Addressing Female Genital Mutilation

Approaches, Lessons Learned and Challenges

giz

On behalf of

Federal Ministry
for Economic Cooperation
and Development

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Abbreviations and Acronyms

BCC Behaviour Change Communication

BMZ Bundesministerium für wirtschaftliche Zusammenarbeit und Entwicklung (Federal Ministry for Economic Cooperation and Development)

CEDAW Convention on the Elimination of All Forms of Discrimination against Women

CEDPA Centre for Population and Development Activities

CRIGED Centre de recherche et d'intervention en genre et développement

CRC Convention on the Rights of the Child

DHS Demographic and Health Survey

EP European Parliament

EU European Union

FC Female Circumcision

FGC Female Genital Cutting

FGM Female Genital Mutilation

FPIDC Forum de la pensée Islamique et du Dialogues des cultures

GIZ Deutsche Gesellschaft für Internationale Zusammenarbeit GmbH

GTZ Deutsche Gesellschaft für Technische Zusammenarbeit GmbH (German Technical Cooperation)

HIV/AIDS Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome

HRBA Human Rights-Based Approach

ICPD International Conference on Population and Development, Cairo 1994

IEC Information Education Communication

M&E Monitoring and Evaluation

MICS Multiple Indicator Cluster Survey

NGO Non-governmental Organisation

PDA Positive Deviance Approach

RHR Department of Reproductive Health and Research (WHO)

STD(I) Sexually Transmitted Disease (Infection)

UN United Nations

UNESCO United Nations Educational, Scientific and Cultural Organisation

UNFPA United Nations Population Fund

UNICEF United Nations International Children's Emergency Fund

UNIFEM United Nations Development Fund for Women

USAID United States Agency for International Development

WHO World Health Organisation

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Preface

Female genital mutilation (FGM), female circumcision (FC), or female genital cutting (FGC), as it is termed by different actors and in differing circumstances, is a collective name given to 'all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons'[1]. More than 130 million women and girls in 29 countries throughout Africa and the Middle East[2] are currently living with the consequences of female genital mutilation.[3] The practice is concentrated in, but not limited to these 29 countries. There are an estimated three million girls at risk of undergoing female genital mutilation every year.[4] FGM is a subject of global concern: not only is it practised in communities in Africa and the Middle East. Asian countries such as Indonesia, Malaysia, Thailand, India and Pakistan are also affected to varying degrees. Moreover, immigrant communities throughout the world continue to practise FGM. The procedure has no known health benefits, causes pain and suffering and exposes women and girls to serious health threats. FGM violates basic human rights of women and girls and restricts their chances for self-development.

Since 1999, the Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) GmbH[5] on behalf of the German Federal Ministry for Economic Cooperation and Development (BMZ) has been working to promote and encourage initiatives with the aim of overcoming FGM in its partner countries. Numerous development cooperation activities address this severe human rights violation, which is forbidden by law in many countries. Through in-depth cooperation with national and international non-governmental organisations (NGOs) and lobby groups, development cooperation programmes address the closely interrelated governance, health, legal, educational and women's rights dimensions when supporting local activities to end FGM.

This publication first appeared in 2003 and was thoroughly revised in 2012 and 2014. An overview presents the different frameworks and approaches used to promote the abandonment of FGM and shows how they are being further developed and adapted to suit the context on the ground. Experience has shown that no standard solution would work in every situation or country, or with every target audience.

With all the information gathered in recent years, there has never been a better understanding as to why FGM persists. Innovative programmes for addressing FGM provide encouraging evidence of change. Over a relatively brief period of ten years, this initiative has gained momentum, and significant progress has been made towards the abandonment of FGM. We hope that the approaches presented in this publication support the work of development practitioners and encourage them to follow a comprehensive and integrated strategy to overcome FGM. There is good reason to believe that by applying appropriate approaches, FGM will further decline and eventually be abandoned.

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[1] As defined by World Health Organisation (WHO) and the United Nations (UN) agencies (WHO 2011b). – GIZ has decided to opt for the term 'female genital mutilation' because it clearly expresses that the right of girls and women to physical integrity is being grossly violated. Many UN organisations speak of female genital mutilation/cutting (FGM/C) in order to stress the human rights violation involved and yet at the same time to enable a value-free dialogue at the local level.

[2] UNICEF (2013); UNICEF (2014).

[3] UNICEF (2013).

[4] UNICEF (2013).

[5] Established on 1 January 2011, the GIZ brings together under one roof the long-standing expertise of Deutscher Entwicklungsdienst (DED; German Development Service), Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ; German technical cooperation) and InWent – Capacity Building International, Germany.

Introduction

FGM is a global concern. There is more and more international and regional commitment to work towards the abandonment of FGM, and a number of international instruments have established a common framework to reach this goal. Promoting gender equality and empowering women, improving maternal health, reducing child mortality and combating HIV/AIDS are measurable development targets as defined by the Millennium Development Goals[6] which are also indicators significant for ending FGM.

There has been a paradigm shift in the international debate and work on FGM. Whereas in the past FGM was seen predominantly as a health-related issue, today it is perceived under the broader heading of governance and human rights. Most encouragingly, the practice itself is declining.[7]

The GIZ on behalf of the German Federal Ministry for Economic Cooperation and Development supports international efforts to overcome FGM. The contribution to both international policy dialogue and well-informed technical assistance offered to partner governments at national, regional and local levels are essential factors of German development cooperation.

Depending on the context causes and dynamics vary, as do approaches and potential solutions to FGM. This is why one key to success is to rely on strategies and programmes that have been designed or adapted, implemented and monitored locally. At the same time general lessons have been learned in the course of the years. This publication aims to present a selection of approaches and promising strategies to end FGM. They recognise that the communities themselves must make the decision to abandon the practice. It should reflect a collective choice, which is reinforced publicly and grounded on a sound human rights foundation. A greater understanding of human rights provides communities with the tools to direct their own social transformation. The explicit collective dimension empowers individual families, while liberating them from having to make the difficult choice of breaking with tradition.

This publication first appeared in 2003. Its revision in 2012 and 2014 is based on a review of published and grey literature including project-related documentation. Hence it provides a concise presentation of the most relevant issues. Furthermore, recent evaluation reports have been analysed and lessons learned have been incorporated to give guidance to those engaged in efforts to abandon FGM, including decision-makers. Readers wishing to obtain more information about FGM are invited to consult the GIZ's 'Ending Female Genital Mutilation' website.[8]

Chapter 1 provides a factual overview of the prevalence and distribution of FGM and introduces common frameworks for action that guide specific approaches. These include the health framework, the human rights framework, the corresponding legal framework and the religious framework. Chapter 2 describes and assesses selected approaches[9] to end FGM, including the retraining of traditional circumcisers, the use of alternative rituals, positive deviant approaches as well as generation and family dialogues. Educational approaches and dialogues with religious leaders, behaviour change campaigns and the comprehensive social development approach are introduced. Based on the experiences of their evaluation, it gives an insight as to why certain approaches were more successful than others. Chapter 3 addresses the need for monitoring, evaluation and research as a cross-cutting issue. The publication concludes with recommendations based on lessons learned and promising practices.

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[6] The international debate on defining the post-2015 agenda is ongoing at the time of this publication's review. The issue of FGM had been addressed in the Outcome Document of the United Nations Open Working Group on Sustainable Development Goals, which proposed a set of 17 sustainable development goals (SDGs).

[7] See WHO (2011a) and UNICEF (2013).

[8] Available at www.giz.de/fgm

[9] For better understanding, the approaches are presented according to their key characteristics; however, the differentiation is to some extent artificial, as most programmes are already using a combination of the various frameworks and approaches.

1.

The present situation and the range of frameworks to address FGM

FGM is a practice that affects millions of women in various countries and socio-cultural contexts. UNICEF estimates that more than 130 million women and girls worldwide have experienced FGM, with another three million girls at risk of undergoing some form of the procedure every year.[10] Some experts, however, question the reliability of such figures and do not provide an estimate for 'women and girls worldwide' since so little data on its prevalence[11] is available for countries outside Africa (e.g. Indonesia), and reliable prevalence figures for girls aged less than 15 years hardly exist.[12] Since 2010, though, there are efforts to remedy the lack of data concerning girls under the age of 15.[13]

The short- and long-term consequences of FGM will not be dealt with in detail here; these include a wide range of physical and psychological sufferings that severely affect the quality of life and the life expectancy of millions of women and girls.

Reliable data on FGM practices is available for 29 countries, with a wide range of variation in prevalence rates between and also within these countries.[14] The practice is by no means limited to sub-Saharan Africa. Due to their population size, Egypt and Ethiopia are top on the list of the 29 countries in terms of absolute numbers of women and girls affected by FGM.[15] In most countries, the practice's frequency follows mainly ethnic lines. Outside Africa, FGM is practised in Yemen, with a prevalence of 23%[16], in Iraq with a prevalence of 8%, among segments of the Kurdish population in Iran, as well as in Jordan, Oman, Saudi Arabia, Malaysia and Colombia.[17] Indonesia has the largest population in Asia practising FGM. However, to date estimates for Indonesia are incoherent and systematic data collection is scarce, which is the case for most countries in Asia. Small minority populations in India, Thailand and Pakistan also adhere to the practice.[18] Immigrants to Europe, the United States or the Arab Gulf region who originate from countries where FGM is still common have imported the practice to their host countries. In Europe, 500,000 women are estimated to be living with the consequences of FGM, while an estimated 180,000 are thought to be at risk.[19]

[10] UNICEF (2013); UNICEF (2014).

[11] Prevalence is defined as the percentage of women aged 15 to 49 who have undergone some form of FGM; obtaining data on FGM prevalence among girls under 15 years of age poses methodological challenges.

[12] Yoder and Khan (2008).

[13] UNICEF (2013), Box 4.3

[14] UNICEF (2013).

[15] WHO (2011a).

[16] UNICEF (2013).

[17] UNICEF (2013); Stop FGM Middle East.

[18] Terre des Femmes (no year).

[19] EIGE (2013).

Present data available on FGM prevalence are promising; they reveal a shift towards its decline.[20] In most countries where FGM is practised, women aged between 15 to 19 years were less likely to have been subjected to FGM than women in older age groups. Also, support for the discontinuation of the practice is particularly high among younger women.[21]

The first attempts to overcome FGM were undertaken by missionaries at the beginning of the twentieth century.[22] Perceived by African communities as yet another attempt at colonisation, they provoked widespread resistance and resulted in an increase in the practice.[23] European and American feminists brought up the question again in the 1960s and 1970s. They tackled the problem by focusing primarily on the negative health consequences and called for an immediate end to the practice. These programmes, too, were perceived as being imposed by foreign countries and failed to achieve change.

For a long time, aid workers and many development agencies aware of the cultural sensitivity regarding the issue were reluctant to engage in the field of female circumcision. It was viewed as a cultural practice to be accepted in terms of cultural relativism. At the same time, more and more African women organised themselves into women's groups to pursue common economic, political and social goals. Some of them became advocates for the abolition of FGM. Following this evolution, an international consensus against FGM emerged in the 1990s.[24] It was backed by many African nations, by international lead agencies and numerous bilateral and

[20] UNICEF (2013).

[21] USAID (1999); WHO (2011a); UNICEF (2013).

[22] Note that local initiatives against FGM also existed. In Egypt, doctors started to raise awareness against the practice as early as the 1920s, see GIZ (2011d).

[23] Boddy (2007)

[24] An important consensus document, among others, is the Beijing Declaration and Platform for Action of the Fourth World Conference on Women.

Box 1:
WHO Classification of FGM

Several types of 'operations' are performed to modify the normal anatomy of the female external genitalia. They are classified into four types:[25]

Type I:
Partial or total removal of the clitoris and/or the prepuce (clitoridectomy).

Type II:
Partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (excision).

Type III:
Narrowing of the vaginal orifice with creation of a covering seal by cutting and appositioning the labia minora and/or the labia majora, with or without excision of the clitoris (infibulation).

Type IV:
All other harmful procedures to the female genitalia for non-medical purposes, for example pricking, piercing, incising, scraping and cauterisation.

[25] WHO (2011b).

non-governmental organisations.[26] With this increasing political and financial commitment[27] the issue gained growing recognition among governments, the international community, and professional health associations.

At first, development projects addressed FGM mainly as a health issue, drawing attention to the negative health consequences for women. Experience, however, showed that this strategy not only failed to induce a decline in the prevalence of FGM, but also had adverse effects.[28] Programmes focusing on human rights aspects and on the empowerment of women gained increasing attention and appeared to be more successful. Further qualitative and quantitative research showed that, due to social constraints and religious concerns, many communities continued to pursue the practice, even though they were aware of its negative consequences.[29]

Today projects combatting FGM have recognised the complexity of the issue. Meanwhile, FGM is regarded as part of a range of development concerns that include reproductive health, gender-based violence and harmful traditional practices such as child marriage or forced marriage. Thus FGM has become an issue of good governance. Addressing FGM requires considering various aspects – including social relations, gender, and religion – within an overall human rights framework.

Past experience has shown that effective efforts to end FGM require multi-level and multi-sectoral interventions, ranging from the international level with the active commitment and involvement of governments to

the community level. Such a comprehensive approach, which targets stakeholders at individual, interpersonal, community and national levels, is at the heart of the German government's policy and GIZ's strategy. German development cooperation strongly advocates this multi-level approach in various sectors and implements it in its policy to abandon FGM. This requires cooperating with partners in local, national and international settings. At the regional and international levels, GIZ works to strengthen the international response to FGM concerning policy dialogue and funding.

The rationale behind interventions to end FGM is based on different conceptual frameworks. This also has implications on the approaches, methods and arguments selected to tackle the issue. Comprehensive approaches incorporating various frameworks and addressing larger contexts like women's health, human rights, gender, economic, religious and social issues have proven to be most effective. These approaches entail working with different target audiences such as policy makers, religious and traditional leaders, civil society organisations dealing with women's and children's rights, local authorities, and health personnel. Working with multiple stakeholders at different levels can lead to effective and sustained behavioural changes and, ultimately, to communities abandoning the practice.

Yet, further research is still needed. Despite a growing body of research, rigorous evidence regarding the effectiveness, appropriateness and responsiveness of interventions is still scarce.[30] For example, a Norwegian evaluation revealed that long-term studies are essential to ensure the viability and reliability of FGM abandonment

[26] The Inter-African Committee on Traditional Practices is one example for an organisation that has been active to end FGM for 28 years.

[27] USAID (1999).

[28] It is believed that a link can be drawn between health risk messages connected to FGM and the so-called medicalisation of the practice. This means that people prefer to have their daughters cut by trained health practioners in order to reduce the immediate health risks of FGM.

[29] UNICEF Innocenti Research Centre (2005).

[30] Campbell Collaboration (2011); Johansen et al. (2013).

programmes and that such research should take into account regional, ethnic and socio-demographic variations.[31]

1.1. The health risk framework

In the past twenty years, the health risk framework has been the most widely used rationale for efforts to overcome FGM.[32] Interventions based on this rationale use messages that emphasise the harmful physical effects that these procedures can have on women. These include haemorrhage, infection, pain, fever, and shock, as well as subsequent complications such as difficulty in urinating, difficulty with sexual intercourse and particularly the risk for mother and child during delivery. An important positive aspect of this approach is that it helps to break the silence, because it is acceptable to talk about FGM from a health perspective.

While a health risk message is an integral part of awareness raising information, it is in itself insufficient to undermine a practice based on cultural beliefs and often rooted in the desire to control women's sexuality. However, findings suggest that the health risk approach is not as ineffective as initially thought: in a study on the dynamics of decision-making in Senegambia[33], the researchers assumed that knowledge of health risks does not influence motivation to change, because campaigns have delivered health risk messages for decades without much success. Surprisingly, they found that the health risk message resonates strongly among those willing to abandon the practice largely because of a shift from a focus on obstetrical risk to the risk of contracting HIV/AIDS. Shell-Duncan et al. conclude that the novelty of the danger of HIV/AIDS makes this message less threatening to the values and wisdom of the elders.

One major disadvantage of the health risk approach is that it seems to have led to a medicalisation of the practice: in some regions girls are circumcised by trained health personnel such as doctors, nurses, and midwives rather than by traditional practitioners. This is a logical response by parents who want to sustain the practice while trying to reduce the harmful effects on their daughters' health.

Analysis of survey data by age group has revealed that the medicalisation of FGM has been on the rise dramatically in countries such as Egypt, Guinea and Mali.[34]

In Egypt, there has been an increase from 55% in 1995 to 77% in 2008. The figures for Kenya also show an increasing trend of medicalisation: from 34% in 1998 to 41% in 2008/09.[35] On the one hand there are countries with rates of just under 1%, whereas in six specific countries figures range from 9% to 77%. But the overall trend is increasing.[36] In Indonesia, too, there are reports of a significant increase of FGM, which is almost exclusively performed by medical professionals.[37] There is, however, a lack of systematic evidence and coherent data.

The motivations of healthcare providers who agree to perform FGM vary:

> *"Most often they are themselves a part of the FGM-practicing community in which they serve. Hence, the reasons why they agree to perform FGM are often the same as those that motivate those requesting it. (…) Others see medicalization as a form of harm reduction, considering that, by performing it, they help to prevent the expected greater dangers if the procedure were to be carried out by traditional practitioners. Finally, some healthcare providers are also motivated by the opportunity for financial gain.*[38]

[31] Norwegian Knowledge Centre for Health Services (2009).

[32] Shell-Duncan (2010); Toubia and Sharief (2003).

[33] Shell-Duncan et al. (2010).

[34] UNICEF Innocenti Research Centre (2005); Norwegian Knowledge Centre (2009).

[35] UNICEF (2013).

[36] WHO (2010).

[37] Stop FGM Middle East.

[38] WHO (2011 b).

Box 2:
WHO's and GIZ's position on the medicalisation of FGM

WHO has condemned *all* forms of the practice and called for its abolition; it unequivocally stated that *no* form of FGM should be practised by any health professional in any setting, including hospitals and other health establishments.[39]

GIZ endorses the WHO's stance that medicalisation should never be considered an option.

[39] WHO (1998).

Although some of the immediate risks may be reduced, when FGM is performed by medical personnel in health clinics, the procedure is nonetheless excruciating and irreversible and as such a violation of girls' and women's right to physical integrity. Here the question of medical ethics arises, since the patient's welfare should be a doctor's overriding concern. The International Federation of Gynaecology and Obstetrics (FIGO) declared that FGM is medically unethical and violates human rights principles. Therefore, medicalisation is not acceptable.[40] Moreover, there is no evidence to suggest that it would reduce obstetric or other long-term complications such as sexual and psychological problems.[41] The most weighty argument in this debate is that the involvement of medical professionals may wrongly legitimise FGM as a medically sound practice, thus supporting the misconception that it is acceptable and safe. In fact, the involvement of health professionals may contribute to the institutionalisation of FGM, because they often hold power, authority and respect.[42] It can also cause some healthcare providers to develop a professional and financial interest in upholding the practice. And while some argue that a medically performed FGM could be a first step to abandonment, there is no evidence to support such an assumption. Hence, in order to avoid the promotion of medicalisation among communities who see it as a way of preventing the spread of HIV, campaigns should emphasise that the safest way to prevent HIV infections is to entirely abandon the practice of FGM.[43]

In 2010 WHO together with seven other UN agencies and various professional organisations issued a global strategy[44] to stop healthcare providers from performing FGM. WHO suggests that while providing care for women and girls who have suffered from the negative health consequences of FGM is a key role for healthcare providers, support for the abandonment of the practice is also important.

[40] FIGO Committee for Ethical Aspects of Human Reproduction and Women's Health (2012).

[41] WHO (2008).

[42] Budiharsana (2004), quoted in Norwegian Knowledge Centre (2009).

[43] Shell-Duncan et al. (2010).

[44] WHO et al. (2010).

Health professionals not directly involved in the practice can assume a role by informing and educating their community about the dangers and possible ways of abandoning FGM; they can foster a better understanding and informed behavioural changes, which will be much more sustainable than changes due to fear of repression. In countries with laws against FGM, health professionals could explain the meaning of the law to the community. This happens for example in Ethiopia.[45]

Capacity building in the healthcare sector is essential if health professionals are to be supportive and able to participate in advocacy sessions with community leaders and to engage in awareness raising and community education. To this end, the WHO implements training courses and has developed technical tools, including guidance videos for counselling training. Yet, a meta-review by The Norwegian Knowledge Centre for the Health Services reports that the training of health workers as agents of change has shown little effect. One reason may be the dilemma faced by health workers as community and family members; another reason is the possible loss of financial incentives.

In any case, the issue of FGM needs to be integrated into activities, services and interventions that are related to sexual and reproductive rights. Also, the integration of health arguments into other approaches remains important.

1.2. The human rights framework

Nowadays, FGM is widely recognised as a violation of human rights. However, this perception only evolved over time. For many years, FGM has been viewed as a cultural practice to be accepted in terms of cultural relativism and was regarded as a 'private' act carried out by individuals in given cultural contexts, rather than a governance issue. Consequently, human rights arguments were often perceived as 'Western concepts' in the targeted communities.

The impact of all types of FGM on women and girls is wide-ranging, and the practice affects a range of human rights, including the right to life, the right to physical and mental integrity, the right to the highest attainable stand-

[45] UNFPA (2013).

Box 3:
Potential entry points for health personnel as change agents

- Provide care for women and girls who suffer from the negative consequences of FGM and help them recover from both the physical and psychical trauma.
- Perform reconstructive surgeries.
- Accompany women and girls who are at risk of being circumcised and support them in the process of abandoning FGM.
- Take part in information, education and awareness-raising activities in the community.
- Participate in advocacy efforts towards the abandonment of the practice.

Case 1: The human rights-based approach in Sudan

In northern Sudan, where FGM prevalence is about 90%, efforts on community, state and national level to end the tradition were based on a human rights approach. The approach included human rights education that introduced development activities to communities. This was complemented by a national media campaign to raise the status of those 'uncut' and to change attitudes towards the practice. The country has national and state policies to protect the rights of women and children. Between 2008 and 2009 some states have passed laws against FGM.

'The country's "Saleema" (Arabic for "whole" or "undamaged") campaign has helped reinforce positive social values which favour the well-being of children by leading discussions about parental care and family pride, thereby gradually moving towards more direct messages about FGM.[46]

ard of health (including reproductive and sexual health), freedom from discrimination on the basis of sex, the right to freedom from physical or mental violence, from injury or abuse, torture, cruel, inhuman and degrading treatment. The practice is also a violation of the rights of the child to development, protection and participation. A crucial starting point towards addressing the entire range of factors endorsing the perpetuation of FGM is to recognise that civil, political, social, economic and cultural rights are indivisible and interdependent. The practice is addressed in a number of international and regional human rights treaties. As a harmful 'customary' or 'traditional' practice, FGM is mentioned in article 5 of the 1979 Convention on the Elimination of All Forms of Discrimination against Women (CEDAW). CEDAW addresses FGM and other cultural practices in the context of unequal gender relations and calls upon all state parties to the convention to take appropriate measures against it. The 1989 Convention on the Rights of the Child (CRC) makes explicit reference to 'harmful traditional practices' in the context of the child's right to the highest attainable standard of health. In 1994, the International Conference on Population and Development (ICPD) in Cairo has placed reproductive and sexual rights on the international health agenda. In 2012, the UN General Assembly passed a resolution with the aim to overcome FGM globally. The United Nation's Committee on the Elimination of Discrimination against Women, their Committee on the Rights of the Child, and their Human Rights Committee have been active in condemning the practice and recommending measures to overcome it, including the criminalisation of FGM.[47] In November 2014, CEDAW and CRC released a Joint General Recommendation/General Comment on harmful practices in order to provide authoritative guidance and to clarify obligations of states to prevent and eliminate harmful practices. FGM is referred to as one of the most prevalent harmful practices and its severely negative consequences are highlighted.[48]

[46] Afronline (2010); Women living under Muslim Laws (2009); UNICEF (2010).

[47] WHO (2011b).

[48] CEDAW/CRC (2014).

A growing number of regional initiatives to end the practice have also been implemented. In 2001, the European Parliament (EP) adopted a non-legally binding resolution, which called upon Member States to collaborate to harmonise existing FGM legislation, to formulate such legislation where not yet existent and to recognise the right to asylum for women and girls at risk of being subjected to FGM.[49] In 2012, the EP adopted a resolution to end FGM in Europe and elsewhere that calls on Member States to combat FGM through legislation, prevention, and protection measures. In November 2013, the European Commission released a policy communication 'Towards the elimination of female genital mutilation'. This comprehensive strategy to combat FGM places particular emphasis on prevention; however, it addresses a wide range of aspects such as legislation and law enforcement, victim support, data collection and research, international dialogue on ending FGM, and implementation, monitoring and evaluation of the planned actions.[50] Based on this strategy, the European Parliament has adopted a new resolution to this effect on 6 February 2014.[51] In Africa, the ratification of the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, better known as the Maputo Protocol, in 2005 confirmed the commitment of governments to promote and protect women's and children's human rights. Article 5 of this protocol explicitly prohibits and condemns FGM and other harmful practices.

Approaches that are guided by human rights principles have demonstrated the greatest potential for promoting the abandonment of FGM. Rather than addressing FGM as an isolated issue, a human rights-based approach (HRBA) frames FGM as a human rights violation. It also aims at empowering women and girls living with or being at risk of undergoing FGM and seeks active and meaningful participation of those directly affected by the practice.

Human rights arguments certainly have their place in the larger pool of arguments against FGM. However, when these are used as the main argument and become the subject of isolated focus in discussions, they are usually not so effective. Hence, a human rights framework always has to be adapted to fit the cultural and political context as well as the target audience of the intervention.

[49] Powell et al. (2004).

[50] European Commission (2013).

[51] European Parliament (2014).

Box 4:
Countries with legal provisions addressing FGM[52]

There is a clear trend towards the adoption of laws prohibiting FGM in countries where the practice is common. By 2014, 27 countries in Africa and the Middle East had introduced a legal framework:[53] Benin, Burkina Faso, Central African Republic, Chad, Côte d'Ivoire, Djibouti, Egypt, Eritrea, Ethiopia, Ghana, Guinea, Guinea-Bissau, Iraq (Kurdistan region), Kenya, Mauritania, Niger, Nigeria, Senegal, Somalia, South Africa, South Sudan, Sudan (some states), Tanzania, Togo, Uganda, Yemen and Zambia.[54]

Laws prohibiting FGM have also been introduced in a number of countries where the issue has arisen among immigrant communities, e. g. in Australia, Canada, New Zealand, USA and several European countries, including Germany.[55]

Yet, law enforcement remains weak in many countries and the implementation of laws differs widely. According to UNFPA and UNICEF, legal action against law offenders was taken in 141 cases in 2011. In Burkina Faso, legal action was taken in 62 cases; Eritrea reported 54 and Ethiopia eight cases.[56]

[52] The scope of legislation on FGM varies considerably. There are countries where the practice is banned entirely and others where FGM is illegal when carried out by medical practioners in government health facilities. Some states have general criminal law provisions that might be applicable to FGM without referring to the practice specifically. UNICEF (2013).

[53] UNICEF (2013).

[54] UNICEF (2013).

[55] Laws of the world on FGM (no year); The CHANGE project.

[56] UNFPA/UNICEF (2011).

1.3. The legal framework

The implementation of international obligations and commitments does not come automatically. After the ratification of the relevant human rights instruments, governments are obliged to prevent the practice of FGM in their jurisdiction. The international human rights framework needs to be translated into national legislation and plans for action. In addition, governments have to comply with their obligations by enforcing existing laws and provide funds for sustainable programming. Hence, efforts to end FGM should be incorporated into a larger governance framework.

One of the benefits of national, regional and local anti-FGM legislation is that it provides an official legal platform, offering legal protection for women and girls by discouraging excisors and families who want to avoid prosecution from performing the practice. It also supports health professionals in their commitment towards anti-FGM approaches and gives them an official justification for refusing to carry out the cutting or to comply with demands for re-suturing after delivery.

Even though legal frameworks support the implementation of measures against FGM, such a framework alone is not sufficient to change deeply entrenched social practices and traditions. Additional efforts are needed to enforce the laws and to increase the acceptance for the abandonment of FGM at community level. Concerns that criminal laws might force those practising FGM into hiding, leading it to being practised clandestinely, have proven to be justified in many countries. This has resulted in health complications going undetected for fear of prosecution. In Senegal, many women and men who were surveyed confirmed their strong intention to carry on with the practice, if necessary in secret.[57] Other examples show that the criminalisation of FGM can lead families to have the practice performed in neighbouring countries, which have as yet to pass legislation or where its implementation is weak.[58] Therefore, additional efforts are needed to minimise the potential negative effects of an anti-FGM legal framework. Find-

[57] Kessler Bodiang et al. (2000).

[58] UN Women (2008).

ing the right balance between law enforcement, public education and dialogue is challenging, and turning to the law to protect women and girls entails a risk of alienating communities.[59]

Another challenge for women is to successfully lay claim to their rights. In particular, poor women are often unaware of their rights or unable to enforce them in a court. The coexistence of civil and customary laws further complicates their legal realities. As customary laws are usually rooted in social conventions and political motivations, they often reveal a discriminatory practice. Customary law has a major impact on the practice of FGM. A significant debate between human rights activists and traditionalists focuses on whether customary norms are compatible with human rights norms. The conflicts often remain unsolved, thus putting an additional burden on women who want to claim their rights. Hence, it is critical for governments to reform customary and religious laws in order to protect women and girls.

1.4. The 'religious' framework

The 'religious' framework, which has evolved during the past ten years, is based on the premise that religion is an important factor in the decision to practise FGM. In many contexts, cutting is considered a religious obligation. This is particularly true in countries with high prevalence rates. 64% of women and girls in Mali (prevalence 89%)[60] and 57% in Mauritania (prevalence 69%)[61] believe that FGM is a religious injunction.[62] The practice is not limited to one religious context: while a majority of the communities concerned are Muslim, several are Christian or practice a traditional religion.

[59] WHO (2000).

[60] Demographic Health Survey (2006).

[61] Multiple Indicator Cluster Survey (2007).

[62] UNICEF (2013).

Case 2: Enforcement of criminal laws in Burkina Faso

In Burkina Faso, the new legislation from 1996 soon led to the first detention of an excisor. This law calls for a prison sentence of six months to three years and/or a fine ranging between some USD 300 and USD 1,750 (150,000 to 900,000 CFA francs[63]) for anyone found guilty of performing FGM. Higher penalties apply when the procedure results in death. Furthermore, there are special measures against medical or paramedical staff that perform the operation. The law also introduces fines for anyone who knows about FGM being practised and does not report this to the relevant authorities. With international support, the National Committee for the Fight against FGM has also created an SOS Hotline free of charge, which, together with community level whistle-blowing, provides the backbone for the enforcement of the law. It's mostly young people who give information on the hotline. However, due to fear of prosecution, many callers hang up before they reveal, where the circumcision is supposed to be performed.

At the same time, reports indicate considerable difficulties in gaining the communities' trust. The enactment of the law has, in some places, resulted in tensions between activists and the community they are supposed to serve.

In Burkina Faso, the law is one component of a broader approach that includes awareness-raising initiatives and social support. The 2010 Demographic and Health Survey of Burkina Faso provides evidence of positive attitudinal change. The survey found that only 11.7% of circumcised women said that they were in favour of continuing FGM, while 87.4% wanted the practice to end. Whether these responses reflect socially desired answers rather than personal convictions cannot be assessed with certainty.[64]

[63] The CFA Franc is the currency of Communauté Financière Africaine, issued by the Banque Centrale des États de l'Afrique de l'Ouest (BCEAO).

[64] WHO (1999); UNICEF Innocenti Research Centre (2005).

In the scriptures of Islam and Christianity there is no evidence that FGM constitutes a religious requirement. Neither the Qur'an nor the Bible mentions the practice. Nevertheless, there is an ongoing debate among religious leaders whether FGM is a religious obligation. In Islam, one hadith, a saying attributed to the prophet Mohammed, is principally subject to discussion.[65] Some religious leaders consider this as evidence that Muslims should practise FGM. However, there are several versions of this hadith with conflicting meanings; its chain of transmission is weak, too. That is why many Muslim scholars doubt that it refers to FGM and question its authenticity.[66]

As this example demonstrates, religious leaders have a certain freedom of interpretation: they can play an important role in excluding FGM if they believe it is not in accordance with the principles of religion; or they can strongly influence people's decision to continue the practice if they claim that it is prescribed by religion.

It is therefore of utmost importance to tackle the issue of FGM and religion in communities where it is deeply rooted in religious beliefs. The stance taken by religious scholars and imams on FGM has consequences, since they are highly respected opinion leaders and people follow their words. As long as people consider cutting to constitute a religious obligation, they will not abandon the practice. In a study conducted by the Population Council in the North Eastern Province of Kenya, respondents stated they knew that FGM had negative health consequences for women but would still not give up the practice, because they considered it to be a religious principle.[67] Consequently, religious leaders are an essential target audience. Wherever possible, they should be involved in the process of abandoning FGM. They can make a real difference as change agents and should be trained and supported to enable them to participate in the abandonment process. Thus, the 'religious' framework consists of bringing about a change of mind among religious opinion leaders and helping them to engage publicly at all levels towards the abandonment of FGM.

The dialogue with religious leaders forges a strategic partnership. The approach, which has led to satisfactory results in GIZ programmes, was mainly based on religious and health arguments.[68] Human rights and particularly women's rights may be considered a 'Western construct' incompatible with the local religion and culture. The religious framework is thus related to the human rights context. Women's rights should be part of the discussions wherever possible, but most arguments for promoting the abandonment of FGM build on religious and medical aspects. In any case, religion is strongly linked to social dynamics and is far from being the only reason for performing FGM. Besides working with religious leaders, involving the target populations remains essential.

[65] The Prophet, during a discussion with a circumciser named Umm Habibah (or Umm 'Atiyyah), states: 'when you cut, do not cut too much. That way you allow the woman more pleasure, and it is more pleasant for the man.'

[66] For more information see GIZ (2011a); Population Council/USAID/Frontiers (2008).

[67] Population Council/USAID/Frontiers (2009).

[68] GIZ (2013b).

2.

Approaches and target audiences

Today, more in-depth information is available and different approaches have been evaluated in terms of their strengths, weaknesses and impacts. This chapter introduces a range of common approaches and presents practical examples for each of them. The chapter concludes with the comprehensive community development approach. Limited approaches that focus on individuals, on a particular target audience, or which directly address deep-seated customs are less successful in reducing FGM than those aiming for a community-driven change. Successful approaches have to address the complex social dynamics associated with the practice.

As internationally agreed, interventions should take place at various levels in order to address the phenomenon on a broad scale:

- at international level in terms of policy dialogue and funding;
- at governmental level, their various ministries and decentralised structures in the countries concerned;
- and at community level.

A clear policy definition, coordination of all actors involved, networking and advocacy are considered prerequisites to successfully intervene at community level. Apart from the legal aspects and the mainstreaming of FGM activities, interventions targeting the government level are often not very specific to FGM. Therefore, they will have to be pursued in a similar way as reproductive health issues. This is why the approaches presented below focus mostly on interventions at community level, where FGM activities probably differ most from other reproductive health strategies and where well-designed programmes can have a big change-inducing impact.

2.1. Retraining traditional circumcisers

Educating traditional circumcisers[69] about the health risks associated with FGM and/or providing alternative means of income has been attempted in various countries, for example in Mali, Ethiopia, Senegal, Uganda, Kenya and Burkina Faso. Such conversion strategies usually include one or several of three phases:[70]

- identifying excisors and informing them about various issues related to FGM;
- training excisors as change agents and motivating them to inform the community and the families, who ask them to excise their daughters, about the harmful effects of the practice;
- orienting them towards alternative sources of income and giving them resources, equipment and skills with which to earn a living.

Most of the experiences reported have not shown the expected results. The Mali experience[71] reveals that while

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[69] In the present document, the terms 'circumciser' and 'excisor' are employed as synonyms. They designate the people (mostly women) who traditionally perform the cutting in the communities.

[70] Population Council (1998); WHO (1999).

[71] Population Council (1998).

Case 3: Evaluation of retraining efforts of excisors in Mali

In 1998 the Population Council conducted a study in Mali to evaluate retraining strategies used by various NGOs. The results indicate that the strategy of converting excisors appears to have been ineffective: the rates of conversion were low. This may be explained by the fact that the practitioner is a community member, so her conversion depends on raising public awareness among the community she belongs to.

Women from that community were often unaware of the existence of converted excisors and questioned the conversion. The income-generating activities offered to traditional practitioners stopped some from carrying out the practice for a while. But the evaluation showed that, as soon as these activities ceased, the excisors would return to their old role.

Ten years later, an additional study conducted by the Population Council in Mali revealed that the associations created for the retraining and the financial support for former excisors had only limited success. While some associations fell apart as soon as the financial assistance ceased, others apparently gave former excisors the possibility to unite and convince the community to abandon FGM. However, this positive effect has to be regarded with caution, as the community appeared to resist giving up the practice.[72]

[72] Population Council (1998); Population Council/Save the Children (2008).

such efforts may at best stop some practitioners from performing the procedure, they have had no effect on the demand. Thus it is evident that, unless such strategies are accompanied by extensive awareness campaigns addressing the entire community, families will seek someone else who is willing to perform the procedure. Traditional practitioners return to cutting within a short period of time, as circumcision is a profitable business. The same happened in Burkina Faso, where the National Committee for the Fight against FGM (CNLPE) came to the conclusion that the decision of the excisor to engage against FGM is only sustainable when accepted by the community.[73]

Social recognition is an additional factor that has been underestimated by retraining strategies: circumcisers are responsible for a prestigious task; their profession does not only provide financial advantages, but also ensures a high social status and respectability in the community. Programmes which encourage this conversion must ensure that former circumcisers still enjoy a high social status in their new position.[74]

In conclusion, the conversion of excisors does not change social conventions. FGM is a demand-driven social practice: converting traditional excisors can only be successful as a complementary strategy integrated into comprehensive approaches within the community as a whole. In addition, it needs to address not only the issue of income but also the social status of excisors.

2.2. Establishing alternative rituals

Alternative rituals have been developed as a substitute for traditional cutting ceremonies. Initiation rites are practised in many cultures worldwide, usually marking maturity and entry into the adult community. They comprise traditional education about the role the adolescent girl is expected to assume, including aspects of sexuality and motherhood. Such rites are usually the occasion for joyful festivities lasting a number of days and involving the entire community. In countries such as Gambia,

[73] Comité National de Lutte contre la Pratique de l'Excision et Société Africaine d'Etudes et Conseils (2006). See also Population Reference Bureau (2013).

[74] Population Reference Bureau (2002).

Case 4: The alternative Coming-of-Age Programme in Kenya[75]

The 'Alternative Coming-of-Age Programme' is one of many strategies used by the Maendeleo Ya Wanawake Organisation (MYWO) to eliminate FGM from several districts in Kenya.

Extensive quantitative and qualitative research preceded the development of alternative coming-of-age ceremonies. Outreach and mobilisation activities involving peer educators helped raise community awareness about the harmful effects of FGM. The programme was then conceptualised, developed and implemented in close collaboration with community members and various stakeholders, resulting in an elevated sense of ownership. Fears and opposition towards the programme were addressed and solutions were also sought with the communities.

On the basis of these activities, a programme was finally designed that excluded the mutilation of the genitalia, but which otherwise mimicked the traditional seclusion and spreading of information. This also included a final celebration based on the consensus reached.

The first 'Alternative Rites of Passage Programme' was conducted in 1996. It involved two main phases: a week of seclusion for initiates and the coming-of-age ceremony.

The mothers decided that their daughters should attend one week of intensive instructions, guidance and counselling on modern family skills. These comprised self-esteem, decision making, personal hygiene, conception and pregnancy prevention, STD/AIDS prevention and many other aspects as well as more traditional knowledge such as relationship with parents, elders and peers, marriage, religious teachings, etc. The week was followed by the coming-of-age ceremony that included festivities, the giving of gifts and the presentation of graduation certificates.

The programme rapidly gained strength and popularity. Women became strong advocates and encouraged men to join the programme. To ensure the project's sustainability, community members, mostly mothers who participated in the first initiation ceremony, were trained as family-life education trainers.

An external evaluation concluded that the alternative rituals did play a positive role in the process of behavioural change because they were embedded in a context that was favourable to change: the local church was in favour of the abandonment, and individuals started to have a critical attitude towards FGM. The contribution of alternative rituals thus depends on the socio-cultural context in which FGM is practised, including the presence of other factors conducive to change.

[75] Population Council (2011a).

Tanzania, Kenya and Uganda, genital cutting is part of these initiation rituals.[76] To introduce alternative rituals which do not involve cutting would make it possible to give up FGM without abandoning traditions that play a part in the cultural identity. The positive aspects of the ceremonies can be retained, while the harmful aspect – the cutting – is given up.

The alternative rituals strategy is usually implemented in communities where FGM is linked to coming-of-age rituals. Whether such a strategy can also be introduced in contexts where FGM is a clandestine secret practice with no link to official ceremonies is still being discussed.[77] Its success seems to depend mainly on other factors: alternative rites of passage are effective when they take place at the end of a structured girls empowerment programme, involve a communal ceremony, and are explicitly recognised as an alternative to undergoing FGM.[78]

Even then, analyses undertaken by experts in the filed conclude that alternative rituals in themselves have little impact and need to be integrated into holistic strategies to produce good results. According to Zeinab Ahmed, a child protection specialist with UNICEF Kenya,

> *"Some of the [FGM] interventions that have had limited impact are alternative rites of passage focusing on individual girls – girls belong to communities, and dealing with a girl as an individual has limitations if she then goes back into a community that still strongly believes in FGM/C. It's important to involve parents, aunts, uncles, elders – the whole community.*[79]

Alternative rituals do not shift social norms as such, but have to be accompanied by a process of participatory education and collective reflection.[80]

In any case, alternative rites of passage can only be an option in populations where girls are circumcised in their teen years. Currently FGM is more and more being carried out on younger girls. Hence it is being disassociated from coming-of-age ceremonies, and the potential impact of alternative rituals is declining. There are several reasons for parents to have their daughter cut at a younger age: the fear that she might refuse to undergo the procedure and the criminalisation of the practice were among those most cited in Kenya.[81]

2.3. Working with positive deviants

The 'Positive Deviance Approach' (PDA) was initially employed to bring an end to childhood malnourishment in Vietnam in the 1990s. The premise to this approach is that solutions to community problems already exist within the community. It seeks to identify individuals or groups who have already found solutions to common problems and then to replicate their plan of action to solve the problem.[82]

The PDA has several advantages. Culturally appropriate solutions are developed locally and are therefore available equally to all community members; they generally require very few outside resources. Most notably, the PDA mobilises ordinary members of the community, who share the same values and resources as their neighbours, friends, and relatives, but who have found an alternative solution to a particular widespread problem. The key to the approach is to identify positive deviants. In the case of FGM, positive deviants would not be uncircumcised women or girls, but, rather, family members who had de-

[76] UNICEF Innocenti Research Centre (2005).

[77] See contradictory conclusions of Population Council (2011a) and UNICEF Innocenti Research Centre (2010).

[78] Population Council (2011a).

[79] Afronline (2010).

[80] UNICEF Innocenti Research Centre (2010).

[81] Population Council (2011a).

[82] Sternin et al. (1998).

cided against the procedure, religious leaders who spoke out against the practice, excisors who stopped performing it, or husbands who knowingly married an uncircumcised woman.

2.4. Dialogue-based approaches

Dialogue approaches aim at promoting a respectful exchange of views on sensitive topics between various members of a community. The underlying idea is that a collective reflection takes place in a safe setting and leads to a community-driven collective decision against FGM. A major strength of the generation and family dialogue is that it can be adapted to various situations, cultural contexts and issues, such as gender-based violence, HIV/AIDS and women's rights. Values, norms and traditions can thus be addressed in a small group with the help of a facilitator who leads the discussion and ensures respectful communication.

Community consultations follow the same principle, involving all members of a community in a constructive dialogue, and have been successfully implemented in Ethiopia (see Case 6).

New evidence provides strong arguments in favour of dialogue approaches. Shell-Duncan (2011) states:

> *"Being circumcised serves as a signal to other circumcised women that a girl or woman has been trained to respect the authority of her circumcised elders and is worthy of inclusion in their social network. In this manner, FGC facilitates the accumulation of social capital by younger women and of power and prestige by elder women. Based on this new evidence (…), we suggest that interventions aimed at eliminating FGC should target women's social networks, which are intergenerational, and include both men and women.*[83]

Generation dialogue

The generation dialogue as developed by GIZ is a participatory method built around a moderated, respect-based dialogue between genders and across generations. It is specifically designed to empower target audiences to change their behaviour by strengthening their ability

[83] Shell-Duncan et al. (2011).

Case 5: The 'Positive Deviant Approach' in Egypt

In Egypt UNICEF in partnership with the Centre for Development and Population Activities (CEDPA) piloted the PDA from 2003 to 2006 in the FGM Abandonment Programme. The approach was evaluated in 2008. The prevalence rate in the four governorates where the programme was implemented was about 96% to 99%. A significant increase of families opposed to FGM could be observed: with 13% at the start of the intervention rising to 51% in 2006. However, the evaluation highlighted that several lessons had been learned.

First, efforts against FGM need to come from within the community in order to be accepted. Positive deviants, volunteers as well as community and religious leaders were essential for the implementation and success of the programme activities. Second, sustained efforts against FGM at community level yield better results: communities in which there had been earlier interventions against FGM were more receptive to the message. Third, the important role of strong and active local NGOs for the success of the programme needs to be accentuated. Finally, the evaluation showed that focusing on the physical harm caused by FGM results in the medicalisation of the procedure. Recommendations based upon these lessons learned call for the incorporation of the message against FGM within the framework of human and especially children's rights. The evaluation also recommended to integrate the message on FGM into other awareness-raising activities concerning, for example, health issues and hygiene; to include more men into the target audience; to try to increase the visibility of the project by involving the media; and to maximise the potentials of cooperation with the various related ministries, consultative committees, universities and national partners.[84]

[84] Population Council (2008).

Case 6: Community consultations in Ethiopia

Community consultations have been promoted in several regions of Ethiopia with people from different ethnic, religious and cultural backgrounds. They were held on topics such as HIV/AIDS and harmful traditional practices. Several NGOs initiated community consultations, involving political and religious leaders and following different models, which were adapted to the community they worked with. According to an extensive evaluation carried out by UNICEF[85], the NGO KMG Ethiopia had notable success. They carried out their activities in the Kembatta Tembaro Zone, a densely populated region with a majority of Christians, where FGM and marriage by abduction are still commonly practised.

The consultative approach taken by KMG Ethiopia is integrated into a wider range of community development projects. They comprise health education and services, reproductive health programmes, mother and child health centres, community schools, livelihood projects for women and environmental protection. Awareness raising activities on FGM and human rights run together with these numerous initiatives. Community consultations that are open to all villagers provide them with the opportunity to ask questions and share concerns about traditional practices. The groups meet twice a month for a minimum of one year.

Following the consultations in the Kembatta Tembaro Zone, various communities decided to make a public declaration condemning FGM. At the same time, KMG organised public weddings of couples that chose to break with the tradition and 'whole body' ceremonies that celebrate uncut girls. These activities contributed to a dramatic improvement of the status of uncut girls, and strongly influenced many of those who decided to give up FGM.

Following this decision, community members act as watchdogs. Any violation of the declaration is punished with exclusion from the community and religious associations. The local police are deployed when legal action is needed or violations are reported.

The evaluation of the activities showed very satisfactory results. About 96% of the villagers accepted the public declarations. The percentage of villagers planning to have their daughter cut dropped dramatically from 97% to 5%. 85% of the villagers stated that uncut girls are no longer despised. The success of the community consultation can largely be attributed to the fact that it is part of a larger programme, including alternative rituals, human rights and legal aspects. Finally, development projects met practical needs of the people and yielded trust and goodwill among the concerned populations.

[85] UNICEF Innocenti Research Centre (2010).

to take action. These skills are subsequently put to test, using dialogue-driven pledges in which the different generations and sexes agree to make realistic efforts to change.[86] This bottom-up strategy combined with the empowerment of people ensures that the ownership of a possible FGM abandonment process lies within the community. Held in an atmosphere of mutual respect and understanding, the dialogue promotes communication between the generations. The population can integrate its own conceptions, ideas and desires, differentiate between positive and negative traditions and propose modifications. Thus the approach is demand-driven and contributes to an efficient and long-lasting process.[87]

The method has proved effective in Guinea, Mauritania, Mali and Kenya and has evolved over the years of implementation.[88] In Mali, for example, the generation dialogue involves 40 community members: 10 young women, 10 older women, 10 young men and 10 older men. If possible, the local imam is invited to participate as well. The workshops last four days and focus on the following subject areas: 'active listening and dialogue skills', 'family structures and paths through life in the past, present and future', 'traditional practices (including FGM) - then and now' and 'formulating wishes and making personal pledges'.[89] On the forth and closing day, the participants learn how to reproduce the dialogue among members of their community. They are then in charge of organising 'small dialogues' within their peer groups over the following weeks. One or two months later, they meet in a workshop and wrap up their experiences.

According to several studies, the generation dialogue approach is very promising and produces convincing results: in Mali, 74% of community members who participated in a generation dialogue on FGM stated they had taken steps to put an end to FGM in their community while none had done so in the control group. The fact that the elderly members of the community and the religious leaders accepted this approach greatly influenced the entire community. Furthermore, qualitative research provided evidence that FGM was declining. More families in the intervention villages had decided not to have their daughters cut. In a few villages, excisors were denied entry. In others, they had stopped performing the practice. The leader of an intervention village publicly declared that his village should be FGM-free.

A further strength of this approach is its multiplier effect: participants carry the dialogue on FGM into their extended community. Experience in Mali has shown that one participant ultimately reaches on average 28 other people, so that her/his capacity greatly benefits the community as a whole.[90] As to its limitations, it appeared that religious leaders tended to adhere to their conservative opinions. A further difficulty was the collection of data on the 'small dialogues' held by the trained beneficiaries without the direct participation of a facilitator.[91]

A study on a generation dialogue conducted by GIZ in Guinea revealed that the dialogue fostered communication and mutual interest between parents and their children, leading to a better understanding. Difficult topics such as sexual morals, FGM and HIV/AIDS were discussed more frequently among intervention families than among control families. Communication also assumed a more reciprocal form: the older generation better listened to the problems of the youth, while the younger generation appreciated the viewpoints and experience of its elders more than in the control group.[92] Attitudes towards FGM changed notably, too. 19% of parents in

[86] GIZ (2011b).

[87] Fricke (2006).

[88] GIZ (2011b).

[89] GIZ (2011b).

[90] GIZ (2011b).

[91] GTZ/Plan Mali (2009).

[92] GTZ (2005).

the intervention group and 65% of those in the control group intended to have their daughter circumcised.[93] Researchers were told that circumcision ceremonies were no longer being executed, that parents refused to have their daughter cut, and that excisors stopped performing the practice, while stigmatisation towards uncut girls started to decrease.[94] One result of the dialogue was the development of a training programme for uncircumcised girls to help further reduce social pressure and stigmatisation.[95]

Dialogue approaches show good results when moderators are well trained, understand the socio-cultural environment, speak the local language and can adapt to different settings. Thus sound capacity development of community-based organisations is key to successfully implement this method. This is why GIZ has developed a comprehensive tool kit for the implementation of generation dialogues.[96] It consists of a guidance note for organisations that wish to fund and/or implement generation dialogues in addition to four hands-on manuals on how to train trainers and facilitators and how to implement the method itself.

In order for these dialogues to be sustainable, they need to be integrated into a broader strategy and combined with further approaches, for example an educational approach in schools, as undertaken by GIZ in Mali.[97] At the same time, GIZ is working towards the abandonment of FGM at regional and national levels to create synergies and accelerate the process of change in the country, in accordance with its multi-level approach.

[93] GTZ (2005).

[94] Fricke (2006).

[95] GTZ (2005).

[96] The toolkit is available at www.giz.de/fgm

[97] GIZ (2013d).

[98] GIZ (2011c).

[99] Neuhaus (2010); GIZ (2010).

Family dialogue

In a family dialogue, the family unit has a guided discussion and reflection between all its members and generations. Its aim is to bring an end to the taboo on FGM in the family and to promote communication on sensitive topics between family members, thus leading to the expected behaviour change. The dialogue itself starts with family members listening to recorded information about the approach, followed by a discussion moderated by a facilitator in which all family members are encouraged to voice their position. The family is considered to be a protective environment for behaviour change: its members engage in a debate and are encouraged to identify and resolve the family's own particular women's-rights-related issues.[98] Despite its focus on family, this approach also involves traditional and religious leaders in order to promote women's rights in the community and to ensure the acceptance and success of the approach.

Family dialogues have been successfully implemented by GIZ in Burkina Faso. The programme started with a baseline study, which showed that not only FGM, but also various other forms of gender-based violence were common in the intervention area. The dialogues contributed to an overall improvement of the situation of women in the community. They resulted in an increased net school enrolment rate for girls. Violence against women and girls declined, while female victims of violence reported such incidents more frequently to legal services. Regarding FGM, 40% of the population perceived the practice to be a form of violence against women and girls compared to 5% before the intervention.[99]

2.5. The educational approach

To address FGM in schools is a recent approach that has been promoted by GIZ in Mali and Burkina Faso. It consists of integrating FGM in the educational programmes in schools and in extra-curricular educational activities. The issue is addressed through open discussion in a non-judgemental way. The rationale behind this approach is that learning and exchanging views about FGM and its dangers should lead to a change of attitudes among children. In the long run this will contribute to social change in the community.

Classes on FGM can be held in elementary and secondary schools and adapted according to the age of the pupils. The underlying rationale is that today's children

Case 7: Addressing FGM in schools in Burkina Faso and Mali

Burkina Faso has integrated the subject of FGM in school education programmes since 2004. Starting in a number of pilot areas, the educational authorities have developed training modules and participatory methods specifically tailored to such a sensitive issue as FGM. The gradual integration of the topic into national curricula for school children is still in the process of being implemented.[100] Teacher trainers were specifically instructed.

At the same time, sensitisation programmes were developed with the aim of raising the enrolment rate of girls in schools. Preliminary studies conducted in pilot regions indicated that this approach contributed to a shift in attitude towards giving up FGM in the population.[101] The outcome shows that most school students and adults in the intervention zones now disapprove of circumcision. In a growing number of cases, students and adults have reported to teachers or women's groups that girls were at risk of being cut. This has led to successful interventions to protect the girls.

The school-based approach has been integrated in the 2009-2013 action plan of the National Committee for the Fight against FGM, which seeks to complete the integration of FGM into the national curricula for primary and secondary schools by 2014.[102] As a result of young people being increasingly sensitised to the subject through education, many boys and girls now speak out against FGM and are able to explain the reasons: in 2006, 30% of primary school students and 45% of secondary school students were able to list three immediate and two long-term consequences of FGM. These numbers have increased to 54% and 87% in 2009, and to 75% and 89% in 2012.[103]

In **Mali**, the issue of FGM was integrated into 'host subjects' such as languages, biology, or history at 116 schools.[104] The teacher training consisted of a two-day workshop in which the main training tool, a teaching guide, was distributed. The participants would then disseminate their knowledge to their non-trained colleagues.

Following an evaluation in 2009,[105] the teaching activities on FGM contributed to a major change of attitudes among all population groups concerned. The programme managed to break the taboo on the practice. School children were interested in the issue and knew about the negative consequences of FGM. The majority of students, especially girls, declared they would not like their daughters to be circumcised in the future. Similarly, boys in the intervention schools were less inclined to have their daughters cut than boys in the control schools.[106]

It is encouraging to note that the training also contributed to a complete change of attitude among teachers towards the abandonment of FGM. All of them stated that they changed their opinion and started to oppose FGM as a result of the training. This is an important success as teachers enjoy an elevated status in their community. They are considered persons with credentials and can be significant advocates for communication and sensitisation. Furthermore, teachers were found to handle the integrative techniques and active teaching methods with great competence, ensuring the quality of education on the subject of FGM and contributing to a relaxed learning atmosphere. Nonetheless, several obstacles to the multiplier effect were identified, such as the insufficient level of education amongst some of the teachers and the fact that they were often relocated.[107]

Also, a synergy effect was observed between the school approach and generation dialogues that were conducted in villages close to the target schools: parents who participated in a generation dialogue did not oppose the discussion of the subject in class.[108]

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[100] GIZ (2013c).

[101] GIZ (year unknown).

[102] GIZ (2011c).

[103] GIZ (2013c).

[104] GIZ (2013d).

[105] GTZ/Plan Mali (2009).

[106] PROSAD (2011).

[107] GTZ/Plan Mali (2009).

[108] GTZ/Plan Mali (2009).

are tomorrow's parents – and, if they are convinced that FGM is a negative practice and should be abandoned, they will not have their children circumcised. Hence tackling FGM in schools will lay the foundations for an FGM-free future in the community. Moreover, the schoolboys of today are the husbands of tomorrow: if they prefer a wife who is not cut, this will help to reduce stigmatisation of uncut women and contribute to their social acceptance.

The educational approach incorporated more than the subject of FGM. Education provides the opportunity to reflect upon social norms and values. Empowering women and girls, for example by informing them of their rights, can help them make their own decisions about their life and their family.

Children, and in particular girls who do not have the possibility to attend school, should also be reached by the educational programme. Therefore it is of the utmost importance that the formal educational activities on FGM are complemented by non-formal ones. One approach, which has been successful in GIZ's Burkina Faso programme, is to launch peer education campaigns in villages where the school-based approach is being implemented.[109]

[109] GTZ (2009).

Several factors determine the success of school education programmes. Talking about subjects related to sexuality and private life is a challenging task. Teachers need to learn how to address this taboo subject in class. Participatory methods should allow for a more open discussion and free speech. Besides, this approach needs to be complemented by a community dialogue that goes beyond the classroom. If FGM abandonment is to be effective, the entire community needs to support the idea.

The educational approach needs to be addressed at various levels: rules for a compulsory integration of the topic in school curricula are to be adopted at the national level. The implementation of the process requires adequate training of teachers. Finally, the process has to be monitored at the school level. This multi-level approach is essential to guarantee a lasting behavioural change.

2.6. Dialogue with religious leaders

In many countries where FGM is practised, religion plays an important part in people's cultural identity and is frequently invoked as an argument to support FGM. The practice is often regarded as being linked either to Christianity, Islam or traditional religions. In any case, religiously minded people will hardly abandon a custom that is considered to be prescribed by religion. This situation has led to an approach that aims at exchanging views with religious leaders and at convincing them to publicly engage in the discontinuation of the practice.

A public declaration by a popular religious leader, in particular at the national level, is a strong signal for people. If they hear that religion does not impose FGM, they can then decide to give up FGM without fear of violat-

ing a religious obligation. For this reason, cooperation programmes in several countries try to foster a dialogue on cultural traditions and religious values. Gradually, this process should contribute to a better acceptance of interpretations that consider FGM a harmful practice.

An important breakthrough in this respect took place in Egypt in 2006: at an international conference at Al-Azhar University in Cairo, several religious leaders spoke out against FGM. Muslim scholars, medical personnel and scientists met under the patronage of the Grand Mufti of Egypt, Professor Ali Goma'a. The conference issued a fatwa (non-binding Islamic legal opinion) classifying FGM as a harmful practice that contradicts Islamic values and declaring it a crime against humanity.[110] This strategy has been pursued by GIZ in various countries, mostly working in conjunction with the local Islamic religious authorities. Thus public declarations by religious leaders banning FGM have been on the rise in recent years.

Several factors are necessary to obtain good results when using this approach. Before initiating a dialogue, there needs to be clear information about the context in which the discussion is to take place: the relationship between the state, Islamic institutions and religious leaders and their respective opinions towards FGM. Based on this information, one can choose a suitable partner to start the dialogue and launch the reflection process.

The dialogue needs the commitment of religious scholars who are highly respected among their peers and by the

population, and who are ready to publicly engage towards the abandonment of FGM. Since religious discourse can be used to legitimise unpopular policy decisions, the partners for discussion has to be chosen with utmost care.

Religious leaders are encouraged to reflect on their attitudes towards FGM, which might eventually lead to them changing their opinion. However, to convince advocates of FGM to change their minds needs trust, time and on-going communication. Therefore, the subject must be addressed with great tact..[111] For this reason, religious scholars, if possible from various backgrounds and from different age groups, need to be engaged in all stages of the process.

Constant evaluation and re-evaluation of the dialogue with religious leaders is essential. When circumstances prevent a fruitful dialogue, one needs to adapt to the situation and switch between levels and dialogue partners.[112] If the religious authorities are not willing to engage in a dialogue on FGM on a national level, it may be an option to consider the regional and community levels. To initiate talks with local imams is all the more important as they are directly in contact with the target audiences and can be important drivers of change in their community.

Once religious leaders are willing to engage publicly against FGM, people have to be informed about their attitude. It is crucial to relay a national dialogue to the regional and local level. Information campaigns, sensitisation strategies and public declarations ensure that the message reaches the target audiences. Local and national media such as radio and TV should be used to spread information about how religious authorities view the effects of FGM and other harmful traditional practices.

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[110] GIZ (2011a).

[111] Worm (year unknown).

[112] Worm (year unknown).

Case 8: Dialogue with Muslim leaders in Mauritania, Mali, and Kenya

GIZ in Mauritania and Mali

In Mali and Mauritania, GIZ implemented a dialogue with religious leaders. In Mauritania, where in 2005 GIZ engaged in talks with religious representatives, the approach was a success. Dialogues were initiated at national and regional levels. Starting with socio-political questions, the discussions shifted to human rights issues, in particular the rights of women. The religious scholars themselves led the debates facilitated by GIZ's local partner Forum de la Pensée Islamique et du Dialogue des Cultures (FPIDC); they discussed various topics including FGM in an open manner.

The dialogue initiated among religious leaders was fruitful: in 2010, the process led to an 'Islamic colloquium for a fatwa on FGM'. Thirty-three religious leaders representing all religious schools in the country publicly condemned FGM as a harmful traditional practice prohibited by their interpretation of Islamic law. Since then, various actions such as awareness raising workshops for imams took place with the support of GIZ to spread this information. UNICEF and UNFPA also participated in efforts to disseminate the fatwa in five regions of Mauritania.[113]

The process made an impact far beyond the borders of Mauritania. In September 2011, the FPIDC initiated an international colloquium on FGM for Muslim scholars that took place in Nouakchott. It brought together participants from 10 African countries that had approved of most segments of the earlier fatwa,[114] declaring that cutting is not a religious obligation and stressing that it has negative health consequences for women. The religious scholars did, however, not reach a consensus to clearly prohibit FGM in the manner in which Mauritanians had previously done. The conference was supported by several multi-lateral organisations such as UNICEF, UNFPA, and UN Women, as well as GIZ and the Government of Mauritania.

The fatwa of 2011 was the basis for the development of a model sermon that imams could use during Friday prayers to address the topic of FGM. Again, GIZ's Mauritanian partner FPIDC took the initiative and also created a 'compendium of sources on female circumcision'. It refers to contemporary fatwas as well as texts of Islamic law.[115] Based on these, GIZ organised a workshop in Dakar in 2012 for religious scholars from several West African countries including Mauritania who developed two important tools: a guide to preaching and another model sermon. Furthermore, a program on Islam and FGM was broadcast three times on the national radio of Mauritania in 2012 highlighted the fact that it is not a religious obligation to perform the practice.

The situation in Mali is rather complicated, given that conservative currents in Islam have become increasingly powerful in the last few years. A dialogue with Islamic representatives started in 2007. They issued a declaration stating that FGM was not a religious stipulation and that Islam did not allow practices that could harm the human body. In 2008 though, conservative scholars took control of the High Islamic Council, the most important religious institution in the country. Since then, it has become more difficult to address the issue of FGM, and religious leaders who approve of the abandonment of the practice have been banned from various religious institutions. Consequently, the dialogue, which was initially held at the national level, has been reduced to a dialogue with local religious leaders where feasible.[116]

Population Council in Kenya

Likewise the Population Council in the North-Eastern Province of Kenya, where FGM is universal among the Somali community, has implemented a dialogue with religious leaders. Religious justification is a strong argument for Somalis to practise FGM, given they believe that FGM is a religious requirement. Faced with such a strong argument they are unwilling to abandon it just because of some man-made national or international laws, or because of negative health consequences for women. This is why the Population Council started an approach that centred around religious arguments. With this approach, FGM is disconnected from Islam and the subject is discussed with divers strategic groups: religious scholars, community leaders, teachers, youth groups, circumcisers, police officers, parliamentarians, the media and healthcare providers.

The discussions started with religious scholars and focused on a critical examination of the religious basis for FGM and on arguments from Islamic teachings which the practice contravenes. In 2006 and 2007, a regional and a national symposium were organised, and numerous religious scholars participated. They came to the agreement that cutting is a practice with no religious benefit and that abandoning it would not violate any religious command.

The reaction of Somali scholars to the workshops was mixed: while a minority was convinced by the arguments and decided to publicly oppose FGM, the majority of Somali scholars were personally convinced, but reluctant to openly engage against the practice.

In the other discussion groups, the talks related to topics that established the non-Islamic nature of FGM and to legal and medical arguments against the continuation of FGM. A plenary session took place after each discussion. In addition, there were talks about how the reality looked like in the community, supported by evidence from the baseline study, films, testimonies of circumcisers and personal experiences of the participants. The facilitators insisted on the responsibilities of people, especially those of leaders, in correcting the 'ills' in their communities.

Before and after the workshops, the participants' perceptions, their understanding of the practice and their intention to abandon it was assessed. If illiterate, their answers were recorded. The results of these enquiries showed a considerable mind-change among participants. Community members indicated that they were ready to listen to religious scholars, and that they would be prepared to give up any practices that do not conform with Islamic teachings.[117]

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[113] GIZ (2013b).

[114] Burkina Faso, Egypt, Gambia, Guinea-Bissau, Guinea-Conakry, Mali, Mauritania, Niger, Senegal, and Sudan.

[115] GIZ (2013b).

[116] GIZ (2013b).

[117] Population Council/USAID/Frontiers (2009).

Box 5:
Achieving behaviour change: lessons from the game theory

Game theory is based on the recognition that decision-making is an interdependent process: a choice made by one player in a game depends on the (assumed) choice made by another player. That second person's choice, in turn, depends on the choice made by the first person. This interdependency of individual decision-making processes can be applied to the choice to perform or not perform FGM.

FGM is a deeply entrenched tradition. In communities where it is practised, FGM is not viewed as a violation of rights, but as a necessary step to bring up a girl 'properly', to protect her from 'immoral behaviour' and make her eligible for marriage. The social consequences of nonconformity, i.e. of remaining uncut, are reduced marriageability, social exclusion, ostracism, or even violence. They are considered to be more damaging than the physical and psychical harm FGM causes. Conformity, on the other hand, brings respect and social approval and maintains social standing. Thus social expectations play a powerful role in perpetuating FGM, making it difficult for individual families and persons to put an end to the practice on their own. This explains why information campaigns on the harm and dangers connected with the practice do not necessarily lead to a change in behaviour.

However, such social dynamics can also help to support the abandonment of FGM. The challenge for families is to collectively move forward from a situation in which all girls are cut to one in which no girl is cut. Abandonment is possible, but only by co-ordinating a collective process within the intra-marrying community. Families will abandon FGM only when they believe that most other families will make the same choice. Therefore, in order to abandon FGM, comprehensive and integrated efforts are needed that lead to a critical mass willing to promote social change.[118]

[118] UNICEF Innocenti Research Centre (2010).

2.7. Information, education and communication and behaviour change campaigns[119]

Most programmes dealing with FGM include an important 'Information, Education, and Communication' (IEC) component. Early IEC campaigns focused on raising awareness by disseminating information and by teaching target audiences in the hope of motivating them to change behaviour. It turned out, however, that while delivering messages might raise awareness of the risks associated with FGM and even change attitudes, it does not necessarily lead to behavioural change. In addition, many of the strategies and messages used did not consider research into local customs, nor had they been properly pre-tested among specific target audiences. Past experience has shown that ready-made messages have a limited impact and, in certain cases, can even be counterproductive. Approaches developed in collaboration with the target population have proven to be much more effective because they take people's motives and perceptions into consideration and respond to a local context.

Effective 'communication for social change' programmes are based on a thorough analysis of the local circumstances. Instead of focusing on social problems, these approaches value cultural richness and facilitate a process of cultural change. They involve local opinion leaders and resource persons as agents of change. Among these, religious leaders have an important role to play in many countries. It should be noted though that using communication as a means of empowerment requires a shift away from traditional communication strategies. Instead of a top-down approach to formulating and delivering messages, a dialogue is facilitated and encouraged, and ideas are developed jointly.

[119] The term "behaviour change communication" is widely used, but can be misunderstood as reflecting a top-down approach, suggesting an educational attitude towards the target audience.

IEC campaigns should not be expert-driven, but develop community-driven solutions. This implies community involvement in the identification of existing patterns and appropriate solutions. Young people are a priority target audience. Girls and female adolescents interviewed in a number of studies have stated that they are less committed to traditions, more open to discussion and, consequently, more willing to change. Likewise, the need for directing more efforts towards boys and young men to change their inclination to marry circumcised girls has been recognised.

In response to the lessons learned through the social convention approach, another shift in behaviour change campaigns has been made from attempting to change individual behaviour to addressing collective social change.

Examples of strategies used for reaching young people include the training of young girls and boys as peer educators, and educating youth through the use of radio and television. However, experience has shown that such programmes often stay at a rather superficial level and lack continual and follow up support for those who have undergone initial training.[120] As with every other issue, volunteers, who are trained to reach out to communities, need ongoing support, supervision and to be constantly motivated in order to continue their activities effectively.

Well-designed IEC and communication for change campaigns have the potential to raise awareness and change attitudes, but they are usually not sufficient to change behaviour. Communication that aims at comprehensive behaviour change needs to be reinforced by interventions such as skill-building (for example, how to resist being coerced into having a daughter circumcised) and building community support to sustain the change.

The role of the media

The media play a decisive role in campaigns to abandon FGM. They can be very effective in creating a public and private debate on FGM and are therefore important partners. Constant press coverage through regular columns

[120] WHO (1999).

Box 6:
Most commonly used IEC messages

WHO conducted a survey among 85 agencies to ascertain the key anti-FGM messages conveyed in IEC material. These are listed below by order of frequency of reply:

- FGM has negative health consequences on women and children.
- FGM is a harmful traditional practice.
- Using the same instrument to perform FGM on several persons may facilitate the spread of HIV/AIDS infections.
- FGM violates the rights of women and girls.
- FGM is not a religious obligation required by Islam.
- Uncircumcised women are marriageable.
- FGM does not prevent promiscuity.
- FGM reduces a woman's sexual enjoyment.
- FGM is against Christian teachings.[121]
- Since girls are being circumcised at a younger age, circumcision as a rite of passage has lost its significance.
- FGM curtails girls' chances of furthering their education.

Encouragingly, a paradigm shift can be observed in some campaigns that emphasise positive examples of FGM abandonment.

[121] WHO (1999).

in newspapers, interviews with opinion leaders, respected public figures such as artists, athletes, politicians and so on in conjunction with community-based radio programs and video clips all constitute vital ways to inform the public on the dangers and adverse consequences of the practice. They also offer positive examples of change. Radio programs in local languages, where experts such as gynaecologists, children's welfare officers, education experts and religious leaders debate the issue, have proven to be highly effective in promoting discussion on the issue.

During some live broadcasts, women and girls can call in anonymously and talk about how FGM has affected them. Successful examples of different forms of communication include storytelling, which can facilitate a change of behaviour and attitude towards FGM. Other media, such as films in local languages may reach social groups that have been otherwise excluded due to cultural or language barriers. The use of electronic media (CDs, internet-based programs) may constitute future opportunities, particularly in an urban and an educated milieu.

In order to prevent stigmatisation and ensure good quality media work, media personnel needs to be informed about FGM and trained on appropriate ways of communicating. To overcome initial hostilities and resistance to voicing opinions about harmful traditional practices, it is also desirable to place FGM issues within a wider context of gender equality, reproductive and human rights, and social development as a whole.

2.8. Combining the efforts: The comprehensive social development approach

All the above-mentioned initiatives have attracted national and international attention to the issue of FGM. But in the past, activities to overcome FGM were sometimes perceived as being part of a 'struggle' against local traditions. Consequently, communities often viewed such interventions as an attack on their cultural values and thus resisted change. Nevertheless, the strategy of enabling social rather than individual change is a very promising one – provided it is implemented in a culturally appropriate and acceptable way. Successfully addressing FGM requires the implementation of a comprehensive social development approach, integrating the various frameworks and approaches described above. Such a comprehensive approach should address all relevant aspects: the social, political, legal and economic development of a community along with all health and gender related issues.

Of all the strategies outlined above, the community-driven approaches based on human rights principles have demonstrated the greatest potential for promoting the abandonment of FGM. Rather than addressing FGM in isolation, they focus on empowerment and capacity building, especially of women and girls, to promote and safeguard their own human rights. Such approaches usually consist of a variety of elements such as positive deviants and collaboration with community, religious and traditional leaders. Furthermore, they use public discussions as well as educational elements which focus on a range of issues instead of isolating FGM. The appropriate tools should be chosen according to the local context of where the intervention should occur. Once communities have reached a collective decision, a public declaration is another important step towards change. This approach has been applied effectively by Tostan in Senegal, as well as in many other countries.

To boost community-based approaches, support is necessary on many levels: engagement by traditional and religious leaders, legislative and policy measures, forums for public debate, and accurate and culturally sensitive media messages. Co-ordinated efforts are needed in order to abandon FGM at local, regional and national level.

Case 9: The work of Tostan in Senegal and the 'Village Empowerment Programme' in Egypt

Tostan is an international NGO established in **Senegal** in 1991. Its objective is to encourage social change based on capacity building at community level. The underlying idea is that the beneficiary of the programme becomes the leading agent of change. The Tostan approach focuses on an education programme for a specific group in a village and a community mobilisation programme. Tostan primarily targets women because of their involvement in the educative process, and thereby seeks to advance the adoption of healthy behaviour patterns.

In 1998 Tostan initiated a 'Village Capacity Building Programme' covering a wide range of topics. These included basic hygiene, oral rehydration therapy and immunisation, financial management, leadership, women's health and children's development as well as sustainable management of natural resources. Based on the needs of the communities involved, the modules have further evolved and now cover human rights and responsibilities, problem resolution skills, and personal health. Emphasis is placed upon certain traditional practices that are detrimental to women's health, such as early marriage, frequent pregnancies, and FGM.

Education only accounts for one aspect of the Tostan approach; it is accompanied by other socio-economic activities. The culmination of this process is community mobilisation in the form of a public declaration in which villagers collectively commit to giving up harmful practices. As of July 2011, 5,232 communities in Senegal have made such a declaration in which they committed themselves to the abandonment of FGM. The social mobilisation also reaches neighbouring villages that have not taken part in the programme, but are participating in the public declarations. Tostan has directly reached more than 200,000 Africans and perhaps more than two million if all those impacted by the public declarations are counted.

An evaluation conducted by UNICEF in 2008 indicates that the programme helped the villagers to bring about changes in knowledge and perceptions concerning FGM. The majority of those surveyed declared that FGM was no longer performed in their village. These statements were supported by statistical evidence. Furthermore, the status of women within the villages was elevated.[122]

In **Egypt**, the 'FGM Free Village Model', launched in 2003, represents Egypt's national initiative towards eliminating FGM. The project aims to reverse attitudes of families towards FGM by enhancing their knowledge on the harm caused by the practice, thus enabling them to abandon it. It was implemented in 60 villages during the first project phase and in 120 villages after 2005.

The project adopts an innovative multi-pronged approach which seeks to create an enabling environment to abandon FGM. This is achieved by engaging the community at large: civil society, media, community and religious leaders, policy makers, non-governmental organisations, youth groups, and professionals including medical doctors, journalists, lawyers and judges.

The model builds on earlier experiences to eradicate FGM in Egypt, primarily those of the Egyptian Task Force against FGM, and harnesses the knowledge, skills, and lessons learned from these earlier efforts. It represents a unique partnership between government agencies, civil society, and international organisations. By using a comprehensive approach that incorporates medical, social, religious and legal aspects, the National Council of Childhood and Motherhood (NCCM) has established the core infrastructure that triggered society's attention and concern towards FGM and its damaging effects.

Due to a number of awareness raising activities, in June 2008, the Egyptian parliament passed a law which bans the practice of FGM and now forms part of the criminal code. A paradigm shift was thus created, moving the practice from the realm of a socially accepted norm to that of a criminal activity. Furthermore, the public opinion on FGM is changing: according to an evaluation carried out in 2011, 81% of women in the intervention group stated that the information they had received made them re-evaluate their views concerning FGM.[123]

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[122] UNICEF (2008); USAID/Population Reference Bureau (2006); Tostan (no year)

[123] Population Council (2011b).

3.

Undertaking research and evaluating results

With growing efforts and numerous interventions to promote the abandonment of FGM, the need to understand FGM in its various socio-cultural contexts and to assess the effects of the diverse interventions has increased. Effective programme design and implementation must be based on reliable data.

In recent years, there has been a marked increase in the amount of systematically compiled information through large population-based surveys or small project-based studies. Unfortunately, the number, scope and quality of studies remain inadequate, partly due to insufficient funding allocated to evaluation and research. Conversely, the increased funding set aside for interventions has led to a greater expectation that empirical evidence needs to be gathered to highlight their effectiveness.

Demographic and Health Surveys (DHS)[124] and UNICEF's Multiple Indicator Cluster Surveys (MICS) have provided reliable and extensive data on the prevalence and nature of FGM.[125] MICS have a similar structure to the DHS surveys and are designed to provide an affordable, fast and reliable household survey system in situations where no other reliable data sources exist. The questions asked in this type of survey have evolved over time and establish:

- whether or not a woman has undergone FGM, and, if so,
- how old she was at the time of the procedure,
- the type of surgery,
- and by whom it was performed.

The analysis of these data leads to the internationally agreed-upon indicators (see box 7). By 2014, DHS data were available for 25 African and Middle Eastern countries where FGM is practised; countries from which data has yet to be compiled include Djibouti, Guinea Bissau, Liberia, and Somalia.[126]

Both DHS and MICS allow national level data to be disaggregated by age group, by urban or rural residency and by region or province. Many surveys also reveal differences in the prevalence by ethnicity and religion. The possibility of analysing disaggregated data in terms of prevalence is of crucial importance since national averages can disguise significant intranational variations.[127]

Particularly in countries where a significant proportion of the population does not pursue the practice, disaggregation can significantly enhance the understanding of FGM and inform programmatic interventions to support its abandonment. Variation is largely explained by the presence of diverse ethnic communities with differing attitudes and practices regarding FGM. UNICEF points out:

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[124] The DHS Program. Demographic and Health Surveys

[125] UNICEF, Statistics and Monitoring (2014)

[126] The DHS Program. Demographic and Health Surveys

[127] UNICEF Innocenti Research Centre (2005).

“ Data on ethnicity are available for only a limited number of countries and when analysing them at least three important issues need to be considered:

(…) ethnic groupings rarely correspond to clearly defined national administrative divisions, and groups that practise FGM/C may be present in a number of provinces or districts.

(…) even in a relatively detailed survey, the ethnic groups listed may in fact be an ethnic category consisting of many subgroups with differing practices.

(…) while the disaggregation of FGM/C prevalence by ethnicity is useful for informing programmatic action, these data should be interpreted with care to avoid stigmatization.[128]

While the standardised and largely quantitative surveys, such as those conducted by DHS and MICS, provide important information on prevalence, performers and changes over time, they do not make in-depth information on the underlying perceptions and driving forces available. Topics that require further study include: the dynamics of social and cultural change that lead to the abandonment of FGM; the prevalence of immediate and longer term health complications and psychological consequences; care procedures for women and girls; economic impact and costs of FGM, the impact of legal measures to prevent the practice and its medicalisation; the interplay between FGM and other harmful traditional practices (e.g. early marriage); FGM in the context of migration (diaspora's influence on the discussion and on carrying out the practice); FGM in fragile contexts (e.g. civil conflicts). Large-scale quantitative surveys often need qualitative in-depth research to explain findings in a comprehensive way. Conversely, if quantitative research is to be framed in a pertinent way, it often requires prior qualitative research.

An update on WHO's work on FGM[129] summarises some of the studies supported by its Department of Reproductive Health and Research (RHR). Firstly, the aim was to better understand the reasons for both the persistence and the abandonment of FGM, and secondly, to look at the health effects of female genital mutilation. These studies included both quantitative and qualitative methods. The first group of studies addressed the following broad points:

- Who influences decisions on FGM, and how do they do so?

It was found that in many cases multiple family members, including mothers, fathers, grandparents and aunts, make decisions about FGM. The results supported a social convention theory which highlights how actions of individuals are interdependent on those of others, and that any effort to change behaviour must take this interconnectedness into consideration. The theoretical and methodological outcome from these studies can provide practical tools for identifying change, as well as useful hints for the monitoring and evaluation of interventions.

- Concerns about women's sexuality – a key issue for the continuation of FGM.

To investigate whether concerns about a woman's sexuality influence decisions to abandon or continue FGM, RHR supported qualitative studies in Egypt and Senegal. In addition, information on this topic was also collected from studies in other countries, including Burkina Faso, Gambia and Sudan. In each of these countries it was found that the desire to control women's sexuality was a strong motivating force for practising FGM.

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[128] Askew (2005); UNICEF Innocenti Research Centre (2005).

[129] WHO (2011b).

Box 7:
Prevalence and impact indicators

There is international agreement on the use of five indicators in surveys on female genital mutilation:

- prevalence among the 15–49 age cohort
- status of daughters (as declared by mothers aged 15–49 years)
- percentage of 'closed' (infibulation, sealing) and 'open' (excision) female genital mutilation
- performer of female genital mutilation
- support of, or opposition to, female genital mutilation by women and men aged 15–49 years

The consistency in the use of indicators enables comparative analysis at national and international level across different surveys. It is through such studies that – apart from changes in the prevalence – other emerging trends were observed in a number of countries where FGM is practised.[130]

Furthermore, in November 2003 a UNICEF Global Consultation agreed upon three indicators to assess the progress of programmes promoting the abandonment of FGM:

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

Data measuring these indicators can be derived from smaller community studies and programme monitoring and evaluation. Communities should be involved throughout any evaluation process in order to identify indicators and information that reflect their own perceptions of progress.[131]

[130] Yoder et al. (2004).

[131] UNICEF Innocenti Research Centre (2005).

- Community practices and interventions to support the discontinuation of FGM.

The update also reports on operations research initiatives, estimating the effects of the most successful interventions documented so far, in order to better understand which intervention programmes work at community level.

While small-scale interventions are usually not accompanied by comprehensive base- and endline studies, they should be based on a thorough analysis of the situation, including existing data. With any intervention, continuous monitoring of the process and its outcome is required so as to observe effects and to document results. Research involving the target community itself is an important prerequisite for the design and successful implementation of any anti-FGM intervention, including information campaigns and the development of training and IEC materials.

Monitoring and evaluation (M&E)

Research can be a stand-alone activity in terms of an explorative situation analysis. Yet it can also be an integral part of an overall monitoring and evaluation system that should be included in any intervention and programme support.

The purpose of monitoring is to describe the process of a programme implementation and to measure its progress. It is mostly related to outputs and results at intermediate level (results-based monitoring). The purpose of an evaluation is to assess effects in terms of changes at target population level. 'Did a programme achieve what it was designed to achieve', e.g. in terms of knowledge, attitudes, change of norms and behaviour?

Askew[132] emphasises that in order to evaluate interventions aiming at behaviour change, researchers (as well as those implementing the interventions) need a clear understanding of why and how the intervention is expected to instigate such a change. Given the fact that in most cases FGM interventions haven't been designed with reference to a theoretical model, Askew explains why the lack of an underlying theoretical model can make it difficult to identify appropriate indicators for evaluation, as the relationships between cause and effect, intervention activities and expected outcomes are not always clear or logical.

It is important to note that behaviour change will not be brought about through a single decision, but requires constant support over time, especially if it is to diffuse

widely so that it becomes the social norm. A continuous or permanent change, however, can only be measured through a longitudinal study spanning several years. As this is usually beyond the scope of interventions, evaluations tend to limit themselves to measuring an intention to sustain the change (for example, a public declaration or participation in an alternative rite) rather than the sustained change itself.

The long-term impact in terms of improved health (indicators) cannot usually be attributed to a specific intervention. In how far a programme's contribution can be explained plausibly has to be assessed in individual cases.

Lastly, scientific documentation of the programmes' results and a detailed description of the process that leads to the observed results also enable the various actors to share their experiences and actions.

[132] Askew (2005).

Challenges

A number of challenges are related to the validity of the data; hence the quality and reliability of the results are essential. Measuring key variables in communities before and after an intervention is a tempting evaluation-strategy. Askew cautions that this type of approach can only prove whether an intervention might have had an effect, if attitudinal or behavioural changes are noticeable between the 'pre-' and 'post-' measures, but that it cannot account for other possible factors that might have had some influence at the same time. Therefore it is not generally recommended, especially when a change independent of the intervention occurs, for example as a result of legislation being amended, general socio-cultural changes, or influence through media campaigns.

There are extremely few situations where it can be established with certainty that there is no such change in attitudes towards FGM, or where it would be possible to rule out the likelihood that activities by other organisations might have influenced attitudes towards FGM. Therefore, studies which compare communities receiving the intervention with communities not receiving it are preferable.[133]

Other challenges according to Askew include:[134]

- Limitations of self-reporting status: are respondents telling the truth or are they giving the politically desired answer?
- Does a publicly stated intention indicate a change in 'attitude', or a change in 'action'?
- Attribution of change: do people identify the intervention as the/one causal factor?
- Age-specific measures and monitoring changes over time is difficult – but essential.
- Results from cross-sectional as opposed to longitudinal studies: denial can be a common response, especially where FGM has been criminalised or stigmatised.
- There can be confounding influences and 'contaminating' factors as outlined above, if, for example:
  - no distinctive comparison is possible between intervention and control groups – like in the case of nomadic, interrelated groups (Ethiopia) or interrelated families (Senegal);
  - nationwide interventions influence the entire population – for example the use of radio in Tostan intervention areas (Senegal), or the introduction of a specific law (Burkina Faso, Ghana, Senegal, Kenya);
  - there were previous interventions with anti-FGM activities such as community-based workers (Burkina Faso) or long-term church activities (Kenya).
- These have to be seriously assessed and made transparent.

Because of the paucity of high quality evaluation studies regarding interventions to discontinue the practice of FGM, further research is urgently needed. The Norwegian Knowledge Centre for the Health Services strongly recommends:

[133] Askew (2005) refers to studies carried out by CARE International (known as the 'pre-post-control group design') for projects in Ethiopia and Sudan, and by the Population Council for projects in Senegal and Burkina Faso.

[134] Askew/Population Council (2011); Askew (2005).

> *Additional studies and interventions should be implemented in African countries as well as in non-African countries, and they should have both individuals, groups, and communities as target, including religious and community leaders, health personnel, youth, education and legislation sector staff, males, and others. Several of these groups should not just be primary target groups, but should also be empowered as message bearers and change agents. (...) To bring an end to FGM/C, we believe the next generation of intervention studies should be:*

- *randomized controlled studies (whenever possible)*
- *long-term*
- *multi-sectoral*
- *communitydriven*
- *cross-disciplinary, and*
- *international collaborative initiatives.*[135]

In recent years, regional organisations and donors have responded to the need for comprehensive research by planning, implementing and supporting research activities.[136]

The UNFPA-UNICEF's Joint Programme on Female Genital Mutilation/Cutting[137] supports research at local level, data collection in countries affected by FGM and reinforces the collaboration among academic institutions. Challenges in this context are related to the fact that countries often use different monitoring and evaluation systems at national level. Therefore, a uniform monitoring and evaluation system is being designed to ensure that all target countries use identical evaluation standards. At intervention level, evaluation indicators must obviously reflect the intervention approach that is based on the reasons behind the perpetuation of FGM.

Finally, as with any data collection, care must be taken to respect ethical rules of conduct. These include:

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- Beneficence: *maximise potential benefits for individuals and for society.*
- Non-malfeasance: *minimize any potential harms to individuals and society.*
- Respect for autonomy:
  - *respect the rights of individuals and groups to make decisions for themselves,*
  - *and protect persons with diminished autonomy (e.g. children).*
- Justice: *treat all subjects equally.*[138]

According to the Helsinki Declaration by the World Medical Association,[139] population-based research requires approval from the concerned national ethics bodies.

Strengthening research capacities

Many organisations implementing FGM interventions are not familiar with basic M&E concepts and research principles. Therefore it is necessary to strengthen capacities regarding systematic data collection. It may be advisable to first assess existing capacities and reinforce these if need be. This will facilitate more systematic data collection and knowledge management, and it will moreover ensure that valid and evidence-based conclusions concerning the effectiveness of interventions can be drawn.

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135 Norwegian Knowledge Centre for the Health Services (2009).

136 Examples are: the Replace2 project (available at http://www.replacefgm2.eu) and the African Coordination Centre for the Abandonment of FGM/C at the University of Nairobi (available at http://accaf.uonbi.ac.ke/node/306).

137 UNFPA/UNICEF (2011).

138 Askew/Population Council (2011).

139 The World Medical Association (1964-2013)

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Recommendations

Actions taken in the course of the past ten years at international, regional, national and local levels have shown their first positive results: FGM is declining; increasing numbers of communities and individuals have declared support for discontinuing the practice.[140] After decades of investing in attempts which have not shown the expected results, a number of successful experiences have now been evaluated and documented. They combine a variety of the above-mentioned approaches.

Several reviews and evaluations of anti-FGM work have deepened our understanding of the issue and identified key elements that contribute to transforming the social convention of cutting girls, thus encouraging a rapid abandonment of the practice. Even though each intervention must be adapted to the particular context, recommendations can be given based on the evaluations and the lessons learned. While the following list is not exhaustive, it does refer to the main points discussed in the previous chapters.

FGM as a governance topic

The commitment by governments to introduce appropriate social measures and legislation at all levels, complemented by effective advocacy and awareness raising measures, is crucial for the abandonment of FGM. Evidence shows that adopting appropriate governmental policies and strategies to eliminate FGM is more effective than enforcing change by decree. FGM should become a mainstream issue in relevant government policies, strategies and programmes of the Ministries of Health, Education, Information, Family and Social Services, Gender, Women's Affairs, Youth, etc., as this is a prerequisite for long-term sustainability. Civil services dealing, for instance, with women's rights or immigration, and religious institutions should also mainstream FGM into relevant programmes. Of course, civil society constitutes an integral part of this enabling environment.

Addressing and integrating the human rights and legal framework

Using a human rights and legal framework to address FGM is an essential and promising strategy. Communities tend to address the issue of FGM once their awareness and understanding of human rights increases. They are then able to progress towards the realisation of those issues they consider to be of immediate concern, such as health and education. For a better use during implementation, rights-based arguments have to be embedded in a package of comprehensible information that is presented to communities in a locally adapted way.

Enactment of anti-FGM laws has to go hand in hand with community education and communication. Beliefs can be modified through dialogue and information rather

[140] WHO (2011b).

than through legislation. Where a law has been passed, its advantages have to be emphasised rather than presenting it as an instrument of potential sanction. Furthermore, governments should reform customary and religious laws in order to protect women and girls.

Using a gender-transformative framework

Framing FGM as a matter of gender discrimination and challenging existing assumptions or stereotypes about gender relationships and power structures can pave the way for social change. A gender-responsive approach goes beyond addressing FGM; it also entails the abandonment of other harmful practices, thus directly supporting the advancement of the broader goals of reducing gender inequality and violence against women and girls.[141]

Over the last decade, the awareness of the strong gender implications of FGM has increased. FGM is most prevalent in a context of gender inequality, where men control female sexuality. It is widely believed that FGM preserves chastity, reduces promiscuity, safeguards moral behaviour and 'protects' women from excessive sexual feelings.[142] Therefore, the challenge of programmes promoting the abandonment of FGM is to separate the practice itself from ideas about sexual morality. In addition, experience has shown that the abandonment of FGM is closely linked to women's empowerment and their position in the decision-making processes. The practice is more likely to be abandoned if the decision makers in the family are female.[143]

Using comprehensive community-driven and dialogue-based approaches

Abandoning the practice of FGM demands not only individual but more importantly social change. Community discussions and family dialogues can contribute to a deliberation on the practice and the advantages of its abandonment, thus stimulating a decision-making process in the community. Integrated learning that lays the foundation for consensus-based decision-making at community level can be effective in bringing about change. People must arrive at these decisions independently; gaining public support and consensus is essential. It is therefore recommended to promote strategies that are based on community empowerment, consensus-building and collective decision-making; simply exhorting people to change their beliefs and behaviour can even be counterproductive.[144]

Addressing the social dynamics

Programmes addressing the complex social dynamics associated with FGM are more likely to be successful and sustainable. Effective programmes reinforce community values, make them explicit and lead to an understanding that these values can be better maintained, if alternatives to harmful practices are being offered. This frames the discussion surrounding FGM in a non-threatening way. The analysis of social dynamics also proves that such a harmful and rights-violating practice can be changed without disrupting the positive underlying social values.[145]

Aiming at a collective choice

FGM is a community practice. Consequently, its effective abandonment can only be achieved by a closely connected community rather than by individuals acting on their own. Successful transformation of the social convention ultimately depends on the ability of group members to take collective action. An explicit public affirmation of a community's commitment to abandon FGM – for example through a joint community declaration in a large public gathering or an authoritative written statement – supports such a collective choice and makes it visible.

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[141] UNICEF Innocenti Research Centre (2010).

[142] UNICEF Innocenti Research Centre (2005).

[143] Population Reference Bureau (2002).

[144] UNFPA/UNICEF (2011).

[145] UNICEF Innocenti Research Centre (2010).

Working with role models (positive deviants)

Identifying and strengthening so called Development Champions through the positive deviant approach is an effective way to promote social change. They have found a way to overcome FGM and can serve as multipliers, because as members of the community they enjoy more trust and recognition than personnel coming from outside.

Targeting youth

One priority target group for anti-FGM campaigns is the younger generation, since they have the biggest potential and often a strong desire for change. FGM is not an isolated issue. It is best dealt with in the context of reproductive health. Family-life education is an important part of adolescents' sexual and reproductive health education.

Alternative rites can provide an ideal opportunity for family-life education in rural communities. Addressing FGM in schools provides an additional way to reach young people and is a promising perspective for future interventions. Integrating the issue of FGM in school curricula can contribute to a generational change of attitude on a grand scale. However, underprivileged children, in particular girls, are less likely to attend school regularly and may not come under the influence of school activities. Hence, increasing their participation in education can also help to reduce FGM.

Finding alternatives for excisors

While excisors should be included in programme activities, finding alternative income for them should not be the major strategy for change. The community gives excisors their particular role; therefore, if the community decides to ban FGM, excisors can no longer perform circumcisions. Organising alternative income-generating activities for excisors can, however, help to gain their support. The community should be encouraged to identify new roles for them.

Communication for behaviour change

A profound understanding of the role of the socio-cultural environment and the context in which certain behaviours are prevalent is important for project design. Therefore, IEC materials and strategies need to be evidence-based and to target specific audiences and communities. Traditional IEC strategies using ready-made messages are much less effective than behaviour change communication. Important stakeholders and the community as such need to be involved in designing and implementing the elements of a campaign.

The role of the media

The media have a great potential in supporting efforts to instigate social change, particularly when used in a concerted and complementary fashion. They play a key role in facilitating the dissemination of messages that help to abandon FGM and to raise awareness. This can happen through broad media coverage of interventions and activities at grass-roots level (e.g. public pledges) or of policy measures at national level, by disseminating information about legal amendments in a comprehensible way, and by providing platforms for discussion and debate, such as talk shows, documentaries, TV spots, videos, and educational programs for radio and television. In order to address young people, the use of internet and digital media, particularly social network services, should be enhanced.

Media is thus an important multiplying tool for IEC measures aimed at the general public, but also for advocacy efforts towards decision-makers at various levels. Media representatives need to be informed and trained accordingly.

Involving health workers in FGM interventions

WHO recommends giving special attention to the training of healthcare workers at all levels, from obstetrician/gynaecologists and paediatricians, nurses and midwives to community health workers. They need to be convinced that it is important to engage in the campaign against FGM first. They need to receive comprehensive training both to manage and to prevent FGM complications. Competency-based training and a focus on behaviour change skills are essential elements of programmes to eliminate FGM. Support mechanisms for women affected by FGM should include counselling, not only for medical, but also for psychological and marital problems.

Discouraging medicalisation

FGM must not be institutionalised; medicalisation of the practice needs to be prohibited, and health professionals must be actively discouraged from carrying out any form of FGM.

Involving religious leaders

FGM is often strongly connected with religious beliefs. Involving religious leaders in the process of collective change can help people to overcome the tradition without fear of violating a religious obligation. Dialogues with local and national religious leaders which encourage them to publicly oppose the practice are a promising strategy. Dialogues should be carefully prepared and adapted to the local setting.

Addressing training needs

Training needs arise in any anti-FGM programme; adequate training of facilitators is essential, so that they can contribute to change in their communities. Such training should be country specific and adapted to the various target audiences. It should not be limited to formal healthcare providers but include community leaders, teachers, religious leaders, women's groups, youth peer educators, traditional healers and other influential community-members.

Identifying alternative cultural practices

Intervention strategies that lead to a cultural vacuum should be avoided. Where FGM is considered to be part of a girl's transition into adulthood, alternative rites of passage should be encouraged. They should be developed with the communities concerned, embedded into larger programmes and – rather than being the sole focus of the intervention – complemented by suitable strategic elements.

Intersectoral collaboration

The abandonment of FGM cannot be achieved through isolated interventions. As the successful example of HIV/AIDS-prevention demonstrates, intersectoral collaboration is key to progress. The health sector can play an important role within this wider framework. GIZ-assisted health projects are therefore strongly encouraged to put the campaign against FGM on their agenda.
A clear policy definition, coordination of all actors involved, networking and advocacy are vital for a successful intervention at community level.

Adapt approaches to the specific socio-cultural setting

What has worked in one context may not necessarily be a good solution in another. Interventions designed to reduce the prevalence of FGM should be country specific and reflect regional, socio-cultural circumstances. At the same time, they should take the manifold reasons into account as to why FGM is practised among a given ethnic or cultural group. This, in turn, stresses the need for research-based and locally developed approaches, designed with the community itself.

Working with women after FGM interventions

One important aspect of the campaign has recently come to light: the mental anguish that women who already have been cut can experience after they realise that, contrary to what they always believed, the practice is no longer valued as a highly-considered moral feature. In the future appropriate remedial action needs to be taken to help women experience a sense of healing both from the physical and the psychological effects of FGM.[146]

[146] UNFPA/UNICEF (2011).

[147] WHO (2000a).

Promoting the diffusion of change

When communities decide to abandon FGM, a process of organised dissemination should be facilitated to spread this information to other communities. Thus, the social dynamics that originally perpetuated the practice can now serve to accelerate and sustain its abandonment: Social pressure to perform FGM will be replaced by social pressure to stop the practice.

Self-reflection

Engagement in efforts to end FGM requires a non-coercive and non-judgemental approach. Anyone working in the field needs to examine and question his or her own assumptions, attitudes and values and try to see the situation from the communities' perspective rather than evaluating it according to one's own cultural background.[147] Socio-cultural values and settings should be respected when implementing interventions, and organisations must earn the trust of communities in order to overcome resistance to discussing such a sensitive issue as FGM.

The need for monitoring, evaluation, and research

Effective programme design and implementation must be based on sound data. While there has been a marked increase in the amount of systematically compiled information in recent years – be they large population-based surveys or small project-based studies – the number, scope and quality of studies remain inadequate, partly due to inadequate funding for evaluation and research.

Though small-scale interventions are usually not accompanied by comprehensive baseline and endline studies, they should be based on a thorough situation analysis, including existing data. Constant monitoring is required to observe the impact and to document the results of any intervention. Without local context research involving the target community itself, interventions to end FGM can hardly be successfully designed and implemented. Adequate monitoring, evaluation and research clearly require adequate funding.

Many of those who implement FGM interventions are not familiar with research principles and concepts, hence the need to strengthen their capacities regarding systematic data collection. It may be advisable to examine existing capacities in partner and implementing institutions and enhance them if need be. This will facilitate more systematic data collection and knowledge management and ensure that valid and evidence-based conclusions concerning the effectiveness of interventions can be drawn.

Enhancing sustainability

Sustainable change requires long-term commitment regarding funding and technical support. Generating dialogue and facilitating exchange, empowering women and communities, involving influential religious and political leaders, and creating networks of anti-FGM groups from grassroots to national level are vital elements that can contribute to sustained change.

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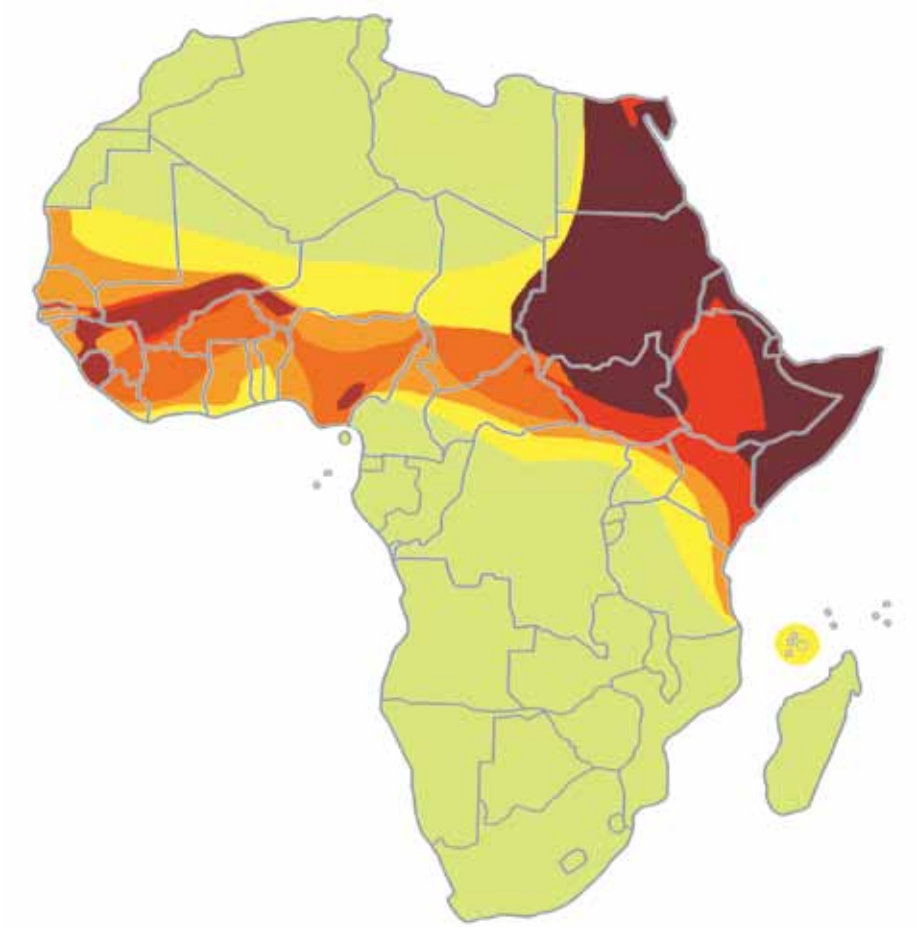
Annex 1

An estimate of FGM prevalence in Africa

Prevalence of FGM in Africa

- 95–100%
- 90–95%
- 75–95%
- 50–75%
- 25–50%
- local



Note that all data are based on very uncertain estimates.

Source: afrol News

Annex 2

The international consensus against FGM[149]

The following selected documents (in order of years of adoption) condemn in some form or another bodily and sexual injuries against women and girls:

Instrument	Year Adoption	Ratifi-cations
Universal Declaration of Human Rights	1948	
European Convention for the Protection of Human Rights and Fundamental Freedoms	1950	n.a.
Covenant on Civil and Political Rights	1966	168
Covenant on Economic, Social and Cultural Rights	1966	162
Convention relating to the Status of Refugees and its Protocol relating to the Status of Refugees	1951+1967	145+146
Convention on the Elimination of all Forms of Discrimination against Women	1979	188
Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment	1984	155
Convention on the Rights of the Child	1989	194
African Charter on the Rights and Welfare of the Child	1990	47
World Conference on Human Rights, Declaration and Programme of Action	1993	n.a.
UN General Assembly Declaration on the Elimination of Violence against Women	1993	n.a.
Programme of Action of the International Conference on Population and Development	1994	n.a.
Beijing Declaration and Platform for Action of the Fourth World Conference on Women	1995	n.a.
Charter of Fundamental Rights of the European Union	2000	n.a.
UNESCO Universal Declaration on Cultural Diversity	2001	n.a.
African Charter on Human and Peoples' Rights (the Banjul Charter) and its Protocol on the Rights of Women in Africa (the Maputo Protocol)	1981+2003	53+28 (46 signed)
EU Parliament Resolution on Combating Female Genital Mutilation in the EU	2009	n.a.
UN Resolution Intensifying Global Efforts for the Elimination of Female Genital Mutilations	2012	n.a.
Communication from the Commission to the European Parliament and the Council. Towards the elimination of female genital mutilation	2013	n.a.
European Parliament resolution of 6 February 2014 on the Commission communication entitled 'Towards the elimination of female genital mutilation'	2014	n.a.
Joint general recommendation/general comment No. 31 of the Committee on the Elimination of Discrimination against Women and No. 18 of the Committee on the Rights of the Child on harmful practices	2014	n.a.

[149] United Nations Treaty Collection, available at http://treaties.un.org (last visited 25.9.2014).

Annex 3

Countries where FGM is concentrated[150]

Country	Prevalence (%)
Somalia	98
Guinea	96
Djibouti	93
Egypt	91
Eritrea	89
Mali	89
Sierra Leone	88
Sudan	88
The Gambia	76
Burkina Faso	76
Ethiopia	74
Mauritania	69
Liberia	66
Guinea-Bissau	50
Chad	44

Country	Prevalence (%)
Côte d'Ivoire	38
Kenya	27
Nigeria	27
Senegal	26
Central African Republic	24
Yemen	23
Tanzania	15
Benin	13
Iraq	8
Ghana	4
Togo	4
Niger	2
Cameroon	1
Uganda	1

[150] UNICEF (2013).

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