Female genital mutilation in Africa

An analysis of current abandonment approaches

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Acronyms

AMWIK	Association of Media Women in Kenya
APAC	Association des Professionnelles Africaines de la Communication (Association of African Communication Professionals)
BAFROW	Foundation for Research on Women's Health, Productivity, and the Environment
C4C	Communication for Change
CAR	Central African Republic
CEDPA	Center for Development and Population Activities
CEDAW	Convention on the Elimination of all forms of Discrimination Against Women
CEOSS	Coptic Evangelic Organization for Social Services
CEWLA	Center for Egyptian Women's Legal Assistance
CNAPN	Comité National pour l'Eradication des Pratiques Néfastes à la Santé (National Committee for the Eradication of Harmful Traditional Practices to Health)
COST	Coptic Organization for Services and Training
CPTAFE	Cellule de Coordination sur les Pratiques Traditionelles Affectant la Santé des Femmes et des Enfants (Coordination Unit on Harmful Traditional Practices to the Health of Women and Children)
DHS	Demographic and Health Survey
FGC	female genital cutting
FGM	female genital mutilation
GTZ	Deutsche Gesellschaft für Technische Zusammenarbeit
ICPD	International Conferences on Population and Development
IEC	information, education, and communication
MYWO	Maendeleo Ya Wanawake Organization
NGO	nongovernmental organization
PATH	Program for Appropriate Technology in Health
PRB	Population Reference Bureau
RAINBO	Research, Action, and Information Network for the Bodily Integrity of Women
REACH	Reproductive Education and Community Health
REM	Review, Evaluation, and Monitoring
RIJOPD	Réseau des Journalistes en Population et Développement (Network of Journalists in Population and Development)
UNICEF	United Nations Children's Fund
UNFPA	United Nations Population Fund
USAID	U.S. Agency for International Development
WHO	World Health Organization

Executive summary

Female genital mutilation (FGM), or female genital cutting, also known as female circumcision, is a traditional practice that involves the partial or total removal or alteration of girls' or women's genitalia.

For those who support the continuation of the practice, FGM is considered to be a thread in the social fabric that defines a woman's social standing and ultimately a community's identity. FGM is often practiced out of respect for and in conformity to society's culture and traditions. Others see it as a religious obligation, or a rite of passage into womanhood that ensures a girl's virginity and consequently her value and that of her family and the increased likelihood of good marriage prospects. Also underpinning the practice are prescribed gender roles and understandings of men's and women's sexuality.

The World Health Organization estimates that some 130 million women worldwide have undergone the practice, and every year another 2 million girls and young women are at risk. Nearly universal in a few African countries, FGM is practiced by various groups in at least 25 others. Through immigration and population movements, it has also spread to Europe, North and South America, and Australia and New Zealand.

FGM is performed among different ethnic and religious groups, in urban and rural areas, and among all education levels and social classes. There is, however, considerable variability across and within countries regarding these factors, as well as in the type of FGM practiced, the age at which FGM occurs, the type of practitioner who performs FGM, and the rituals and traditions surrounding the practice.

The increasing recognition of FGM as an issue of global concern has seen evolving collaborations between nations; donors; international, regional and local nongovernmental organizations; individuals; and communities. These collaborations have proved essential given the complexity of the factors that influence the continuation of the practice and the long-term efforts required to support communities to build the collective will for its abandonment. This report explores FGM practices, evaluates abandonment approaches, describes the roles of various stakeholders in the abandonment process, and shares lessons learned from FGM abandonment programs.

Past experience has demonstrated that to motivate a community to consider abandoning a deeply ingrained and socially sanctioned practice such as FGM, abandonment programs must address the social norms, the beliefs, and the attitudes of communities as a whole, as well as of those individuals who reinforce the continuation of the practice. They must begin with a respect for culture and traditions and an understanding that FGM occurs because parents love their daughters and want the best possible future for them.

Supporting communities to take collective action to change social norms and traditional practices is complex, and it takes time. It requires the engagement of all groups in a community—including those who do not usually have a voice, such as young girls, as

well as influential individuals such as religious leaders—in discussions on issues that affect them.

Interventions must take place within the context of sustained efforts to support gender equality and the empowerment of women and girls, including efforts that enhance women's ability to make decisions about their bodies, to be free from discrimination and violence, and to enjoy equal rights on par with men. At the same time, it necessitates the identification of solutions from within to address individuals' and communities' concerns, and individual and collective action to address these concerns.

FGM abandonment programs can serve as catalysts to support individuals and communities willing to embrace change and abandon the practice of FGM by creating spaces for public discussion and debate, providing information so that action can be formed by knowledge as well as cultural preferences, and supporting individuals and communities in abandoning the practice.

While community-based programs are at the core of efforts to abandon FGM, local initiatives require:

- Active commitment of governments to support the abandonment of FGM through policies, laws, and resources.
- Coordination among governmental and civil society actors at the local, national, regional, and international levels.
- Advocacy efforts to create support for grassroots change.
- Resources and commitment over the long-term to ensure successful and sustainable outcomes.

Experience has demonstrated that change is possible and that FGM can be reduced among groups in practicing countries. But more work is needed to scale up promising results and to ensure the abandonment of the practice over the long haul. Future initiatives should build on the experience of programs to date while further developing or adapting approaches to fit the local contexts. Successful and sustainable abandonment of the practice will no doubt be a long and arduous process, but the positive outcomes are immeasurable, including the improved lives and well being of girls and women for current and future generations.

1 Introduction

Female genital mutilation (FGM), also known as female genital cutting (FGC) or female circumcision, refers to a variety of operations involving the partial or total removal or alteration of female genitalia.

It is a traditional practice that—for those who support its continuation—is considered to be a thread in the social fabric that defines a woman's social standing and ultimately a community's identity.

FGM is often practiced out of respect for and in conformity to society's culture and traditions. Others see it as a religious obligation, or a rite of passage into womanhood that ensures a girl's virginity and consequently her value and that of her family and the increased likelihood of good marriage prospects. Underpinning this is another layer of reasons associated with gender roles and expressions of men's and women's sexuality.[1]

The World Health Organization (WHO) estimates that some 130 million women worldwide are affected, and every year another 2 million girls and young women are at risk of undergoing the practice.[2]

Nearly universal in a few African countries, FGM is practiced by various groups in at least 25 others. Through immigration and population displacement, it has also begun to spread to regions of Europe, North and South America, and Australia and New Zealand.

There is no definitive evidence on the origin or the rationale for the practice, although the tradition is believed to have originated some 2,000 years ago in southern Egypt or northern Sudan.[3] However, in many parts of West Africa, the practice began relative recently—in the nineteenth or twentieth century.[4]

During the 1990s, WHO classified FGM into three types that vary by severity: clitoridectomy, excision, and infibulation. All other types are classified as "other" (*see Box 1*). In 2004, WHO began discussions to revise the typology, although no changes have been made to date.[5]

FGM has health risks, most notably for women who have undergone more extreme forms of the procedure. Immediate potential side effects include severe pain, hemorrhage, injury to the adjacent tissues and organs, shock, infection, urinary retention, and tetanus. Some of these short-

Box 1: Types of female genital mutilation

Type 1: **Clitoridectomy**. Excision (removal) of the prepuce with or without removal of the clitoris.

Type 2: **Excision**. Removal of the clitoris together with part or all of the labia minora.

Type 3: **Infibulation**. Removal of part or all of the external genitalia (clitoris, labia minora, and labia majora) and stitching and/or narrowing of the vaginal opening, leaving a small hole for urine and menstrual flow.

Type 4: **Unclassified**. This includes all other operations on the female genitalia including:

- Pricking, piercing, or incision of the clitoris and/or labia.
- Cauterization by burning the clitoris and surrounding tissues.
- Incisions to the vaginal wall; scraping or cutting of the vagina and surrounding tissues; and introduction of corrosive substances or herbs into the vagina.

Source: WHO 1996:9.

[1] Rajadurai and Igras 2005
[2] ibid.
[3] Carr 1997: 3
[4] Shell-Duncan and Hernlund 2000
[5] MEASURE DHS CD-ROM 2005

term side effects can be fatal.[6] Long-term effects may include cysts and abscesses, urinary incontinence, psychological and sexual problems, and difficulty with childbirth. In the case of infibulation, obstructed labor may occur if the woman's genitalia are not cut open (deinfibulated) during delivery. This can cause life-threatening complications for both mother and child, including perineal lacerations, bleeding, infection, possible brain damage to infants, and the formation of fistulas.[7]

2 FGM prevalence

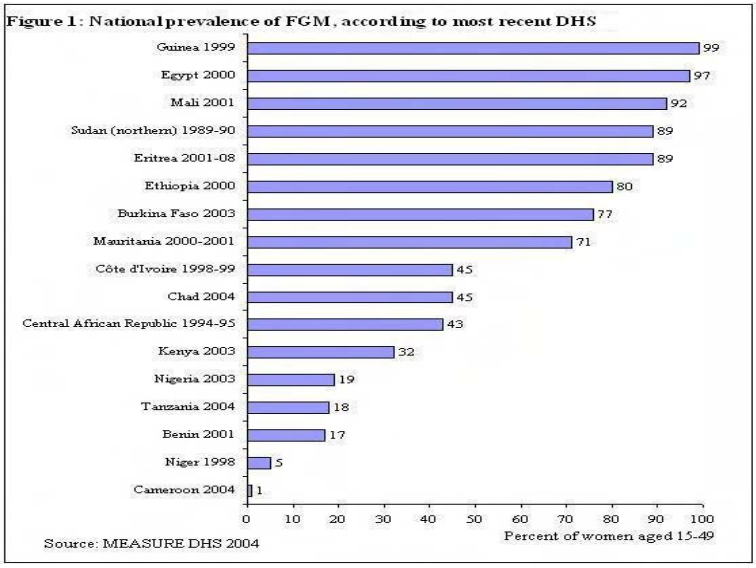
FGM prevalence data are important to help policymakers and program managers determine the extent of the phenomenon, the number of women and girls who may be at risk and trends over time. The first estimates of FGM prevalence were undertaken in the early 1980s for 28 countries, based largely on anecdotal evidence.[8] Nahid Toubia, a decade later, attempted to systematize data collection and reporting on FGM in her report *Female Genital Cutting: A Call for Global Action*.[9] It is only since the 1990s that population-based surveys started collecting national and subnational prevalence data by population characteristics (e.g., residence, ethnic group, age, religion) as a result of a module for FGM being included in the Demographic and Health Surveys (DHS).

Box 2: Demographic and Health Surveys with questions on female genital mutilation in Africa (1989–2004)

- Benin 2001
- Burkina Faso 1998–1999, 2003
- Cameroon 2004
- Central African Republic 1994–95
- Chad 2004
- Côte d'Ivoire 1994, 1998–1999
- Egypt 1995, 2000
- Eritrea 1995, 2002
- Ethiopia 2000
- Guinea 1999
- Kenya 1998, 2003
- Mali 1995–1996, 2001
- Mauritania 2000–2001
- Niger 1998
- Nigeria 1999, 2003
- Sudan (northern) 1990
- Tanzania 1996, 2004

Source: MEASURE DHS

By mid-2005, more than 20 DHS surveys had been undertaken that included questions on the status of FGM (*see Box 2*). Notably, no DHS surveys with questions on FGM have been conducted in Djibouti, the Gambia, Sierra Leone, or Somalia, where FGM prevalence is thought to be high.[10]



In five countries—Egypt, Eritrea, Guinea, Mali, and northern Sudan—FGM is nearly universal, with prevalence ranging from 89% to 99% (*see Figure 1*). In Burkina Faso (77%), Ethiopia (80%), and Mauritania (71%), large

[6] Obermeyer and Reynolds 1999
[7] Koso-Thomas 1987
[8] Hosken 1982
[9] Toubia 1993
[10] Yoder, Abderrahim, Zhuzhuni 2004: 8

proportions of women undergo the procedure, while more moderate overall levels can be found in Benin (17%), Niger (5%), Nigeria (19%), and Tanzania (18%).

Valid data on the prevalence of FGM and the circumstances surrounding the practice can facilitate the monitoring of trends over time. However, tracking changes in the practice is difficult because of:

- Lengthy retrospective periods that can lead to "recall bias" as respondents are asked about an experience that occurred in the past, often when they were very young.
- Incompatible survey instruments.
- The time required for significant behavior change, requiring surveys at multiple points across long periods of time.

By the end of 2004, FGM data were available for multiple DHS surveys in eight countries (*see Table 1*), enabling data from two points in time for the same country to be compared. Only Eritrea, Kenya, and Nigeria show measurable declines in prevalence (of six to seven percentage points). In Burkina Faso, the increased levels are believed to be attributed to improved knowledge of the practice rather than increased levels of girls and women undergoing FGM.[11] In Côte d'Ivoire, the increase is within the range of sampling error, suggesting an unlikely increase in the practice.[12]

Table 1: Female genital mutilation prevalence at two points in time

Burkina Faso 1998–1999	72%
Burkina Faso 2003	77%
Côte d'Ivoire 1994	43%
Côte d'Ivoire 1998–1999	45%
Egypt 1995	97%
Egypt 2000	97%
Eritrea 1995	95%
Eritrea 2002	89%
Kenya 1998	38%
Kenya 2003	32%
Mali 1995–1996	94%
Mali 2001	92%
Nigeria 1999	25%
Nigeria 2003	19%
Tanzania 1996	18%
Tanzania 2004	18%
Source: MEASURE DHS	

FGM prevalence by residence

Data on the distribution of FGM and how it is practiced are important to guide strategies to promote its abandonment. In Egypt, Eritrea, and Guinea, FGM prevalence is 75% or more in every region of the country. In other countries, the extent of the practice varies widely among regions. For example, in Mali, nearly 90% or more of women in five regions (the capital of Bamako, Kayes and Koulikoro, Mopti, Ségou, and Sikasso) have undergone FGM, compared with 10% or fewer of women in Gao and Timbuktu. In Tanzania, a high prevalence of FGM can be found in Arusha (81%), Dodoma (67%) and Mara (43%), while prevalence levels under 2% can be found in ten other regions.[13]

While FGM prevalence is higher in rural than in urban areas for most countries (Benin, Central African Republic, Côte d'Ivoire, Kenya, Mauritania, Niger, and Tanzania), urban and rural rates are either the same or differ only slightly in Eritrea, Guinea, and Mali. In three countries (Burkina Faso, Nigeria, and Sudan), FGM prevalence was substantially higher in

[11] MEASURE DHS CD-ROM 2005 [*see* Burkina Faso 2003 DHS]
[12] Yoder, Abderrahim, Zhuzhuni 2004: 49
[13] MEASURE DHS CD-ROM 2005. Note: Data for Tanzania are from 1998 DHS. The ten regions include: Coast, Lindi, Ruvuma, Mbeya, Tabora, Rukwa, Kagera, Kigoma, Mwanza, and Shinyanga.

urban than in rural areas. Ethnicity is likely to explain higher FGM rates in urban areas in these countries, as well as regional differences in others.[14]

FGM prevalence by ethnicity

National prevalence figures can hide variations in FGM practices among different ethnic communities. For example, FGM prevalence ranges from 3% to 83% in the Central African Republic (CAR), from 2% to 75% in Côte d'Ivoire, and from 1% to 97% in Kenya, depending on the ethnic group.[15] Indirect evidence for similar ethnic variations is available for northern Nigeria, (northern) Sudan, and Tanzania.[16] In other countries, such as Eritrea, FGM is practiced fairly uniformly across ethnic groups.[17]

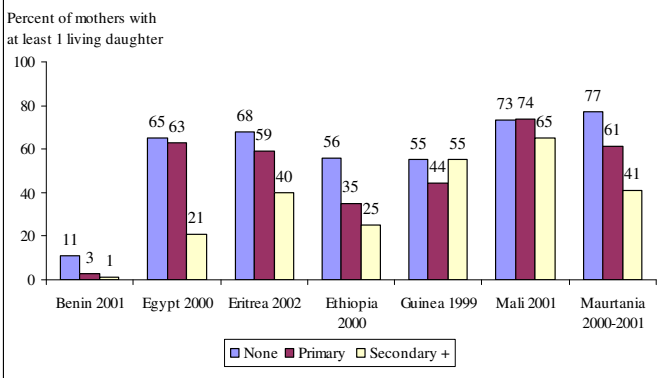
Ethnicity may also determine the type of FGM practiced. For example, infibulation—the most severe form of FGM—is more likely to be practiced among certain ethnic groups in Eritrea and Guinea. In Guinea, 80% or more of women having undergone FGM were infibulated among the Guerze, Kissi, and Toma, compared to only 1% among the Malinke and Peulh. Similarly, in Eritrea, around 70% to 80% of women having undergone FGM were infibulated among the Anseba and Semenawai Keih Bahri, compared to fewer than 5% in the Maekel groups. In Nigeria, among the Yoruba—who have the largest proportion of women in Nigeria having undergone FGM (61%)—fewer than 1% of women are infibulated.[18]

FGM prevalence by education

Women generally undergo FGM at too young an age for education to influence their likelihood of getting cut.[19] However, in many of the countries in which FGM data are available, educational attainment is a proxy for higher socioeconomic status and greater autonomy among women. The educational status of mothers can also be examined in relation to the circumcision status of their daughters to determine the effects of education.

In most countries, women with more education are less likely to have undergone FGM. However, in Egypt, Guinea, and Mali, where FGM prevalence is high (97%, 99%, and 92%, respectively), education does not seem to have a noticeable influence.[20]

Figure 2: Prevalence of FGM among daughters, by mother's education



Source: Yoder, Abderrahim, Zhuzhuni 2004

Overall, it appears that daughters of mothers who are more highly educated are less likely to have undergone FGM than daughters of mothers with little or no education (*see Figure 2*). Guinea is an exception, likely due the small number of women with primary and secondary education.[21]

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[14] Creel, Ashford, Carr, Roudi, Yinger 2001
[15] MEASURE CD-ROM 2005. Note: Data for Kenya are from 1998 DHS.
[16] Yoder, Abderrahim, Zhuzhuni 2004: 31
[17] Creel, Ashford, Carr, Roudi, Yinger 2001: 11
[18] MEASURE DHS CD-ROM 2005. Note: Data for Nigeria are from 2003 DHS.
[19] Creel, Ashford, Carr, Roudi, Yinger 2001
[20] MEASURE DHS CD-ROM 2005
[21] Yoder, Abderrahim, Zuzhuni 2004:29. In Guinea, 76% of respondents had no education, while only 5% had some secondary schooling or higher.

FGM prevalence by religion

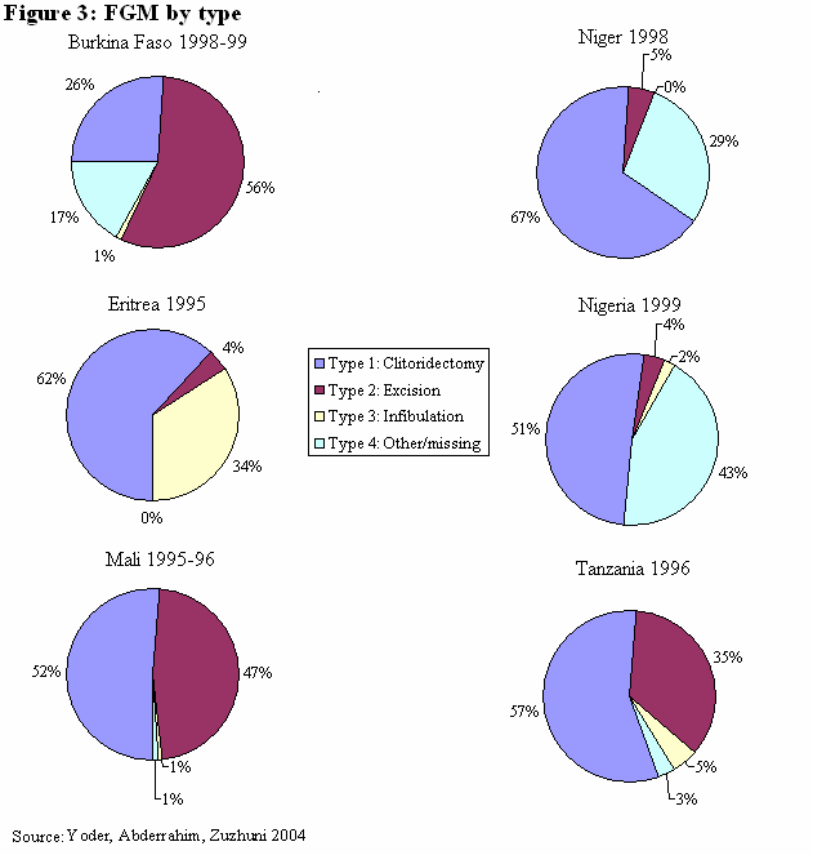
FGM is a cultural and social practice, rather than a religious one. It occurs among all religious groups (Christian, Muslims, a small sect of Jews, and indigenous groups) in Africa, although no religion mandates it.[22] In Burkina Faso, CAR, Côte d'Ivoire, Mali, Niger, and (northern) Sudan, Muslim women are more likely to have undergone FGM than Christian women.[23] However, in Kenya and Tanzania, a higher percentage of Christian than Muslim women undergo FGM (38% vs. 28%, and 19% vs. 14%, respectively). In Mali and Tanzania, women who practice traditional religions have the highest prevalence of FGM in the country (95% and 22%, respectively).[24] Notably, ethnicity also confounds efforts to examine the role that religion plays in FGM prevalence.[25]

3 Circumstances surrounding the practice

Type of FGM performed

Information on the type of procedure performed can provide insight on the severity of consequences likely to follow cutting. WHO has estimated that clitoridectomy (type 1) is the most common procedure, accounting for up to 80% of all cases. Fifteen percent of all women having undergone FGM are believed to have been infibulated (type 3), the most invasive and damaging type of FGM.[26]

Figure 3: FGM by type



Source: Yoder, Abderrahim, Zuzhuni 2004

The DHS questionnaires initially attempted to use the WHO typology as a guideline to determine which of the three types of cutting a woman had undergone.[27] In all of the countries that used this approach (*see Figure 3*), the most prevalent types are clitoridectomy (type 1) and excision (type 2). Infibulation (type 3) is

[22] Althus 1997: 130
[23] MEASURE DHS CD-ROM 2005; Creel et al. 2001
[24] MEASURE DHS CD-ROM 2005. Note: Data for Tanzania are from 1996 DHS.
[25] Yoder, Abderrahim, Zhuzhuni 2004: 31.
[26] WHO 1996:9
[27] Yoder, Abderrahim, Zhuzhuni 2004: 35. Note: In Burkina Faso, Eritrea, Mali, Nigeria, and Tanzania, respondents were asked to identify—-based on three categories—the type of FGM they had undergone. In Niger, women were asked to name what was done to them, and local specialists classified their answers into the three pre-defined categories. Data from Sudan not included (see footnote 28).

chiefly practiced in the Horn of Africa (Ethiopia, Somalia, Sudan, and neighboring countries). In Eritrea and Sudan, for example, 34% and 82%, respectively, have been infibulated.[28] The large numbers of responses in Nigeria and Niger listed as "other" or "missing" are likely due to problems with data collection or, in the case of Niger, problems with the classification of responses into discrete categories. Of note, in 2000, DHS reports adopted an approach that seeks to identify only cases of the extreme—from symbolic cuts to infibulation.[29]

In some countries, there are intra-country differences in the type of FGM practiced depending on education, residence, economic status, and ethnicity (*see Section 2, "FGM prevalence/FGM prevalence by ethnicity")*. For example, in Eritrea, women from the lowest economic group are more likely than those in the highest economic group to have undergone infibulation. In Guinea, women with higher educational attainment are less likely to have undergone the more severe forms of FGM.[30]

Although Nahid Toubia has suggested that women in urban areas—who may have fewer traditional norms placed upon them—are more likely to have undergone less severe forms of excision, the picture is not clear from available data.[31] For example, women in the urban areas of Eritrea and Guinea are more likely to have undergone less severe forms of FGM; however, the opposite phenomenon can be found in Mali and Niger.[32]

Age at which FGM is performed

FGM is generally performed on girls between the ages of 4 and 12 years, although in some cultures it may occur as early as a few days or weeks after birth or as late as just prior to marriage, during pregnancy, or after the first birth.[33] At early ages, FGM may be performed to ensure virginity, whereas in the context of adolescence, FGM may be part of an elaborate coming-of-age ritual that includes a period of seclusion and education about the rights and duties of a wife (*see Section 4, "Rationale for FGM")*.[34]

"What I see is that girls are circumcised when very young, even those who are extremely young…When we went for circumcision, we were all big girls above the age of 17 years…"
-Health Nursing Officer, Nyamira, Kenya

About 90% of girls in the CAR and Egypt underwent FGM between the ages of 5 and 14 years, whereas in Côte d'Ivoire, Eritrea, Ethiopia, Mali, and Mauritania, 55% or more of girls underwent FGM before their fifth birthday. In Benin, Niger, and Nigeria about one-third of girls underwent FGM in their first five years of life. In Kenya and Tanzania, around 60% to 70% of girls were cut between the ages of 10 and 19.[35]

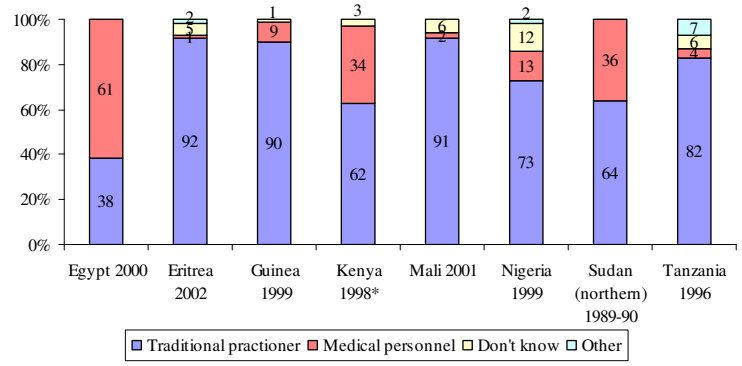
[28] ibid.: 36. Note: Sudan 1989–1990 DHS not included in Figure 3 as the list of categories was not the same in the Sudan DHS. Nonetheless, the categories correspond closely to the WHO types (sunna: clitoridectomy, intermediate: excision, pharaonic: infibulation).
[29] ibid.: 19
[30] MEASURE DHS CD-ROM 2005. Note: Data for Eritrea are from 2002 DHS.
[31] Toubia and Sharief 2003
[32] MEASURE DHS CD-ROM 2005. Note: Data for Eritrea are from 2002 DHS; data for Mali are from 2001 DHS.
[33] Toubia 1993
[34] Kratz 1994; Johnson 2000
[35] MEASURE DHS CD-ROM 2005. Note: Data for Egypt are from 2000 and 2005 DHS, data for Eritrea are from 1995 and 2002 DHS, data for Kenya are from 1998 DHS, data for Mali are from 2001 DHS, data for Nigeria are from 2003 DHS, data for Tanzania are from 1996 DHS.

In Burkina Faso, Côte d'Ivoire, Kenya, Mali, and Senegal, there is evidence that the age of circumcision is declining.[36] For example, in Mali, the median age at circumcision for women aged 30 to 45 was about three years, whereas for those aged 15 to 29, it was less than one year.[37]

Person performing FGM

Traditional practitioners—local specialists (circumcisers), traditional birth attendants, traditional healers, experienced grandmothers, and barbers—perform the majority of FGM procedures (*see Figure 4*). In some countries, medical personnel including doctors, nurses, and certified midwives perform FGM. The highest rates of use of medical personnel can be found in Egypt (61%), Kenya (34%), and Sudan (36%). In Guinea and Nigeria, 9% and 13% respectively, of circumcisions are carried out by medical personnel.[38]

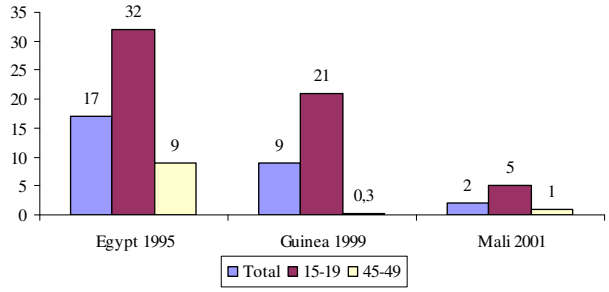
Figure 4: Proportion of women having undergone FGM by practioner



Source: Yoder, Abderrahim, Zhuzhuni 2004
Note: *Kenya: Question asked about daughter's experience, not that of the woman

As awareness of potential health consequences of FGM has increased with information, education, and communication (IEC) campaigns, awareness-raising programs, and general improvements in education, there has been a trend in some countries of the "medicalization" of the practice (*see Figure 5*). In these cases, younger girls and women are more likely to have been cut by medical professionals than older women. Similar trends toward medicalization have been found in western Kenya[39] and Tanzania.[40]

Figure 5: Proportion of women having undergone FGM who were cut by a medical professional, by age



Source: Yoder, Abderrahim, Zhuzhuni 2004

While medicalization may improve the conditions under which FGM is performed (e.g., better hygiene, under anesthesia, in combination with anti-tetanus vaccinations), it violates principles of professional health ethics and does not address the potential long-term medical, psychological, and psychosexual complications and the violation of women's rights (*see Section 5, "Abandonment approaches/Health risk approach"*).[41]

[36] Yoder, Abderrahim, Zhuzhuni 2004; Diop 2004b
[37] Yoder, Abderrahim, Zhuzhuni 2004:46
[38] ibid.: 37
[39] Njue and Askew 2004; MYWO/PATH 2000
[40] MEASURE DHS CD-ROM 2005. Note: Data for Tanzania are from 1996 DHS.
[41] Shell-Duncan 2001; GTZ 2001

Numerous organizations have opposed the medicalization of FGM, including the WHO, which stated that "female genital mutilation in any form should not be practiced by health professionals in any setting—including hospitals or other health establishments."[42] Similar statements have been made by the International Federation of Gynecology and Obstetrics, the African Union (*see Box 3*), and the US Agency for International Development (USAID).

Box 3: Protocol to the African Charter on Human and People's Rights on the Rights of Women: Article 5: Elimination of Harmful Practices

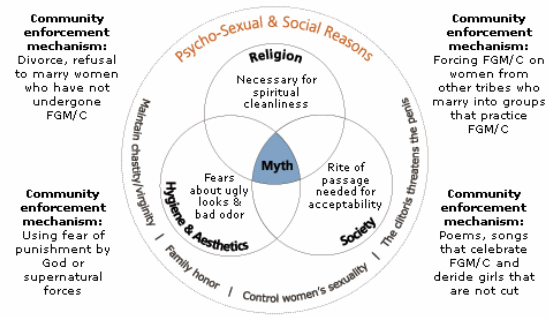
States Parties shall prohibit and condemn all harmful practices which negatively affect the human rights of women and which are contrary to recognized international standards. States Parties shall take all necessary legislative and other measures to eliminate such practices, including…prohibition, through legislative measure backed by sanction, of all forms of female genital mutilation, scarification, medicalization, and para-medicalization of female genital mutilation and all other practices in order to eradicate them.

Source: African Union 2003

4 Rationale for FGM

To orient actions toward the abandonment of FGM, it is important to understand why the practice is performed and why it continues. WHO and PATH have developed a conceptual framework or "mental map" (*see Figure 6*) to understand the role of FGM in society. Details of the mental map will vary across countries, but there are distinctive features that contribute to the practice including religious, personal, and societal beliefs.

Figure 6: Why FGM continues: A mental map



Source: adapted from: Asha Mohamud, Nancy Ali, Nancy Yinger, World Health Organization and Program for Appropriate Technology in Health (WHO/PATH), FGM Programs to Date: What Works and What Doesn't (Geneva: WHO, 1999): 7.

Religious beliefs

Although FGM is not mandated by any religion, the importance of religion in sustaining the practice is well documented. For example, 60% of women in Eritrea, 30% in Guinea, 19% in Mali, and 29% in Mauritania reported FGM to be required by religion. In Egypt, 73% of women reported it to be a religious tradition.[43] In all of these countries, older women, women with low levels of education, and Muslim women were more likely to invoke religion than their counterparts.

In some countries, including Mauritania and Niger, men were more likely than women to cite religion when supporting the continuation of the practice. In Mauritania, FGM was reported to be a religious obligation by 29% of women compared to 41% of men. In Niger, religion was mentioned as a reason by 6% women and 15% of men who favored continuing the practice.[44]

[42] WHO 2001
[43] MEASURE DHS CD-ROM 2005. Note: Data for Egypt are from 2000 DHS, data for Eritrea are from 2002 DHS, data for Mali are from 2001 DHS.
[44] MEASURE DHS CD-ROM 2005

Although FGM is not sanctioned by religious texts, individual subjective interpretations of the Koran and the Hadith have been used to justify the practice.[45] In Ethiopia, Kenya, and Sudan, community residents explained that FGM was part of a cleansing and purification process, by which the *haraam* [unclean] parts are removed (*see Box 4*). While this was the prevailing belief among the majority of residents, a minority presence argued that the religious obligation was only for men and that FGM was optional.[46]

While Christian women who have undergone FGM are more likely to rationalize the maintenance of tradition, religious justification was cited by 15% of Christian women in Guinea (compared to 33% of Muslim and 10% of animist women) and 4% of Catholic women in Côte d'Ivoire (compared to 17% of Muslim women and 1% of those following a traditional religion).

Box 4: Beliefs about the religious justification for female genital mutilation

"Some people think that eating food prepared by an uncircumcised girl is haaram [unclean]."
-Elderly woman in Sudan

"It is good. One who is not circumcised is not a Muslim."
-Elderly man in Kenya

Source: Rajadurai and Igrasrelis 2005

Many groups working on FGM abandonment programs include religious leaders. For example, Tostan and CARE have been working with religious leaders to deliver messages that Islam guarantees the integrity of the human being—both in body and spirit—and that FGM violates that integrity.[47] In Kenya, the Kikuyu have nearly abandoned the practice due largely to sermons and interventions by Catholic priests at the community level. Messages such as "God has made us complete," "we have no right to destroy our God-given body," and "our body is the temple of the soul" are said to have contributed to this change (*see Section 6, "Abandonment programs–stakeholders/Religious and community leaders"*).[48]

Personal beliefs

Female genital cutting may also be justified to maintain cleanliness—often linked with religious purification as discussed earlier—or for other hygienic and aesthetic reasons. Cleanliness and hygiene was invoked as a benefit of FGM by 17% of women in Guinea, 21% of women in Mali, and 13% of women who had heard of FGM in Eritrea and Mauritania. Women in rural areas, older women, and less educated women were generally more likely to support this belief. In Mali and Mauritania, women were more likely than men to report cleanliness as a perceived benefit (21% vs. 17%, and 19% vs. 13%, respectively).[49]

Other studies have revealed the belief that the female genitalia in their natural form are ugly and that cutting (particularly infibulation) makes them presentable and beautiful. For example, among Sudanese communities that practice cutting, FGM is said to liberate "a [woman's body] from its masculine properties and when the clitoris, which is ugly and misbegotten, is

[45] Toubia 1993. The Hadith are a collection of sayings of the Prophet Mohammed. Toubia has noted that a directive of the Prophet Mohammed has been misinterpreted. Toubia argues that the directive arose out of a question to the Prophet about circumcision, and the Prophet is recorded as saying to "circumcise but not to destroy for not destroying would be better for a man and would make a woman's face glow."
[46] Rajadurai and Igras 2005: 13
[47] See Tostan website; Rajadurai and Igras 2005
[48] GTZ 2001: 14
[49] MEASURE DHS CD-ROM 2005. Note: Data for Mali are from 2001 DHS.

excised the woman's genitalia is made more beautiful."[50] In discussions with older Somali women in Kenya, one respondent said, "I will circumcise my daughter because I don't want people to say that my girl is empty, I want her to be beautiful and her thing [to be] shiny like a mirror." A female teacher from Mandera added that, "you know, this clitoris grows with the body of the girl. They don't want to see that thing, it will look abnormal, and it becomes ugly."[51]

Addressing personal beliefs will require confronting some of the myths and rumors surrounding FGM in a sensitive and non-threatening way that encourages dialogue.

Societal beliefs

Upholding tradition

"We are going to perform salot [infibulation] even though we are dying. Our mothers and grandmothers did it, we did it, and our daughters will do it."[52]

—Woman in Ethiopia

The majority of people who report wanting to continue the practice explain that FGM is customary or part of their tradition—passed down from generation to generation. For example, among women favoring the continuation of FGM, tradition was invoked by 68% of women in Côte d'Ivoire, 56% in Kenya, and 68% in (northern) Sudan.[53] In community discussions in Ethiopia, Kenya, and Sudan, women in particular saw themselves as the custodians of traditional practices, bestowed with the duty to preserve and ensure them.[54]

Some communities have established elaborate rite-of-passage ceremonies in which FGM and accompanying rituals welcome young girls into womanhood and confer social acceptance or a sense of belonging.[55] For example, among the Sabiny in Uganda, cutting marks the beginning of community and civic responsibility. Prior to the procedure, a girl is not permitted to speak in public in front of those who have already been cut.[56] According to Jomo Kenyatta, former President of Kenya, "the moral code of the tribe [of Kikuyu] is bound up with this custom and symbolizes the unification of the whole tribal organization...[it] marks the commencement of participation in various governing groups."[57]

FGM and the accompanying rituals are often believed to signify new status. For example, among the Meru of Kenya, a daughter's initiation into womanhood through FGM heightens the social standing of the mother and defines relations of authority among girls and woman.[58] In Tanzania, a resurgence of FGM in the late 1980s was believed to be due to the declining value and status of school education, which led some young women to undergo FGM to enhance their social status and marriage prospects. [59]

[50] Abusharaf and Halim 2000
[51] Jaldesa, Askew, Njue, Wanjiru 2005: 8
[52] Rajadurai and Igras 2005: 13
[53] MEASURE DHS CD-ROM 2005. Note: Data for Kenya are from 1998 DHS.
[54] Rajadurai and Igras 2005: 13
[55] Masterson and Swanson 2000
[56] Horsfall and Salone 2000: 4
[57] Kenyatta 1965: 133
[58] Thomas 2000
[59] ibid.

Critics of these justifications point to trends that FGM is being performed on girls at younger ages (*see Section 3, "Circumstances surrounding the practice/Age at which FGM is performed"*), making it unlikely that the ritual signifies enhanced roles for the newly initiated. Moreover, the alternative rites approach (*see Section 5, "Abandonment approaches/Alternative rites approach"*) has demonstrated that traditional wisdom, education, and celebration of coming of age can be undertaken without FGM.

Regulating sexuality

"The elders tell people not to marry an uncircumcised girl because she cannot control herself."[60]

—Schoolgirl in Kenya

FGM is often described as a means to safeguard against premarital sexual activity and, as such, prevent girls' promiscuity and preserve virginity. In Kenya, 30% of women supporting the continuation of the practice agreed that FGM helped to preserve virginity and avoid immorality. In Nigeria, similar levels (36%) were reported by women, although 45% of men supporting the continuation of the practice agreed with this statement.[61]

In Ethiopia, Kenya, and Sudan, CARE found that FGM was believed by many communities to serve as a deterrent for rape or for premarital sex, as men may be hesitant about engaging in sex with a girl who has been cut.[62] FGM was believed to be proof of a girl's virginity, thereby improving marriage prospects for unmarried girls having undergone the procedure. In Côte d'Ivoire, "improved marriage prospects" was invoked by 36% of women favorable to the continuation of the practice.[63]

Once married, FGM is also believed by some communities to ensure that a woman is faithful and loyal to her husband. For example, 51% of women in Egypt believed that FGM prevents adultery. Urban women, highly educated women, and women "working for cash" were somewhat less likely than their counterparts to hold this belief.[64]

In some places, FGM is also believed to enhance male sexuality. In Nigeria, for example, 5% of women and 23% of men who reported favoring continuation of the practice cited "more sexual pleasure for men" as a perceived benefit.[65] In community discussions in Ethiopia, Kenya, and Sudan, some men said that, during the first nights of marriage, penetrating a girl who had been cut reaffirmed their masculinity and gave them a sense of achievement. Others, however, reported to be conflicted by the pain they caused their new wives.[66]

At the heart of these various rationales rendering a woman marriageable—a factor of ultimate importance in societies in which women get support from male members, particularly husbands. As a study of FGM in Ghana explained, "those who practice FGC/M consider it a

[60] Rajadurai and Igras 2005: 13
[61] MEASURE DHS CD-ROM 2005. Note: Data for Kenya are from 1998 DHS, and data for Nigeria are from 2003 DHS.
[62] Rajadurai and Igras 2005
[63] MEASURE DHS CD-ROM 2005
[64] ibid. Note: Data for Egypt are from 2000 DHS.
[65] ibid. Note: Data for Nigeria are from 2003 DHS.
[66] Rajadurai and Igras 2005: 14

beneficial act...especially if a woman's quality of life depends on her status as a wife and mother, and as a respectable woman." [67]

Families who practice FGM have done so as an act of love for their daughters, to help provide them with a stable life and to ensure their full participation in the community.[68] Efforts to support the abandonment of the practice need to address issues of sexuality and gender roles and marriageability. To address marriageability, programs need to include work with inter-marrying groups to ensure that social change is occurring across villages and clans.

Ensuring social acceptance

Social acceptance has been widely reported as a reason for the continuation of FGM; for example, it was cited by 42% of women in Eritrea, 65% in Guinea, 42% in Mali, and 35% in Mauritania.[69] The negative social consequences that result from noncompliance with the tradition were reported in a study by CARE in Ethiopia, Kenya, and Sudan to include: shame, stigmatization, a decrease in marriage prospects, rejection of being married without first being cut, and possible ostracism of the girls' families, denying them full participation in community activities.[70] In Sudan, women who have not undergone FGM have been reported to face divorce or forcible excision in many practicing communities.[71] In southern Senegal, female relatives of girls who have not been cut may take advantage of an absence of the girl's parents to have the girl cut without the parents' consent.[72]

If the girls are not circumcised, [they] will bring shame to [their] mother and also to [their] relatives. A lady whose daughter is not circumcised is pointed [at] by others."
-FGM practitioner, Mandera, Kenya

Source: Jaldesa *et al.* 2005

As such, abandoning the practice demands not only individual change but more importantly social change that supports the abandonment of FGM within and across communities.

5 Abandonment approaches

History of abandonment approaches

Efforts to abandon the practice in Africa can be traced back to the beginning of the twentieth century when missionaries and colonial authorities emphasized the alleged adverse health effects and framed the practice as "uncivilized, barbaric, and unacceptable in the eyes of Christianity."[73]

Early efforts to ban FGM were seen by many African communities as another attempt at colonial imperialism and led to widespread resistance resulting, in some places, in an increase in the practice and in driving the practice underground. For example, in colonial Kenya, communities in the Meru District believed that FGM "remade girls into women"; there the practice was accompanied by attendant teachings and celebrations to mark the rite of passage

[67] Owusu-Darku [no date]: 2
[68] Shell-Duncan, Obiero, Muruli 2000: 119; Creel et al. 2001
[69] MEASURE DHS CD-ROM 2005. Note: Data for Eritrea are from 2002 DHS, data for Mali are from 2001 DHS.
[70] Rajadurai and Igras 2005: 14
[71] Abusharaf and Halim 2000
[72] GTZ 2001
[73] Shell-Duncan and Hernlund 2000

into adulthood. In response to the ban, the girls of Meru—fearing being denied adulthood—cut themselves, becoming known as *ngaitana*, meaning "I will circumcise myself."[74] Currently, the Meru District has one of the highest incidences of FGM in Kenya.[75]

Attempts in the 1960s and 1970s by European and American feminists to persuade Africans to abandon the practice also failed to provoke much change, as they were perceived as imposed by foreign countries and alien to the culture and reasoning of the people concerned.[76] A lack of cultural sensitivity may have been to blame in some of these efforts, as campaigns often called for the "eradication" of a practice that was "pathological" or "an atrocity"—language that does not invite positive dialogue about its abandonment.

The increasing importance of African women's groups in pursuing economic, political, and social advancement and their interaction with the international community led many women to become activists for the abandonment of the practice. Their participation in international conferences such as the International Conference on Population and Development (ICPD) in 1994 and the Fourth World Conference on Women in Beijing in 1995 led to the growing recognition of FGM as a health and human rights issue. In these and subsequent international forums, African governments, international agencies, and nongovernmental organizations (NGOs) have supported international declarations to support the abandonment of the practice (*see Box 5*).

Box 5: International Conference on Population and Development Program of Action 1994

FGM violates the Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW 1979) and the Convention against Torture and other Cruel, Inhumane, or Degrading Treatment or Punishment 1984.

Governments are urged to prohibit female genital mutilation wherever it exists and to give vigorous support to efforts among nongovernmental and community organisations and religious institutions to eliminate such practices.

Source: UN. ICPD's Programme of Action,4.22, 1994

The increasing recognition of FGM as an issue of global concern has seen evolving collaborations between nations, international donors, international, regional and local NGOs, individuals, and communities. Such joint activities have proved essential given the diversity of stakeholders, the complexity of the factors that influence the continuation of FGM, and the differences in the practice.

Recent efforts have contributed to a large body of evidence on different approaches that can be analyzed to determine their impact on raising awareness and changing behavior. Rigorous evaluation of these approaches is often lacking, as many interventions have been small in scale, worked with limited budgets, or lacked indicators to monitor and evaluate impact. With larger levels of funding by and collaboration with international development assistance organizations and philanthropic foundations, more evaluations are being conducted—although this still remains far from systematic.[77]

[74] Thomas 2001
[75] Banda 2003
[76] GTZ 2001
[77] Population Council 2002

This section presents some of these approaches to abandonment and their implications for future initiatives, including:

- Human rights approach
- Legal approach
- Health risk approach
- Training health workers as change agents
- Training and converting circumcisers
- Alternative rites approach
- Positive deviance approach
- Comprehensive social development approach

The way the approaches have been described here is, to some extent, artificial, as most programs have used a combination of approaches.

Human rights approach

Human rights approaches focus on how FGM violates women's reproductive and sexual rights as outlined in numerous international conventions such as the International Declaration of Human Rights, the Convention on the Rights of the Child, and the Convention Against all forms of Discrimination against Women (CEDAW). Major international human rights violated by FGM include:

- The right to be free from all forms of gender discrimination.
- The right to be free from torture.
- The right to health and to bodily integrity.
- The right to life.
- Children's right to special protections.

The concept of human rights has been more difficult to introduce in the FGM discussion than the public health implications. Human rights may be considered abstract, Western-ways of thinking; international agreements may not seem applicable to local realities. For example, many Egyptians report not seeing themselves as active participants in the international scene and thus do not respond to or are alienated by arguments based on international conventions.[78]

Rights-based approaches are considered to be effective when they:[79]

- Focus on obligation, participation, empowerment, and human dignity.
- Include women, men, and children as key stakeholders rather than objects of development efforts.
- Address how communities themselves understand rights and responsibilities.
- Focus on how people are instrumental in bringing about the enjoyment of their rights and in holding States accountable for ensuring these rights are promoted and projected.

[78] Tkalec 2000
[79] Masterson and Swanson 2000

A number of community-based educational programs have included FGM as part of models on human rights education and reproductive health. For example, Tostan's model of community education aims to increase participants' awareness of human rights and women's health and to reduce violence against women—including the practice of FGM.[80] This program for men and women, in partnership with social mobilization approaches, was first implemented in Senegal and has been replicated in other countries including Burkina Faso and Guinea. In Burkina Faso and Senegal, the program was found to have contributed to lower levels of domestic violence, lower levels of approval of FGM and intent to cut girls, and lower reported levels of FGM among girls.[81]

CARE, in collaboration with PATH and the Population Council/Frontiers in Reproductive Health project, recently implemented a project integrating a basic human rights framework into community-based health projects in Ethiopia, Kenya, and Sudan. The project expanded health education outreach to include education and awareness of social and rights issues, facilitated public discussions with women and men to encourage community debate, and undertook community-level advocacy with religious and other influential people to build support for grassroots initiatives to abandon FGM. Project activities in Ethiopia and Kenya to have led to: [82]

- Increased public discussions by women and men on FGM.
- Increased knowledge of the adverse health, social, and psychosexual effects of FGM.
- Increased awareness of how women's and girls' rights were compromised by the practice.
- In Ethiopia, a doubling in the level of support for abandonment of FGM.
- In Ethiopia, a doubling in the proportion of respondents who said that they did not intend to cut their daughters in the future.

Lessons learned:

- Human rights approaches are one part of a comprehensive strategy to promote the abandonment of FGM; when used as a central and isolated focus of discussion, they show little effect.
- Involving men, opinion leaders, religious leaders, and other stakeholders is key to fostering informed dialogue, influencing gender relations, and promoting community capacity to mobilize for social change.
- Community institutions, women's groups, community education programs, and other local initiatives should be supported in promoting rights among their members.

[80] See Tostan website.
[81] Diop, Ouoba, Congo, et al. 2004a; Diop, Faye, Morea, et al. 2004b
[82] Chege, Askew, Igras, et al. 2005

Legal approach

Several governments in Africa have established legal measures criminalizing FGM (*see Table 2*). Penalties range from a minimum of six months to a maximum of life in prison; several countries also impose monetary fines. In Egypt, the Ministry of Health issued a decree declaring FGM unlawful and punishable under the Penal Code.[83] Some countries, such as Nigeria, have established laws at the state level.[84]

While enforcement of the law has been poor in many countries, there have been reports of prosecutions or arrests in cases involving FGM in Burkina Faso, Egypt, Ghana, and Senegal.[85]

Table 2: Criminal legislation/decree and year enacted

Benin	2003
Burkina Faso	1996
Central African Republic	1966
Chad	2003
Cote d'Ivoire	1998
Djibouti	1994
Egypt (Ministerial Decree)	1996
Ethiopia	2004
Ghana	1994
Guinea	1965, 2001
Kenya	2001
Niger	2003
Senegal	1999
Tanzania	1998
Togo	1998

Source: Center for Reproductive Rights 2005

Legislation that criminalizes the practice of FGM is one of the most controversial aspects of FGM-abandonment movements. Critics of legal measures argue that legislation can:[86]

- Drive the practice underground, making it harder to address.
- Discourage treatment by trained health care providers and institutions in cases of medical complications, due to fear of being denounced.
- Cause underreporting of FGM in national surveys because respondents are unwilling to report having or intending to carry out an illegal act.
- Lead to community opposition to coercive top-down directives.

Advocates insist that legislation:[87]

- Provides a supportive environment for local initiatives.
- Offers protection for women seeking safeguards.
- May discourage circumcisers and families who fear prosecution.
- Helps health care providers justify their engagement in abandonment programs and gives them a reason to reject the medicalization of the practice or to refuse to comply with demands for re-infibulation after delivery.
- Reminds women and their families that women have rights to bodily integrity and that such rights are inalienable.

[83] Center for Reproductive Rights 2005
[84] For example, in Nigeria, Enugu State's House of Assembly established legislation against the practice of FGM in 2005. Personal communication, Edith Nwanguma, August 15, 2005.
[85] ibid.
[86] Izett and Toubia 1998
[87] GTZ 2001; Center for Reproductive Rights 2000; Rahman and Toubia 2000

Lessons learned:

- Laws alone are unlikely to change traditions. To have an impact, they must be complemented by multifaceted programs at the community level.
- To be successful, laws prohibiting FGM must come to be seen as an expression of popular will. As Nahid Toubia explains, criminalization and regulation "are only effective once a substantial body of public opinion has been raised against the practice."[88]
- Legislation should be presented as a protective measure and promoted through a delicate balance of law enforcement, public education, and dialogue.[89]

Health risk approach

One of the oldest and most widely used strategies, the health risk approach engages authoritative individuals (e.g., doctors, nurses, midwives, educators, and other professionals) in delivering messages about the short- and long-term medical complications of FGM. This approach was guided by beliefs that:

- The evidence base on health complications would be enough to influence the abandonment of the practice.
- Addressing health would be met with less resistance and be more acceptable than human rights or gender discrimination.
- Once women recognized the health hazards of FGM, they would abandon the practice.

This approach has been popular in Egypt and in the Somali community, both in Somalia and among emigrant Somalis. The Mother and Child Health Care/FGM Project explained that "the health aspects are our principal argument, the thing that can make people listen to us. Health is by far the most important issue in Africa and it is easier to relate to something everyone accepts and understands."[90]

However, focusing on the harmful medical effects alone does not address how FGM violates women's and girls' human rights and has led to a number of problems, including:

- Disbelief about the harmfulness of the practice among some women who have not experienced any complications.
- Shifts to less severe forms of FGM (e.g., from type 3, infibulation, to type 2, excision, or to pricking or nicking the clitoris as a symbolic cut) rather than the abandon of the practice itself.[91]
- Increased medicalization of the practice, whereby doctors, nurses, and midwives perform the procedure—often in health structures.

[88] Toubia 1995:45
[89] WHO 2000
[90] Mother and Child Health Care/FGM Project 2000
[91] Njue and Askew 2004

Medicalization of the practice has been observed in a number of countries including Egypt, Guinea, western Kenya, Mali, and Tanzania. [92] For example, in Egypt, girls aged 15 to 19 are more than three times as likely to have been cut by a medical professional (32%) than women aged 45 to 49 (9%); in Guinea this difference was even greater (21% compared to 0.3%) (*see Section 3, "Circumstances surrounding the practice"*).[93]

While medicalization may improve the conditions under which FGM is performed, it does not address the long-term issues including medical, psychological, and psychosexual complications and the violation of women's rights. Moreover, it contradicts two of the most important principles of professional health ethics, notably 1) to do no bodily harm and 2) to preserve the healthy functioning of the body organs at all costs unless they carry life-threatening disease.[94]

Lessons learned:

- The health risk approach, used alone, has led to a number of problems, including medicalization of the practice and shifts to less intrusive forms of FGM rather than abandonment of the practice.
- Information on the long-term psychological and psychosexual effects of FGM need to be included in health risk approach messages.
- Education on existing policies and laws is required so that health care providers can dissuade communities from its continuation, support women and girls who oppose the practice, and manage complications arising from FGM.

Training health workers as change agents

This approach emphasizes that health workers, equipped with knowledge and skills, can act as advocates to promote the abandonment of FGM because of their roles as:

- Providers of care to women having undergone FGM.
- Counselors to women and couples.
- Opinion leaders in communities.
- Fathers, mothers, uncles, and aunts with influence on decisions as to whether to cut female family members.

The content of training programs depends on local needs, but often includes:[95]

- Types of FGM, reasons for the practice, and its sociocultural, historical, and religious context.
- Existing government laws, policies, and directives on the practice.
- Prevention, identification, and management of FGM complications.

[92] MEASURE DHS CD-ROM 2005; Njue and Askew 2004, MYWO/PATH 2000
[93] MEASURE DHS CD-ROM 2005. Data for Egypt are from 2000 DHS.
[94] GTZ 2001
[95] Guidelines exist for obstetrical and gynecological care for women who have undergone FGM. See Toubia 1999, Mwangi-Powell 2001, WHO 2001a, WHO 2001b, WHO 2001c.

- Health education strategies, including behavior change communication and counseling techniques to help clients abandon the practice.
- Appropriate documentation of FGM in clinical records and health information systems.

Evidence demonstrates that training programs should be participative and interactive, using case studies, simulations, and discussions (*see example in Box 6*) and reinforced by gender-responsive and culturally-sensitive job aids (e.g., checklists), IEC materials, and ongoing supervision.

Box 6: Case study for discussion among medical practitioners

Mrs. Piego is a 20-year-old who comes to the labor ward with a family member complaining of contractions for the last five hours. From her antenatal records you note that she is full-term and also that she has undergone type 3 FGM (infibulation). It is your responsibility to admit her and to monitor her labor.You need to develop a care plan for Mrs. Piego that takes account of the importance of reducing the risk of complications during labor and delivery associated with type 3 FGM.

Source: WHO 2001c: 115

In Mali, PRIME II, a partnership of leading global health care organizations funded by USAID, recently conducted training to improve providers' knowledge, skills, and awareness related to FGM. In collaboration with the Ministry of Health and a local NGO technical working group, PRIME II developed and tested a national FGM curriculum, which was used to train 120 reproductive health care providers in Bamako Commune I and in Bougouni and Koulikoro districts. The curriculum was part of an FGM resource package for providers that included job aids and a 35-minute video designed to help providers understand and identify complications from FGM.

The training was found to increase the quality of reproductive health services in the three project sites and, specifically, led to the following results: [96]

- Providers were three times more likely to ask pregnant women if they had FGM complications that might affect birthing.
- The mean number of FGM complications treated onsite increased by 26%.
- Nearly three-quarters of providers passed the counseling skills performance test, up from 12% at baseline.
- At the end of the intervention, the proportion of clients reported to be in favor of abandoning FGM rose from the baseline of 44% to 89%, while the reported proportion of clients intending to have their daughters cut declined from 70% at baseline to 52%.

There are still many countries, however, where training curricula for health professionals do not include FGM. It is essential that updated FGM curricula[97] are shared publicly, and that funds are provided to support the local development and adaptation as well as regular review for continuous improvement of these materials.

[96] Newman and Nelson 2003
[97] WHO 2001c; Newman and Nelson 2003; Diop, Traore, Diallo, et al. 1998; Mwangi-Powell 2001

Evidence demonstrates that health workers also need support from the central level, including directives from the government or Ministry of Health. For example, in 1999, the Kenyan Ministry of Health launched a National Plan of Action for the Elimination of Female Circumcision in Kenya. In 2001, the Ministry circulated a policy directive making FGM illegal in all health facilities.[98]

The continued practice among medical professionals in western Kenya suggests, however, that national directives alone are not enough—nurses and midwives have been found to take leave during the school holidays to open temporary "clinics" for FGM for financial reward. Education on existing policies and laws is needed so that health workers and other community leaders understand and can discuss FGM, promote its abandonment, and support those who oppose FGM.[99]

Mechanisms at the facility level are also required to detect medical professionals and facilities (including seasonal clinics) that perform the practice, as are punitive measures (e.g., suspending medical licenses, imposing fines, and closing facilities). For example, countries such as Burkina Faso, Ghana, Kenya, and Senegal have enacted specific laws outlawing FGM with varying degrees of punishment, which can include imprisonment, fines, and/or the suspension of medical licenses and closing of facilities. In Egypt, parental consent does not relieve a physician of liability (*see also Section 5, "Abandonment approaches/Legal approach").*[100]

Lessons learned:

- Health workers can play a role as change agents when provided with quality training beyond just health—including the cultural, sexual, legal, human rights, and ethical dimensions of FGM.
- Choosing the right health care providers to be trained as change agents is key. To be persuasive, such individuals need to be trusted and believed and to have a good understanding of the cultural context in which they work.
- Attention should be paid to training health care and paramedical workers at all levels, from obstetricians/gynecologists and pediatricians, nurses and midwives, down to community health workers and community-based distributors.
- Training health workers should be part of wider strategies to involve community stakeholders (e.g., community leaders, teachers, religious leaders, women's groups, youth peer educators, and traditional healers) in evaluating the costs and benefits of continuing or abandoning FGM.

Training and converting circumcisers

Efforts have been made over the past 10 to 15 years to educate circumcisers about the health risks associated with cutting and to provide them with alternative means of income that would make it possible for them to abandon FGM.

[98] Njue and Askew 2004: 3
[99] Njue and Askew 2004
[100] Cook, Bernard, Fathalla 2003

In countries including Burkina Faso, Ethiopia, Ghana, Kenya, Mali, Senegal, and Uganda, most conversion strategies have included at least one of several phases: [101]

- Identifying circumcisers and educating them about various issues related to FGM.
- Training circumcisers as change agents and motivating them to inform the community and families that request FGM about its harmful effects.
- Orienting them toward alternative sources of income and giving them resources, equipment, and skills with which to earn a living. For example, in Ghana, circumcisers were trained to become traditional birth attendants. In Ethiopia, circumcisers were provided instruction in sandal-making and bread-baking.[102]

An evaluation of unsuccessful conversion strategies by various NGOs in Mali found that: [103]

- There was no awareness campaign for the general public, meaning that the supply of circumcisers was reduced, but not the demand.
- Parents continued to seek out other (non-converted) circumcisers, sometimes from as far away as Burkina Faso.
- The new income-earning activities addressed the economic benefit of performing FGM but not the community recognition that accompanied their work.
- Circumcisers were often subject to certain caste rules and therefore felt they had no ability to decide their occupation.

The study also found that those who *had* stopped performing FGM typically did so for two reasons: they were retiring due to old age, poor eyesight, or replacement by their daughter, or they had the promise of income from alternative activities.

Lessons learned:

- While conversion efforts may—at best—get a few individual practitioners to stop performing FGM, they have no effect on demand. As Toubia explains, "this approach in relation to a service that is in high demand may benefit the supplier but may not improve the overall situation since the same suppliers may continue despite alternative training or, even if they stop, other suppliers will step in to fill the demand."[104]
- Income generation and loan programs to convert circumcisers are not cost-effective, as they require long-term resources and commitment.
- Conversion efforts need to be accompanied by extensive, community-based awareness campaigns that address the community as a whole and promote community consensus to abandon the practice.

[101] Diop, Traore, Diallo, et al. 1998; WHO 1999
[102] Armstrong 1991
[103] Diop, Traore, Diallo, et al. 1998
[104] Toubia 1998: 47

Alternative rites approach

Offering alternative rites of passage, without cutting, is an acknowledgement of the original purpose of the tradition of FGM, namely to celebrate the rites of passage of girls into womanhood. Traditionally, these rites met a number of individual and community needs, including introducing girls to their responsibilities as community members, educating them on their future roles as wives and mothers, and teaching them about sexuality and motherhood. Moreover, they were an occasion for family and community cohesion and celebration.

Alternative "healthy initiation celebrations," "circumcision without cutting" and "circumcision with words" are strategies that have been pioneered in Kenya (by PATH in collaboration with the community-based women's group, Maendeleo Ya Wanawake Organization (MYWO)) and developed in Uganda (the Reproductive Education and Community Health (REACH) project) and the Gambia (by the Foundation for Research on Women's Health, Productivity, and the Environment (BAFROW)).

In Kenya, a baseline study was conducted in 1996 in four districts reputed to have high FGM prevalence. While the project staff envisioned the development of alternative coming-of-age ceremonies as a logical outcome, they recognized that first a) the community would need to be engaged in a thorough examination of its values, norms, practices, and fears; and b) awareness would need to be raised among local policymakers, community leaders, parents, and girls themselves about the harmful health and social effects of the practice.

The approach was thus developed with three phases including:

- Community sensitization.
- Seclusion of the girls for life-skills education.
- Community celebration of the girls' new status as young women.

The girls, parents, grandmothers, and community leaders who were committed to the approach decided on the particulars.

During *community sensitization,* awareness was raised about human rights, gender roles, and the health implications of FGM. In Kenya, women peer educators, recruited through MYWO, initially formed the core of the outreach strategy. Later, youth and men were also included as peer educators. Target audiences were prioritized according to: who makes the decisions about FGM, the age at which it occurs, and the level of opposition to abandonment efforts. For example, where girls are cut before the age of 12, it is mainly the parents who make the decision, whereas in communities where the girls are cut at older ages, they themselves have some say in the decision.

In Kenya, girls were traditionally secluded after they had been cut, to give them time to heal as well as to receive instruction. S*eclusion of girls* continued in the MYWO/PATH project to allow for some instruction. For example, in Meru—where the alternative rites-of-passage project was first initiated—mothers decided that their daughters should have a one-week instruction, guidance, and counseling period during which they would receive modern life skills and traditional wisdom. As such, girls were trained in decision-making, hygiene, relationships (with parents, the opposite sex, peers, elders, and so on), dating, courtship, peer pressure, reproductive anatomy, sexually transmitted infections and how to prevent them, harmful traditional practices, and myths about FGM. The project also created opportunities

for girls to discuss traditional wisdom with their grandmothers and aunts and to prepare songs and dramas promoting the abandonment of FGM for their coming-of-age celebrations.

The last phase, the *ceremony and celebration,* included feasting, gift giving, and presentation of certificates. The first alternative-rite ceremony was attended by 500 people and was held in the District Chief's compound. The press covered the ceremony extensively, considerably raising awareness of the approach.

Since the initial ceremony in Meru, the alternative rites-of-passage approach has gained community acceptance. In the first five years of the project, nearly 5,000 girls participated. Encouragingly, none of the girls who had participated had been excised and they seemed motivated to recruit others.[105] The Kenya Ministry of Health has since replicated this alternative rite in new areas such as the Transmara district in collaboration with the German government-owned German Technical Cooperation Organization (Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ)).[106]

In the Gambia—where over 70% of the girls and women have undergone FGM—the practice has traditionally been conducted in a context of secrecy, and excision is seen as empowering girls in their transition to womanhood.[107]

BAFROW in 1996 began working with local communities on an alternative rites project, beginning with participatory baseline studies focusing on the Western and Central River divisions of Gambia. The baseline information provided knowledge on the nature, prevalence, justification, and factors contributing to the continuation of FGM. This information was shared with community leaders who were expected to participate in the design and delivery of the new rite of passage. BAFROW also conducted awareness-raising projects that targeted women, youth, religious leaders, and local chiefs.[108]

BAFROW then formed a 30-member technical advisory committee comprising health workers, religious and community leaders, circumcisers, and local government officials. The purpose was to develop alternative rites of passage that emphasized girls' health, girl's rights as individuals, community responsibilities, and religious education. Next, 200 religious scholars from around the country attended a two-day workshop to debate issues of religious obligations and FGM. The outcome was the establishment of a committee of religious leaders to support BAFROW efforts. Then, 35 administrative-district-level chiefs, 50 village heads, and numerous local government officials attended a workshop to plan implementation of the alternative rites curriculum. Former circumcisers were trained as village health promoters and as official facilitators of the new rite-of-passage curriculum. Permanent sites were built in targeted districts for new rite-of-passage ceremonies so that communities would have a place to celebrate their culture and traditions.[109]

An evaluation of the project found that, in Niamina District, 92 girls were cut as part of their initiation ceremonies in 1996, compared with only 12 girls in 1997. In Fulladu District, 412 girls were cut in initiation ceremonies in 1996, compared with 190 girls in 1997. Attitudes

[105] Folsom 2003
[106] GTZ 2000
[107] ICRW and CEDPA 1999
[108] ibid.
[109] ibid.

were also found to have been influenced—after the project, 78% of women surveyed were in favor of abolishing FGM, compared to 30% to 40% in 1996.[110]

Results suggest that this approach is clearly an option when FGM is practiced as part of an initiation. However, in some countries, for example, in Somalia, FGM is not considered a rite of passage and girls are now being cut between the ages of five and eight, often within their own homes.[111] In such situations, developing alternative rituals may not be effective in promoting the abandonment of FGM.

Lessons learned:

- Alternative rites approaches have been successful because of their comprehensive nature—from preliminary discussions on the practice with a wide range of stakeholders, to the tradition of the seclusion hut (without the cutting), to the community-wide graduation ceremony.
- Alternative rites approaches are effective in communities where girls are initiated during adolescence through coming-of-age- rituals; further evaluations are required of programs adapted for communities where girls are excised at an earlier age.
- While the approach targets girls, it must also involve parents (both men and women) and village leaders to ensure support, appropriateness, and feasibility.
- The alternative rite can promote family dialogue on sexuality and can be an entry point for life-skills education in rural communities.

Positive deviance approach

This approach identifies individuals who have challenged or "deviated" from societal expectations of FGM by abandoning the practice, urging others to do so, or publicly declaring their opposition to the practice. Such individuals can then act as powerful advocates and role models to encourage others to do the same. They include mothers, fathers, older sisters, grandmothers, traditional birth attendants, circumcisers, doctors, community leaders, priests, imams, teachers, and officials.

The approach was pioneered in Egypt by the Center for Development and Population Activities (CEDPA). CEDPA/Egypt, in collaboration with local NGOs including the Coptic Organization for Services and Training (COST), Manshiet Nasser, the Center for Egyptian Women's Legal Assistance (CEWLA), and Caritas, piloted a project from 1998 to 1999 to understand the factors that support the promotion of FGM. The team found that positive deviants existed in every community and could effectively be used as educators and advocates.[112]

In the pilot project, CEDPA/Egypt identified nine positive role models; with these individuals and local NGOs, CEDPA/Egypt conducted orientation workshops focusing on the practice of

[110] Ibid.: 2
[111] World Bank 2004
[112] CEDPA 2005

FGM, past efforts to address the issue, and an overview of the positive deviance approach. Additionally, role models were interviewed about:

- Their opinions on and their personal experience with FGM.
- Specific reasons or events that led to their rejection of FGM.
- Conflicts that arose within their families when the choice was made to stop FGM and how they dealt with the difficulties encountered.
- What advice they would provide on FGM to family and friends.
- Ideas for community-based strategies to end FGM.
- The role, if any, that they can see themselves playing in promoting the abandonment of FGM.
- Awareness of other community members not practicing FGM and the possibility of introducing them to the interviewer or NGO staff.

CEDPA/Egypt also provided training on effective communication skills, and interviewing and information recording techniques.

The information collected through interviews with role models became the foundation for proposed strategies and activities to abandon FGM in participating communities. From 1998 to 2001, CEDPA implemented positive deviance programs in collaboration with local NGOs in Cairo/Giza, Beni Suef, and Minya governates. Under the project, role models made 2,607 visits to the parents of 1,033 girls at risk of being cut. Nearly three out of four families (73%) visited declared that they would not have their daughters cut. Community groups provided ongoing monitoring of the girls, since a girl in Egypt cannot be categorized as "no longer at risk" until she is married.[113] Other positive outcomes of the project included:

- Open discussion about a formerly taboo subject.
- Increased opportunities for women to speak more publicly.
- Development of local approaches to the abandonment of FGM instead of top-down directives.

CEDPA/Egypt expanded the model, combining a positive deviance strategy with social mobilization—building community support through advocating to leaders, broadening community participation in meetings and other events, and developing networks of supporters. This expanded model was implemented in 2003 and 2004 under the USAID-funded Towards New Horizons Project in Assiut, Qena, Sohag, and Minya governments with additional funding from UNICEF and is currently implemented in 42 communities.[114] Further evaluation results are pending.

Lessons learned:

- Understanding why positive deviants abandon the practice, urge others to do so, or publicly declare their opposition to the practice enables the design of more effective approaches to FGM abandonment in communities.[115]

[113] McCloud, Aly, Goltz 2003
[114] ibid.
[115] Masterson and Swanson 2000

- The positive deviant approach strengthens collaboration and capacity and creates new advocates for the abandonment of FGM.
- The strength of the positive deviant approach lies in the understanding that the solution to a problem already exists in a community and that building community support for the abandonment of FGM is key.

Comprehensive social development approach

The comprehensive social development approach aims to bring about social change through guided processes that involve learning and consensus building. Social injustices—including the practice of FGM—are addressed in specific cultural contexts and stakeholders are given the opportunity to come to the forefront and raise concerns that are pertinent to them. Fatima Ibrahim, a Sudanese activist, captures this holistic approach towards abandonment:[116]
"Our main goal in the [Sudanese] Women's Union since its founding in 1952 has been to ameliorate social injustice towards women. We also attempted to create avenues to full political participation, literacy, legal rights, health care, and equality. In light of these goals we thought practices such as circumcision would end when women are able to enjoy full equality in economic, political, family rights, and decision making in and out of the home. Once these demands are met, women will be able to halt the practice."

An NGO called Tostan, meaning "breakthrough" in the Senegalese language of Wolof, is also using this approach. The program aims to "contribute to the human dignity of African people through the development and implementation of a non-formal, participatory education program…provid[ing] learners with the knowledge and skills to become confident, resourceful actors in the social transformation and economic development of their communities." The program integrates FGM into a wider learning package that includes modules in national languages on a range of issues such as human rights, project planning, women's empowerment, hygiene, health, and other subjects relevant to the community.

The social development model is based on public discussion and dialogue and the precept of "people coming together to decide who they are, what they want, and how they will obtain what they want."[117] The Tostan educational program is reportedly successful because it:[118]

- Provides basic education vital for empowering villagers.
- Uses participatory teaching methods based on African traditions, for example, theater, songs, and the sharing of personal experiences.
- Encourages dialogue between generations and dialogue between men and women on the practice.
- Involves religious and community leaders who can address Islam's position on the issue.
- Makes people aware of alternatives (i.e., not everyone excises their daughters).

Once communities have collectively made the decision to abandon the practice, a public declaration follows in which the communities pledge to end the practice of FGM. Often these

[116] Abusharaf and Halim 2000
[117] Figueroa, Kincaid, Rani, Lewis 2002: 4
[118] Tostan 2005; Creel, Ashford, Carr, Roudi, Yinger 2001

declarations include multiple, intermarrying villages, because, as the imam of Kër Simbara, in Senegal, explains, *"We are part of an intermarrying community, and unless all the villages involved take part, you are asking parents to forfeit the chance of their daughter getting married."*[119]

Since 1997, more than 1,500 communities in Senegal have made public declarations to abandon FGM, representing 32% of the 5,000 communities that practice FGM.[120] A replication of the Tostan program in Burkina Faso also led to public declarations in intervention communities, involving 66% of female and 74% of male program participants.[121] Public declarations have also been used in other countries such as Kenya, with the MYWO/PATH alternative-rites program.

Public declarations are seen to be pivotal, as they support social rather than individual change. They enable people to collectively agree to halt the practice so that no one family stands out or no one person becomes socially stigmatized, and thus, unmarriageable.[122] They also serve as recognition that "FGM is a collective cultural pattern with benefits and sanctions anchored in a broad system of social behavior."[123] Finally, while public declarations are promising, monitoring and follow-up are required to ensure that declarations are also followed by widespread abandonment of the practice.

Lessons learned:

- Abandoning the practice of FGM demands not only individual change but also social change.
- The social development approach can lay the foundation for consensus-based decision-making that can bring about social change.
- Public declarations are an important part of encouraging dialogue about FGM, resolving conflicts, and building consensus.
- Interventions to promote the abandonment of FGM are more successful when they take place within the context of sustained efforts to support gender equality, the empowerment of women and girls, and the development of communities.

6 Abandonment programs—key stakeholders

Regardless of the approach employed, efforts must address a range of community stakeholders, including government officials, religious leaders, youth, teachers and education sector staff, men, health workers, and traditional circumcisers.

[119] Easton and Monkman 2001
[120] Tostan 2005
[121] Diop, Faye, Morea, et al. 2004b: 43
[122] Mackie 1998
[123] Easton 2001

Government officials

While most FGM abandonment programs focus on interventions at the local level, advocacy with government leaders is important to create support for FGM abandonment through strong policies, laws, and resources. Government leaders can also ensure that FGM abandonment is incorporated into national and sectoral health, education, and development plans.

In Kenya, political leaders indicated that they were willing to advocate against FGM provided that they were supported with correct information, particularly regarding its adverse effects. They also considered themselves to be vital in ensuring that government laws were enforced at the community level.[124]

To ensure that government officials have the information required to make evidence-based decisions and investments, FGM abandonment programs need to be able to effectively communicate research and program results. The Population Reference Bureau (PRB) has supported "policy communications training" for researchers, program officials, and policy advisors from Benin, Burkina Faso, Côte d'Ivoire, Democratic Republic of the Congo, Egypt, Ethiopia, Gambia, Guinea, Kenya, Mali, Nigeria, Senegal, Sudan, and Togo. During this training, participants identify the policy and program implications of available information, understand how research findings and information can influence policies and programs related to FGM, explore how to present sensitive information using culturally appropriate messages, and learn to communicate these messages in simple and compelling formats to policy audiences.[125]

In the Nyamira District of Kenya, the Seventh Day Adventist Rural Health Services have worked with PATH to mobilize health care providers and community leaders to endorse FGM interventions. Subsequent formative research identified the knowledge about, attitudes toward, and practices of FGM in the community. This information was then disseminated to community leaders and local government administrators to ensure support.[126]

Religious and community leaders

As respected figures, religious and community leaders have considerable power to guide the opinions of their communities and bring about the attitude changes necessary for abandoning FGM.

"Whatever is said in Islam is what I will abide [by]. I don't see any need to contradict with religion. If the religious scholars have resolved the issue and say we [must] obey [the] laws, so be it.

-FGM practitioner,
North-Eastern Kenya

Source: Jaldesa et al. 2005

The involvement of religious leaders is particularly important in communities in which there is a strong belief that FGM is performed to fulfill religious requirements. Here, the most effective advocates are religious leaders because they can contest the authenticity of sayings attributed to religious texts and thereby begin to unlink the practice from religious requirement. Religious leaders are also well placed to urge "communities and girls to aspire to sexual modesty and abstinence in ways other than FGM and boys can also be

[124] Jaldesa, Askew, Njue, Wanjiru 2005: 22
[125] PRB's policy communications training programs have been held regionally in Ethiopia (2003) and Burkina Faso (2005) in collaboration with CARE/Ethiopia, the National Committee on Traditional Practices of Ethiopia (NCTPE), and Mwangaza Action in Burkina Faso
[126] PATH and MYWO 2000

taught to restrain themselves; such that concerns about virginity and health are ensured"[127] (*see also Section 4, "Rationale for FGM/Religious beliefs"*).

A number of FGM abandonment programs have included religious leaders in their activities, providing information, training, and strategic planning skills to enable them to carry out outreach through sermons, prayer time, and religious events.

For example, CARE has worked with religious leaders in Ethiopia and Sudan to support them to be advocates for change. In Ethiopia, project staff organized a four-day seminar with local religious leaders to review the position of religious texts on FGM. At the conclusion of the meeting, religious leaders reached a consensus that there was no religious recommendation related to FGM; as a group, they committed to informing communities. During subsequent community activities, more than 58 imams advocated for the abandonment of FGM.[128]

In Sudan, CARE supported religious leaders to make public speeches condemning the practice and established mobile theaters depicting religious views on FGM and its related harmful effects. They also held mixed-media events in communities including drama and a video depicting a well-known imam's view on FGM. After the show, village religious leaders held public discussions and answered questions on FGM.[129]

In Mali, although activists have underscored the importance of facilitating dialogue with religious leaders, they acknowledge the need to tread lightly when working to change Islamic leaders' views on FGM and religion. A recent evaluation of efforts undertaken over the last 20 years to promote the abandonment of FGM in Mali underscored that activists should encourage religious leaders to explore for themselves the Koran's position on FGM and to discuss their findings with others, rather than telling leaders what the Koran does or does not say. It also found that it is best not to press leaders to make public stands against the practice, but rather to simply ask that they refrain from blocking efforts to encourage abandonment of the practice.[130]

Efforts to stop the practice of cutting in Christian communities are often part of ongoing opposition to all harmful traditions. For example, the Coptic Evangelic Organization for Social Services (CEOSS) in Egypt—the first NGO to address FGM issues in the country—established "local leaders" committees made up of an *omda* (mayor), a sheik, and a Coptic priest. Leaders worked with program implementers to introduce girls aged 7 to 13 to issues regarding health and literacy, followed by the sensitive topic of FGM. A review of the program found that CEOSS had succeeded, over seven years, in reducing the rate of FGM in 8 of the 22 communities in Minya Governate, leading to an FGM abandonment rate of over 70% in these villages.[131] Now implemented in Muslim communities, the program has not yet duplicated the same levels of success.

Youth

Young men and women play an important role as target audiences and implementers of FGM abandonment programs. Young men need to be involved in order to change attitudes about the need to marry girls who have undergone FGM. Young women must be involved because not

[127] Cook, Bernard, Fathalla 2003
[128] Rajadurai and Igras 2005
[129] ibid.
[130] PATH 2005
[131] WHO/PATH 1999

only are they at risk of being cut, but they have also demonstrated repeatedly (particularly in urban areas) that they are more open to discussion, less committed to traditions, and more open to change than their older counterparts.[132]

Outreach activities for this group can be carried out through formal and informal education programs. Approaches that have been used by different FGM abandonment programs include integrating FGM into school curricula as part of life skills education, developing out-of-school activities (including FGM abandonment clubs), and training youth as peer educators.

In Kenya, MYWO and PATH supported the integration of FGM into life skills education and also supported extracurricular activities including the development of dramas to support girls' rights, as well as songs and poems with FGM abandonment messages. In some cases, schools even stayed open during the holidays—the peak season for cutting—so that girls who were trying to avoid being cut would have somewhere to go.[133]

The project also made extensive use of peer educators. At first, women were trained about the health and human rights issues surrounding FGM and trained in peer education, communication, counseling, decision-making, and conflict-mediation skills. Later youth and men were also included as peer educators.[134] Notably, peer educators require ongoing support, supervision, and motivation in order to continue their activities successfully.

Teachers and education sector staff

Teachers play an important role in developing students' capacities to think, understand, and learn, as well as helping them to develop self-confidence and decision-making skills. Teachers, school headmasters/mistresses, and other educational staff can also support the integration of FGM into school curriculum when they are provided with teacher training, educational materials, and adequate support and supervision.

In Kenya, most girls are cut at school-going age, so teachers are in a good position to influence and address the practice of FGM. PATH/Kenya, in collaboration with several international organizations, developed an FGM curriculum for teachers, trainers, and adult education specialists.[135] This curriculum was used to train teachers on how to address FGM in the classroom, to stress the importance of girls' education, to instruct students on how to communicate with parents and how to withstand social pressure. Similar efforts were also undertaken in Ghana by CEDPA to support teachers to sensitize students to the negative consequences of FGM, form FGM clubs, and sensitize parent and teacher association members.[136]

In Burkina Faso, GTZ is supporting the integration of FGM into primary and secondary school education. In a pilot project implemented from 2001 to 2002, modules on FGM were designed for primary and secondary school teachers, as well as education materials for a number of disciplines including French, history, geography, biology, and social and family economics. A sensitization campaign accompanied the launch of the materials and targeted

[132] GTZ 2001; Creel, Ashford, Carr, Roudi, Yinger 2001
[133] PATH and MYWO 2000
[134] ibid.
[135] PATH and MYWO 2000
[136] Owusu-Darku [no date]

parents of the children attending the pilot schools. To prepare the teachers, a seminar and a training workshop were held, addressing:[137]

- Perceptions, causes, and consequences of FGM.
- Methods for clarifying value systems and resolving conflicts.
- Group motivation techniques.
- Methods for evaluating changes in knowledge, attitudes, and behaviors related to FGM.

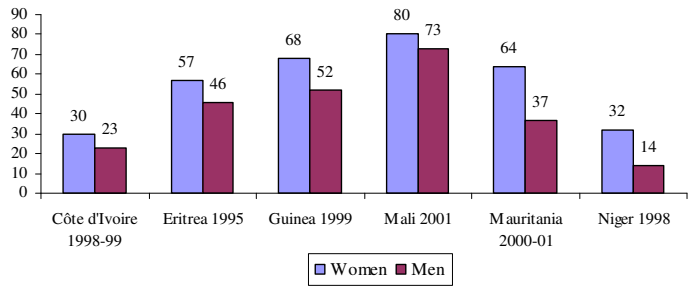
A total of 7,900 pupils benefited from the teaching; the program is currently being scaled up in selected districts.

Men

While men have not always been the targets of abandonment interventions, their involvement is critical in encouraging the abandonment of FGM. As husbands, fathers, and community leaders, men influence the decision to continue or abandon the practice.

Interestingly, DHS data from multiple countries demonstrate higher proportions of men than women favoring abandonment of the practice (*see Figure 8*). Among these countries, the greatest differences can be observed between men and women in Mauritania and Niger. Yoder, Abderrahim, and Zhuzhuni[138], however, caution against a hasty interpretation of these data. These differences, the authors explain, may be due to:

Figure 8: Percentage of men and women who say FGC should continue



Source: Yoder, Abderrahim, Zhuzhuni 2004:44

- Belief that the daughter's cutting is the responsibility of women, with men playing a more peripheral role in planning and related activities.
- Increased access among men to abandonment messages due to greater exposure to media and political life.
- Higher levels of education among men.

Whatever the reasons, qualitative studies in Mali and Burkina Faso by the Population Council indicate that men recognize that the practice will not be abandoned without their involvement. In Burkina Faso, fathers were reported by both men and women to play a critical role in determining whether to have a daughter cut. For example, 89% of men and 88% of women reported "fathers" having a role in the decision—compared to only 46% of men and 38% of women reporting "mothers" having a role.[139] A qualitative and quantitative study of FGM knowledge, attitudes, and practice of men in two districts in Kenya also found a willingness among men and boys to participate in abandonment activities.[140]

[137] GTZ [no date]
[138] Yoder, Abderrahim, Zhuzhuni 2004
[139] Population Council/Africa OR/TA 1999: 87. Similar findings were also reported, more recently, in Diop et al. 2004a
[140] PATH, FORWARD, MYWO 1999

Tostan projects in Senegal and Burkina Faso[141] and the REACH project in Uganda provide examples of the successful involvement of men. In both projects, traditional male leaders, after becoming sensitized to the harmful effects of FGM, have been engaged to advocate for the abandonment of the practice in their communities.

In Tostan, the inclusion of male religious leaders in the structured educational programs and village forums has enabled men to agree collectively with women to stop the practice in numerous locations. Since 1997, more than 1,500 communities in Senegal have made public declarations to abandon FGM, representing 32% of the 5,000 communities that practice FGM.[142]

In the REACH project (funded by the United Nations Population Fund (UNFPA)), members of the Sabiny Elder's Association and clan leaders were sensitized to the harmful effects of FGM. Initially, elders were shown through a cost-benefit analysis that FGM was not good for their community. They were then encouraged to make a declaration denouncing FGM. The Sabiny elders themselves proposed replacing FGM with symbolic gift-giving and other festive activities. Between 1994 and 1996, FGM declined by 36%. However, subsequent years showed a resurgence of the practice.[143]

To address this resurgence, REACH staff broadened the base of those included in the project to include other stakeholders, including Sabiny elders, women, youth, religious leaders, traditional birth attendants, and government officials. The project was redesigned and implemented with the participation of all the stakeholders to ensure culturally acceptable strategies and messages.

The REACH project has had several important achievements, including: [144]

- Increased community support for and commitment to abandoning FGM.
- More open dialogue on FGM and reproductive health.
- Increased involvement of adolescents in awareness-raising among their peers about the harmful effects of FGM.
- Greater demand for information on FGM and its associated effects.

Evidence has shown that involving men is critical to initiating community-wide understanding for social change. However, this participation must be structured in close collaboration with women at all stages, from project design to implementation and evaluation.

Health workers

The involvement of health workers as allies in efforts to abandon FGM has been discussed extensively earlier (*see Section 5, "Abandonment approaches/Training health workers as change agents"*). Their inclusion cannot be overemphasized, as they have an important role as allies in efforts to abandon the practice and as caregivers for women and girls who have experienced negative consequences.

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[141] Diop, Ouoba, Congo, et al. 2004a; Diop, Faye, Morea, et al. 2004b
[142] TOSTAN 2005
[143] Creel, Ashford, Carr, Roudi, Yinger 2001: 23–24
[144] ibid.

Involving health workers as stakeholders, however, often requires a behavior change among health workers themselves. Many health care providers may support the practice, and in some cases may be performing FGM. For health workers to be able to promote the abandonment of FGM among their clients and the wider community, they themselves need to be targeted for sensitization and behavior change campaigns and to be supported over the long term.

Traditional circumcisers

Although efforts to train and convert traditional circumcisers have largely been unsuccessful (*see Section 5, "Abandonment approaches/Training and conversion of circumcisers"*), traditional circumcisers cannot be ignored by FGM abandonment programs. Tostan, for example, has included them in community-based education programs to promote discussion about FGM and to support them to publicly decry the practice. Some traditional circumcisers have become active advocates for Tostan.

In 2004, Equality Now convened the first international meeting of former circumcisers, including nine women from six African countries (Djibouti, Gambia, Guinea-Conakry, Kenya, Mali, and Tanzania) who are now campaigning to abandon the practice. Equality Now's Fund for Grassroots Activism to End FGM has found that supporting traditional circumcisers to work as activists can help encourage others to "lay down their knives."[145]

7 Abandonment programs—key supporting elements

Research

Much of the research undertaken to date on FGM has been quantitative (e.g., proportion of women aged 15 to 49 who have undergone FGM) although there is a growing body of qualitative research providing essential information on communities' values, beliefs, and practices. Recently, a variety of research has been undertaken to inform the development of FGM interventions. The following list provides an introduction into relevant study designs, with accompanying examples:

- Some research is purely descriptive, such as case studies of ongoing and completed projects. For example, a study in Egypt by the Population Council reviewed case studies of several different interventions and synthesized the findings in a comparative analysis.[146]
- In Kenya, a post-intervention assessment was undertaken at the end of an alternative rites program to compare the characteristics of those families who participated in the program and those who had not.[147]
- CARE International has used a pre-post intervention evaluation design in its programs in the Daadab refugee camps for displaced Somalis in northern Kenya. In this case, a baseline survey measured pre-intervention attitudes and an endline survey measured post-intervention attitudes. This study compared communities receiving two types of interventions with a community receiving only one type of intervention. This evaluation

[145] Equality Now 2004
[146] Abdel-Tawab 2000
[147] Chege, Askew, Liku 2001

design enabled researchers to determine the extent to which particular combinations of interventions have caused greater changes compared to one intervention.[148]

- In pre-post control evaluations, studies compare communities receiving an intervention and those not receiving it, at pre-intervention and post-intervention measures. An example of this is a Population Council study of the Tostan program in Senegal.[149] In this study, women and men participating in the program were interviewed before and after the intervention, and again two years later, to measure their awareness, attitudes, and behaviors related to FGM. A group of women from 20 similar villages that did not receive the program were interviewed at the same time to serve as a comparison group.
- In operations research studies, researchers identify problems and test new programmatic solutions to these problems by 1) identifying and diagnosing the problem; 2) selecting the strategy; 3) experimenting with and evaluating the strategy; 4) disseminating the information; and 5) using the information.[150] In pre-post control operations research studies, researchers use the same methodology to compare communities that receive an intervention and those not receiving one, both before and after the intervention. In Population Council's operations research study in Burkina Faso,[151] community-based education programs were implemented in a select set of locations and compared with similar comparison villages in which no programs were in place. Pre- and post-intervention assessments enabled researchers to monitor changes in knowledge, attitudes, and practices.
- CARE International's two-intervention control evaluations in Sudan and Ethiopia compared the effect of a targeted activity in one set of communities with a combined intervention in another. The matching communities were believed to be very similar, apart from not receiving interventions during the research period.[152]
- In Navrongo, Ghana, a randomized control trial was used, during which three high-FGM-prevalence areas were randomly assigned intervention strategies. The relative effectiveness of each of the three interventions was then tested and compared.[153]

Monitoring and evaluation

Systems to monitor and evaluate progress are part of WHO's four essential steps for a successful program:[154]

- Carry out baseline research (both qualitative and quantitative).
- Build in monitoring of the implementation process.
- Add new information by carrying out operations research.
- Carry out evaluations based on baseline indicators.

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[148] Population Council 2002. For more information on the project see www.careinternational.org.uk/cares_work/where/kenya/stories/changingtraditions.htm (Accessed September 19, 2005).
[149] Diop, Faye, Morea, et al. 2004b
[150] See www.popcouncil.org/frontiers/ordefined.html
[151] Diop, Ouoba, Congo, et al. 2004a
[152] Population Council 2002
[153] Nazzar, Reason, Akweongo, Sakeah 2000
[154] WHO 2000

The past two decades have seen an increased recognition of the importance of stakeholder participation in developing, implementing, monitoring, and evaluating programs. In Nigeria, Johns Hopkins University's Population Communication Services and Save the Children have been supporting a community mobilization program to abandon FGM. The main activity, called the Community Action Cycle, focuses on strengthening community members' abilities to identify, analyze, and address their most pressing health issues. A core group of community members identifies health priorities, develops action plans to achieve improvements and meet community needs, and monitors and evaluates activities.[155] In Mali, PATH and the National Committee for the Abandonment of Harmful Practices (CNAPN) and local partners used participatory monitoring and evaluation methods to document behavior change, providing new ways to understand, define, and translate the complex process required to end FGM.[156]

Participatory monitoring and evaluation in both Nigeria and Mali have been advantageous to programs as they have:

- Helped create consensus among stakeholders about what works and what doesn't.
- Enabled programs to modify approaches when necessary.
- Focused on how and why change occurs, rather than quantifying change.
- Created greater ownership and commitment to future action among stakeholders.

The Research, Action, and Information Network for the Bodily Integrity of Women (RAINBO) recently conducted through its Review, Evaluation and Monitoring (REM) project a review of indicators currently used to evaluate interventions. The review emphasized linking indicators to models of the stages of behavior change. For example, in a community in which individuals have never questioned the practice because everyone in the community embraces it, a reasonable objective might be getting them to begin to question long held beliefs, seek more information, and think about the alternative behavior of not cutting. This objective would then feed into the development of relevant indicators.[157]

Others have also emphasized that indicators to monitor FGM abandonment approaches should: [158]

- Measure the degree of change that can reasonably be attributed to the intervention.
- Include several layers of measurement (e.g., process, input, output, and outcome indicators).
- Be reviewed periodically for relevance and comprehensiveness.

Training

Training is critical for program implementers to be able to design, implement, and evaluate FGM abandonment programs. While almost all NGOs involved in abandonment activities are carrying out training for their staff and resource persons,[159] there is evidence that further

[155] JHUCCP 2005
[156] PATH 2005
[157] Preliminary findings were presented at the Consultative Meeting on Methodological Issues for FGM Research (see Population Council 2002). See also RAINBO 2003.
[158] Population Council 2002
[159] WHO/PATH 1999

efforts are needed to support participatory learning techniques, communication methods, and behavior change communication.[160]

PATH/Kenya has been providing program implementers, health care providers, and other resource persons with a comprehensive four-week training program entitled "Communication for Change." The training uses a participatory approach to build:

- Capacity in problem solving and value clarification.
- Knowledge and specific skills in communication for behavior change.
- Knowledge and specific skills in interpersonal relationships.

Trainees are also introduced to skills for materials development, program implementation, group negotiation, and counseling for social change.[161]

Materials

FGM abandonment programs require materials (e.g., posters, booklets, anatomy models, and so on) to support their activities. A wide range of materials related to FGM is now available, many of which can be found on the Johns Hopkins Population Information Program's Media/Materials Clearinghouse (www.jhuccp.org/mmc). As a general rule, materials should:

- Be tailored for specific target audiences and pretested to ensure that messages are well understood, responsive to audience needs and concerns, and culturally sensitive.
- Include accurate and current information and nonjudgmental messages.
- Address the context and motives behind the practice, as well as local rumors, myths, and misconceptions.

In a 1999 review of 85 agencies with FGM abandonment programs in Africa, health messages notably dominated IEC and public information activities (*see Table 3*), although the majority (80%) of agencies reported addressing the issue of human rights as well. Efforts were also made to debunk the belief that religion mandates the practice (with messages on Islam made by 64% of agencies, and messages on Christianity made by 48% of agencies). Nearly three in five agencies (57%) reported using messages that address women's sexuality—a topic often seen as taboo in most communities—which bodes well for the demystification of the issue.

[160] Owusu-Darku [no date]; Abdel-Tawab and Hegazi 2000
[161] PATH and MYWO 2000

Table 3: Key messages of 85 organizations with female genital mutilation abandonment programs	
FGM has negative health consequences for women and children	92%
FGM is a harmful traditional practice	81%
Performing FGM with the same instrument may facilitate the spread of HIV/AIDS infection	81%
FGM violates the rights of women and girls	80%
FGM is not required by Islam	64%
Uncircumcised women are marriageable	62%
FGM does not prevent promiscuity	58%
FGM reduces a women's sexual enjoyment	57%
FGM is against Christian teachings	48%
Since girls are circumcised at a younger age, excision as a rite of passage has lost its significance	44%
FGM curtails girl's chances of furthering their education	34%
Other	14%
Source: WHO 1999	

More recently, many organizations have adopted communication materials and interventions that focus not only on changing knowledge and attitudes but also on building skills (e.g., how to respond to pressure to have a daughter cut) as well as community support mechanisms to sustain social change.[162] For example, in eastern and southern Africa, UNICEF has been supporting "communication for social change" approaches that:

- Help community members to create "safe spaces" in which sensitive topics can be discussed.
- Facilitate discussion—or develop the capacity of community members to facilitate discussion—allowing all people to exchange opinions and listen to each other.
- Negotiate collective change by helping community members reach consensus on what should be done.[163]

In Guinea, an innovative project used videos to promote the abandonment of FGM. The "Projet Vidéo Sabou et Nafa" was a collaborative project developed by the New York-based communications group, Communication for Change (C4C), and a Guinean organization, CPTAFE (La Cellule de Coordination sur les Pratiques Traditionelles Affectant la Santé des Femmes et des Enfants).

The project began in 2002 with a workshop for regional teams of trainees that included CPTAFE staff, rural radio journalists, teachers, youth, and several former circumcisers. Participants learned how to use the video equipment; practiced production skills; and critiqued examples of a variety of advocacy videos. The participants, with technical assistants, then fanned across the country with locally purchased equipment and created video productions that included mini-dramas designed to convince families to abandon FGM. A documentary featuring music and poetry was also developed showing former circumcisers how to create alternative livelihoods.

[162] GTZ 2001
[163] UNICEF [no date]; Ford 2005

The playback of these videos by the regional teams in their communities was used as an occasion to facilitate discussions about FGM. The project continues to build regional partnerships for new video productions on a whole range of reproductive health issues.[164]

Advocacy

Advocacy is essential for creating a strong social and political environment to support the abandonment of FGM and for ensuring that programs are established and maintained. A meta-assessment of activities in Egypt found that very few organizations were conducting advocacy activities. Clear definitions of advocacy and a comprehensive understanding of the concept were also absent.[165]

UNFPA has been supporting advocacy efforts aimed at policymakers, parliamentarians, and other decision-makers. This includes, for example, support to: [166]

- The Forum of African and Arab Parliamentarians to advocate for population and development issues, including FGM.
- The Inter-African Committee on Traditional Practices Affecting the Health of Women and Children for information campaigns, research, and advocacy.
- An International Round Table on eradicating FGM at the community level, in collaboration with the International Planned Parenthood Association.

Accurate media coverage helps to desensitize the issue of FGM and encourage dialogue. More than 60% of all groups working to abandon FGM cite collaboration with the media as a program strategy.[167] In Ghana, CEDPA supported radio discussions of FGM in local languages.[168] In Kenya, MYWO and PATH conducted media advocacy programs to build national and community awareness of FGM. Media representatives were specifically trained to broaden their understanding of FGM and invited to project workshops and activities to promote awareness of and interest in the project.[169] In Mali, CNAPN invited journalists familiar with campaigns to promote the abandonment of FGM to share their views on the effectiveness of CNAPN's advocacy efforts targeting policymakers and religious leaders.[170] PRB has also supported training for African program managers and researchers to advocate for policy and program change on FGM through the media.[171]

[164] Communication for Change website: www.c4c.org
[165] Abdel-Tawab and Hegazi 2000
[166] UNFPA website: www.unfpa.org/gender/faq_FGM.htm
[167] Creel, Ashford, Carr, Roudi, Yinger 2001: 27
[168] Owusu-Darku [no date]
[169] PATH and MYWO 2000
[170] PATH 2005
[171] Training workshops were held in 2003 for East Africa audiences and in 2005 for West Africa audiences, with funding from the USAID Global Bureau and USAID's Africa Bureau.

Local media associations, including women's media groups, can be important allies. For example, in Burkina Faso, the Réseau des Journalistes en Population et Développement (RIJOPD) and the Association des Professionnelles Africaines de la Communication (APAC) have been active in supporting public discussion of the issue. In Kenya, the Association of Media Women In Kenya (AMWIK) has been collaborating with the Italian Association for Women in Development across a wide mandate to:[172]

- Raise awareness in Africa, Europe, and beyond on the violation of human rights resulting from the practice of FGM.
- Collect and disseminate information on abandonment programs in Africa and Europe.
- Enhance the capacity of African NGOs to collect and disseminate data and information on FGM through the Internet.
- Foster the role of civil society in monitoring government efforts to eliminate FGM and in holding governments in Africa and Europe accountable for failure to fulfill their international obligations;
- Assess the role of the judiciary system in enforcing legislation prohibiting FGM.
- Support legislative measures with nationwide appropriate information and communication activities.

Sustainable funding arrangements

In a 1999 review of more than 85 agencies with FGM abandonment programs in Africa, more than 85% of respondents identified lack of funding as a "major" or "very important" constraint.[173] While the range of funding sources may have increased since this review due to the increasing number of private foundations supporting FGM abandonment, funding arrangements have largely remained small-scale, piecemeal, and fragmented.

As a consequence, FGM abandonment programs have often had to pull together resources from different funding sources in order to implement projects. This strategy has led to a considerable administrative burden for implementing agencies due to differing procurement and disbursement procedures and reporting systems. The uncertainty or unpredictability of aid disbursements has also undermined effective and efficient budget management and led to discontinued or delayed projects and small-scale initiatives with limited reach.

Programs require sustained and significant levels of financial commitment over the long-term to obtain results. This includes funding not only for materials (e.g., training curricula) or activities (e.g., alternative rites ceremonies), but also for initiatives that may not have immediate demonstrable results (e.g., advocacy to create enabling environments and to support changing social norms) as well as core funding for organizations. Funding agencies can also improve the effectiveness of their aid by harmonizing and simplifying their procedures through common arrangements and procedures and improved coordination.

Implementing agencies, for their part, will need to continue to strategically advocate and mobilize resources and to network and collaborate with one another to reduce the duplication of efforts and to improve the efficiency of programs. Improved monitoring and evaluation systems will also enable agencies to track—and report on—program results.

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[172] Association of Media Women in Kenya website: www.amwik.org/FGM.htm
[173] WHO/PATH 1999

8 Conclusions and lessons learned

Some important lessons can be learned from the experience of national governments, local organizations, and donor agencies in promoting the abandonment of FGM over the past two decades.

First, a number of FGM abandonment approaches have been found to be insufficient or ineffective when implemented alone. For example, approaches aimed at training and converting circumcisers have not been successful because they typically have not addressed community demand for FGM. Similarly, laws criminalizing FGM are alone unlikely to change traditions—to have an impact, they must be complemented by multifaceted programs at the community level. Finally, health risk approaches have, in many countries, led to the medicalization of the practice or shifts to less severe forms of FGM rather than to abandonment of the practice.

The cultural roots and enduring nature of the practice require using more than one approach to changing behavior around FGM. This may include using several different approaches simultaneously—for example, Tostan program components include health education, awareness of social and rights issues, and advocacy activities involving religious and other influential leaders to create support for the abandonment of FGM. It may also include the adoption of different approaches for different stages of an intervention. There is no standard solution that will work in every situation or country or with every target group.

Second, while many approaches have been shown to be effective in raising awareness that FGM has negative health consequences and that not all societies support the practice, these approaches have neither converted this awareness into changed practice nor produced large-scale abandonment of FGM. Communication campaigns have primarily focused on FGM as a "harmful traditional practice," explained why it is harmful (focusing on the health-related consequences), and then tried to persuade individuals to stop it.

Past experience demonstrates that any intervention to promote the abandonment of FGM must take place within the context of sustained efforts to support gender equality and the empowerment of women and girls. This includes programs that improve women's health and well-being overall, including enhancing women's ability to make decisions over their bodies, to be free from discrimination and violence, and to enjoy equal rights on par with men. Beyond the impact that the abandonment of FGM makes on health and well being at the individual level, abandoning FGM also contributes to the achievement of the UN Millennium Development Goals by promoting gender equality, reducing child mortality, and improving maternal health.

For large-scale change to occur, individuals and communities need to decide to abandon FGM through dialogue, shared understanding, and collective will. Programs can support this by creating opportunities for a range of stakeholders to discuss health and development issues, including sensitive issues such as FGM alongside other concerns.

Within these safe environments for reflection and discussion, programs can provide information and facilitate public discussions and debate but they are most successful when they support communities to make informed decisions. Successful interventions were initiated and carried out by local communities, addressed culture, and involved long-term commitment to community consensus and individual and collective empowerment.

Third, to ensure the sustainability of collectively agreed-upon actions, and to prevent stigma and discrimination against individuals who first abandon the practice, programs must focus not only on changing knowledge and attitudes but also on building skills (e.g., how to respond to pressure to have a daughter cut) as well as on building community support mechanisms to sustain the change. This requires that interventions be supported long enough for new behavior to become the norm, requiring resources and program commitment over the long-term from governments, donors, and implementing agencies.

Fourth, although decisions to abandon FGM occur at the individual and the community level, efforts by governments to create an enabling environment for local initiatives are also important. Governments should adopt clear national policies and laws that promote the abandonment of the practice and devote resources to scale up successful programs. Collaboration between sectors should be prioritized across relevant ministries including, for example, Ministries of Health, Education, Family and Social Services, and Information as well as between government and nongovernmental agencies.

Fifth, improved coordination between agencies working on this important issues is required to reduce the duplication of efforts and to improve the efficiency of programs. To this end, donors, governments, and implementing agencies should promote coordination mechanisms and collaborative funding arrangements. However, agencies shouldn't be asked to do more with less—significant additional resources are required to expand the effectiveness and reach of programs promoting the abandonment of FGM.

Experience to date has demonstrated that changes can occur on a small scale and that FGM can be reduced among groups in practicing countries. More work is needed to scale up these results. Future initiatives should build on the experience of programs while further developing or adapting approaches to fit local contexts. Successful and sustainable abandonment of the practice will no doubt be a long and arduous process, but the positive outcomes are immeasurable, including the improved lives and well being of girls and women for current and future generations.

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Appendix 1: FGM abandonment programs and research interventions in Africa

The following list of FGM abandonment programs and research interventions is meant to be illustrative. Inclusion in this table does not imply any judgment or endorsement on the part of PATH. International NGOs and agencies listed in Appendix 2 (Donor and technical assistance for FGM abandonment) are not included here.

ORGANIZATION	GEOGRAPHICAL REGIONS COVERED	CONTACT INFORMATION
Agency for Co-operation and Research in Development (ACORD)	Sudan Five villages, Halaib and Sinkat provinces, Eastern Sudan	ACORD PO Box 986 Khartoum, Sudan Tel: +249-183-244556-8 Email: acousud@hotmail.com
Association de Soutien au Développement des Activités de Population (ASDAP)	Mali	ASDAP BP 951, Rue 876 Porte 29, Faladié Sema Bamako, Mali Tel.+223-2202769/2203843, Fax: +223-2203841 Email: asdap@datatech.toolnet.org
Association Malienne pour le Suivi et l'Orientation des Pratiques Traditionnelles (AMSOPT)	Mali	AMSOPT BP 1543 Bamako, Mali
Association pour le Progrès et la Défense des Droits des Femmes Maliennes (APDF)	Mali	APDF (Association pour le Progrès et la Défense des Droits des Femmes Maliennes) BP 1740 Bamako, Mali
Foundation of Research on Women's Health (BAFROW)	Gambia - Western and Central River Divisions	BAFROW 214/217 Tafsir Demba Mbye Road Tobacco Road Estate, Banjul PO Box 2854 Serrekunda, The Gambia Tel: +220-22-5270 or +220-22-3471 Email: bafrow@gamtel.gm

CARE	Kenya: Dadaab Refugee camps Ethiopia: Awash region Sudan: among the Arabic Dar Hamid people	CARE-USA Senior Program Advisor, Sexual & Reproductive Health 1625 K Street, NW Suite 500 Washington, DC 20006 USA Tel: +1-202-595-2805 Fax: +1-202-296-8695
		CARE-Kenya Project Manager CARE-RAP Dadaab Mucai Road Off Ngong Road PO Box 43864 Nairobi, Kenya Tel: +254-20 2717367 Website: www.care.or.ke CARE-Ethiopia FGM Project Coordinator Afar Female Genital Cutting Eradication Project PO Box 4710 Addis Ababa, Ethiopia Tel: +251 1 538 040/033 Fax: +251 1 538 035 Email: careFGM@telcom.net.et
Caritas	Egypt	Caritas 8 Mostafa Kamel Street Ard Sultan El Minya, Egypt Tel: +202 086 344 174 Fax: +202 086 344 174
Cellule de Coordination sur les Pratiques Traditionnelles Affectant la Santé des Femmes et des Enfants (CPTAFE)	Guinea	CPTAFE 01 BP 141 Conakry, Guinea Tel: +224-278644 Fax: +224-422830

Center for Development and Population Activities (CEDPA)	Egypt, Mali, Nigeria	CEDPA Headquarters 1400 16th Street, NW, Suite 100 Washington DC, 20036 USA Tel: +1-202-667-1142 Fax: +1-202-332-4496 Email: cmail@cedpa.org Website: www.cedpa.org CEDPA/Egypt 53 Manial Street, Suite 500 Manial El Rodah PO Box 110 Cairo, 11451 Egypt. Tel: +202-365-4567 Email: CEDPA@idsc.gov.eg Email: cedpa@intouch.com
		CEDPA/Mali BPE-1524 Zone Industrielle Bamako, Mali Tel: +223-21-5429 Fax: +223-21-0246 Email: cedpa@spider.toolnet.org CEDPA/Nigeria 18A&B Temple Road Off Kinsway Road Ikoyi, Lagos, Nigeria Tel: +234-1-260-0022 Fax: +234-1-288-2719 Email: cedpa@usips.org
Centre Djoliba	Mali	Centre Djoliba BP 298 Bamako, Mali Tel: +223-228332 Fax: +223-228332 Email: centredjoliba@afribone.net.ml
Comité National de Lutte Contre la Pratique de l'Excision (CNLPE)	Burkina Faso	CNLPE BP 515/01 Ouagadougou 01, Burkina Faso Tel: +226 307915
Comité National de Lutte Contre les Pratiques Néfastes	Guinea Buissau	Comité National de Lutte Contre les Pratiques Néfastes CP 560 Bissau

Comité National de Lutte Contre les Pratiques Traditionnelles Néfastes à la Santé de la Mère et de l'Enfant (CNLCPT)	Djibouti	CNLCPT (Comité National de Lutte Contre les Pratiques Traditionnelles Néfastes à la Santé de la Mère et de l'Enfant) c/o UNFD BP 10217 Djibouti Tel. +253 351981/350421
Comité National Sénégalais contre les Pratiques Traditionnelles Néfastes (COSEPRAT)	Senegal	COSEPRAT Hôpital Le Dantec BP 3001 Dakar, Senegal
Comité Nigérien sur les Pratiques Traditionnelles (CONIPRAT)	Niger	CONIPRAT BP 11613 Niamey, Niger Tel: +227-724207 Fax: +227-724207
Commission Internationale pour l'Abolition des Mutilations Sexuelles (CAMS)	Senegal	CAMS BP 11.345 Dakar, Senegal
Coptic Evangelical Organization for Social Services (CEOSS)	Egypt Minya Governorate	CEOSS PO Box 162-11811 El Panorama, Cairo, Egypt Tel: +202-297-5901/2/3 or +202-297-5872/3/4 Fax: +202-297-5878 Email: Int.relatns@ceoss.org.eg Website: www.ceoss.org
Coptic Organization for Services and Training (COST)	Egypt	COST No. 1 Fikri Street West Quarter PO Box 30 Beni Seuf, Egypt Tel: +202-082-329-114
The Egyptian Society for the Care of Children	Egypt	The Egyptian Society for the Care of Children 25 Kadri Street, Sayeda Zeinab Cairo, Egypt
Egyptian Task Force on FGM	Egypt	Egyptian Task Force on FGM c/o Ministry of Population and Family Planning Corniche El Nile Maadi Cairo, Egypt

The Federation of Female Nurses and Midwives of Nigeria (FENAM)	Nigeria	FENAM (The Federation of Female Nurses and Midwives of Nigeria) 22 Bajulaiye Road Shomolu Lagos, Nigeria Tel/Fax: +234 1 820 483
The Gambia Committee against Traditional Practices (GAMCOTRAP)	Gambia	GAMCOTRAP PO Box 2990 Serrekunda, The Gambia
Ghanaian Association of Women's Welfare	Ghana (Northern and Volta Regions) .	Ghanaian Association of Women's Welfare PO Box 9582 Airport Accra, Ghana Tel: +233-21-77-3151
Hanang Women's Counseling and Development Association (HAWOCODE)	Tanzania Barbaig Community	Email: hata@twiga.com

Inter African Committee (IAC)	Headquarters in Addis Ababa, Ethiopia with an international Liaison Office in Geneva, Switzerland. National Committees in 26 African countries	Inter-African Committee on Traditional Practices Affecting the Health of Women and Children 147, rue de Lausanne 1202 Genève Tel: +41 22 731 2420/732 0821 Fax: +41 22 738 1823 Website: www.iac-ciaf.org Inter African Committee (IAC) Headquarters ACGD UNECA PO Box 3001 Addis Ababa Ethiopia Tel: (251) 1 44 53 72/51 57 93 National Committees: IAC/Benin BP 538 Porto-Novo, Benin IAC/Chad Comité national du CI-AF c/o CIRAD-CA/TCHAD BP 764 N'Djamena, Chad IAC/Liberia PO Box 6006 Monrovia, Liberia IAC/Mauritania (AMPTSFE) BP 3772 Nouakchott, Mauritania IAC/Nigeria PO Box 71607, Victoria Island Lagos, Nigeria Tel: +234 1 614909/614912 Fax: +234 1 635072, 637547 IAC/Tanzania IAC Dodoma Project Coordinator c/o Ministry of Labour and Youth Development PO Box 2862 Dodoma, Tanzania IAC/Togo BP 3907 Lomé, Togo

International Center for Research on Women (ICRW)	Egypt, Gambia, and Mali	1717 Massachusetts Ave, NW Suite 302 Washington, DC 20036 USA Tel: +1-202-797-0007 Fax: +1-202-797-0030 Email: info@icrw.org Website: www.icrw.org
Kenya National Council on Traditional Practices (KENTRAP NC, IAC)	Kenya	Kenya National Council on Traditional Practices (KENTRAP NC, IAC) Valley Arcarde Kunde Road PO Box 20428 0200 Nairobi, Kenya Tel: +254 20 565 606 Fax: +254 20 565 606
Kenya Red Cross Society	Kenya	Kenya Red Cross Society Attention: Information Officer PO Box 40712 Nairobi Tel: +254 2 503 781/ 503 789 Fax: +254 2 503 845
Maendeleo ya Wanawake Organization (MYWO)	Kenya (Tharaka, Narok and Gucha, Nithii and Kisii Districts)	MYWO Maendeleo House, Monrovia Street PO Box 44412 Nairobi, Kenya Tel: +254-20-222095 or +254-20-242093
Movement for the Eradication of Female Genital Mutilation (MEFEGM)	Sierra Leone	MEFEGM 90 Sanders Street Freetown, Sierra Leone Tel: +232 22 242264 Fax: +232 22 241620
Muniwat Group	Sudan	Munawinat Group Saadabulla Street PO Box 2348 AC.11111 Khartoum Sudan Tel: +249 784 300 Fax: +249 776 690
Muslim Family Counseling Services	Ghana (Northern and Volta Regions)	Muslim Family Counseling Services PO Box 9543 K.I.A Accra, Ghana Tel: +233-21-231215

Mwaganza Action	Burkina Faso (23 villages in Zoundweogo province)	Mwangaza Action 11, rue 13.58 06 BP 9277 Ouagadougou 06, Burkina Faso Tel: +226 50 36 07 70 Fax: +226 50 36 33 85 Email: mwangaz@fasonet.bf
National Association of Nigerian Nurses and Midwives (NANNM)	Nigeria	NANNM 16 Shokumbi St Mushin PO Box 3857 Ikeja, Lagos, Nigeria
National Committee on Traditional Practices, Uganda (NCTPU)	Uganda	NCTPU PO Box 7296 Kampala, Uganda
National Council for Childhood and Motherhood (NCCM)	Egypt	NCCM PO Box 11 Misr Al Kadima Cairo, Egypt Tel: +20 2 524 0288/0408/0406/0122 Fax: +20 2 524 0701/0638 Website: www.nccm.org.eg
National Committee on Harmful Traditional Practices of Ethiopia (NCTPE)	Ethiopia	NCTPE PO Box 12629 Addis Ababa, Ethiopia Tel: +251 1 62 45 02/47 77 or +251 1 18 11 63 Fax: +251 1 62 12 43 Email: nctpe@telecom.net.et
PATH	Eritrea, Ethiopia, Kenya, Mali, Somalia, Tanzania, Uganda	PATH 1455 NW Leary Way Seattle, WA 98107 USA Tel: +1-206-285-3500 Fax: +1-206-285-6619 Email: info@path.org Website: www.path.org PATH/Kenya ACS Plaza, 4th Floor Lenana and Galana Road Nairobi, Kenya Tel: +254-20-387-7177/80 Fax: +254-20-387-7172 Email: info@path-kenya.or.ke
Pathfinder International	Ethiopia	Pathfinder International/Ethiopia PO Box 12655 Addis Ababa Ethiopia Tel: +251 1 61 33 30 Fax: +251 1 61 52 09

Population Action International (PAI)	Mali	PAI Main Office 1300 19th Street, NW, Second Floor Washington, DC 20036 USA Tel: +1 202 557-3400 Fax: +1 202 728-4177 Website: www.populationaction.org
Population Council	Burkina Faso, Egypt, Ethiopia, Kenya, Senegal, Sudan	Population Council New York Headquarters One Day Hammarskjold Plaza NY, NY 10017 USA Tel: +1-212-339-0500 Fax: +1-212-755-6052 Email: pubinfo@popcouncil,org Website: www.popcouncil.org Population Council/Eastern and Southern Africa Regional Office Multichoice Towers, Upper Hill PO Box 17643 Nairobi, Kenya Tel: +254-2-713-480/481/482/483 or +254-2-712-814 Fax: +254-2-713-479 Email: pcnairobi@popcouncil.or.ke Population Council/West and Central Africa Regional Office BP 21027 Dakar, Senegal Tel: +221-824-1993/4 Fax: +221-824-1998 Email: Pcdakar@pcdakar.org Population Council/West Asia and North Africa Regional Office PO Box 115 Cairo, Egypt Tel: +202-571-9252 Fax +221-580-1804 Email: pcouncil@pccairo.org
Reproductive Education and Community Health (REACH)	Uganda	REACH Program Project Manager PO Box 156 Kapchorwa, Uganda Tel: +256-045-51190

Seventh Day Adventist Rural Health Services	Kenya: Nyamira District, Nyanza province	Seventh Day Adventist Rural Health Services PO Box 42276 Nairobi, Kenya Tel: +254-20-5666022
Sierra Leone Association on Women's Welfare (SLAWW)	Sierra Leone	SLAWW PO Box 1069 Freetown, Sierra Leone Tel: +232 33 24456 Fax: +232 33 226031
Sudan National Committee on Traditional Practices (SNCTP)	Sudan	SNCTP PO Box 10418 Khartoum, Sudan
Tostan	Senegal, Guinea	Tostan BP 326 Thies, Senegal Tel: +221-51-1051 Website: www.tostan.org
World Neighbors/Voisins Mondiaux	Burkina Faso	World Neighbors/Voisins Mondiaux 01 BP 1315 Ouagadougou 01 Burkina Faso Tel: +226-50303146 Email: voisins.mondiaux@fasonet.bf

Appendix 2: Donors and technical assistance for FGM abandonment

The following list of agencies who provide financial and technical assistance is meant to be illustrative. Inclusion in this table does not imply any judgment or endorsement on the part of PATH.

AGENCY	CONTACT INFORMATION	PROJECT/FUNDING ARRANGEMENTS
Amnesty International (AI)	International Secretariat 1 Easton Street London WC1X 0DW, UK Tel: +44 20 741 35500 Fax +44 20 79561157 Website: www.amnesty.org	AI has established a Working Group on FGM to act as a consultation point for the organization's work, to coordinate FGM activities in Africa with other NGOs, and to review AI initiatives. The Working Group has representatives in Benin, Côte d'Ivoire, Ghana, Mali, Nigeria, Sierra Leone, and Togo. To date, AI has conducted media work and advocacy at the local and national level in numerous countries and supported regional awareness-raising seminars in Côte d'Ivoire, Tanzania, and Ghana.
Australian High Commission	PO Box 39341 Nairobi, Kenya Tel: +254 4445034	In recent years, Australia has provided assistance through the Small Activities Scheme and Direct Aid Program—administered by the Australian High Commission in Kenya—to activities in the Horn of Africa aimed at eradicating FGM.
Canadian International Development Agency (CIDA) Gender Equity Support Project (GESP)	Canadian High Commission in Kenya CIDA/GESP P.O. Box 1013 00621-Nairobi, Kenya Tel: +254 20 366 3000	CIDA's GESP promotes the full participation of women in Kenya as equal partners in the sustainable development of their country. The current second phase of the project (2002–2008) aims to strengthen and achieve this objective. GESP contributes to the reduction of systematic impediments that prevent Kenyan women from participating in their society. It does so by supporting the initiatives of civil society organizations and government bodies engaged in working strategically on gender equality issues.
Center for Reproductive Rights (formerly the Center for Reproductive Law and Policy (CRLP))	120 Wall Street NY, NY 10005 USQ Tel: +1 917-637-3600 Fax: +1 917-637-3666 Email: info@crlp.org Website: www.crlp.org	The Center promotes women's equality worldwide by promoting reproductive rights as human rights. The Center's work has focused on analyzing worldwide laws and policies relating to FGM and on advocating a holistic approach to the problem. It has supported local women lawyer's associations in numerous countries to advocate for government action.
Comic Relief	5th floor 89 Albert Embankment London, UK Tel: +44 21-7820-5555 Peter Bennett-Jones (Chair) Richard Curtis (Vice-Chair)	Every two years Comic Relief issues a set of Grant-Making Guidelines. These guidelines are decided on with the help of experts in development and social issues. They have supported the East Africa for Literacy Program to improve the rights of women in East Africa. This is a partnership of organizations from Egypt, Ethiopia, Kenya, Somalia, Somaliland, Sudan,

		and the UK with the goal of improving the rights of women in East Africa, focusing on issues such as FGM, early marriage, and other forms of discrimination against girls and women.
Danish International Development Agency (DANIDA)	Main office contact- Denmark Royal Danish Ministry of Foreign Affairs Asiatisk Plads 2 DK 1448 Copenhagen K Tel: +45 33 92 00 00 Fax: +45 32 54 05 33 Email: um@um.dk	DANIDA established guidelines on the prevention of FGM for use within DANIDA's programs. It draws attention to the issue of FGM from a sexual, reproductive health, and human rights perspective. The guidelines promote the prevention and abolition of the harmful practice of FGM within the framework of sexual and reproductive health and rights, as part of the primary health care strategy, and within the education and legal systems. Through international and local NGO workshops and seminars, DANIDA aims to influence policymakers and religious leaders to develop initiatives supporting the prevention and eradication of FGM in accordance with the Cairo and Beijing recommendations. In 1995, an international seminar on FGM was organized by DANIDA and an NGO called Women and Development (KULU) to highlight the issues surrounding FGM. DANIDA promotes the empowerment of women as a primary means of prevention of FGM, alongside support for local NGOs and the development of national efforts.
British Department for International Development (DFID)	1 Palace Street London SW1E 5HE Tel: +44 20 7023 0000 Fax: +44 20 7023 0019	DFID is addressing the complex causes and consequences of FGM in multiple ways. It seeks to reduce FGM incidence by ensuring wide awareness of the practice and its consequences, funding research, and supporting activities and projects designed to change behavior in the long term. DFID supports the WHO's work on FGM, and also supports international NGOs that collaborate with African women in their efforts to increase awareness of the practice. DFID realizes there is no easy solution to this problem, and is committed to fighting FGM on a long-term basis.
Equality Now	New York Office 250 W 57th Street, Suite 1527 NY, NY 10107 USA Tel: +1 212 586 0906 Fax: +1 212 586 1611 Website: www.equalitynow.org London Office 6 Buckingham St London WC2N6BU UK Tel: +44 20 7839 5456 Fax: +44 20 7839 4012	Equality Now's Fund for Grassroots Activism to End Female Genital Mutilation supports awareness raising, legal and judicial assistance, FGM abandonment clubs, nonformal education on FGM (e.g., drama and puppetry shows), capacity building and community empowerment activities, and other initiatives. Grantees of the Fund in 2004 included groups from numerous countries including Djibouti, Egypt, Ethiopia, Eritrea, the Gambia, Ghana, Guinea, Kenya, Mali, Senegal, Somalia, Sudan, and Tanzania.

	Nairobi Office PO Box 2018 KNH 00202 Nairobi, Kenya Tel: +254 20 271 9913/9832 Fax: +254 20 271 9868	
The European Union	Directorate-General EuropeAid Co-operation Office Gary Quince Head of Delegation Nairobi Kenya Tel: +254 2713020/21	Grants awarded include micro-projects which are selected on the basis of calls for proposals conducted locally. They go to regional projects aimed at strengthening the capacity of civil society networks to promote human rights, especially the rights of women, children, and prisoners, and particularly freedom of association and expression.
Finnish Department for International Development cooperation (FINNIDA)	FINNIDA Katajanokanlaituri 3, 00160 Helsinki 16, Finland Paivi Mattila Advisor Gender issues Tel: +358-9-1605-1605/ 1341-6370	FINNIDA funding focuses on gender-based violence and gender assessment tools among other gender issues.
German Technical Cooperation for Development Agency (GTZ)	Postfach 5180 65726 Eschborn Germany Fax: +49 6196-79-7177 Website: www2.gtz.de/fgm Kerstin Lisy Email: Kerstin.Lisy@gtz.de Emanuela Finke Email: Emanuela.Finke@gtz.de Gisela Rosenberger Email: Gisela.Rosenberger@gtz.de	Since May 1999, a GTZ supra-regional project has been supporting and promoting action groups campaigning for the abolition of FGM. It is commissioned by the Federal German Ministry for Economic Cooperation and Development (BMZ). The project aims for close cooperation between the areas of health, education, promotion of women's issues, and human rights in particular, in order to respond to the manifold socio-cultural aspects of the topic. In the long term, it wishes to deliver comprehensive information to the general public about the consequences of FGM through the work of local initiatives, and convince them to abandon the damaging practice. Their contribution can be divided into four areas: • Promoting initiatives • Evaluating experience • Support networks • Advising technical cooperation projects In several West and East African states, local organizations and institutions are being provided advisory services and financial support. The activities promoted include: • Integrating FGM teaching modules into syllabi for schools and other educational establishments. • Developing and supporting alternative initiation rites for girls. • Raising awareness among decision-makers/religious leaders. • Developing materials for multipliers. • Conducting public relations work. • Holding training courses and further-training

		sessions for health staff and teachers. Education institutions develop teaching modules which look in detail at FGM. • Developing information campaigns for rural areas. GTZ also collects information and experience and identifies promising approaches (good practices) among these action groups, and further develop these as a sustainable contribution to raising awareness. They also support an exchange of experience between action groups, lobby groups, and influential individuals in partner countries. Within the scope of seminars or mutual project visits, those involved can gather new ideas and find inspiration. They also offer the following services: • Providing processed information. • Providing on-site consultancy services. • Promoting information exchange among projects. • Creating contacts to local actors. • Informing and raising awareness among institutions and staff members working in the field of development co-operation in order to ensure that the topic of FGM is integrated throughout development co-operation.
William and Flora Hewlett Foundation	2121 Sand Hill Road Menlo Park, CA 94025 USA Tel: +1 650-234-4500 Sara Seims, Program Director Population Program- Special Initiatives.	The Fund has, for historical reasons, made limited funds available for the support of highly leveraged initiatives to eradicate the practice of FGM.
Italian Cooperation	Piazzale della Farnesina 1 - 00194 Roma, Italy Tel: +39 0636911	The Development Cooperation Office of the Italian Government has supported research, international conferences on FGM, and country programs. They have also worked with other European partners in the Donors Working Group on Female Genital Mutilation/Cutting on developing a response for FGM among immigrants in European countries.
Moriah Fund	One Farragut Square South 1634 I Street, NW Suite 1000 Washington, DC 20006-4003 Tel: +1 202.783.8488 Fax: +1 202.783.8499 Email: info@moriahfund.org Shira Saperstein Program Director, Women's Rights and Reproductive Health	Moriah provides funds for institutional (general) support; policy analysis, advocacy and organizing; technical assistance, training and leadership development; research and information dissemination to share lessons learned, and innovative local programs that link local reproductive health service delivery with national and international policy and advocacy. In all of its funding, Moriah looks for programs that have an impact beyond their own constituencies or geographic location, through information dissemination and sharing of lessons learned,

	Adwoa A. Agyeman Program Assistant, Women's Rights and Reproductive Health	leveraging of additional public or private support, or advocacy to promote systemic change. They also give priority to programs that directly involve project beneficiaries—women and adolescents—in all levels of project design, implementation, management, and evaluation.
Netherlands Embassy	Embassy of Netherlands, Nairobi, Kenya Tel: +254 4447412	Advocacy and training on FGM from 2002–2004 in association with the Ghana Association for Women's Welfare.
Norwegian People's Aid	Storgt. 33 A, 9. etg 0028 Oslo, Norway Tel: +271793/2717934 Jan Erling Haugland Regional Director	Norway supports efforts to raise awareness of human rights by allocations to the UN High Commissioner for Human Rights, including allocations to women's and girls' rights. Combating FGM is regarded as an integral part of the efforts for better RH and combating violence against women. The government of Norway has implemented some measures to counter FGM including: • Through the Ministry of Foreign Affairs, maintaining a high profile in multilateral fora where FGM is on the agenda. • Intensifying its bilateral cooperation with African countries working to combat FGM in their own countries. • Seeking to establish cooperation with interested organizations in the appropriate countries to assist immigrant girls who have been taken to their parents' home countries to undergo FGM and who are seeking help.
Public Welfare Foundation	1200 U Street, NW Washington, DC 20009-4443 Tel: +1 202-965-1800 Fax: +1 202-265-8851 Email: reviewcommittee@publicwelfare.org Website: www.publicwelfare.org Charisse Williams Grants making	The Public Welfare Foundation supports organizations that address human needs in disadvantaged communities, with strong emphasis on organizations that include service, advocacy, and empowerment in their approach: service that remedies specific problems; advocacy that addresses those problems in a systemic way through changes in public policy; and strategies to empower people in need to play leading roles in achieving those policy changes and in remedying specific problems. They also look for organizations that link their community and local work to other efforts to effect broader public policy change. The Foundation provides both general support and project-specific grants. Although most grants cover a period of one year, the Foundation accepts requests for funding renewals and also makes multi-year grants. Grants for one-time purposes are also considered.
Research, Action, and	Suite 5A, Queens Studios 121 Salusbury Road	RAINBO offers direct grant making to organizations with projects focusing on FGM in Africa. Since 1995,

Information Network for the Bodily Integrity of Women (RAINBO)	London, NW6 6RG UK Tel: +44-20-7625-3400 Fax: +44-20-7625-2999 Email: info@rainbo.org Website: www.rainbo.org	the project has worked with 76 organizations in 20 African countries and awarded over $850,000 in grants. The fund prioritizes grants to smaller organizations who promote innovative and effective approaches which facilitate women's and girls' self empowerment and involve the community. Through its Small Grants Project, RAINBO works in partnership with local African NGOs to help them develop solid proposals that will result in innovative projects and sound research initiatives. They also help to build institutional capacity within organizations. The Small Grants Project provides three kinds of support: 1. Technical Assistance: communication and dialogue with grantees and the particular use of regional consultants. 2. Organizational Support: capacity training workshops, material documentation and distribution support, information technology support, and networking opportunities. 3. Thematic Support: Examples of themes they support are as follows: • Adolescents • Linking services with advocacy • Policy review and analysis • Projects that review historical policy trends, analyze the impact of legal measures, and other efforts to document and/or affect national policy guidelines related to FGM and the sexual, RH and rights of girls and women. • Research, documentation and evaluation • Small-scale studies that build on existing research or examine a previously unexplored area. Of particular interest is research that evaluates the impact of programs and explores what brings about behavioral change toward FGM. In addition, they support projects that document and assess the work of organizations whose efforts to address FGM have had a measurable impact. • Targeted education, communication, or training activities • They also seek to fund projects that involve the provision of counseling or peer support services to assist women and girls who have already undergone FGM or are seeking to stop the practice.
The Rockefeller Foundation	420 Fifth Ave NY, NY 10018 USA Tel: +1-212 869 8500	The Rockefeller Foundation has provided funding to support conferences, research activities, and programs to support the abandonment of FGM. Research work includes funding for "communication for social change" and "participatory communication for social change." The foundation also supports the Population

		Council's INTACT Network, an international network to analyze, communicate and transform the campaign against FGM/FGM/FC (www.intact-network.net/).
Swedish International Development Agency (SIDA)	Sida Sveavägen 20 105 25 Stockholm, Sweden Tel: + 46 8 698 50 00 Fax: +46 8 20 88 64 Website: www.sida.se	Program priorities include human rights and gender equality, maternal health and newborn care, fertility regulation, abortion, HIV/AIDS, adolescent health, FGM, discrimination, violence, and abuse.
Swiss Agency for Development and co-operation (SDC)	SDC - Head office Freiburgstrasse 130, 3003 Berne, Switzerland Tel: +41 31 322 34 75 Fax: +41 31 324 13 48 Email: info@deza.admin.ch	Some of the FGM activities supported by SDC: • Contribution to the production of a film in Burkina Faso in 1994 called "Ma fille ne sera pas excisée." • Financial contributions to UNICEF and the Inter African Committee. • Support to CONIPRAT, the National Committee against Harmful Traditional Practices in Niger. • Support of preventive activities in Tanzania. • Integration of the topic of FGM into SDC's 5-year plan in Mali. Previous to this intervention, the Institut Universitaire d'Etudes du Développement (IUED) had already taken up the topic in that country. • Support in the production of an anatomic model for health education by the IAC in 1996. • Financial contribution to the production of a film: "la Lumière d'étoile," which will show best practices, by the IAC. • Financial contribution for the organizational costs of the seminar on FGM in Switzerland organized by UNICEF and PLANES in May 2001. • Funding a project in Mali through AMANEH.
United Nations Development Programme (UNDP)	One United Nations Plaza New York, NY 10017, USA Tel: (212) 906-5558 Fax: (212) 906-5364 Website: www.undp.org	UNDP has supported the monitoring of legislation and the drafting of new bills on land entitlements, marriage, and social security, among other issues. For example, Nigeria passed a law banning FGM, and Vanuatu agreed to provide poor women with free legal aid. UNDP has also undertaken numerous public awareness campaigns related to women's rights, including on domestic violence, the trafficking of women and children, and FGM. UNDP will work with local community-based organizations and NGOs who will ensure the close involvement of both female and male members of the community in the project, which, in turn, will collaborate with a larger project approved for WHO funding. This relatively small-scale project will, therefore, provide practical hands-on experience that will complement and inform the more research- and health-service-oriented WHO project. And vice versa.

United Nations Children's Fund (UNICEF)	UNICEF House 3 United Nations Plaza New York, New York 10017 U.S.A. Tel: +1 212 326 7000 Website: www.unicef.org	In Burkina Faso, UNICEF's support helped secure passage of legislation that makes FGM punishable by prison terms ranging from 6 months to 10 years, and fines of up to $1,800. In Eritrea, UNICEF works to reach school-aged children and men. Young people have been trained as advocates against the practice and FGM abandonment school clubs have been established in all regions. In Senegal, UNICEF provided financial and communication support to local NGO's, which helped create the movement against genital mutilation. In January 1999, the Parliament of Senegal approved legislation to ban FGM. In Somalia, UNICEF supported the "training-of-trainers," bringing together health workers, teachers, communication professionals, women's NGO representatives, and religious leaders for the eradication of FGM. UNICEF Kenya analyzes the situation of children and women based on human rights principles.
United Nations Development Fund for Women (UNIFEM)	UNIFEM Headquarters 305 East 45th St, 15th Floor NY, NY 10017 USA Tel +1-212-906-6400 Fax +1-212-906-6705 Email: unifem@undp.org Website: www.unifem.undp.org	The UNIFEM Trust Fund to Support Actions to Eliminate Violence Against Women identifies and supports projects around the globe aimed at preventing and eliminating violence against women. These projects address such issues as: HIV/AIDS; female infanticide; sexual abuse; FGM; trafficking; forced prostitution; dowry-related violence; domestic violence; and marital rape. Since the Fund began in 1996, UNIFEM has awarded more than $7 million in grants to 73 countries.
United Nations Population Fund (UNFPA)	UNFPA Headquarters 220 E. 42nd Street NY, NY 10017 USA Tel: +1-212-297-5020 Fax: +1-212-557-6416 Email: hq@unfpa.org Website: www.unfpa.org Dr Nicholas Dodd, Reproductive Health Branch (HQ)	In 1998, UNFPA developed a program advisory note on the reproductive health effects of gender-based violence, including FGM. This Advisory Note provides guidance on how to address FGM programmatically in Reproductive Health, Population and Development Strategies, and Advocacy Programs. Activities for the eradication of FGM are integrated into the core areas of UNFPA's mandate: reproductive health including family planning and Sexual Health; Population and Development Strategies, and Advocacy. Support is given at the country level for various activities that IEC on FGM targeting parents, teachers, and community leaders. Support is equally provided for advocacy, policy and legal reforms and the provision of reproductive and sexual health care. UNFPA also supports special programs that target FGM eradication, often in collaboration with national and regional NGOs that advocate and educate for FGM eradication. UNFPA, UNICEF, and WHO issued a joint policy statement on the eradication of FGM, expressing their common purpose in suggesting the efforts of governments and communities to promote and protect

		the health and development of women and children.
United States Agency for International Development (USAID)	USAID Headquarters Ronald Reagan Bldg Washington, DC 20523-1000 USA Tel: +1-202-712-4810 Fax: +1-202-216-3524 Website: www.usaid.gov	Since September 2000, the Agency incorporated eradication of FGM into its development agenda. To integrate the policy into its existing family programs and strategies, USAID: • Collaborates with other donors and activist groups to implement a framework for research, policy change, and advocacy and to coordinate efforts, share lessons learned, and increase public understanding of FGM as a health-damaging practice. • Partners with indigenous groups at the community level, as well as with global and national policymakers, to reduce demand through behavior change programs including community education, alternative rituals, and by promoting broader education and disseminating information on the harmful effects of FGM. In Kenya, USAID works with a local organization to substitute FGM with a safer coming-of-age ritual for young women. Another project involves health professionals in programs to train teachers, religious leaders, community leaders, and other medical practitioners about the need to eradicate FGM. In Egypt, where the FGM prevalence rate is 97 percent, USAID funds a program that identifies individuals who said "no" to FGM, and then works to determine how these women overcame the social ostracism that can result from being uncut. In Senegal, USAID has been involved in community education. USAID recently reviewed its FGM programming and increased its support for FGM eradication programs by working with technical agencies such as PATH, RAINBO, International Centre for Research on Women, CEDPA, The Focus Project, and the Population Council. USAID says it is helping several African countries adopt a "zero tolerance" stance against the procedure
Wallace Global Fund	Wallace Global Fund 1990 M Street, NW, Suite 250 Washington, DC 20036 USA Tel: +1 202 452-1530 Fax: +1 202 452-0922 Website: www.wgf.org Email: tkroll@wgf.org	Population pressures exacerbate many of the fundamental obstacles to sustainable development: degradation of natural resources, income disparity, gender inequality, and poor maternal and child health. The Fund believes that it can achieve population stabilization by expanding RH choices for women, thereby reducing unwanted childbearing and improving the lives of women and their families. The Fund seeks policy initiatives which promote globally: • Eradication of the practice of FGM. • Improvements in adolescents' ability to make informed reproductive choices and obtain quality

		reproductive health services and information. • Access to safe abortion services. • Increased resource mobilization from the US and other donor nations for population and RH programs. • Empowering low-income women to seize control of their financial destinies, through access to micro enterprise loans. One of the funded projects resulted in a paper, Eradicating FGM: Lessons for Donors. This paper summarizes the lessons learned during early efforts to oppose FGM in Africa and provides guidelines to donors interested in supporting efforts to eradicate this intolerable practice.
World Health Organization (WHO)	WHO Headquarters Ave Appia 20 1211 Geneva 27 Switzerland Tel: +41-22-791-21-11 Fax : +41-22-791-31-11 Email: wmh@who.int Website: www.who.int/frh-who/FGM	The WHO strategies for the elimination of FGM: • Increase available knowledge • Encourage countries to promote technically sound policies and approaches that would ensure that FGM is incorporated into broader concerns of women's health, RH, safe motherhood, and child health, as well as human rights and health issues.
Women's Action Against FGM, Japan (WAAF)	#401, Nakameguro 1-4-18 Meguro-ku, Tokyo 153-0061, Japan Tel: +81-3-3760-6641 Fax: +81-3-3760-6643 Email: waafjapan@hotmail.com or waaf@jca.apc.org	The WAAF Fund was established to help fund projects dedicated to the abolition of FGM in African countries. Donations are used to fund projects of the Inter-African Committee (IAC) members and other organizations working for the abolition of FGM in Africa. Applications are accepted from non-governmental organizations, local associations, and community-based groups; preference is given to projects undertaken in Africa. Applications from individuals or organizations with religious or political affiliations will not be considered.
World Bank	World Bank Headquarters 1818 H Street, NW Washington, DC20433 USA Tel: +1 202 473 1000 Fax: +1 202 477 6391 Website: www.worldbank.org	Since 1994, the World Bank has supported a number of activities aimed at the abandonment of FGM. Through its Development Grant program, the Bank supports the activities of several local NGOs working on FGM. The Bank's assistance program in Burkina Faso and Gambia also includes information, education, communication, and training activities to reduce the practice of FGM.