation/Cutting in Egypt", UNICEF Update, September 2004.*
11 *Ford, Neil "A Human Rights Approach to FGM/C Programming". Presentation delivered at UNICEF technical meeting on FGM/C, Florence, Italy, 18-20 October, 2004.*
12 *See Herlund, Ylva, "Cutting without Ritual and Ritual without Cutting: Female 'Circumcision' and the Re-ritualization of Initiation in the Gambia" in Shell-Duncan, Bettina and Ylva Hernlund, eds, (2000), Female "Circumcision" in Africa: Culture, Controversy and Change, Lynne Rienner Publisher, London, and Dorkenoo, Efua (1994), Cutting the Rose. Female Genital Mutilation: the practice and its prevention, Minority Rights Group, London.*
13 *For more information about the approaches carried out to promote the abandonment of FGM/C by MYWO/Path see: PATH/ Maendeleo Ya Wanawake Organization (2002), Evaluating Efforts to Eliminate the Practice of Female Genital Mutilation. Raising Awareness and Changing Harmful Norms in Kenya, PATH, Washington DC.*
14 *Chege, Jane, Ian J Askew and Jennifer Liku (2001), "An assessment of the alternative rites approach for encouraging abandonment of FGC in Kenya", FRONTIERS Final Report, Population Council, Washington DC.*
15 *GTZ (2001), Addressing Female Genital Mutilation; Challenges and Perspectives for Health Programmes. Part 1: Select approaches, GTZ, Eschborn.*
16 *The Population Council carried out a study in Mali to evaluate the reconversion strategies utilized by three NGOs. All three NGOs employed outreach workers to educate excisers and communities on the adverse effects of FGM/C on women's health. Two of them developed income generation schemes to provide the excisers with alternative revenues, and one sought to train excisers to advocate ending FGM/C. No comprehensive awareness campaign for the general public accompanied the strategies. The study results indicate that the strategy of converting excisers was ineffective: there was a low rate of conversion, and parents continued to seek out excisers and also found health workers willing to perform the procedure. In addition, community members and NGO staff reported that the excisers continued to perform FGM/C despite statements to interviewers that they had abandoned the practice. Population Council (2000), "Mali: FGC Excisors Persist Despite Entreaties," FRONTIERS OR Summary no. 2, Population Council, Washington, DC.*
17 *"Female Genital Mutilation in the Netherlands. From policy to practice. September 2000-December 2002", Extracts from the project evaluation, Pharos - Utrecht, translated by UNICEF National Committee for the Netherlands, 2004.*

A Sudanese girl on an awareness raising visit with her mother in the village of Adarma, Kassala State.
UNICEF/Sudan/2004/1141/Ellen Gruenbaum

6

CREATING AN ENABLING ENVIRONMENT FOR CHANGE

Communities need support if they are to abandon FGM/C on a large scale. National governments must create a protective environment for women and children and support abandonment of the practice through social measures and appropriate legislation. Advocacy and awareness-raising activities, involving media and opinion leaders, also play an important role in increasing local, national and international level commitment.

National legislation

Introducing national legislation that prohibits FGM/C can accelerate change most effectively when a process of societal change is already under way, and citizens are sensitized to the issue.[1] Legislation has at least three clear purposes: to make explicit a State's disapproval of FGM/C; to send out a clear message of support to those who have renounced, or would wish to renounce the practice; and to act as a deterrent to the practice. It is important that legislation introduce or be complemented by appropriate child protection measures, comprehensive social support mechanisms, and information and awareness-raising campaigns, which are dissuasive rather than punitive. Imposing sanctions alone runs the risk of driving the practice underground and having a very limited impact on behaviour change.

In Africa and the Middle East, a large number of countries have introduced specific legislation to address FGM/C, by statute or decree. These include Benin (2003), Burkina Faso (1996), Central African Republic (1966[2]), Côte d'Ivoire (1998), Djibouti (1995), Egypt (1996), Ghana (1994), Guinea (1965, updated 2002), Kenya (2001), Niger (2003), Senegal (1999), Tanzania (1998) and Togo (1998). In some cases, the practice is forbidden under the national Constitution. For example, in Ethiopia, the 1994 Constitution explicitly prohibits harmful traditional practices, including those that oppress women and cause them physical or mental harm. The Constitutions of Ghana, Guinea and Uganda contain similar prohibitions. In a number of other countries, including Chad, Mali and Niger, FGM/C is addressed as an injury, in the context of criminal law.

A study of national laws published in 2000 found that of the 28 countries of Africa and the Middle East where FGM/C is practiced, prosecutions had been brought in only four: Burkina Faso, Egypt, Ghana and Senegal.[3] In Burkina Faso, the first detention of an *exciseuse* followed soon after the introduction of legislation in 1996. The national law stipulates a prison sentence of six months to three years and/or a fine between the equivalent of $US300 and $US1850[4] for anyone found guilty of performing FGM/C. Higher penalties apply where the procedure results in death, and there are special measures against medical or paramedical staff who perform the operation. The law also introduces fines for anyone who, aware that FGM/C is taking place, fails to inform the authorities. In Burkina Faso, the law is one component of a broader approach that includes awareness raising initiatives and social support. The 1999 DHS survey of Burkina Faso provides evidence of positive attitudinal change. The survey found that only 23.8 per cent of circumcised women claimed that they wished FGM/C to continue, while 63.7 per cent wanted the practice to end. These responses may reflect a reluctance to give explicit support to an outlawed practice, rather than a personal conviction that FGM/C should end.

Laws prohibiting FGM/C have also been intro-

duced in a number of countries where the issue has arisen among immigrant communities including Australia (various states 1994-6), Canada (1997), New Zealand (1995), USA (1996) and several countries in Western Europe (see Box 12).

While acknowledging the significance of national legislation, it is also important to recognize its limitations. In some cases, loopholes may remain which can be exploited by those who seek to perpetuate FGM/C. In Egypt in 1996, the Ministry of Health issued a decree prohibiting FGM/C, except when it was required for medical purposes. Despite a subsequent ruling by the Egyptian High Court in 1997 confirming that the practice was prohibited, the exception regarding medical grounds remained. Effectively, this clause has provided a loophole which, together with strong advocacy messages on the potential health risks of FGM/C, has contributed to the rapid medicalization of the practice.

Regional standards

Developing and adopting international legal instruments is also important for creating an enabling environment that can lead to support efforts and to the abandonment of the practice. The Protocol to the 1981 African Charter on Human and Peoples' Rights on the Rights of Women in Africa, known as the Maputo Protocol, is a legal document adopted by consensus in 2003 by Heads of States of the African Union. Article 5 of this Protocol explicitly prohibits and condemns FGM/C and other harmful practices. It calls upon States Parties to take measures to create public awareness of the issue, introduce legislation to prohibit and sanction the practice of FGM/C, provide support for victims of harmful practices and protect women who are at risk of these practices. For the Protocol to enter into force, it must be ratified by 15 Member States of the African Union. By April 2005, it had been ratified by 10 states.[9]

In Europe, significant developments have also taken place and supported the process of change in countries concerned. Resolution 1247 of the Parliamentary Assembly of the Council of Europe (2001) on Female Genital Mutilation urges governments to take a range of actions, including the introduction of national legislation, the promotion of awareness raising, the prosecution of those who perpetrate FGM/C and the adoption of more flexible measures regarding the granting of asylum to mothers and their children who fear being subjected to FGM/C.[10] The European Parliament Resolution on Female Genital Mutilation, also dating from 2001, strongly condemns FGM/C as a violation of fundamental human rights and inter alia calls upon the European Commission to draw up a complete strategy to eliminate the practice of FGM/C in the European Union which should "establish both legal and administrative and also preventive, educational and social mechanisms to enable women who are or are likely to be victims to obtain real protection".[11]

Major international conferences have supported governments in their efforts to introduce appropriate national legislation and social mobilization initiatives on FGM/C. In June 2003, the Afro-Arab Expert Consultation on Legal Tools for the Prevention of Female Genital Mutilation served to define both legal content and strategies for more effective legislation to prevent FGM/C.[12] The resulting "Cairo Declaration" makes 17 concrete recommendations, including that governments adopt specific legislation addressing FGM/C, and that these laws be one component of a multi-disciplinary approach to stopping the practice. The declaration also recommends that governments

Box 12 - Legal responses to FGM/C in Western Europe

Today, three of the ten largest citizenship groups applying for asylum in the European Union come from African countries where FGM/C is practiced (Nigeria, Somalia and the Democratic Republic of Congo).[5] One of the most tangible responses on the part of European states has been the use of legislative measures to prohibit the practice and punish those who carry out, aid or abet this act.[6]

Legislators in Europe have tended to favour one of three responses to FGM/C: the introduction *ex nuovo* of specific legislation criminalizing the practice (Norway, Sweden and the United Kingdom), the modification of existing legislation to make specific reference to this procedure (Belgium, Denmark, Italy and Spain), or the prohibition of FGM/C under existing criminal laws pertaining to physical injury and abuse of minors (Finland, France, Germany, Greece, the Netherlands and Switzerland)[7]. Additionally, several European countries include the principle of extraterritoriality in their legislation in recognition of the danger that legal prohibition may result in families sending women and girls back to their country of origin to undergo FGM/C.

An indicator of the response of European states to FGM/C is the level of prosecutions brought under these various laws. For example, in the United Kingdom, since the introduction in 1985 of specific legislation to criminalize the practice, there have been no prosecutions for FGM/C. In Sweden, only one case had been brought to court by 2000, some 18 years after this country had introduced specific legislation. By the same date in France, there had been 25 prosecutions for involvement in FGM/C using criminal injury legislation. Reliance on general criminal legislation does not necessarily lead to prosecutions. For example, the Dutch legislative position is similar to that in France, but to date there have been no prosecutions for FGM/C, and the government has explicitly stated that its policy must be geared towards prevention, with judicial intervention as a last resort.[8] This is also the direction in which Italy is moving. The 2004 draft legislation on FGM/C bears testimony to the lobbying efforts of civil society organizations, headed by AIDOS (the Italian Association for Women in Development) to include budget allocations for prevention campaigns and training for medical staff in addition to the punitive measures originally foreseen.

Box 13 - TAMWA media campaigns in Tanzania

TAMWA uses media campaigns to lobby and advocate for cultural, policy and legal changes to promote the human rights of women and children. In 2002, as part of the activities of the STOP FGM Campaign, TAMWA conducted a nationwide education and information campaign, using all the active media in the country and, particularly, those in the regions with a high prevalence of FGM/C, including Arusha (81 per cent), Dodoma (68 per cent) and Mara (44 per cent).[13] TAMWA tackled the issue using what it labelled "bang-style" journalism, a strategy which relies upon the simultaneous dissemination of stories and information through various local media institutions, thus allowing greater outreach. Key to the effectiveness of TAMWA's activities is the use of social and journalistic surveys to promote community discussions and the involvement of communities in implementing and monitoring initiatives. TAMWA has also organized sessions for media practitioners, NGOs, community-based organisations and theatre groups to increase understanding of FGM/C and promote the use of appropriate language and approaches.

and NGOs work together to support an ongoing process of social change leading to the adoption of legislation against FGM/C.

In September 2004, the Government of Kenya hosted an international conference, which focused on developing a political, legal and social environment for the implementation of the Maputo Protocol. In February 2005, a sub-regional conference hosted by the Government of Djibouti, organized by the NGO No Peace Without Justice and supported by UNICEF, provided a platform for Djibouti's official ratification of the Maputo Protocol. Further conferences around the Maputo Protocol are planned for 2005.

Raising awareness and promoting dialogue

Legislative measures are most effective when complemented and even preceded by a range of broader policy measures, involving both general and focused awareness raising and the promotion of dialogue within and among different groups. If the introduction of a law is poorly timed (prior to a shift in social attitudes towards the practice, for example) or is not accompanied by complementary social support mechanisms, it may drive the practice of FGM/C underground or encourage cross-border movement. The threat of imprisonment or a fine may act as a deterrent, but alone it does little to change parents' perception that it is in the interest of their daughters to undergo this procedure.

The media can play an important role in "breaking the silence" around FGM/C and bringing the issue into the public realm. The experience of the Tanzanian Media Women Association (TAMWA) indicates that providing media with accurate, up-to-date information regarding FGM/C and strengthening media operators' skills to disseminate this information can contribute to the abandonment of the practice (see Box 13). This experience is consistent with the findings of a UNICEF-commissioned study in Egypt which noted that lack of knowledge of FGM/C is a major obstacle preventing many media professionals from discussing the issue.

The involvement of opinion leaders, including traditional leaders, political figures, religious chiefs and intellectuals has had an important role in raising awareness and stimulating public debate. In Senegal, parliamentarians have not only been instrumental in passing legislation to prevent harmful traditional practices, they have also actively promoted its application by visiting villages in the process of abandonment and explaining the legal situation during inter-village meetings. They regularly attend public declarations and have established a partnership with other West African parliamentarians to collaborate on promoting successful strategies. At the international level, the Inter-Parliamentary Union (IPU) decided in 2001 to develop an online database on FGM/C accessible from its own website[14] and to establish a parliamentary think tank for the eradication of FGM/C. When this panel met for the first time in Marrakech, Morocco in 2002, it identified key strategies for ending FGM/C, including public awareness campaigns, the provision of economic support to campaigns, the development of campaigns in partnership with NGOs, the introduction of legislation, and mobilisation of the media.[15]

In communities where there is a strong perception that the practice of FGM/C is required by Islam, the engagement of religious leaders in public discussion has proven to be an essential element in raising awareness of this practice, disassociating it from religious considerations and creating an enabling environment for change. The sub-regional conference on FGM/C, hosted by the Government of Djibouti in February 2005, was notable for the two-day debate among religious leaders from Djibouti and neighbouring countries on the theological dimensions of FGM/C. Following an important debate, the outcome document, the Djibouti Declaration, asserts that claims that the Koran requires FGM/C are baseless and reaffirms that all types of FGM/C are contrary to the religious precepts of Islam.

Integrating the abandonment of FGM/C in government programmes

Creating an enabling environment to support the abandonment of FGM/C requires a strong commitment and policy action on the part of governments to promote equal rights for girls and boys and for women and men. It also entails addressing FGM/C as a component of development programmes and projects that promote poverty eradication, income generation and education, as well as gender equality, girls' and women's participation in society and the

labour force, girls' and women's health, safe motherhood, and HIV/AIDS prevention.

A variety of professional staff are in contact with girls and women who have undergone FGM/C. In Switzerland, for example, a survey undertaken by the Swiss National Committee for UNICEF in collaboration with the Institute of Social and Preventive Medicine of the University of Berne,[16] showed that 61 per cent of gynaecologists,[17] 38 per cent of midwives, 6.3 per cent of paediatricians, and 8 per cent of welfare centres surveyed were confronted with FGM/C victims. The survey also revealed a considerable need for information. All of the surveyed professions called for integrating the issue into their initial or continued training.

Health personnel constitute an important group for the management of FGM/C related complications as well as for the promotion of its abandonment. WHO, UNICEF and UNFPA have recognized the critical role of health workers and have identified their training in FGM/C related issues as a priority strategy.[18] The antenatal period in particular, constitutes a timely opportunity to provide information to women and other family members about the health consequences of the practice.[19] In Sweden, health care professionals are advised that discussions regarding FGM/C should start at the time a new baby considered to be at risk is enrolled with the health services. It is recommended that the issue be raised again at the standard check-up after the child turns five. Health care workers are expected to advise parents of the health risks of FGM/C and inform them that the practice is prohibited under Swedish law.[20] In many countries, including Canada, Denmark, Germany, Italy, Switzerland and the United Kingdom, medical associations have forbidden any involvement of doctors in the practice of FGM/C on the grounds that it is a violation of their code of conduct.

Teachers, in both formal and non-formal learning contexts, can be supported to recognize girls at risk and discuss FGM/C related issues in science, biology and hygiene lessons, as well as in lessons involving personal, social, gender or religious education. Nurses, midwives and doctors can facilitate and assist teachers in these activities.[21] At times, the first to move in this direction are NGOs. FAWE Senegal, a NGO working to improve girls' access to education, has developed reference manuals and guides on FGM/C for teachers and students of third and fourth grade and has also provided training on FGM/C to trainers and teachers.[22]

To strengthen national capacities, the Italian NGO AIDOS, with financing from the World Bank, has developed a prototype training manual for integrating FGM/C in development projects.[23] This manual is intended for trainers working with government officials and NGO staff. Local versions of the manual will be produced to ensure its most effective use.

Coordinating actions

A number of countries including Burkina Faso, Egypt, Norway, Senegal, Sudan and Tanzania, have established national plans of action to coordinate and support the efforts of both government and non-governmental organizations in promoting the abandonment of FGM/C. In Sudan, the National Plan of Action on FGM/C, endorsed by the Ministry of Health in 2001, has promoted the establishment of mechanisms at all levels to end FGM/C. At the federal level, a steering committee ensures coordination among government departments, networks of NGOs and civil society groups. At the state level, there are councils and steering committees for FGM/C, while at the community level, community-based organizations bring together women's groups, religious leaders, midwives, community leaders, as well as children and youth to promote behavioural change. Media campaigns are promoted at the federal and state levels, while at the community level, radio programmes featuring key community members are broadcast in local languages.

The development of specific governmental institutions or coordinating mechanisms charged with carrying out activities to promote the abandonment of FGM/C, including in the broader context of a holistic child rights agenda, can facilitate the task of translating plans into concerted action. In Egypt for instance, this role is fulfilled by the National Council for Childhood and Motherhood with the support of UNDP and UNICEF. The Council is the highest national body entrusted with childhood issues and establishes policy, drafts legislation and mainstreams childhood and motherhood development in the five-year state plans. It supports action at community level, promotes a national dialogue on FGM/C, as well as legal and policy reform.

In recent years, there has been significant progress at the global level towards achieving a common framework for action to promote the abandonment of FGM/C (Box 14). The stronger sense of common purpose is driven in part by the shared challenge of working toward the Millennium Development Goals. The 2001 "Road Map Towards the Implementation of the United Nations Millennium Declaration" makes specific reference to "harmful traditional practices, such as female genital mutilation" under the goal of combating all forms of violence against women.[24] At the same time, *A World Fit for Children*, the outcome document endorsed by the 2002 UN General Assembly Special Session on Children, specifically calls for an end to such practices. More broadly, both the Millennium Development Goals and *A World Fit for Children* aim to achieve universal primary education for girls and boys. Education is one of the best means to overcome discrimination, empower girls and women and build societies founded on human rights principles. Concretely, it is becoming apparent that girls who have received some level of education are less likely to have their own daughters cut than women with little or no education.

United Nations Agencies are also increasingly coordinating policies and actions with bilateral donors. Since 2001, the Donor's Working Group on Female Genital Cutting, comprised of UN Agencies, the World Bank, governments and foundations, has met regularly to share strategies and increase their effectiveness as donors.[26]

Box 14 - The United Nations' increasing engagement with FGM/C and other harmful traditional practices

There has been a growing commitment within the United Nations system to address the issue of FGM/C. This engagement is demonstrated by a number of developments, including the establishment of a Working Group on Traditional Practices Affecting the Health of Woman and Children, which submitted its report to the Commission on Human Rights in 1986; the appointment of the Special Rapporteur on harmful traditional practices by the Commission on Human Rights in 1988; the adoption, by the General Assembly, of the Declaration on the Elimination of Violence Against Women in 1993, which clearly defines FGM/C as a form of violence against women; and the appointment of the Special Rapporteur on violence against women, its causes and consequences in 1994. In the same year, the UN Sub-Commission on Prevention of Discrimination and Protection of Minorities adopted the Plan of Action for the Elimination of Harmful Traditional Practices Affecting the Health of Women and Children.

In 1997 WHO, UNICEF and the United Nations Population Fund (UNFPA) issued a significant joint statement affirming support for policies to prevent the practice of FGM/C, reinforcing their commitment to support the work of governments and communities to promote and protect the health and development of women and children.[25] This joint statement is presently being revised and expected to be reissued at the end of 2005 with additional international partners. The UN Secretary General's Studies on Violence Against Women and Violence Against Children, due for submission to the General Assembly in 2005 and 2006 respectively, also represent important opportunities to address the issue of FGM/C.

The NGO community plays a central role in generating national and international commitment to end the practice of FGM/C. At a regional level, the Inter-African Committee on traditional practices affecting the health of women and children (IAC) is the oldest NGO network dedicated to the abandonment of FGM/C in Africa. It works through National Committees in all African countries where FGM/C is practiced and promotes awareness raising and advocacy, evaluation of relevant laws and programmes, training and capacity building. Beyond Africa, the European Network for the prevention of FGM (Euronet-FGM) aims to improve the health of female immigrants in Europe and prevent harmful traditional practices affecting the health of women and children, in particular FGM/C.

The STOP FGM Campaign builds and reinforces public opinion to abandon FGM/C in African as well as European countries and stimulates action at national and international levels. The Campaign, established in 2002, is coordinated by the Italian NGO AIDOS in collaboration with No Peace Without Justice and various African NGOs.

In recent years, momentum to end FGM/C has been growing, and new actors, including the Governments of Italy[27] and Japan,[28] are providing strong support to advance this agenda. Given the greater understanding of FGM/C and the encouraging indications that positive results at community level are possible on a large scale, conditions are ripe for the accelerated abandonment of the practice.

Notes

1 Rahman, Anika and Nahid Toubia (2000) *Female Genital Mutilation: A guide to laws and policies worldwide*, Zed Books, London.
2 In this case, a presidential order. Wheeler, Patricia (2003), "Eliminating FGM: The role of the law", *The International Journal of Children's Rights*, 11, 2003, pp. 257-71.
3 Rahman, Anika and Nahid Toubia (2000) *Female Genital Mutilation: A guide to laws and policies worldwide*, Zed Books; London.
4 At an exchange rate of 487.300 CFA Fr: 1 US $.
5 Figures refer to the EU prior to enlargement in 2004. Eurostat, New Asylum Applications EU by Main Group of Citizenship, January – September 2003.
6 For further details on relevant legislation in 15 European Union states see Leye, Els and Jessika Deblonde (2004), *Legislation in Europe Regarding Female Genital Mutilation and the Implementation of the Law in Belgium, France, Spain, Sweden and the UK*, International Centre for Reproductive Health, Ghent.
7 Trechsel, Stefan et Schlauri, Regula (2005), "Les mutilations génitals féminines en Suisse. Expertise juridique. Edité par le Comité Suisse pour l'UNICEF.
8 Rahman, Anika and Nahid Toubia (2000) *Female Genital Mutilation: A guide to laws and policies worldwide*, Zed Books, London.
9 Comoros, Djibouti, Lesotho, Libya, Mauritius, Namibia, Nigeria, Rwanda Senegal, and South Africa.
10 Parliamentary Assembly of the Council of Europe, Resolution 1247 (2001), Female genital mutilation, para. 11. Under this Resolution, the Parliamentary Assembly urges governments, *inter alia*: "i. to introduce specific legislation prohibiting genital mutilation and declaring genital mutilation to be a violation of human rights and bodily integrity; ii. to take steps to inform all people about the legislation banning the practice before they enter Council of Europe member states; iii. to adopt more flexible measures for granting the right of asylum to mothers and their children who fear being subjected to such practices; […] v. to prosecute the perpetrators and their accomplices, including family members and health personnel, on criminal charges of violence leading to mutilation, including cases where such mutilation is committed abroad[…]."
11 European Parliament resolution on female genital mutilation (2001/2035(INI)), para. 7.
12 For more details see *Legal Tools for the Prevention of Female Genital Mutilation*, proceedings of the Afro-Arab expert consultation, Cairo, Egypt, 21-23 June 2003, Non c'è pace senza giustizia, special supplement to periodical 1/2004.
13 Data from UNICEF (2004), "Tanzania FGM/C country sheet",

based on Tanzania Demographic and Health Survey 1996. Country sheet available at www.childinfo.org/areas/fgmc/profiles/Tanzania%20FGM%20profile.pdf

14 See www.ipu.org/wmn-e/fgm-prov.htm, accessed 5.5.2005.

15 Together with UNICEF, the IPU has also developed a child protection handbook for parliamentarians which includes basic information on FGM/C, the major international standards on the subject, and the main challenges and strategies indentified by the IPU panel. See O'Donnell, Dan (2004), *Child Protection. A handbook for parliamentarians*, IPU/UNICEF, Switzerland.

16 Edited by the Swiss Committee for UNICEF, "Les Mutilations Génitales Féminines en Suisse. Enquête auprès des sages-femmes, gynécologues, pédiatres et services sociaux suisses." Zurich 2004. The survey was supported by Professor Patrick Hohlfeld, former President of the Swiss Association for Gynaecology.

17 As far as the gynaecologists are concerned, this is an increase of 10 percent compared to the survey conducted by UNICEF Switzerland in 2001. Jäger, Fabienne, Sylvie Schulze and Patrick Hohlfeld (2002), "Female Genital Mutilation in Switzerland: a survey among gynaecologists," Swiss Medical Weekly, 132, 2002, pp 259-64.

18 WHO/UNFPA/UNICEF (1997), *Female genital mutilation. A Joint WHO/UNICEF/UNFPA Statement*, World Health Organization, Geneva.

19 WHO (2001), *FGM. Integrating the Prevention and Management of the Health Complications into the Curricula of Nursing and Midwifery. A Teacher's Guide*, World Health Organisation, Geneva.

20 Rahman, Anika and Nahid Toubia (2000) *Female Genital Mutilation: A guide to laws and policies worldwide*, Zed Books, London.

21 WHO (2001), "Management of pregnancy, childbirth and the postpartum period in the presence of female genital mutilation", report of WHO Technical Consultation, Geneva, 15-17 October 1997.

22 UNICEF (2004), "Rapport de la reunion inter-pays sur les mutilations genitales feminines et pratiques nefastes", Dakar, Senegal 22-24 Septembre 2004.

23 The manual, produced by AIDOS is entitled "Mainstreaming the Fight Against FGM/C"

24 Secretary General of the United Nations, (2001) "Road map towards the implementation of the United Nations Millennium Declaration. Report of the Secretary-General", A/56/326, 6 December 2001, para. 209.

25 World Health Organization, Female Genital Mutilation: a joint WHO/UNICEF/UNFPA Statement, 1997.

26 As of March 2005, members include UNFPA, UNICEF (Coordination Secretariat), UNIFEM, WHO, the World Bank, USAID, GTZ, The Dutch Cooperation, The Ford Foundation, The Wallace Global Fund and The Public Welfare Foundation. Membership has grown yearly.

27 In June 2004, the Government of Italy made a 1.8 million euro contribution to support the work of UNICEF and international and national NGOs toward abandonment of FGM/C in 8 African and Middle Eastern countries.

28 In August 2003, the Government of Japan joined with the Government of Sudan and UNICEF to hold a Regional Symposium on the Abolition of FGM to Ensure Safe Motherhood in Khartoum. The symposium deepened understanding of FGM/C among sectors of government and throughout civil society, and reinforced Sudan's political will to end the practice.

7

CONCLUSION

Female genital mutilation/cutting has been perpetuated over generations by social dynamics that make it very difficult for individual families as well as individual girls and women to abandon the practice. Even when families are aware of the harm it can bring, they continue to have their daughters cut because it is deemed necessary by their community for bringing up a girl correctly, protecting her honour and maintaining the status of the entire family. Not conforming to the tradition brings shame and stigmatization upon the entire family and prevents girls from becoming full and recognised members of their community.

This *Digest* demonstrates that change is possible. Societal attitudes do shift and communities are making the choice to abandon this harmful practice. The elements needed to transform communities have become increasingly clear.

The most successful approaches guide communities to define the problems and solutions themselves to ensure that they do not feel coerced or judged. They also encourage communities who have made the decision to abandon the practice to publicly declare their choice and spread their message to their neighbours. Approaches that are based on the principles of human rights have demonstrated the greatest potential for promoting the abandonment of FGM/C. Rather than addressing FGM/C in isolation, they focus on building the capacity of people, and especially of girls and women, to promote and safeguard their own human rights. Finally, communities need support if they are to abandon FGM/C on a large scale. They need the engagement of traditional and religious leaders, legislative and policy measures, fora for public debate, and accurate and culturally sensitive media messages.

The time is right to catalyze a global movement for positive and lasting change. CEDAW and the CRC represent important international standards to shape States' policies and programmes to address and promote the abandonment of FGM/C and other harmful traditional practices. Regional initiatives are building on a growing momentum to end the practice. In Africa, ratification of the Maputo Protocol to the African Charter on Human and Peoples' Rights reaffirm States' commitment to promoting and protecting the human rights of women and children.

Ending FGM/C is an ever-growing reality. The basic knowledge of how best to support communities to end FGM/C exists today. It can be applied widely, within and across countries. With global support, it is conceivable that FGM/C can be abandoned in practicing communities within a single generation.


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UNICEF/MENA/2004/1288/Ellen Gruenbaum

Links

This section contains information about a number of the UN agencies, international organizations and NGOs referred to in this *Digest*, as well as additional web resources on human rights. These contacts should serve as links to other types of organizations, particularly national and local NGOs, professional and community organizations, academic and other institutes and government bodies, whose work is also relevant to this issue. This is not intended to be a comprehensive listing, nor does it prioritize or rank the organizations listed.

UNITED NATIONS SPECIALIZED AGENCIES AND OTHER INTERNATIONAL ORGANIZATIONS

Inter-Parliamentary Union (IPU)

5, chemin du Pommier
Case postale 330
CH-1218 Le Grand-Saconnex / Geneva
Switzerland
Tel.: (4122) 919 41 50
Fax: (4122) 919 41 60

The IPU is the international organization of Parliaments of sovereign States. It is the focal point for worldwide parliamentary dialogue and works for peace and cooperation among peoples and for the firm establishment of representative democracy. Among its activities, it fosters contacts, coordination, and the exchange of experience among parliaments and parliamentarians of all countries; considers questions of international interest and concern; and contributes to the defence and promotion of human rights. Over 130 national parliaments are currently members of the IPU.

Website:
www.ipu.org/english/home.htm

United Nations Development Fund for Women (UNIFEM)

304 East 45th Street, 15th floor
New York, NY 10017
USA
Tel.: +1 212 906 6400
Fax: +1 212 906 6705

UNIFEM is the women's fund at the United Nations. It provides financial and technical assistance to innovative programmes and strategies that promote women's human rights, political participation and economic security. Strategies include strengthening the advocacy capacity of national and regional women's organizations, increasing women's access to and use of international human rights machinery and mainstreaming the subject in UN system-wide activities.

Website: www.unifem.org

UN Office of the High Commissioner for Human Rights (OHCHR)

8-14 Avenue de la Paix
1211 Geneva 10
Switzerland
Tel.: +41 22 917-9000
Fax: +41 22 917 9016

OHCHR plays a leading role in coordinating human rights issues and emphasizes the importance of human rights at the international and national levels. It promotes international cooperation for human rights, undertakes preventive human rights action and carries out human rights field activities and operations. The website provides access to all comments on States parties reports by the Committee on the Rights of the Child.

Website: www.unhchr.ch

United Nations Population Fund (UNFPA)

220 East 42 Street
New York, NY 10017
USA
Tel.: +1 212 297 5020
Fax: +1 212 557 6416

UNFPA works with governments and non-governmental organizations in over 140 countries. It aims to help ensure universal access to reproductive health, including family planning and sexual health; support population and development strategies that enable capacity-building in population programming; and promote awareness of population and development issues.

Website: www.unfpa.org

World Bank

1818 H Street, N.W.
Washington, DC 20433
USA
Tel.: +202 473 1000
Fax: +202 477 6391

The World Bank Group's mission is to fight poverty and improve the living standards of people in the developing world. It is a development Bank that provides loans, policy advice, technical assistance and knowledge sharing services to low and middle income countries to reduce poverty. The Bank promotes growth to create jobs and to empower poor people to take advantage of these opportunities.

Website: www.worldbank.org

World Health Organization (WHO)

Avenue Appia 20
1211 Geneva 27
Switzerland
Tel.: + 41 22 791 21 11
Fax: + 41 22 791 3111

WHO gives worldwide guidance in the health field, sets global standards for health, cooperates with governments to strengthen health programmes and develops appropriate health technology, information and standards. Within WHO, the Special Programme of Research, Development and Research Training in Human Reproduction (HRP) brings together health care providers, policy-makers, scientists, clinicians and consumer and community representatives to identify and address priorities for research aimed at improving sexual and reproductive health.

Website: www.who.int

RESEARCH INSTITUTES, NETWORKS, NON-GOVERNMENTAL ORGANIZATIONS AND NATIONAL INSTITUTIONS

Centre for Education, Development and Population Activities (CEDPA)

1400 16th Street, NW, Suite 100
Washington, DC 20036
USA
Tel.: +1 202 667 1142
Fax: +1 202 332 4496

CEDPA works to improve the lives of women and girls worldwide and regards gender equality as essential for development, democracy, and global progress. CEDPA's approach to development is rooted in its commitment to broader social and economic development and to the enhancement of the critical role women play in achieving it. CEDPA works to ensure that women have the resources, tools, and means to influence their social, cultural, and political context. Its programmes focus on girls' education and youth development, gender and governance, and reproductive health and HIV/AIDS.

Website: www.cedpa.org

Coptic Evangelical Organization for Social Services (CEOSS)

P.O. Box 162-11811 El Panorama,
Cairo,
Egypt
Tel.: +202 6221425/6/7/8
Fax: +202 6221434

CEOSS is one of Egypt's largest development organizations, providing integrated approaches to poor communities in areas of economic, agricultural and environmental development, health care, and education. CEOSS, which encourages Muslim and Christian neighbours to work together toward common goals, is a leader in grassroots community development, and serves as a catalyst for cooperation and capacity building among other civil society organizations.

Website: www.ceoss.org.eg

Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ)

Postfach 5180,
65726 Eschborn,
Germany
Tel.: +49 6196 790
Fax: +49 6196 791115

GTZ works in international cooperation for sustainable development and operates worldwide. It seeks to provide viable solutions for political, economic, ecological and social development in a globalised world. All activities are geared to improving people's liv-

ing conditions and prospects on a sustainable basis. GTZ works on a broad range of specialised topics including cross-sectoral themes, such as gender.

Website: www.gtz.de

European Network for the Prevention of Harmful Traditional Practices, especially FGM (Euronet FGM)

c\o Amazone,
Middaglijnstraat 10-14,
B-1210 Brussels,
Belgium
Tel.: +32 (0)495 99 24 27
+32 9 240 35 64

Euronet FGM was established in 1998 through a project funded by the European Commission and was strengthened through subsequent meetings of the participating organizations. The essential criterion for membership of the network is that organizations manage a relevant project in a European context. The objectives of Euronet FGM are: ending FGM/C in Europe by finding a global solution; promoting information exchange, sharing knowledge and experience; and establishing and maintaining links among the Inter African Committee and other organizations.

INTACT Network

The Network, which brings together researchers, scholars and activist committed to bringing scientific evidence to bear on the practice, was established at the initiative of the Population Council in 2002. The INTACT website facilitates communication throughout the network and serves as a forum for interaction between members and the interested public.

Website: www.intact-network.net

Inter-African Committee on Traditional Practices Affecting the Health of Women and Children (IAC)

P.O.Box 3001
Addis Ababa
Ethiopia
Tel.: +251 1 51 57 93
Fax: +251 1 51 57 93

IAC focuses on the elimination of harmful traditional practices, including FGM/C through networking, workshops and advocacy. It undertakes advocacy and awareness raising at national, regional and international levels. It works with governments, NGOs, research institutions, women and youth organizations, schools, universities, unions, religious institutes and UN agencies. The IAC has evaluated country policies, laws and programmes that protect the bodily integrity of women and girls. It has also supported the establishment of national and international networks and has promoted capacity building for staff of national committees as well as of other organizations.

Website: www.iac-ciaf.ch

International Centre for Reproductive Health (ICRH)

ICRH - University Hospital Ghent
De Pintelaan 185 4K3 Ghent – 9000
Belgium
Tel.: +32 (9) 240 3564
Fax: +32 (9) 240 3867

ICRH was established in 1994 within the Faculty of Medicine and Health Sciences of the University of Ghent. Its key philosophy is the recognition of reproductive health as a basic human right. As a university group, ICRH focuses on research, training and interventions within the broad area of reproductive health. ICRH has also facilitated many of the workshops and training sessions that have contributed to the development of the European Network for the Prevention of FGM.

Website: www.icrh.org

Italian Association for Women in Development (AIDOS)

30, Via dei Giubbonari
00186 Rome
Italy
Tel.: +39 06 687 3214
Fax: +39 06 687 2549

In collaboration with local partners, AIDOS carries out demonstrative projects that identify the specific needs of women and develop appropriate strategies to satisfy them. By means of advocacy and information activities, the projects also aim to influence government policies and improve the living conditions of the populations of the areas where AIDOS works. This approach aims to ensure project sustainability after donor phase-out and project completion. Among its activities, AIDOS supports programs for the eradication of gender-based violence and the abandonment of FGM/C in Africa and Europe.

Website: www.aidos.it

Maendeleo Ya Wanawake (MYWO)

P.O. Box 44412,
Nairobi
Kenya
Tel.: +254 2 222095

Maendeleo Ya Wanawake ("Women's Progress") works to improve the living conditions of women in Kenya and promote their empowerment. Areas of activity include reproductive health and FGM/C.

National Council for Childhood and Motherhood, Egypt (NCCM)

Kornish El Nile - Al Maadi Cairo
P.O. Box 11 Misr Al Kadima
Cairo
Egypt
Tel.: +20 2 524-0288
Fax: +20 2 524-0701

The NCCM is a governmental organization in charge of proposing general strategies and policies in the field of childhood and motherhood and laying down a comprehensive national plan within the framework of Egypt's general national plan. The Council cooperates with governmental agencies and NGOs working in the field of childhood and motherhood at the regional and international levels.

Website: www.sis.gov.eg/women/child/html/mother1.htm

No Peace without Justice (NPWJ)

Via di Torre Argentina 76,
Rome 00186,
Italy
Tel.: +39 06 6880 3613
Fax: +39 06 6880 3609

NPWJ is an international committee of parliamentarians, mayors

and citizens, whose objective is the establishment of an effective system of international justice. NPWJ also actively campaigns for the eradication of FGM/C, and to this end has organized several important international and regional conferences.

Website: www.npwj.org

Pharos

Herenstraat 35,
Postbus 13318,
3507 LH Utrecht,
Netherlands
Tel.: +30 234 9800
Fax: +30 236 4560

Pharos is a national knowledge centre that concentrates on developing, studying and conveying knowledge in the field of health and health care for refugees and asylum seekers in the Netherlands.

Website: www.pharos.nl

Population Council

1 Dag Hammarskjold Plaza
New York, NY 10017
USA
Tel.: +1 212 339 0500
Fax: +1 212 755 6052

The Population Council focuses on research on a broad range of population issues, including demographic studies, research, technical assistance and the development of new contraceptives. In addition, it helps to improve the research capacity of reproductive and population scientists in developing countries through grants, fellowships, and support for research centres. The Population Council is also particularly concerned with the reproductive health and well-being of the one billion adolescents in the developing world.

Website: www.popcouncil.org

Public Welfare Foundation

1200 U Street, NW
Washington, DC 20009-4443
USA
Tel: +1 202 965 1800
Fax: +1 202 265 8851

The Public Welfare Foundation is a non-governmental grant-making organization dedicated to supporting organizations that provide services to disadvantaged populations and who work for lasting improvements in the delivery of services that meet basic human needs. International efforts to end the practice of female genital mutilation have been furthered with Foundation help in countries such as The Gambia.

Website: www.publicwelfare.org

RAINBO

Suite 5A, Queens Studios
121 Salusbury Road
London NW6 6RG
United Kingdom
Tel.: +44 20 7625 3400
Fax: +44 20 7625 2999

RAINBO is an African led international non-governmental organisation working on issues of women's empowerment, gender, reproductive health, sexual autonomy and freedom from violence as central components of the African development agenda. RAINBO specifically strives to enhance global efforts to eliminate the practice of FGM/C through facilitating women's self-empowerment and accelerating social change.

Website: www.rainbo.org

STOP FGM Campaign

Established in 2002 by AIDOS in collaboration with No Peace Without Justice and a number of African NGOs including TAMWA, the Campaign contributes to the constitution of an international front of actors promoting the abandonment of FGM/C. The creation of a web portal in English, French and Arabic has been central to generating greater understanding and consensus. This portal serves to document, analyze and disseminate information concerning FGM/C, promote good practice for its abandonment and provide a forum for interaction among different actors. In addition, the portal provides support and information for media associations in countries where FGM/C is practiced.

Website: www.stopfgm.org

Tanzanian Media Women's Association (TAMWA)

Mkunguni Street,
P.O.Box 8981
Dar es Salaam,
Tanzania
Tel.: +255-22-2115-278
Fax: +255-22-2115-278

TAMWA uses media to bring about cultural, policy and legal change for the promotion of the human rights of women and children. Through its work, TAMWA raises awareness and debate on a range of issues related to gender-based violence including domestic violence, sexual violence and FGM/C.

Website: www.tamwa.or.tz

Tostan

BP 326, Thiès
Senegal
Tel.: +221 951 10 51
Fax: +221 951 3427

Tostan works to empower African communities to take charge of their own development through the development and implementation of a non-formal, participatory education program in national languages. Tostan provides learners with the knowledge and skills to become resourceful actors in the social transformation and economic development of their communities. Quality, holistic education and development activities based on principles of human rights provide communities with the tools to direct their own social and economic transformation.

Website: www.tostan.org

United States Agency for International Development

Ronald Reagan Building
Washington, D.C. 20523-1000
USA
Tel: +1 202 712 4810
Fax: +1 202 216-3524

USAID supports long-term and equitable economic growth and advances U.S. foreign policy objectives by supporting economic growth, agriculture and trade, global health and democracy, conflict prevention and humanitarian assistance. The activities relating to FGM/C are within its objective to improve global health.

Website: www.usaid.gov

Wallace Global Fund

1990 M Street, NW, Suite 250
Washington, DC 20036
USA
Tel: +1 202 452 1530
Fax: +1 202 452 0922

The mission of the Fund is to promote an informed and engaged citizenry, to fight injustice, and to protect the diversity of nature and the natural systems upon which all life depends. Within the area relating to women's human rights, the Fund supports initiatives that are highly leveraged and have potential for global impact.

Website: www.wgf.org

ADDITIONAL WEB RESOURCES

www.crin.org

The Child Rights Information Network (CRIN) is a global network that disseminates information about the Convention on the Rights of the Child and child rights amongst non-governmental organizations, United Nations agencies, intergovernmental organizations, educational institutions and other child rights experts. The network is supported by, and receives funding from, UNICEF, Rädda Barnen, Save the Children UK and the International Save the Children Alliance. Extensive information, resources and publications are available on this website.

www.eldis.org

Eldis provides extensive links to on-line information on development in areas such as the environment, agriculture, disasters, human rights, civil rights and population. It also provides access to statistical information, major international organizations, research organizations, bibliographical information and databases.

www.hri.ca

Human Rights Internet (HRI) is dedicated to the empowerment of human rights activists and organizations, and to the education of governmental and intergovernmental agencies, officials and other actors on human rights issues and the role of civil society. HRI has a child rights programme highlighting such areas as legal rights and protection.

www.umn.edu/humanrts/index.html

The University of Minnesota Human Rights Library, developed by the University's Human Rights Centre, offers more than 7,200 human rights documents and materials on-line. These include treaties and other international instruments, regional materials, bibliographies and research guides, refugee and asylum sources, and links to over 3,000 other sites. The site also provides a search engine that can locate documents on multiple human rights sites.

The practice of female genital mutilation/cutting (FGM/C) violates the human rights of an estimated three million girls and women every year in Africa and the Middle East alone. Meanwhile, increasing migration has made FGM/C a growing concern beyond the countries in which it is traditionally practiced. Despite concerted advocacy work over recent decades, communities have been reluctant to abandon the practice - with some significant exceptions. This *Innocenti Digest* meets a pressing need to take stock of progress to date, identify what works and what does not, and provide direction regarding the most successful strategies to end FGM/C. Combining concrete field experience with tested academic theory, the *Digest* provides a practical tool to bring about positive change for girls and women.

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