



ADDRESSING FGM IN DEVELOPMENT PROJECTS AND PROGRAMMES



TRAINING OF TRAINERS (TOT)
MANUAL

END
FGM

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PREFACE

This Manual has been produced in the framework of the Europaid project “Cooperation, synergies and structured dialogue among civil society and EU institutions to address female genital mutilation as a development issue”.

It has been developed to address FGM as a gender and development issue, by mainstreaming activities for its abandonment in all development policies and programmes. The necessity of adopting a holistic approach in programming activities addressing FGM and of including them in broader development programmes is the result of the lessons learned from field projects. In developing contexts, projects that focused on changing women’s consciousness and, in some cases, their material conditions had a significant effect on accelerating the rate of abandonment. Moreover, for the change in women’s attitude and behaviour towards FGM to take root and be sustained, it must gather sufficient support from power holders in the community such as husbands, health professionals, religious leaders and policy makers. That is why, instead of implementing projects focusing exclusively on the abandonment of the practice, it would be more effective, both financially and in terms of decrease in the prevalence of FGM, to integrate the activities for the abandonment of the practice in development policies, programmes and projects, from projects on SRH&R (Sexual Reproductive Health and Rights) and safe motherhood, education, child health to more comprehensive programmes on rural and industrial development and poverty reduction.

The manual is meant to be a practical tool to be used by skilled trainers for training EU Local Authorities officials (LAs) and project managers of Non State Actors (NSAs) when programming development projects and programmes in order to enable them to better understand the facts, root causes and socio-cultural dimensions of the practice, be knowledgeable about the most successful interventions and be able to design programmes/projects which also address FGM.

Moreover, because FGM is a global concern, the manual tries to go beyond the traditional line from international cooperation projects and domestic ones by presenting some pilot experiences of building bridge projects linking communities and people living in Europe with their relatives and communities of origin in developing countries.

The final version of the manual is the result of the feedback received by individuals belonging to the organisations members of the End FGM Network, its personnel and other NSAs involved in the validation training held in July 2016 in Rome, to whom AIDOS expresses its sincere thanks.

ACRONYMS

AIDOS	Associazione Italiana Donne per lo Sviluppo
AKIDWA	Akina Dada Wa Africa
APF	Associação para o Planeamento da Família
ARP	Alternative Rites of Passage
B.C. E.	Before the Common/Current/Christian Era
CBOs	Community Based Organizations
Equipop	Équilibre et Population
FGM	Female Genital Mutilation
FI-KI	Female Integrity (Kvinnointegrity)
FORWARD UK	Foundation for Women's Health Research and Development
FSAN	Federation of the Somali Association in the Netherlands
GAMS	Groupe pour l'abolition des mutilations sexuelles (Belgique)
IAC	Inter-African Committee
IOM	International Organization for Migration
IOs	International Organisations
LAs	Local Authorities
LebKom e.V.	Lebendige Kommunikation mit Frauen in ihren Kulturen e.V
MIGS	Mediterranean Institute for Gender Studies
NGOs	Non-Governmental Organisations
NSAs	Non State Actors
TOT	Training of Trainers
UNICEF	United Nations Children's Fund
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
WHO	World Health Organization

INTRODUCTION

The introduction is aimed at providing a brief description of the main purposes, structure and target groups of this TOT manual; it also includes indications about the methodology and how to use the manual.

At the end of this section some activities are proposed which can be readapted by participants during their respective training courses. The activities are:

Activity 1.1. Getting to know the issue and each other (20 minutes);

Activity 1.2. Participants' and trainers' introductions and expectations (40 minutes);

Activity 1.3. General presentation of the course (20 minutes).

1. PURPOSES OF THE MANUAL

This manual has been developed in the framework of the "END FGM. Cooperation, synergies and structured dialogue among civil society and EU institutions to address female genital mutilation as a development issue" project, co-financed by the European Commission, the UNICEF-UNFPA Joint Programme on FGM/C and the Waldensian Church.

The project involves four partner organisations including AIDOS (Italy) as the lead agency, FORWARD (UK), MIGS (Cyprus) and APF (Portugal).

The current manual has been developed as part of the capacity reinforcement component of the project, which also includes a ToT activity on addressing Female Genital Mutilation (FGM) in development projects and programs.

The main purpose of this manual is to build the skills and capacities of the END FGM European Network to facilitate similar training workshops targeted to development program officers of Non-Governmental Organisations (NGOs), Civil

Society Organizations (CSOs), Non State Actors (NSAs), Local Authorities (LAs) and International Organisations (IOs). The core learning objectives of the manual are the following:

1. Increase understanding of the cultural environment and the reasons behind FGM as a social norm;
2. Improve understanding of FGM as a gender and development issue;
3. Develop participants' skills and capacities to adopt strategies, tools and approaches to address FGM in development projects and programmes.

It is expected that the END FGM European Network will be enhanced in their capacities and skills to provide similar trainings targeting NSAs, LAs, NGOs, CSOs and IOs in their respective countries, with the final aim of raising their awareness about FGM as a crucial sector for development to be considered and included in programmes and projects focusing on gender and/or many other development areas such as poverty alleviation, reproductive health, education and human rights, among others.

As the final outcome, it is envisaged that NSAs,

LAs, NGOs, CSOs and IOs will have increased awareness about the importance of addressing the ending of FGM in their development programmes and projects as an issue of gender, human rights and sexual and reproductive health and rights.

2. WHO IS THE TARGET GROUP?

The main target group of this manual is composed of the members of the End FGM European Network, who will undertake training on addressing FGM in development projects and programmes targeting NGOs, CSOs, NSAs, LAs, IOs and their respective programme officers working in the areas of sexual and reproductive health, women's and girls' rights, women's empowerment and poverty eradication, among others.

The manual has been developed for skilled trainers who are expected to adapt the modules and proposed activities to their specific needs and targets. The trainers should have a good understanding of gender and human rights issues and also be knowledgeable about FGM issues. In addition, they should be able to facilitate group learning as well as being skilled in project planning in order to assist trainees to integrate and/or improve the FGM component in their projects and programmes.

3. STRUCTURE OF THE MANUAL

The manual is structured around three modules:

Module one provides a general understanding of **FGM as a social norm**; it focuses on the cultural environment, origins and historical evolution of this practice, as well as the reasons behind it; it also provides relevant information about the prevalence and distribution of FGM, including migrant communities' destination countries.

Module two focuses on FGM as a **gender issue**. It is aimed at building common understanding of the concept of FGM as a gender issue and how it is related to development sectors such as sexual and reproductive health & rights, girls' education, poverty eradication, women's empowerment, gender equality, girls' and women's human rights, among others.

Module three describes existing **approaches and tools** applied by UN agencies, NGOs, governments and other actors which have been developed and tested in order to enable the ending of FGM. Amongst main approaches, also mentioned is the use and effective role of the law and main legal instruments developed at international, regional and national level to promote the abandonment of FGM.

The aim of this module is to highlight the success factors of several approaches and extract the main lessons applicable to all kinds of interventions in order to improve programmes and projects mainstreaming the ending of FGM.

Each module is structured around the following sections: i) learning objectives; ii) main contents of the module; iii) suggested readings; iv) activities, materials and handouts.

1. The **learning objectives** section details the issues that will be covered in the module and provides a brief introduction to the module and the expected results in terms of learning;
2. The **contents "at a glance"** section provides a summary of the basic information trainees should acquire with respect to the specific module, without claiming to be exhaustive, but with the intention of providing a summary of the basic information necessary to have a general understanding of the issue;
3. The **suggested readings** suggest key reading material for those who want to go into more depth on the contents of each module, including trainers;
4. The activities, **materials and handouts** section provides a proposed selection of guided

exercises aimed at facilitating participants' learning about specific issues. The section includes audio-video documentaries that are available on the CD-ROM version and on the AIDOS website. The set of proposed exercises and materials can be used and adapted by the trainers when they organize their trainings. The majority have been used in the framework of the trainings held in Rome, Nicosia, London and Portugal during the implementation of the above mentioned project.

Finally, the "Improve your programmes and projects" section is a transversal activity carried out during the three days of training and structured around discussions aimed at (see Annex 1):

1. orienting the trainees in the identification and adoption of appropriate tools and approaches;
2. stimulating knowledge sharing amongst participants;
3. Improving the design and implementation of participants' programmes and projects focusing on FGM and/or projects and programmes which may include an FGM component.

4. HOW TO USE THIS MANUAL

Each module is structured as an independent section, therefore trainers can follow the proposed structure of the manual as well as decide to modify the sequence, contents and activities of each module according to the specific learning needs of the trainees.

Trainers should prepare by reading through the entire manual. References to key reading that will enhance the conceptual framework within which the trainer works have been included. Trainers should take the time to read these. The proposed activities were tested during the TOT training implemented with members of the END FGM European Network on July 2015 and were modified and adapted where necessary thanks to their suggestions.

5. METHODOLOGY

The training curriculum is readapted from the existing training curriculum for a 5-day training workshop entitled "Programming tools to mainstream the abandonment of FGM into development programs and projects" developed by AIDOS in collaboration with RAINBO in 2006-07, in the framework of a project co-funded by the European Union (DDH/2005/099-035). The curriculum will use a participatory adult learning training methodology, where the knowledge to be acquired will be generated through the involvement of participants in dynamic and participatory exercises, small group discussions, plenary presentations and discussions, use of audio/video material, and analysis of case studies.

Because FGM and gender are very sensitive subjects and the awareness of people needs to be increased in order to change attitudes and values, it is important that participants in the training have the opportunity to share their own experiences, ideas, beliefs and cultural values as much as possible.

ACTIVITIES

Activity 0.1: (20 minutes)

Getting to know the issue and each other

Objectives:

This activity has two purposes. The first is to get participants comfortable with each other and to create a relaxed atmosphere. It helps to break down barriers and hierarchies among participants. Also, by the end of the exercise, each participant will have spoken to at least five other participants, making speaking again easier.

The second purpose of this activity is to get participants thinking about the issues that the course focuses on. Participants may have walked into the course worrying about personal matters, or thinking about a proposal they have to submit to a donor. This step helps to orient everyone.

While it may seem strange to begin the course before people have formally introduced themselves (activity 2), beginning with this activity actually means that even the formal introductions in activity 2 are listened to more carefully by participants, who will feel more relaxed in making them.

Description:

Divide the participants into two groups. Get one group to form an inner circle and the other group to form an outer circle. People from the inner circle turn to face someone in the outer circle. You need an even number of participants.

You will give the group a word. One partner should talk about that word - anything that they want to say about that word - for one minute. Their partner (facing them from the outside circle) may not interrupt. When you call or ring a bell to show the time is over, the partner has one minute to talk about the same word from her/his perspective. When that time is over, the participants will choose another

partner. You start the process again with a new word. Continue in this way. Note that you should choose words that will be particularly meaningful to this group of people, given the kind of work that they do, the social/cultural environment they live in, etc. You want to choose words which push participants to talk about things they may not usually talk about. At the same time you do not want to cause great embarrassment or discomfort.

You should start with words that are more neutral (i.e.: friends, job, education, etc.) and move on to words that require reflection on questions of gender, human rights and development. Some words are suggested below:

- Gender;
- FGM;
- Men's role in parenting;
- Women's empowerment;
- Human rights;
- Approaches and tools;
- Development

You should use between six and eight words, depending on how much time you have and how well you think the exercise is working. The exercise usually makes people laugh. They get very frustrated when you tell them to stop, and you have to be very firm that it is time to move on to their partners' chance. When you stop, you can ask the group if they enjoyed the activity. Then ask them to take their seats. Explain to the group that the issues they have been discussing are the issues that will be covered in this course. Say that now that they are all comfortable with each other, it's time to make formal introductions. Go on to activity 2 for the introductions.

Materials:

- A watch or clock so that you can stop participants after each minute;
- A bell so that participants can hear you when you tell them to stop talking;

Activity 0.2: (40 minutes) Participants' and trainers' introductions and expectations

Objectives:

This activity will help people to get to know each other's names and some basic information about each person. If this course is being run with participants who all know each other well, then the facilitator might instead want to explore more personal questions.

This activity is also aimed at raising participants' expectations about the training and also at setting in a participatory way some general rules for the group about how the course will be run.

This activity will also give participants an opportunity to talk about what they are hoping to gain from this course. This will allow the facilitator to ensure that participants' expectations match the content of the course, and where expectations cannot be met, she/he can make this clear, so that participants do not have unrealistic expectations and end up being disappointed by the course.

Description:

Write down the following items on a flipchart:

1. Name
2. Organisation you work for
3. What work do you do there and what is your role?
4. What are your expectations of the training?
5. What are your worries about the course procedures?
6. What can you contribute to ensure that the group works well during the course?

Ask participants firstly to write their names (how they want to be addressed during the course) with a marker on a card. They should put this up in front of them so everyone can read their name.

Then give them five minutes to think about their answers to the other items. Explain that you do not

want a lot of detail, but just a few sentences to get to know each other.

Then give each person a chance to tell the group their name, organisation and role (items 1, 2 and 3).

If time allows, ask each participant to answer questions 4, 5 and 6, while the co-trainer writes down the different answers provided on different flipcharts (one for expectations, another for worries, and the last one for contributions). If there isn't enough time, get the group to give some of their answers to those questions. This might include things like:

Expectations:

- Learn more about FGM issues focusing on gender dimensions / human rights;
- Being gender sensitive while planning and implementing a project;
- Learning about links between FGM and gender, human rights and health issues.

Worries:

- Fear that they will be too shy to participate;
- Fear that there will be too much work;
- Women who fear that men will not listen to the women;
- Men who fear that men will be accused of being bad people;
- Fear of being attacked for having a different view from other participants.

Contributions:

- No individual should dominate discussions;
- People should raise a hand if they want to speak and wait for the facilitator to ask them to do so;
- No personal attacks; people should respect each other's right to speak;
- Everything personal that is said in the course will be kept confidential;
- We are all responsible for speaking when we have something to say;
- We are all responsible for our own learning.

Explain to the group that through their contributions,

their anxieties can be faced and some of their expectations can be met.

Once the group is satisfied with the list of contributions, you can label it “Group Contract” and ask if everyone is happy to abide by this agreement.

The group contract should be pasted on the wall and left up for everybody to see throughout the course.

During the course, if there are problems with group dynamics, remind participants of the relevant commitments in the group contract.

Take five minutes to introduce yourself; the co-trainer and training course assistant should also introduce themselves. Also tell participants what your expectations regarding the course are.

Materials:

- X number of coloured cards; these are for participants to write their names on;
- X numbers of markers;
- Four flipcharts:
 1. Expectations;
 2. Worries;
 3. Contributions;
 4. Group contract.

Activity 0.3: (20 minutes) General presentation of the course

Finally, the trainer will provide a general presentation of the structure of the course, introducing the main objectives, contents, methodology and agenda of the course so that the participants get an overview of the activities and modules that will be undertaken during the three days of training. Providing an outline of the course and its methods also gives the facilitator an opportunity to go back to the expectations raised by the participants in activity 3 and to show where different expectations will be met.

After the presentation, allow for some minutes of Questions and Answers from participants if requested.

Materials:

Power point presentation focusing on:

- Objectives of the training;
- Agenda and modules;
- Target;
- Methodology;
- The manual and how to use it;
- Logistic information.

MODULE 1: UNDERSTANDING FGM

Module one defines what FGM is and provides a general understanding of **FGM as a social norm** deeply rooted in gender power imbalance; it focuses on the cultural environment, origins and historical evolution of this practice, as well as the reasons behind it; it also provides relevant information about the prevalence and distribution of FGM, including migrant communities' destination countries.

LEARNING OBJECTIVES

General Objective:

To increase understanding of the reasons behind FGM as a social norm.

Specific objectives:

1. To increase understanding of what is to be considered FGM, where and how it is practiced, including the main data about the prevalence in different regions;
2. To analyse the cultural and social reasons behind the practice and what the main effects are on the lives of women and girls;
3. Understand the causes of persistence of FGM and how it is possible to transform the social norm associated with it.

List of activities:

Activity 1.1. Introduction to FGM;

Activity 1.2. The reasons behind the practice and the consequences on the health of women;

Activity 1.3. Understanding the reasons and consequences of the practices through the life-stories of migrant women dealing with FGM;

Activity 1.4. Myths and realities behind the practice.

FGM AT A GLANCE

1. What, when and how

1.1 Definition

Female genital mutilation (FGM), which is also known as “female circumcision” or female genital cutting, refers to “all procedures which involve partial or total removal of the female external genitalia or other injury to the female genital organs for cultural and other non-therapeutic reasons.”⁽¹⁾ Some organizations use the term ‘cutting’ as it avoids the risk of ‘demonizing’ certain cultures and communities by using non-judgemental language. On the other hand, the term ‘mutilation’ helps to emphasise the severity of the act. In 1991, the WHO recommended the adoption of this terminology, which has since been widely used by the United Nations in documents and by the international and scientific community in general. The word “mutilation” reinforces the idea that the practice is a violation of girls’ and women’s human rights, thus strengthening the national and international commitment to its elimination. However, in local communities the term can be problematic, as it gives a negative connotation to this custom, which is by no means shared by those who perform it, who on the contrary perceive it as a necessary and beneficial tradition. Therefore in communities where the practice is the norm several different words are used and these are often related to the notions of purity, beauty, cleanliness, etc. In most West African countries the term “excision” is used, as it is a common French word, while in African Anglophone countries “circumcision” is the commonly used term.

In this document we have adopted the definition Female Genital Mutilation (FGM) which is the one

adopted by the End FGM European Network⁽²⁾.

WHAT PROGRAMME MANAGERS MUST KNOW

Due to the high sensitivity of the topic, the matter of what term to use is highly important. While addressing the subject inside a given community, it is crucial to choose a terminology that our audience will understand and by which people will not be offended or feel judged. It is of course a matter of respect but also of effectiveness: a well designed campaign addressing FGM at community level which uses a term such as FGM could lead to people closing up and simply refusing to talk about the matter, or put up resistance.

According to the kind of intervention that you are planning to implement you must choose the correct term. Indeed, working at political level may need a more formal and understandable word such as FGM or FGC, whereas when working with communities you must look for the appropriate and common term.

1.2 When and how it is practiced

Although there is considerable variation in the average age that women experience FGM, in around half of the countries where estimates are available most of the girls were cut before they were 5 years old. In the rest of the countries, cutting generally takes place between the ages of 5 and 14.⁽³⁾ Patterns of FGM show that there are generally lower levels of cutting among younger women today than among older women, which points to reduced levels of cutting overall in the younger generation and gives hope that efforts to abandon FGM are gradually having an impact.

FGM is usually carried out by elderly people in the community (usually, but not exclusively, women)

1. WHO. 2008. ‘Eliminating Female Genital Mutilation: An Inter-agency Statement - OHCHR, UNAIDS, UNDP, UNECA, UNESCO, UNFPA, UNHCR, UNICEF, UNIFEM, WHO’. Geneva: World Health Organization.

2. <http://www.endfgm.eu/en/>

3. UNICEF, 2013. ‘Female Genital Mutilation/Cutting: A Statistical Overview and Exploration of the Dynamics of Change’. New York: UNICEF

designated to perform this task or by traditional birth attendants. Among certain populations, FGM may be carried out by traditional health practitioners, and other members of society.

In some cases, medical professionals perform FGM. This is referred to as the medicalization of FGM (see module 3 for more details). FGM is carried out with special knives, scissors, scalpels, pieces of glass or razor blades. Anaesthetic and antiseptics are generally not used unless the procedure is carried out by medical practitioners. In communities where infibulation is practiced, girls' legs are often bound together to immobilize them for 10 - 14 days, to allow the formation of scar tissue⁽⁴⁾.

1.3 Origins and evolution

The origin of FGM is uncertain although there is some evidence that female circumcision may have been practiced over 5000 years ago in ancient Egypt.⁽⁵⁾ Historical writings show that FGM was practiced in Egypt in the 5th century B.C.E., and in Greece in the 2nd century B.C.E. It has been suggested that the practice may have spread from Egypt to other areas, partly because FGM is known by some Sudanese communities as 'pharaonic circumcision',⁽⁶⁾ but ironically it is known as 'Sudanese' circumcision in parts of Egypt.⁽⁷⁾ What is clear is that FGM has been practiced in parts of Africa for millennia and that it is far more than just a physical operation imposed on women. It is part of a complex cultural and symbolic practice which relates to the marriageability of

women, and the role of women in their communities.

In some ways, the story of the origin of FGM, which is hard to trace and verify, is a distraction from the ongoing contemporary reality of a practice and institution that continues to determine the life and social relations of large sections of society in Africa and beyond. The practice of FGM has deep historical roots, and varies from one ethnic group to another and from one country to another, but there are similarities across the board in the impact of this traditional practice on gender relations and the relationship between different generations.

Above all, FGM is a rite of passage, often carried out during a ceremony or ritual to mark the change in status or transition of women and girls from one life stage to another. It is one of the means by which certain societies mark the transition from girl into woman, giving access to the status of 'woman' to those who have undergone FGM. Even when FGM is performed outside of the ritual and ceremonial context, as with medical FGM interventions, many people still consider the intervention as having a symbolic meaning. As such, while FGM may not always be considered a rite of passage by the communities and people who carry it out, it is always possible to see FGM as a symbolic intervention which marks the life of women in particular ways. Today, with many countries legislating against FGM, there are signs of increasing numbers of families carrying out the practice in more secretive ways with a reduced ceremonial part of the practice.

WHAT PROGRAMME MANAGERS MUST KNOW

This is important to consider when designing projects and interventions focusing on FGM, because despite the fact that there are some countries in which the practice is considered illegal by national law, there could be a secret way of carrying out this practice by local communities, and project managers should be aware of the way in which the practice is considered and practiced by targeted communities.

4. <http://tinyurl.com/q2pz8ly>

5. James Whitehorn, Oyedemi Ayonrinde, and Samantha Main-
gay. 2002. 'Female Genital Mutilation: Cultural and Psychological
Implications'. *Sexual and Relationship Therapy* 17 (2): 161-70.

6. Carla Pasquinelli, 2004. 'Anthropology of female genital mutilation'. Proceedings of the Afro-Arab Expert Consultation on Legal Tools for the Prevention of Female Genital Mutilation Cairo, 21-23 June 2003. Cairo: NPWJ. (First published in C. Pasquinelli, *Antropologia delle mutilazioni genitali femminili. Una ricerca in Italia*. Roma: AIDOS, 2000).

7. Leonard J. Kouba, and Judith Muasher. 1985. 'Female Circumcision in Africa: An Overview'. *African Studies Review* 28 (01): 95-110. doi:10.2307/524569.

1.4 Types

The most commonly used classification system lists four types of female genital mutilation, with the extent of genital tissue cutting, and therefore the severity and risk involved, increasing from the first to the fourth type. The final type encompasses all other types of harmful or potentially harmful practices that are performed on female genitalia for non-medical reasons. As with any classification, difficulties can arise when trying to identify the exact category, as girls and women who undergo FGM themselves are not necessarily aware of the type of FGM they were subjected to. When asked to define “their type” they generally tend to underestimate the severity of the cut, which may impact on the results of survey estimates. Anyway the classification remains a useful tool to better define and understand the phenomenon; in particular it may assist when programming specific health and social intervention.

- Type 1. The partial or total removal of the clitoris and/or the prepuce. This practice is known as a clitoridectomy.
- Type 2. The partial or total removal of the clitoris and the labia minora, with or without the removal of the labia majora. This practice is known as excision.
- Type 3. The narrowing of the vagina with the creation of a covering seal by cutting and repositioning the labia minora and/or the labia majora with or without the removal of the clitoris. This practice is known as infibulation.
- Type 4. All other harmful or potentially harmful non-medical procedures including pricking, piercing, incising or stretching the clitoris and/or labia, as well as scraping and cauterization (burning) of the clitoris and surrounding tissue, and using herbs or chemicals to cause bleeding or narrowing of the vagina.⁽⁸⁾

8. Ibid. 24.

WHAT PROGRAMME MANAGERS MUST KNOW

Depending on the countries where your organization is implementing projects and/or on the communities you are targeting, different types of FGM may be practiced with different implications on health, psychological wellbeing and social relationships within the communities.

Information about which type of FGM is mainly practiced and how it is perceived at community level should be collected in the design phase of any intervention in order to better tailor your intervention. For instance, in an area where infibulation is the norm, you may decide to provide targeted health services such as deinfibulation accompanied by counselling at individual and couple level to inform, sensitize and support the women in remaining deinfibulated.

2. Where

Despite the fact that FGM is widespread and prevalent in many countries, it is extremely difficult to get precise data on the exact number of women and girls affected and at risk. FGM is a private, sensitive and, in many countries, illegal matter. Generally it is thought that prevalence data is easier to collect than type of FGM data, but the reliability of reported FGM rates tends to be low and there is usually considerable under-reporting of the extent of FGM rates.⁽⁹⁾

2.1 Globally

While the exact number of girls and women worldwide who have undergone FGM remains unknown, at least 200 million girls and women in 30 countries have been subjected to the practice.

9. Susan Elmusharaf, Nagla Elhadi, and Lars Almroth. 2006. 'Reliability of Self Reported Form of Female Genital Mutilation and WHO Classification: Cross Sectional Study'. *BMJ* 333 (7559): 124. doi:10.1136/bmj.38873.649074.55.

More than half live in just three countries: Indonesia, Egypt and Ethiopia.⁽¹⁰⁾ Most FGM is concentrated in a belt of African countries that runs from the Atlantic Coast (countries like Burkina Faso, Gambia, Guinea, Liberia, and Sierra Leone) through central Africa (including Chad and the Central African Republic) to countries in the Horn of Africa (including Somalia, Sudan and Ethiopia), Egypt to the north and as far south as Tanzania. In countries like Somalia, Guinea, Djibouti and Egypt, over 90% of women and girls undergo FGM. In Eritrea, Mali, Sierra Leone and Sudan over 80% of women and girls are subjected to FGM. At the opposite end of the scale are countries like Uganda, Cameroon, Niger, Togo and Ghana where less than 5% of women and girls undergo FGM.

However, the figure is likely to be higher because there is very little reliable data and also because certain minority groups and migrant communities have continued this practice in countries in the Global North. Moreover, the practice is also known in parts of Asia, and in Europe, North America and Australia among migrant communities. But the practice also exists in Jordan, Oman, Saudi Arabia, Indonesia, Malaysia.⁽¹¹⁾

For all these countries no systematic data have been collected and no reliable estimates are yet available.

WHAT PROGRAMME MANAGERS MUST KNOW

Depending on the countries where your organization is implementing projects and/or on the communities you are targeting, it is fundamental to have an estimate of the number of FGM affected women and girls and those at risk of FGM. Indeed, when designing a project or a programme this estimate will help you to better identify the kind of activity to be implemented and also the human and financial resources

you may need. In an area where the majority of women and girls are subjected to the practice the maternal mortality rate or girls' school dropout rates and child marriage may also be very high. Being informed on the magnitude of the practice will help you to better understand what the real causes of this phenomenon are and what needs must be addressed.

2.2 FGM and migration

FGM continues to be practiced by migrants coming from countries and communities where FGM is more prevalent. Data on the extent of the practice are rarely available and based on rough estimates. FGM in migrant communities is a particularly sensitive subject not only because of health and human rights issues, but also because it is linked to the issue of "integration". Some communities may find themselves withdrawing into their own cultural practices as a way of defending their identity and their traditions against fear of loss or dilution.⁽¹²⁾

The European Commission is currently undertaking efforts aimed at developing a common methodology and indicators to estimate the number of women and girls at risk of being mutilated and the number of women affected by FGM in the EU. Some methodological approaches to estimate the FGM risk in the EU have been developed⁽¹³⁾.

In the United Kingdom, it is estimated that 24,000 girls under the age of 15 are at risk of FGM,⁽¹⁴⁾ despite it being illegal to carry out FGM in the UK as well as illegal to take a girl outside the country to subject her to FGM. In the United States, around 513,000 women and girls are at risk of FGM, and the number of girls under 18 at risk has

10. Female Genital Mutilation/Cutting: A Global Concern. Unicef 2015.

11. Ibid., 23.

12. IOM. 2008. 'Supporting the Abandonment of Female Genital Mutilation in the Context of Migration'. Geneva: International Organization for Migration.

13. EIGE. 2015. 'Estimation of girls at risk of female genital mutilation in the European Union. Step by step guide'. Vilnius: EIGE

14. World Vision UK. 2014. 'Tackling FGM in the UK: Lessons from Africa'. London: World Vision UK

quadrupled since 1997.⁽¹⁵⁾ In the European Union, there are an estimated 500,000 women and girls with FGM and a further 180,000 girls are at risk, although the figure could be much higher since it does not include either second-generation migrants or undocumented migrants.⁽¹⁶⁾

WHAT PROGRAMME MANAGERS MUST KNOW

Official statistical data about FGM within a specific country are not exhaustive and methodologies to collect data are not always reliable. However, when undertaking a project with an FGM component, it is important to contextualize the practice in the specific countries where your organization is operating, relying on data provided by recognized international and national organizations/institutions.

Moreover it should be considered that despite data at national level, the incidence of FGM can be diversified depending on specific regions and areas, and may vary amongst rural and urban areas. Therefore if you are working with a specific migrant community you may need to collect further information to understand which ethnic groups they belong to, as you could target the wrong population, thus providing unneeded services.

2.3 Changing rates of FGM

FGM rates have lowered in many countries and attitudes towards the practice are changing. In Ethiopia, the prevalence of FGM among women aged 15 to 49 has fallen from 73% to 57% over the last ten years. In Niger, the number of women and girls experiencing FGM has halved. Data also show that in almost all countries, the percentage of women and girls who report supporting the practice of FGM has also fallen.⁽¹⁷⁾ The statistics on attitudes towards FGM give us an indication that rates will probably continue to fall, since the younger generations of men and women tend to be more likely to abandon the practice than the older generations. But these kinds of shifts take a long time.

WHAT PROGRAMME MANAGERS MUST KNOW

It is important to know that changes in behaviours take a long time and may vary depending on the specific contexts and situations. Projects should therefore consider this factor when designing interventions with an FGM component, and be able to propose, according to the specific conditions, achievable outputs in the short term as well as expected impacts in the long term.

Available outputs could for instance be changes in the attitude towards FGM thanks to awareness raising campaigns and activities. While in the long run what is expected is a change in the behaviour leading to the sustainable abandonment of the practice.

15. AHA Foundation. 2015. 'Female Genital Mutilation - The AHA Foundation'. New York: AHA Foundation

16. European Parliament. 2012. 'European Parliament Resolution of 14 June 2012 on Ending Female Genital Mutilation (2012/2684(RSP))'

17. Ibid., 88.x

3. Attitudes towards FGM

3.1 What people from practicing communities think about FGM

There is a huge variation in attitudes towards FGM across the countries that practice it. In most of the 29 countries in which FGM is a relatively widespread practice, most women and girls think that the practice should end.⁽¹⁸⁾ In countries where a high percentage of women and girls have had FGM, an equally high proportion of the female population think the practice should continue. This is supported by the theory of social norms mentioned below.

Despite this, in almost all countries, the proportion of women and girls who support FGM, and want it to continue, is always lower than the proportion of women and girls who have experienced FGM. The standout case highlighted in a UNICEF statistical report is Burkina Faso, where 76% of women and girls have had FGM, but only 9% of them would want the practice to continue.⁽¹⁹⁾ Similarly high differences between prevalence and support are found in Djibouti, Sudan, Ethiopia, Eritrea, Egypt and Somalia. Overall, older women tend to want FGM to continue more than younger women.

The attitude of men and boys towards FGM is in some ways similar. As with women and girls, attitudes vary considerably across countries. In four of the countries with a high prevalence of FGM, Mauritania, Mali, Egypt and Guinea, most of the men and boys want FGM to continue unchanged. In nine other countries, most of the men and boys want the practice to stop. In most of the countries, the proportion of older men who want FGM to continue is usually twice and sometimes almost three times as high as the proportion of boys who support it.

18. UNICEF 2013. 'Female Genital Mutilation/Cutting: A Statistical Overview and Exploration of the Dynamics of Change'. New York: UNICEF, 59.

19. Ibid., 53.

There is considerable variation in support for FGM between women and girls from poorer backgrounds and those from richer ones, with support for FGM generally stronger among women and girls from poorer backgrounds. Interestingly, in some countries there is much less variation than others. For example, in Gambia, 59% of women and girls in the poorest quintile of the population support FGM compared to 54% of women and girls in the richest. On the other hand, in Mauritania, 72% of women and girls in the poorest quintile of the population support FGM compared to 18% of women and girls in the richest.

As with wealth, similar patterns are found in relation to education levels: women and girls with no education are considerably more supportive of FGM than women and girls with primary or secondary school education.

When comparing men with women, generally the percentages of each who want to see an end to FGM are fairly similar. In a handful of countries such as Guinea, Sierra Leone and Chad, considerably more men than women want to see FGM end. In other countries, such as Mali, Sudan and Côte d'Ivoire, slightly more men than women want the practice to stop. It has also been found that women and girls generally underestimate the proportion of men and boys who want to end FGM.⁽²⁰⁾

WHAT PROGRAMME MANAGERS MUST KNOW

It is important to emphasise that intention or desire to change certain behaviours does not necessarily equate with actual behaviour change. Therefore despite the fact that there could be a general impression that in specific communities there is a change in the attitudes towards FGM, this does not necessarily mean that the practice is not being carried out.

20. Ibid., 62.

Evidence shows that changes in attitude and mentality don't necessarily bring sustainable changes in the behaviours.

3.2 FGM and education

Girls are usually subjected to FGM before they have completed their education. Girls are also generally not involved in the decision to carry out FGM. For this reason it is useful to know the education status of the mothers of girls undergoing FGM. Both in countries with high levels of FGM and in those with lower levels, increases in a mother's education level will tend to correspond to decreases in FGM rates. Education seems to have an important role in changing social norms around FGM and helps lead people and communities to abandoning the practice.⁽²¹⁾ Given that opposition to FGM is higher among women who have received secondary education, in societies where women are discouraged from educating themselves and becoming socially and financially independent, it might be harder to change ideas about FGM.

WHAT PROGRAMME MANAGERS MUST KNOW

It is important to consider mothers' and grandmothers' education levels, as well as girls', when designing projects with FGM components, because this may influence the change in behaviours. For instance, educated girls and women may more easily be supported in becoming advocates of change in their communities.

3.3 FGM, ethnicity and religion

FGM is an ancient practice that predates the establishment of Islam across Africa and Asia. Although there is a common perception that FGM is somehow connected to Islam and that there is a religious component to the practice, FGM actually occurs across a variety of religious communities, whether they are Muslim, Christian or non-theistic belief systems. The practice of FGM should rather

be thought of as a cultural practice, which has come to be associated with religious practices.

In relation to Islam, there is no mention of FGM in the Quran. The belief among certain schools of thought that FGM is recommended seems to come from interpreting a Hadith (saying of the Prophet Muhammad), but even this Hadith is far from clear and scholars agree it does not state that FGM is obligatory for women. Scholars argue that the broader principle of avoiding harming others trumps any ambiguous interpretation of the Hadith. Many religious leaders have come out strongly against FGM. For example, Professor Ali Gomaa, the Grand Mufti of Egypt, issued a Fatwa on FGM in 2006 which stated that not only were there "no written grounds for this custom in the Qur'an [or] with regard to an authentic tradition of the Prophet" but that "female genital circumcision practiced today harms women psychologically and physically. Therefore, the practice must be stopped in support of one of the highest values of Islam, namely to do no harm to another – in accordance with the commandment of the Prophet Mohammed 'Accept no harm and do no harm to another'".⁽²²⁾

The variation across Africa in FGM rates matches the variations in ethnic composition of the different regions. In other words, ethnic identity plays an important role in the prevalence of FGM. In Benin, for example, the regions with high levels of FGM are inhabited by ethnic groups with the highest percentages of FGM levels in the country.⁽²³⁾ There are also huge variations between religious groups within countries. For example, in India most FGM is practiced by the Dawoodi Bohra, a Shia Muslim group that migrated from Yemen in the 16th century.

22. Islamic University Rotterdam. 2006. 'Female Circumcision Fatwa'. Rotterdam: Islamic University

23. UNICEF 2013. 'Female Genital Mutilation/Cutting: A Statistical Overview and Exploration of the Dynamics of Change'. New York: UNICEF, 33.

21. Ibid., 39.

WHAT PROGRAMME MANAGERS MUST KNOW

Despite the lack of a theological basis to justify FGM, many communities continue to carry out FGM in the belief that the practice has religious roots. The task of any NGOs or IOs working on FGM issues is to understand the cultural, social and religious contexts which continue to play a role in perpetuating this practice, as well as involving and gaining support from local religious leaders and imams in projects, in order to raise awareness about the issue. Public interventions by religious leaders pointing out that FGM is not supported by Islam or any religious laws are therefore important in creating a shift in cultural understandings of the practice.

3.4 FGM and urban or rural residence

FGM is generally more common in rural areas although it is not clear what causes this difference. It is possible that the ethnic diversity of urban areas, and in particular interaction with people who do not share FGM practices, helps to shift people's cultural ideas. In Kenya, for example, girls living in rural areas are four times more likely to be subjected to FGM than girls in urban areas.⁽²⁴⁾

WHAT PROGRAMME MANAGERS MUST KNOW

It is considered to be harder to address the issue of FGM in rural areas where communities tend to have more conservative norms and where the smaller and tighter social groups may make it harder to shift the barriers to changing behaviours.⁽²⁵⁾

3.5 FGM and household wealth

In most cases, increases in household wealth and improved economic status lead to decreases in the practice of FGM. This may be in part because economic development increases migration and leads

to an increase in female participation in the labour market as well as a weakening of traditional family structures. The changing role of women in relation to their families, as well as increased economic independence, contributes in part to a reduction in FGM practice.

WHAT PROGRAMME MANAGERS MUST KNOW

Changes in FGM behaviours happen as a consequence of several changes in multiple sectors, such as those in gender relations within the family and increased empowerment of women in their society, including their economic independence. Working towards the economic empowerment of women may therefore be related to the abandonment of FGM.

4. Effects

The effects of FGM may range from physical, psychological, sexual and social. The health and psychological consequences vary according to the age of the girl when subjected to the practice, her state of health, the type of mutilation, the ability and tools of the practitioner, etc. The immediate impact of FGM can cause severe bleeding and problems urinating in many women, as well as infertility, difficulties related to childbirth, and an increase in neonatal death.⁽²⁶⁾ Women who experience FGM are exposed to greater risk of infection from a range of diseases,⁽²⁷⁾ and some women need to resort to surgery to be able to have sexual intercourse or give birth, which can increase the risk of infections and complications. FGM can also lead to women developing cysts and genital ulcers, chronic pain and chronic pelvic infections. The health complications of FGM depend on different factors, including the type performed, the

24. Ibid., 37.

25. UN WomenWatch. 2012. 'Rural Women - UNFPA: Good Practice Example 1 - UNFPA-UNICEF Joint Programme on Female Genital Mutilation/Cutting (FGM)'.

26. WHO, 2014. 'WHO | Female Genital Mutilation'.

27. Christos Iavazzo, Thalia A. Sardi, and Ioannis D. Gkegkes. 2013. 'Female Genital Mutilation and Infections: A Systematic Review of the Clinical Evidence'. Archives of Gynecology and Obstetrics 287 (6): 1137–49

practitioner's medical training, the hygiene conditions, the amount of resistance and the general state of health of the girl/woman undergoing the procedure. Complications may occur in all types of FGM, but are most frequent with infibulation.

Health effects: results from a study in Somalia

A study on medical problems resulting from FGM based on interviews with women in Mogadishu, Somalia, found that a significant number of women had suffered from a range of medical problems including: haemorrhages, infections, urine retention, pelvic inflammatory disease, infertility, and difficulty during labour. In addition, women who had just been married suffered from pain during sexual intercourse as well as additional problems related to childbirth. Women with FGM Type 3, also known as infibulation, had up to 5 times longer second-stage labour than women who had not been subjected to FGM. Women who had been infibulated were therefore faced with health hazards and pain at multiple points throughout their lives.⁽²⁸⁾

In terms of psychological impact, women who have experienced FGM are more likely to suffer from psychological problems such as Post-Traumatic Stress Disorder and affective disorders such as depression, bipolar disorder and anxiety disorder.⁽²⁹⁾ They are also more likely to experience increased pain and reduced sexual satisfaction and desire.⁽³⁰⁾ FGM has come to be seen as a public

health concern due to its large geographical distribution and the large number of women and girls that it has an impact on.

There are also considerable social impacts on women who decide their daughters should not undergo FGM. They may be ostracized or cut off from social contact, beaten, disgraced and stigmatized. For more on this see section 5 'WHY' below.

WHAT PROGRAMME MANAGERS MUST KNOW

When programming interventions with FGM components, the health and psychological consequences on girls and women who have already undergone FGM should be considered. It is fundamental to further investigate what kind of consequences the target girls and women are encountering so as to design specific services with the aim of improving their health and psychological conditions and their overall wellbeing. Not all the women for instance may need and want reconstructive surgery even if it may seem to be a brilliant solution. Instead, medium-long term psychological counselling could lead to a sustainable solution where the woman feels empowered in her sexual/sentimental life.

28. Rogaia Mustafa Abusharaf, 2013. 'Female Circumcision: Multicultural Perspectives'. Philadelphia: University of Pennsylvania Press, 191

29. Peggy Mulongo, Caroline Hollins Martin and Sue McAndrew. 2014. 'The Psychological Impact of Female Genital Mutilation/Cutting (FGM) on Girls/women's Mental Health: A Narrative Literature Review'. *Journal of Reproductive and Infant Psychology* 32 (5): 469–85.

30. Rigmor C. Berg and Eva Denison. 2011. 'Does Female Genital Mutilation/Cutting (FGM) Affect Women's Sexual Functioning? A Systematic Review of the Sexual Consequences of FGM'. *Sexuality Research and Social Policy* 9 (1): 41–56.

5. Why

*My grandmother called it the three feminine sorrows.
The day of circumcision, the wedding night, and the
birth of a baby
Are the three feminine sorrows!
I cry for help as my battered flesh tears.
No mercy. Push! They say,
It is only feminine pain,
And feminine pain perishes.
When the spouse decides to break the good tie,
Divorce and desertion,
I am left alone with my wounds.
Now hear my appeal!
Appeal to dreams broken
Appeal to all peace-loving people:
Protect and defend the innocent little girls,
So trusting and obedient,
To their parents and elders
Help them to live in a world of love
Not a world of feminine sorrows!
Dahabo Musa, 1988⁽³¹⁾*

5.1 FGM as a social norm

There are many reasons why people say they practice FGM. These include: religious beliefs (mistakenly believing that it is a religious requirement), maintaining a woman's virginity or chastity, cultural tradition and a rite of passage, hygiene, improving female fertility, and increasing sexual pleasure for men. Of all these, the desire to achieve social approval or acceptance and avoid disapproval and social sanctions are some of the main reasons for carrying out this practice. It has also been found that for some practicing communities, FGM is a kind of gender identity marker, which makes a woman more 'female' by removing parts of the vagina which resemble male parts or are considered more 'male'.⁽³²⁾

31. Rogaia Mustafa Abusharaf. 2013. 'Female Circumcision: Multicultural Perspectives'. Philadelphia: University of Pennsylvania Press, 187

32. Ellen Gruenbaum, 2005. 'Socio-Cultural Dynamics of Female Genital Cutting: Research Findings, Gaps, and Directions'.

Over and above those reasons, families in communities that practice FGM may be concerned that their failure to conform could lead to social exclusion, disapproval, reduced marriageability of daughters and sometimes even violence.⁽³³⁾ On the other hand, conforming to tradition, and going ahead with FGM, means that families may be offered respect, admiration and social approval by their community. This means that FGM is not simply a cultural practice or a social convention, but also a social norm.

A social norm is a rule that defines what behaviours are correct within a specific social group. In many communities that practice FGM, the social norm is maintained through a combination of social rewards for participating in FGM, and social sanctions such as social rejection and exclusion from the community of mothers who have failed to carry out FGM on their daughters, and women who haven't been cut. The social cost of not conforming to the expected social norms can be extremely high, particularly in communities that give so much importance to the dual roles of mother and wife which women are expected to perform, and in societies where there are few economic and labour opportunities to help women become financially and socially independent.

It is widely considered that female marriageability is one of the main reasons that women and girls continue to practice FGM, and that makes women fear that they will be rejected by men or excluded from marriage if they have not conformed to the cultural practice of FGM. While there is evidence that marriageability plays a role in maintaining the practice of FGM, there is equally strong evidence that the cultural convention of FGM is driven mainly by 'peer convention'. That is, by younger women who want to be accepted into the network of support, respect and prestige from older women who

Culture, Health & Sexuality 7 (5): 429–41.

33. UNICEF, 2010. 'The Dynamics of Social Change: Towards the Abandonment of Female Genital Mutilation/cutting in Five African Countries'. Florence: UNICEF, Innocenti Research Centre.

have already been subjected to FGM.⁽³⁴⁾

The traditions and social norms that surround FGM can change over time. For example, a study of FGM among the Mandinga people in Guinea-Bissau, showed how in the 1940s FGM was associated with marriageability.⁽³⁵⁾ More recently though, concerns about religious and social identity and what it means to become a 'person' are more dominant and the link between FGM and marriage has become less important. There can be a wide range of beliefs that underpin a certain social norm and cultural practice, and some of these beliefs will be more important than others at different times in history. The bottom line is that social norms and beliefs of any kind are not fixed things but are instead subject to change.

A large review of studies on FGM concludes that there are six main reasons for the continued existence of FGM: cultural traditions; sexual morals; marriageability; religious beliefs; health benefits; and ideas of male sexual enjoyment. One of those studies also suggests four main reasons for the reduction, in many countries, in levels of FGM: education related to the health consequences of FGM; awareness that FGM is not a religious requirement; laws that make FGM illegal; and the differing cultural and social traditions of countries that migrants have moved to.⁽³⁶⁾

5.2 Changing a social norm

Most social norms are a combination of individual decision-making, such as the decision of a family to cut their daughters, and social pressure created by the wider community. It is this social pressure that leads to cultural practices continuing to exist, but it is this same pressure which can also rapidly shift and lead to sudden changes in social norms. The practice of footbinding in China⁽³⁷⁾, which existed for around 1000 years before the abandonment of the practice within one generation, is widely used as an example of a rapid cultural shift.

Practices like FGM only exist when enough people continue to believe that they need to exist. When a critical mass of people decides that a social norm needs to change, the 'tipping point' is reached and sudden social changes can then occur. The idea of the 'tipping point' was developed further to include a number of rules or 'agents of change' which can be applied to any 'social epidemic'.⁽³⁸⁾ One of these rules is 'The Law of the Few' which describes how most social change 'epidemics' occur because of the involvement of three kinds of people with specific characteristics:

- Connectors: people in the community who are well connected and know a lot of people.
- Mavens: people who have a lot of information and are good at sharing and exchanging information.
- Salesmen: charismatic individuals who can help to convince other people to agree with their ideas.

34. Bettina Shell-Duncan, Ylva Hernlund, Katherine Wander, and Amadou Moreau. 2010. 'Contingency and Change in the Practice of Female Genital Cutting: Dynamics of Decision Making in Senegambia'. Geneva: WHO.

35. Gerry Mackie and John Le Jeune. 2009. 'Social Dynamics of Abandonment of Harmful Practices: A New Look at the Theory'. Innocenti Working Papers 2009-06. Florence: UNICEF, Innocenti Research Centre.

36. Rigmor C. Berg and Eva Denison, 2013. 'A Tradition in Transition: Factors Perpetuating and Hindering the Continuance of Female Genital Mutilation/Cutting (FGM) Summarized in a Systematic Review'. *Health Care for Women International* 34 (10): 837–59.

37. Gerry Mackie, 'Ending Footbinding and Infibulation: A convention account', *American Sociological Review*, vol. 61, no. 6, December 1996.

38. Malcolm Gladwell, 2006. 'The Tipping Point: How Little Things Can Make a Big Difference'. London: Little Brown.

Research by UNICEF has come up with six key elements which can help to transform the social norm associated with FGM, thereby leading to the large-scale abandonment of the practice. The six elements are:⁽³⁹⁾

1. Using a non-coercive and non-judgmental approach focused on human rights and the empowerment of girls and women.
2. Awareness by the community of the harm caused by the practice of FGM.
3. Emphasising the collective and communal nature of the social norm and that acting collectively to end it will be more effective than individuals acting on their own.
4. Public affirmations on the part of communities of their collective commitment to abandon FGM.
5. Organizing the process of diffusion so that the decision to abandon FGM spreads rapidly from one community to another and is sustained.
6. An environment that enables and supports change.

WHAT PROGRAMME MANAGERS MUST KNOW

Understanding that FGM is a social norm is the first step for any programme manager or development officer who wants to promote development interventions with an FGM component. Understanding the deep reasons behind the practice and the key elements necessary to change a social norm is a crucial step prior to the design and implementation of any successful development intervention with an FGM component. In the past, projects focusing only on the possible negative effects of FGM on health, for instance, had the unwanted effect of leading to the medicalization of the practice, as people clearly understood the danger related to FGM but they continued to perceive it as a social obligation to be fulfilled.

39. UNICEF. 2005. 'Changing a Harmful Social Convention: Female Genital Mutilation/Cutting'. Innocenti Digest. Florence: UNICEF, Innocenti Research Centre.

READINGS

- Abusharaf, Rogaia Mustafa. 2013. 'Female Circumcision: Multicultural Perspectives'. Philadelphia: University of Pennsylvania Press.
- AHA Foundation. 2015. 'Female Genital Mutilation - The AHA Foundation'. New York: AHA Foundation. <http://tinyurl.com/lrczauo>.
- Berg Rigmor C., and Denison Eva. 2011. 'Does Female Genital Mutilation/Cutting (FGM) Affect Women's Sexual Functioning? A Systematic Review of the Sexual Consequences of FGM'. *Sexuality Research and Social Policy* 9 (1): 41–56. <http://tinyurl.com/hd4yudv>
- . 2013. 'A Tradition in Transition: Factors Perpetuating and Hindering the Continuance of Female Genital Mutilation/Cutting (FGM) Summarized in a Systematic Review'. *Health Care for Women International* 34 (10): 837–59. <http://tinyurl.com/guyantx>
- EIGE. 2015. 'Estimation of girls at risk of female genital mutilation in the European Union, Step by step guide'. Vilnius: EIGE. <http://tinyurl.com/hltzvbe>
- Elmusharaf Susan, Elhadi Nagla, and Almroth Lars. 2006. 'Reliability of Self Reported Form of Female Genital Mutilation and WHO Classification: Cross Sectional Study'. *BMJ* 333 (7559): 124. doi:10.1136/bmj.38873.649074.55. <http://www.bmj.com/content/333/7559/124>
- European Parliament. 2012. 'European Parliament Resolution of 14 June 2012 on Ending Female Genital Mutilation (2012/2684(RSP)'. <http://tinyurl.com/q6fasrq>.
- Gladwell, Malcolm. 2006. 'The Tipping Point: How Little Things Can Make a Big Difference'. London: Little Brown.
- Gruenbaum, Ellen. 2005. 'Socio-Cultural Dynamics of Female Genital Cutting: Research Findings, Gaps, and Directions'. *Culture, Health & Sexuality* 7 (5): 429–41. <http://tinyurl.com/h24nb9b>
- Iavazzo, Christos, Sardi Thalia A., and Gkegkes Ioannis D.. 2013. 'Female Genital Mutilation and Infections: A Systematic Review of the Clinical Evidence'. *Archives of Gynecology and Obstetrics* 287 (6): 1137–49. <http://tinyurl.com/j35wgu4>
- IOM. 2008. 'Supporting the Abandonment of Female Genital Mutilation in the Context of Migration'. Geneva: International Organization for Migration. <http://tinyurl.com/k6efs3o>.
- Islamic University Rotterdam. 2006. 'Female Circumcision Fatwa'. Rotterdam: Islamic University. <http://tinyurl.com/jhwzw9e>
- Kouba Leonard J., and Muasher Judith. 1985. 'Female Circumcision in Africa: An Overview'. *African Studies Review* 28 (01): 95–110. doi:10.2307/524569. <http://tinyurl.com/hmyaapo>
- Mackie Gerry, and LeJeune John. 2009. 'Social Dynamics of Abandonment of Harmful Practices: A New Look at the Theory'. Innocenti Working Papers 2009-06. Florence: UNICEF, Innocenti Research Centre. <http://tinyurl.com/ngujaby>
- Mackie, Gerry, 'Ending Footbinding and Infibulation: A convention account', *American Sociological Review*, vol. 61, no. 6, December 1996, pp. 999–1017. <http://tinyurl.com/gq2qoql>
- Mulongo, Peggy, Hollins Martin Caroline, and McAndrew Sue. 2014. 'The Psychological Impact of Female Genital Mutilation/Cutting (FGM) on Girls/women's Mental Health: A Narrative Literature Review'. *Journal of Reproductive and Infant Psychology* 32 (5): 469–85. <http://tinyurl.com/jsmho9m>

- Pasquinelli, Carla. 2004. 'Anthropology of female genital mutilation'. In Proceedings of the Afro-Arab Expert Consultation on Legal Tools for the Prevention of Female Genital Mutilation Cairo, 21-23 June 2003. Cairo: NPWJ. (First published in C. Pasquinelli, *Antropologia delle mutilazioni genitali femminile. Una ricerca in Italia*. Roma: AIDOS, 2000). <http://tinyurl.com/nvzrca8>
- Shell-Duncan, Bettina, Y. Hernlund, K. Wander, and A. Moreau. 2010. 'Contingency and Change in the Practice of Female Genital Cutting: Dynamics of Decision Making in Senegambia'. Geneva: WHO. <http://tinyurl.com/pzvunwf>
- UN WomenWatch. 2012. 'Rural Women - UNFPA: Good Practice Example 1 - UNFPA-UNICEF Joint Programme on Female Genital Mutilation/Cutting (FGM)'. <http://tinyurl.com/pmp8c6c>
- UNICEF. 2005. 'Changing a Harmful Social Convention: Female Genital Mutilation/Cutting'. Innocenti Digest. Florence: UNICEF, Innocenti Research Centre. <http://tinyurl.com/pdj4szj>
- . 2010. 'The Dynamics of Social Change: Towards the Abandonment of Female Genital Mutilation/cutting in Five African Countries'. Florence: UNICEF, Innocenti Research Centre. <http://tinyurl.com/qbhmw4u>
- . 2013. 'Female Genital Mutilation/Cutting: A Statistical Overview and Exploration of the Dynamics of Change'. New York: UNICEF. <http://tinyurl.com/lmpg6a9>
- UNICEF, 2015. *Female Genital Mutilation/Cutting: A Global Concern*. New York: UNICEF. <http://tinyurl.com/zrouzck>
- Whitehorn, James, Ayonrinde Oyedemi, and Maingay Samantha. 2002. 'Female Genital Mutilation: Cultural and Psychological Implications'. *Sexual and Relationship Therapy* 17 (2): 161–70. <http://tinyurl.com/omuebaz>
- WHO. 2008. 'Eliminating Female Genital Mutilation: An Interagency Statement - OHCHR, UNAIDS, UNDP, UNECA, UNESCO, UNFPA, UNHCR, UNICEF, UNIFEM, WHO'. Geneva: World Health Organization. <http://tinyurl.com/ou2tdrh>
- . 2014. 'WHO | Female Genital Mutilation'. <http://tinyurl.com/yrtjlx>
- World Vision UK. 2014. 'Tackling FGM in the UK: Lessons from Africa'. London: World Vision UK. <http://tinyurl.com/ohmwwxd>

ACTIVITIES

Activity 1.1: (1 hour) introduction to FGM

Objective:

The main objective is to start familiarising the group of participants with the basic information and main issues related to the practice of FGM.

Description:

Divide the participants into three or four groups (depending on the number of participants); each should focus on different issues associated with FGM as follows:

1. What FGM is: definition and terminology;
2. Where it is practiced: countries and regions;
3. How many: estimates and data.

Once the groups have been formed, ask the participants to listen to the audio and watch the videos carefully and to take notes by groups, especially concerning those issues they are responsible for as a group.

Then you can play the following video and audio, or any video and audio support describing the above elements:

- UNICEF and UNFPA, Abandoning FGM: Amina and Desta's story (play the video until 3'.00"), Joint Programme on Female Genital Mutilation/Cutting: https://www.youtube.com/watch?v=_LKk3vyFyGA
- UNICEF, Ending female genital mutilation & child marriage – No Time to Lose (play the video until 2'.45"): <https://www.youtube.com/watch?v=kpUZXwR5-pw>

You can play some parts of the videos and/or audio again if this is requested by the participants because they may need to improve their notes. Each group has 10 minutes to verify the information collected and organize it. One volunteer per

group will present the information collected by his/her group with the support of a flipchart.

After the group presentation, the trainer will summarize and highlight the main information related to: i) what FGM is (definition and associated terminology); ii) countries and regions (worldwide); iii) estimates of the prevalence of FGM).

During the wrap-up, it is very important to show the world map (because the practice is widespread not only in African countries) and highlight that it is not possible to rely on exact figures and data.

It is recommended to highlight why it is important for a project manager to consider this information when designing a project with an FGM component.

Materials:

- Video player with audio;
- Internet connection for playing the video;
- Notebooks or paper;
- Flipcharts;
- Markers;
- Pens.

Activity 1.2: (1 hour) The reasons behind the practice and the consequences on the health of women

Objective:

This activity is aimed at exploring the reasons and consequences of the practice, through the active listening of audio documentaries extracts which can be found either on the AIDOS website or at <http://tinyurl.com/jfj6uxc> in English and French

If the training is targeted to Italian trainees, the trainer may choose to listen the audio doc titled: "Uno due minuti appena. Donne Africane contro l'escissione" focusing on FGM in Mali and Burkina Faso and available at the following link: <https://www.youtube.com/watch?v=MesUPCmzgkA>

Description:*Step 1 (25 minutes):*

The trainer will select two audio documentaries and then divide the participants into two groups; the first group will focus its attention on one of the selected audio documentary, for instance the one describing the situation of FGM in Mali, while the second one will focus on the situation of FGM the other audio documentary, for instance the one focusing on Burkina Faso. During the active listening the objective of the two groups is to listen to the audio documentary and take notes on the following issues:

1. Why;
2. Effects and consequences;
3. How and when (age);
4. Who.

Step 2 (25 minutes):

The trainer asks the groups to organize their notes and select a volunteer who will present the results of the group discussion according to the following questions:

- What are the reasons why FGM is practiced?
- What are the effects and consequences on women and girls?
- When (age) is it practiced?
- Who practice the FGMs and how?

Each group will present the results of the discussion on a flipchart. A plenary discussion will follow, highlighting the main differences between the two contexts and the information about the reasons behind the practice and the possible consequences on the life of women and girls.

Step 3 (10 minutes):

Wrap-up by the trainer, stressing the most important information and introducing the social norm theory.

Materials:

- Audio documentary;
- Audio;
- Flipcharts.

Activity 1.3: (45 minutes)

Understanding the reasons for and consequences of the practice through the life stories of migrant women dealing with FGM

Objective:

Discuss and highlight the main reasons and consequences through some selected life stories of migrant women dealing with FGM. The trainer will select some story lives which are significant as related to FGM in a migrant context.

Step 1: (20 minutes)

Divide the participants into three groups and distribute three stories of women dealing with FGM in a migrant context. Each group will read the story and then prepare a presentation on the following issues:

1. Content of the story;
2. Reasons for the practice;
3. Consequences and impact;
4. How has the migration experience influenced the practice?

Step 2: (25 minutes)

Each group will have 5 minutes to present the results of the discussion and then the main issues will be highlighted by the trainer, with regard to the reasons for and consequences of the practice on the life of women, with reference to migration.

Activity 1.4: (50 minutes) Myths and realities behind the practice

Objectives:

This activity prompts program officers to explore the broad range of reasons, both social and cultural, for the persistence of FGM.

The objectives of this activity are:

1. Understanding the reasons for the persistence of the practice by looking at what people say about why it should be done;
2. Recognizing the gender power dynamics lying behind the justification given for the performance and perpetuation of FGM;
3. Defining the cultural aspects that should be addressed when including FGM prevention activities in development programs and projects.

Description:

This activity is divided into different steps;

Step 1: (15 minutes)

Divide the participants into three groups and provide them with handout n. 1. Ask the participants of the groups to read the contents of the handout and choose one volunteer per group who will represent the position of a specific stakeholder who is part of an imaginary community of a non-defined country where FGM is practiced.

The groups can choose to represent the position of: grandmothers, mothers, girls, elder family members, traditional authorities, religious leaders, excisors, young men/husbands, peers (other girls), migrants, the community at large, and they must provide specific statements to support their position.

The trainer will ask the groups to support one volunteer per group in the preparation of a number of arguments and statements to be presented to the rest of the group in an imaginary community assembly. The actors will have about 3 minutes each to challenge the arguments and statements

from the point of view of his/her stakeholder.

Step 2: (15 minutes)

After the preparation, the three actors will present their statements and arguments in front of the others. The trainer will invite everybody to be respectful of the position of "others" when discussing and arguing the different positions, while the rest of the group will act as observers and take notes. If the participants do not feel comfortable acting in a role-play, they can present the arguments prepared by their group in the plenary session.

Step 3: (15 minutes)

The facilitator will guide the discussion around the following questions:

1. Ask the actors: how did you feel playing this role?
2. Ask the observers: what did you observe?
3. What worked well in the arguments provided?

Step 4: (15 minutes)

The facilitator will distribute handout n. 2, asking the participants to read it and make a last round of comments. It is very important to stress in the wrap-up how FGM is a complex issue and that the reasons behind the practice are very much related to myths and beliefs which are extremely differentiated according to different countries and cultures. Last but not least, the activity shows how there may be different views on FGM within the same community according to the different stakeholders. The facilitator will then conclude, stressing the idea that the reasons behind the practice are above all linked to the social norm theory, which better explains why people continue to perform FGM.

Materials

- Flipcharts;
- Markers;
- Handout n. 1: Myths and beliefs to justify the practice of FGM;
- Handout n. 2: The reality of myths and beliefs behind the practice of FGM.

Handout 1.1: **Myths and beliefs to justify the practice of FGM**

FGM contributes to gender identity

Through the myth of “twin birth” (duality of the soul) it is suggested that every human being has a double identity, and that FGM is used as an instrument that affirms femininity or masculinity. Thus, the clitoris would be a male organ in a girl and the female organ in a man is the prepuce covering the penis. Moreover, the clitoris is perceived as an organ where evil forces may cause problems with the psyche or make a girl vulnerable to evil spirits. Because of all these magical powers attributed to the clitoris, FGM is conceived as a preliminary to marriage in those areas, believing that this protects the husband and progeny from the misfortunes that can assault a non-excised woman.

FGM contributes to women’s health

It is believed that women who have been subjected to FGM are always in good health and rarely fall ill; it is also believed that FGM has healing powers. It has, people say, healed women suffering from depression, melancholy, nymphomania, hysteria, madness and epilepsy, and has the ability to stop women from having kleptomaniac tendencies. Some supporters of FGM believe that the secretions produced by the labia and the clitoris gland (Skene and Bartholin), produce bad odours, compromise hygiene and keep women from caring for their bodies. In those communities where washing the vulvar region with soap and water is common after relieving oneself, it is believed that the hand that washes is contaminated by the secretions and that the contamination is extended to food, water, clothes, etc. It is therefore deemed necessary to eliminate the glands and organs that produce these secretions to avoid contamination and safeguard individual cleanliness.

FGM beautifies the sexual organs of women

It is said that the prepuce of the penis is removed essentially for aesthetic reasons, and that the clitoris – homologous to the penis – is removed for the same reason. In addition, in some cultures, there is a prevailing theory that female genital organs have

the capacity to develop as the body grows, like those of a man, and that if the clitoris becomes longer it can hang in an embarrassing way against the thighs, like the penis. Even when there is a more rational concept of the size of a clitoris, a large number of ethnic groups consider this organ ugly to look at and indecent to touch. In their opinion a smoother female genital organ, with all protuberances removed, is much more attractive.

It is a rite of passage for girls

FGM, practiced in groups at the onset of puberty and with a period of reclusion for the excised girls, used to be - and still is in some rural areas - an important rite of initiation for girls. The decision to carry out FGM is made by the extended family (family chiefs, aunts, grandmothers or in-laws) or by local authorities (traditional chiefs, councils of elders and diviners). Girls’ initiation was/is a socialization of their roles as wives and mothers, and an apprenticeship of the secret rites and codes of behaviour of adult females. It sometimes included a transfer of occult knowledge or professional training. Girls in puberty submitted courageously to the torments of FGM and the entire community rejoiced in what was known as the girls’ “blessed day” and their preparation for life. It was the setting in which discussing and learning the details of sexuality was allowed, and the chance to create group solidarity. The greatest recompense for excised girls was acquisition of the status of adulthood and the rights that came with it, including the chance to be given in marriage, while in general boys who underwent circumcision were then allowed access to the highest spheres of power and sacred knowledge.

Excisors play an important role in the community

Traditionally, the practice was an occupation given to specific women (excisors) exclusively by the community, as a sort of heritage (from mother to daughter), and by their membership in a certain social group (for example, blacksmiths in most countries in West Africa). Prestige and social acceptance were their main reward, since they worked mainly in agriculture or trade. In most cases, payment in kind and in

money represented a symbolic reward for a job well done and not a strategy for survival.

FGM preserves virginity before marriage and ensures faithfulness during marriage

Remaining a virgin until marriage is strongly encouraged in most African societies. So much so that virginity confers a high level of prestige and, even more than the morality of the girl herself, it symbolizes the morality of her family. In the communities that practice FGM, people are convinced that it is very difficult for a non-excised girl to remain a virgin until marriage given the hyper-sexuality of the exterior organs of the female genital apparatus. So FGM, infibulation in particular, is supposed to guarantee girls' chastity. It is thought that excised girls are more capable of controlling their sexual desire and themselves more easily, and will be more inclined to remain faithful during their marriages.

FGM helps to increase the male's pleasure

According to certain social groups the clitoris is analogous to the penis and increases male arousal, leading to premature ejaculation. In these societies, when the sexual act is completed too rapidly (even though it is beyond the man's control), it is considered an insult and causes resentment and conflict within the marriage. It is also felt that the man should be able to control all aspects of sexual relations, from initial arousal to orgasm and ejaculation. In those types of FGM that call for the cutting of the labia minora and majora and suture of the vulva, one of the aims is to convert the organ into a tight orifice whose size is calculated to increase male sexual pleasure.

FGM is recommended by religion, in particular Islam

There is an ambiguous relationship between affiliation to Islam and the justification of FGM in Africa. Some Muslims make reference to a dialogue that the Prophet Mohammed apparently had with a traditional practitioner during his lifetime, in order to affirm that by excising their daughters they are following the Hadiths, which are important elements in their religions. Indeed, in most of these countries, the majority of the women who practice FGM are Muslim, which

some consider a *de facto* confirmation of the relationship between Islam and FGM, supported by the fact that the practice is almost universal in Islamic countries such as Somalia or Egypt. Nevertheless, the contradiction is that in the countries where FGM is practiced by a minority (e.g. Senegal, Mauritania and Niger), most of the Muslim population does not follow this practice. Moreover, the most fundamentalist subgroups of some countries (for example, Mali and Senegal) do not practice FGM while some of their countrywomen submit to it, convinced that all good Muslim women must have their daughters undergo FGM. Some Christians claim that they practice FGM in keeping with Christian tradition. They explain the practice of FGM as being in keeping with their affiliation to given ethnic groups. In contrast, the symbols and initiations that accompany FGM adapt easily to animist beliefs and the tradition of blood sacrifice to their gods or fetishes.

FGM is essential for preserving ethnic identity

It is alleged that membership of an ethnic group and identification with that group requires that certain obligations be met to achieve full admission. Those adhering to the group must conform to the group's rules and regulations and defend its cultural basis. The chiefs of certain ethnic groups firmly believe that non-compliance with these obligations takes away any right for members to claim the privileges and advantages they would normally be due. Most African families, who want their children to be accepted by their societies and to make full use of their social rights, hold that it is very important to identify with the culture or group of their lineage. They attribute a very high value to membership in the group and the creation of ties with other children without fear of exclusion. In some communities, FGM is the rite that gives women this acceptability and social integration. Otherwise, they risk being separated from the group and losing their right to contribute to and participate in community life. Loss of these rights and privileges could even be extended to the head of a family where women and girls have not undergone FGM.

Source: AIDOS, IAC, ILO, MGF. Une question de relations entre hommes et femmes, droits humains et santé.

Handout 1.2:**The reality of myths and beliefs behind the practice of FGM**

None of the reasons provided for carrying out excision have any scientific justification. From a medical point of view, modernization of the procedure (which means turning to specialized health care personnel to avoid possible infection and pain) is against medical ethics.

Preserving hygiene

The normal secretions of the vulvar glands are practically imperceptible—just enough to moisten the vulva area. Under normal conditions, in a healthy, clean female these secretions are colourless and their odour is not disagreeable. Thick, coloured, bad smelling, continuous vaginal secretions are signs of an infection and should be treated immediately. In areas where the women are required to wash the vulva after urinating, washing one's hands with a sponge and soap is sufficient if there is fear of contamination. In addition, excision can close the vulva (by scarring or infibulation) and prevents urine and menstrual fluid from flowing through the usual channels. This can provoke acute retention of urine and menstrual blood, and lead to a state known as haematocolpos which can seriously threaten the health of the girl or woman concerned and cause much worse odours than those from normal hormonal secretions.

Aesthetic aspects

The configuration, structure and function of most of the organs of the human body are determined by genetic and hormonal influences. The body's sexual hormones determine the distinctive characteristics of each sex. The male hormone stimulates the growth and function of all those organs which (like the penis) play a role in the male, just as it stops the growth of all those organs that the two sexes have in common (the breasts, for example). In the same way, the female hormone stimulates the development of the mammary glands (for the production of milk). Just as no one would ever

dream of excising the breasts of a young man (to prevent him from developing them later), a girl's clitoris should never be touched since it cannot grow beyond a certain size.

Safeguarding health

The belief that an excised woman has a better chance of maintaining good health is clearly not valid. In traditional communities, women rarely complain. There are numerous examples in literature of excised women suffering from a multitude of illnesses caused by their operation. Their societies have taught them that this suffering is part of their condition as women. Generally speaking, in communities that practice excision, certain organs and certain bodily functions are never mentioned and women are therefore required to ignore and bear any of the harmful consequences of excision as well as possible. We should also point out that it is often difficult for excised women to see the connection between infirmities or illnesses that they suffer from as adults and the FGM to which they were subjected during childhood and which they consider as an isolated, far-off episode.

Protection of fertility

The reasoning by which excision reinforces fertility and fecundity is absolutely groundless. Actually, the opposite is true. Excision is one of the causes of sterility, particularly among girls who develop pelvic infections after excision. The secretions believed to have a toxic effect on sperm are actually innocuous and are a lubricating mucus which eliminates the friction between the extremely sensitive walls of genital organs.

Prevention of stillbirths

There is no scientific basis to the idea that contact of the infant's head with the clitoris during labour can cause death. Actually, the large number of healthy children born to non-excised women is proof that the argument is groundless. On the contrary, there is a much higher percentage of stillbirths due to prolonged labour in excised women.

Improvement of male sexual performance

The reasoning that excision improves male sexual performance is only valid where tradition leads men to believe that sexual pleasure and performance can be obtained with excised women who passively support the sexual act. The truth is that men only rarely claim that female passivity contributes to sexual pleasure. Men interviewed on a random basis in some African countries have admitted that sexual relations with non-excised women were much more satisfying than with excised women. Many women have equally stated to family planning agents working in urban areas their belief that their husbands prefer women who are not excised.

Prevention of promiscuity and preservation of virginity

Every community has the right to take steps to oppose behaviour that risks breaking the daily balance of community life. However, promiscuity is a form of conduct that arises from a complex combination of social conditions on which maintaining or eliminating sensitive sexual organs has no direct influence.

A study conducted in Sudan has demonstrated that excision is not a way of stopping prostitution, which here is seen as a sign of promiscuity. Prostitution aside, some excised women believe that they are prevented from reaching certain levels of pleasure. After interviews with 50 urban women in Sierra Leone who had sexual experiences before excision, the researchers observed that none of these women ever reached the level of satisfaction they had before excision—and that before the interview they had no idea that this lack was the result of excision. Some of the women interviewed admitted that their stubborn search for an ideal partner had cost them their husbands and their homes. Thus, an operation aimed at eliminating promiscuity risks achieving the opposite effect.

Promotion of social cohesion

The belief that excision assures social integration is a real problem, since the right of membership in

a community and to be accepted as a full member should not be obtained at the price of human suffering and death. It should be possible to formulate other rules and conditions of acceptability that do not compromise the health of women and girls while preserving the social values and positive rules inherent in rites of passage. Practices that are dangerous to health (such as excision) should be eliminated. Actually, societies that are responsible for organizing rites of passage often set laudable goals. In order to achieve these goals, initiation rites need to be altered and there must be teaching to prepare girls for their new status of womanhood (without excision). That kind of change does not necessarily mean, as is believed, dissolution of feminine society. It should be understood as a way of achieving transformation or orientation towards a better life for everyone.

A religious practice

Neither the Qur'an nor the Bible mentions FGM. In reviewing the writings of Muslim exegetes, no mention of excision is found in the Qur'an. According to the Qur'an, God created human beings in the best possible form, so why deform the work of God? Islam prohibits the practice of all that is harmful and, as a result, prohibits excision because it is physically and psychologically abusive. Actually, some of the most prestigious religious leaders and theologians completely disapprove of the practice, although there is absolutely no consensus within Islam in favour of the elimination of excision.

Source: AIDOS, IAC, ILO, MGF. Une question de relations entre hommes et femmes, droits humains et santé.

MODULE 2: FGM AS A GENDER ISSUE

Module two focuses on FGM as a harmful practice associated with specific gender roles and gender power relations within communities. It is aimed at building common understanding around main concepts associated with gender, such as gender equality, division of labour, access to resources, power, empowerment and how those issues relate to FGM.

LEARNING OBJECTIVES

General Objective:

Improve understanding of FGM as a gender issue.

Specific objectives:

1. To understand the main differences between sex and gender;
2. To understand FGM as a harmful practice based on gender inequalities;
3. To understand why empowerment is key to ending FGM.

List of suggested activities:

Activity 1.1. Differentiating between sex and gender

Activity 1.2. Is FGM a women's issue?

Activity 1.3. Division of labour;

Activity 1.4. Access and control over resources;

Activity 1.5. FGM, power and empowerment;

Activity 1.6. Women's empowerment and community consensus inputs.

FGM AS A GENDER ISSUE AT A GLANCE

1. Why we consider FGM as a gender issue

In every society in which it is practiced, female genital mutilation is a manifestation of deeply entrenched gender inequality. Where it is widely practiced, FGM is supported by both men and women, usually without question, and anyone departing from the norm may face condemnation, harassment and ostracism. Being a social norm (module 1), in fact, it is often practiced even when it is known to inflict harm upon girls because the perceived social benefits of the practice are deemed higher than its disadvantages.

FGM is embedded in the gender power relations within communities and societies which practice it; nevertheless it can be abandoned if the gender roles, power relations and social norms associated with the practice are modified.

Some of the key issues of the gender analysis are presented below in order to provide a frame to contextualize FGM as a gender related issue and explore the relation between FGM, social change and women's empowerment.

1.1 Sex and gender

Sex is about the biological characteristics that determine if someone is a male or a female. Gender is about the social and cultural ideas, behaviours and practices that a society regards as appropriate for men and women.

Biological characteristics that determine sex do not vary much between societies, whereas gender characteristics can widely differ. While the biology that determines sex is fixed, gender roles and behaviours can change according to time and place. The gender issues in Sweden will be very

different to those in Swaziland because the social, cultural and political structures in the two countries are also different.

Nevertheless there are gender characteristics that are common in the majority of societies. For instance it is more acceptable for women to cry than men, statements (and underlined beliefs) like "women are more sensitive and sweeter than men" "men are stronger than women" "boys perform better in science than girls" are quite common around the world. There are widespread differences between men and women in access to health care, employment, education, finance, and community and political participation. Men tend to be the main wage earners in families, while women tend to work in lower paid jobs while also managing the bulk of housework and childcare. These gender norms play an important part in creating gender inequality or disparity.

FGM is closely related to gender relations because it is related to gender inequalities within societies and to the power relations between gender roles. Actually it's a practice which is deeply rooted in gender imbalances, it is performed on girls because they are biologically born female and through the practice they are meant to become women in gender terms. As such FGM is a gender marker.

As a result of those gender differences where the status of women is usually perceived as less powerful than that of men women face considerable disparities in access to and control over resources as well as in the division of labour.

1.2 Gendered division of labour

The gendered division of labour around the world means that women often have less access to paid work than men. Paid employment can lead to expanding opportunities for women and closing the gender gap in both the labour market and within households. But women typically have fewer opportunities than men and generally carry out more of the household and reproductive responsibilities (child rearing and caring for families) leaving them with less capacity and time for paid employment. This is particularly the case in rural areas where poor infrastructure and the lack of facilities and social support often make the unequal division of labour more exacerbated.

In many African societies rural women are responsible for child rearing, caring and providing for the immediate health needs of the family and household, and subsistence food production. Men will tend to seek wage labour further afield. This means that women are often responsible for the management of environmental resources such as water, land and energy (firewood) and as a result often have more environmental and indigenous knowledge than men.⁽⁴⁰⁾

Women and girls tend to be responsible for collecting and storing water, providing water for animals and crop growing, gathering non-timber forest products, fuelwood, and child care and household nutrition.⁽⁴¹⁾ Technological changes such as using bicycles to collect water can help free up time for women and enable them to pursue other, potentially money-earning, activities.

1.3 Access and control over resources

Labour, whether productive, reproductive or social, requires access to resources. These can be

economic, technological, social, political, or even time. Access to these resources is unevenly distributed, with men usually taking the greater share. By access what is meant is: having the opportunity to make use of resources to satisfy various needs, whether individual or social. Control refers to the power an individual can have over a particular resource, and the capacity to make decisions about how and for what purpose that resource is used.

There are huge inequalities between men and women when it comes to access to and control of resources. The United Nations has estimated that if rural women had access to the same tools and credit as men, there would be 150 million fewer hungry people in the world.⁽⁴²⁾ Women are essential to global agriculture and make up almost half of the world's farmers. But they have significantly less control of land than men. It is estimated that less than 20% of landholders are women. This inevitably means they have less access to farming inputs like seeds and fertilizers, as well as less access to financial credit and extension services.⁽⁴³⁾

Women also have less access to financial institutions and credit and saving mechanisms. For example, in 2011 55% of men reported having a financial account of some kind, while only 47% of women did. In 2014, 65% of men had accounts while only 58% of women did, a considerable gap of 7%. In developing countries the gap between men and women was even higher at 9%.

Gender inequality and unequal control of resources is not only experienced in the economic domain, but also in social and political dimensions. For example women tend to have less access to political resources such as the opportunity to be elected to parliament or government. According to the UN, only 22% of national parliamentarians were female in 2015, up from 11% in 1995. Around the

40. Howard, Patricia L., and others. 2003. 'Women and Plants: Gender Relations in Biodiversity Management and Conservation'. London: Zed books.

41. UNEP, 2006, 'Environmental Change and Socioeconomic Factors'. Nairobi: UNEP

42. FAO, 2011, 'Women – Key to Food Security'. Rome: Food and Agriculture Organization.

43. UN Women. 2015. 'Facts and Figures: Economic Empowerment'. New York: UN Women

world there were, in January 2015, only 10 females who acted as Head of State and 14 females who acted as Head of Government.⁽⁴⁴⁾ At a more local level, control over household and community decision-making also tends to be dominated by men. Men tend to have more control over household finances and therefore over decisions about how household money will be spent.

Women tend also to have less access to education and information than men. Due to the unequal control of household resources, men will give advantages to sons over daughters in terms of educational and economic opportunities. Men generally have more access to the internet and other sources of information such as TV and radio, so they have more control over what information the household is exposed to. A report by the UN Broadband Commission Working Group stated that in developing countries, 33% of men have access to the internet compared to 29% of women.⁽⁴⁵⁾

Finally, unequal access and control over resources can undermine a person's sense of their own worth. For example, in the context of FGM being imposed on women through certain social norms, women may feel they have little control over their own bodies. Having little control over her own body may make it harder for a woman to feel she has control over other aspects of her life. If, for example, a woman suffers violence from her husband or other family members, this will also reinforce the idea that she has little control over her life. Having a sense of self-esteem and self-worth are fundamental to allowing people to develop themselves and take up social and political opportunities. A person with a strong sense of self-worth is more likely to engage in community activities and gain more control over his/her life than someone who

has been made to feel worthless and powerless.

Some FGM-practising communities come from patriarchal societies where resources and power are passed down and held solely under male control and a woman's access to resources is exclusively through her husband or the male members of her family. In such a context, for a woman marriage represents the main means of survival and access to resources. In order to be eligible for marriage it is usually essential that she is a virgin and, due to the association between virginity and FGM, an uninfibulated or unexcised girl has virtually no chance of marrying. FGM is often viewed as a way to preserve virginity before marriage and to ensure faithfulness after the marriage.

1.4 Gender equality

"One of the most serious violations of gender equality is violence against women."⁽⁴⁶⁾

The term 'gender equality' means treating men and women, boys and girls, the same way. Gender equality does not mean ignoring the biological or social and cultural differences between men and women that exist around the world. It means that men and women should be seen equally under the law, and that they should have equal rights, opportunities, and access to resources, including the possibility to participate in the public sphere. It also means allowing men and women equal freedom to choose the sort of gender roles they would prefer to have.

UNICEF has demonstrated that there is a 'double dividend' for campaigns that increase gender equality because healthier and more educated women will tend to raise healthier and more educated children. The World Health Organization has pointed out that without improvements in gender equality, the success of health programmes, development projects, and any new laws and policies will be limited.

44. Ibid.

45. UNESCO and ITU. 2013. 'Doubling Digital Opportunities: Enhancing the Inclusion of Women & Girls in the Information Society'. Geneva: International Telecommunication Union (ITU) and the United Nations Educational, Scientific and Cultural Organization (UNESCO).

46. EUFRA. 2015. 'Gender'. Vienna: European Agency for Fundamental Rights.

This is why programmes and projects not necessarily addressing FGM but aimed at improving gender equality may have a positive impact on ending the practice. The way round: a project addressing the issue of FGM with a gender perspective, taking into account the perception and concerns of men and women, supporting women in gaining access and control over resources and involving men in the changing role of women, for instance, may have positive impacts on the health of the whole family.

2. FGM, gendered power relations and empowerment

The issue of FGM is closely tied to power relations between men and women in the communities where FGM is practiced. Social norms about FGM should be considered from the perspective of gender relations and “silent power negotiations” that take place between men and women in FGM affected communities.⁽⁴⁷⁾

In every community, the status that women and girls have, and their level of empowerment or agency, will have a direct impact on the degree of choice that women have over their lives and therefore over decisions related to FGM. If women have less or no choice over their own lives, and over decisions about carrying out FGM on their daughters, this is in part due to the gender power imbalance between men and women. In societies where men have more social and economic power than women, they may exercise this power by making decisions on behalf of women without their consent or by simply refusing to marry a woman not subjected to FGM in a context where marriage is fundamental for girls’ and women’s survival and social acceptance. Many of the countries with high rates of FGM are also ranked extremely low on the Global Gender Gap Index, which indicates that gender imbalance

47. Toubia Nahid, “Legislation as a tool for Behavioural and Social Change”. In: Proceedings of the Afro-Arab Expert Consultation on Legal Tools for the Prevention of Female Genital Mutilation Cairo, 21-23 June 2003. Rome: NPWJ and AIDOS.

plays an important role in maintaining a cultural practice that negatively affects women.

In some communities women may continue to practice FGM as a way of having some power over their daughters and therefore over the social and financial standing of their family within the community.⁽⁴⁸⁾ Because of this, women may actually feel reluctant to give their power away – in the case of programmes that aim to reduce or stop FGM – unless power, and therefore status, is offered to them in another way.

In other words, programmes that aim to educate communities about the negative impacts of FGM, and eliminate the practice in the long run, need to be combined with approaches that increase female empowerment.

“Empowering women and girls through education and economic opportunities has shown great promise in convincing communities to abandon the practice.”⁽⁴⁹⁾

2.1. Benefits of gendered empowerment

There are huge potential benefits of improving women’s access to and control of resources. Studies have shown that by investing in rural women there can be a range of economic and social benefits. For example, in Burkina Faso, when access to agricultural inputs for women was increased so that it was equal to men’s, agricultural production increased by up to 20%. Women in Kenya were able to increase their agricultural yields by over 20% when they had access to the same levels of education and agricultural inputs as men.⁽⁵⁰⁾

48. EndFGM, Repositioning FGM as a Gender and Development Issue - Position Paper.

49. PRB, Ending Female Genital Mutilation/Cutting: Lessons from a Decade of Progress, 9.

50. USAID. 2010. ‘Effective Gender Integration Practices for Agriculture. Brief 2: Increasing Women’s Access to Resources’. Washington: USAID

Giving women more access to and control of resources means that women are more able to participate in the labour force, which in turn has a significant positive impact on economic growth. The more women work, the faster economies are able to grow.⁽⁵¹⁾ It has also been shown that when a greater share of household income is controlled by women, there are direct benefits to children with long term positive effects on economic growth. In Brazil, higher amounts of income for women correlate with increased height of their daughters.⁽⁵²⁾ In China, a 10% increase in the average adult female income correlated with an increase in survival of girls as well as increased years of schooling for both boys and girls.⁽⁵³⁾ Similarly, it has been found that higher incomes for women lead to increased numbers of years of schooling for their children.⁽⁵⁴⁾

FGM lies at the heart of the subordinate role of women, as women are perceived as unable to control themselves, particularly in the area of sexuality, and therefore do not correspond to men's requests and gender role models, and are thus in need of a "normalisation" that comes with the whole socialization process of girls and women, going as far as cutting off a part of their healthy body. Empowerment of women comes therefore with the abandonment of FGM, as much as the abandonment of FGM comes with the empowerment of women. For both to happen, the community around the target group needs to approve and consent to this major change in behaviour.

WHAT PROGRAMME MANAGERS MUST KNOW

FGM can be perceived as a "women's affair" in the sense that it is often performed with the consent and the direct involvement of mothers, grandmothers, mothers-in-law etc. in the rituals related to the practice and in its organisation. Empowering women and girls through education and economic opportunities is fundamental in convincing communities (including women and girls) to abandon the practice. Nevertheless, as FGM is a social norm rooted in gender imbalances, women must not be the sole target of projects, as they can't change gender roles by themselves. In order to be challenged, gender roles and gender power relations also need the involvement of men, boys and the whole community.

When planning an intervention to support the abandonment of the practice it is therefore fundamental to involve the whole community in the process, even if the action is meant to empower women and girls.

51. Stephan, Klasen and Francesca Lamanna. 2009. 'The Impact of Gender Inequality in Education and Employment on Economic Growth: New Evidence for a Panel of Countries'. *Feminist Economics* 15 (3): 91-132

52. Thomas, Duncan. 1990. 'Intra-Household Resource Allocation: An Inferential Approach'. *Journal of Human Resources*, 635-64

53. World Bank. 2012. 'World Development Report: Gender Equality and Development', 5. Washington: World Bank

54. Nancy, Luke and Kaivan Munshi. 2011. 'Women as Agents of Change: Female Income and Mobility in India'. *Journal of Development Economics* 94 (1): 1-17

READINGS

- Duncan, Thomas. 1990. 'Intra-Household Resource Allocation: An Inferential Approach'. *Journal of Human Resources*, 635–64. <http://tinyurl.com/p3sbtgh>
- EUFRA. 2015. 'Gender'. Vienna: European Union Agency for Fundamental Rights. <http://tinyurl.com/k2u9nsu>
- FAO, 2011, 'Women – Key to Food Security'. Rome: Food and Agriculture Organization. <http://tinyurl.com/lh7xd8c>
- Howard, Patricia L., and others. 2003. 'Women and Plants: Gender Relations in Biodiversity Management and Conservation'. London: Zed books.
- Klasen, Stephan, and Francesca Lamanna. 2009. 'The Impact of Gender Inequality in Education and Employment on Economic Growth: New Evidence for a Panel of Countries'. *Feminist Economics* 15 (3): 91–132. <http://tinyurl.com/pbs6rr5>
- Luke, Nancy, and Kaivan Munshi. 2011. 'Women as Agents of Change: Female Income and Mobility in India'. *Journal of Development Economics* 94 (1): 1–17. <http://tinyurl.com/hgfkawv>
- Toubia, Nahid "Legislation as a tool for Behavioural and Social Change". In: *Proceedings of the Afro-Arab Expert Consultation on Legal Tools for the Prevention of Female Genital Mutilation* Cairo, 21-23 June 2003. Rome: NPWJ and AIDOS <http://tinyurl.com/nvzrca8>
- UNEP. 2006. 'Environmental Change and Socio-economic Factors'. Nairobi: UNEP. In: *Africa Environment Outlook 2. Our Environment, Our Wealth*. Section1, p. 4. <http://tinyurl.com/3z9ylb6>
- UNESCO and ITU. 2013. 'Doubling Digital Opportunities: Enhancing the Inclusion of Women & Girls in the Information Society'. Geneva: International Telecommunication Union (ITU) and the United Nations Educational, Scientific and Cultural Organization (UNESCO). <http://tinyurl.com/q8954t9>
- UN Women. 2015. 'Facts and Figures: Economic Empowerment'. New York: UN Women. <http://tinyurl.com/q5kksml>
- USAID. 2010. 'Effective Gender Integration Practices for Agriculture. Brief 2: Increasing Women's Access to Resources'. Washington: USAID. <http://tinyurl.com/owxt8op>
- World Bank. 2012. 'World Development Report: Gender Equality and Development'. Washington: World Bank. <http://tinyurl.com/ohlfnfgd>

ACTIVITIES

Activity 2.1: (1 hour)

Differentiating between sex and gender

Objectives:

This activity defines the concepts of sex and gender and it is aimed at understanding differences between sex and gender, and recognising that norms can be changed. The specific objectives are:

1. To understand which differences between women and men can be explained on the basis of biology or sex differences;
2. To understand which differences between men and women are based on social values or gender norms;
3. To recognise that norms and values which are socially constructed can be changed.

Description:

Step 1: (20 minutes)

Ask participants if they have heard about the meaning of sex and gender. Ask participants what comes into their minds when they hear the words “gender” and “sex” and write their responses on a flipchart. Summarize the results by providing working definitions of gender and sex:

Sex refers to the biological differences between male and female.

Gender refers to socially constructed differences between men and women.

Write each of these definitions at the top of separate sheets of flipchart paper and put them on the wall. Add that, being socially constructed, gender differences vary depending on: ethnicity; caste; class; religion; culture; age; marital status and time. While sexual differences vary little across these variables.

Provide participants with a copy of Handout n. 1 (General statements on gender and sex) and ask them to discuss in pairs which statements refer to sex and which to gender. Then ask participants randomly or one after the other to read the statements clearly and define each as an “S” for “sex” statement or as a “G” for “gender” statement. Then check with the rest of the group: how many have chosen “S”, how many “G”, and why? Try to reach a consensus, bearing in mind that for some statements both “S” and “G” apply.

In this case, 1, 4 and 6 are S, the rest are G.

Talk about each statement as you go along, asking people to give reasons for why they think this is a sex or gender statement. Push the group to reach consensus on whether this is a ‘sex’ or ‘gender’ statement. This process helps to bring out all of the complexities of the issue. Write the statements up on the flipchart under the appropriate definition as you go along. It is possible that the participants will conclude that some statements are both sex and gender, and in that case, write them so they are included on both pieces of paper.

Step 2: (20 minutes)

Now the group moves to how ‘sex’ and ‘gender’ link to health issues. Distribute Handout n. 2: Health-related statements about women and men. Again people are asked to mark the handouts as either ‘S’ or ‘G’ and again you distribute them and read out the questions, getting the group to indicate how people interpret the statements. Through group discussion develop a group consensus and again list the statements on the appropriate sheet as statements that refer to either sex or gender.

In this case statements 2, 3, 8 are ‘S’; Statements 5 and 7 are both ‘S’ and ‘G’, the rest are ‘G’.

Step 3: (20 minutes)

Consolidate the activity by using Handout n. 3 ‘Sex and Gender’ to help participants develop a clear understanding about the difference between sex and gender. This section will also give them a deeper understanding of the concept of gender. While running this discussion, draw on the

examples given by participants during the previous activities. These examples will allow you to illustrate the different characteristics of gender. You can do this as follows:

Tell them that what they have done in the previous two exercises is to define the difference between sex and gender. They have seen that there are very few characteristics that are biologically determined; most are socially constructed. You will now try to distinguish the different characteristics of 'gender' based on the previous discussions.

Now distribute Handout n.3 so that you show one concept at a time, starting with 'Relational'. Then ask the participants to give their own examples of how gender manifests itself in that characteristic.

For example, under 'historical', participants may point out that whereas in the past women were expected to do all the cooking, over time men have started to cook too; or that in the past girls were not sent to school whereas now they are - these are changes over time and illustrate that gender roles are historically specific.

Indicate to them that in the next session you will be exploring how gender relationships have to do with access to and control of and over resources and benefits.

Materials:

- Flipcharts;
- Markers;
- Printed Handouts n. 2.1, n. 2.2 and n. 2.3.

Handout 2.1:

Sex or gender? General Statements

1. Women give birth to babies, men do not.
2. Little girls are gentle, boys are rough.
3. Amongst African agricultural workers, women are paid 40-60 per cent of male wages.
4. Women can breast-feed babies, men can bottle-feed babies.
5. In Ancient Egypt men stayed at home and did the weaving. Women handled family business. Women inherited property, men did not.
6. Men's voices break at puberty, women's do not.
7. According to the United Nations, women do 67% of the world's work, yet their earnings for it amount to only 10% of the world's income.
8. 2 million girls are mutilated every year.
9. In one study of 224 cultures, there were five in which men did all the cooking and 36 in which women did all the house-building.
10. Girls cannot ride bicycles, boys can.

Source: Williams, S., Seed, J. and Mwau, A., *The Gender training Manual*. Oxford: Oxfam, 1994: 87-89

Handout 2.2:**Sex or gender health related statements**

Read the statements and write 'S' against those that you think refer to sex and 'G' against those that refer to gender

1. The majority of hospital managers in most countries are men and most of the ward managers are women.
2. Boys and men suffer from haemophilia, whereas girls and women are usually only carriers.
3. Women suffer from pre-menstrual tension, men do not.
4. More health research funds go to research on men than on women.
5. Women are more susceptible to sexually transmitted diseases than men.
6. When infertility occurs in a couple, it is often presumed to be the fault of the woman.
7. The rates of behaviour disorder and hyperactivity for boys is 2-3 times the rates for girls.
8. Women have ovary cancer, men have prostate cancer.
9. Infibulated women suffer from menstrual blood retention.
10. In deprived rural areas girls suffer from malnutrition more than boys.

Source: Xaba, M. and Varkey, S., Women's Health Project Gender and Health Course: *Facilitator's Guide. Women's Health Project. School of Public Health. University of the Witwatersrand. Johannesburg 2000.*

Handout 2.3:

Characteristics of gender

Definition:

Gender refers to the way that society expects men and women to behave. Sex refers to the biological differences between men and women.

Relational:

It is relational because it refers not to women or men in isolation, but to the relationships between them and how these relationships are socially constructed.

Hierarchical:

It is hierarchical because the differences established between women and men, far from being neutral, tend to attribute greater importance and value to the characteristics and activities associated with what is masculine and to produce unequal power relations.

Historical:

It is historical because it is nurtured by factors that change over time and space and thus can be modified through interventions.

Context specific:

It has contextual specificity because there are variations in gender relations depending on ethnic groups, class, culture, etc. It is therefore necessary to recognise diversity in the analysis of gender relations.

Institutional:

It is institutionally structured because it refers not only to the relations between men and women at the personal level, but also within social institutions such as schools or health systems and in the overall social system that is supported by values, religion, legislation, etc.

Gender relationships are personal and political:

Personal, because gender roles that we have internalised define who we are, what we do and how we think of ourselves. Political, because gender roles and norms are maintained and promoted by social institutions and challenging these implies challenging the way society is currently organised.

Activity 2.2: (1 hour)

Is FGM a women's issue?

Objective:

The objective of this activity is to familiarize participants with the role women play in FGM and with its complex outcomes for women's lives and empowerment in both rural and urban settings. As abandoning the practice implies a fundamental change in behaviours, hidden meanings and dynamics also need to be understood by programme officers before planning activities. More in particular, the objective of the activity is to understand the complexity of FGM and why women continue the practice, despite the harmful consequences.

Description:

Step 1: (30 minutes)

This is a small group activity. It is based on the analysis of anthropologists and experts with the aim of challenging the "women's issue" stereotype and investigating it further. Each group is given one of the handouts with different case studies:

- Case 1. Not born as a woman but created as a woman by culture (Carla Pasquinelli)
- Case 2. Sierra Leone: women's secret societies and FGM (Fumbai Ahmadou)
- Case 3. Why FGM is such a strongly upheld traditional practice and whether it is harmful or useful to women (Nahid Toubia)

Ask the group to read their handout carefully and then discuss it. Write on a flipchart "Questions for guiding the discussion". Participants should compare the content of the handout with the myths and realities already discussed in the first activity.

Ask each group to choose a *rapporteur* (spokesperson) to present the group's comments to the plenary. Walk around and listen to the groups. If they are battling, then help them along by offering alternative perspectives to look at the issue.

Step 2: (30 minutes)

Bring the group together. Ask each *rapporteur* (spokesperson) to present the result of the discussion, including a concise presentation of the content of the case study. Ask for the participants' comments. Keep the set of questions that have guided the discussion in mind, and try to let both sides of the practice emerge:

- on one hand, FGM is a practice that oppresses women and girls, violates their bodily integrity and human rights, reduces and subdues their natural sexuality;
- on the other hand, it grants women freedom of movement, dignity, respect and social recognition, access to resources and decision making within the community, adult female identity.

Guide the conclusion of the discussion towards the understanding of FGM as a social norm; there can be a wide range of beliefs that underpin a certain social norm and cultural practice, and those beliefs can also change during time. Social norms and beliefs of any kind are not fixed but subject to change.

Questions to guide the case study analysis and presentation:

Give a concise presentation of the case study;
What is the attitude of the women in the case study towards the practice?
Are any negative consequences of the practice acknowledged?
What are the reasons highlighted in the case study for the continuation of the practice?

Materials:

- Flipcharts;
- Markers;
- Printed case study n. 2.1, n. 2.2 and n. 2.3.

Case study n. 2.1:**Not Born As A Woman, But Created As A Woman By Culture***

Female genital mutilation is a fundamental component of the initiation rites performed in a traditional society to become a “woman”. One is not born a woman, in the sense that the biological connotation is not in and of itself a sufficient factor of identification. For that, rites are needed to transform membership in an ascribed sex to an acquired status, freeing biological destiny of sex and allowing it to become a “social essence”: a woman. It is the rites that decide a person’s identity, starting with ascribed belongings such as sex and age. By separating it from biology, rites inform a person of his/her identity, indicating what s/he is and should be.

Of course, this does not happen only in Africa. With differing emphasis, every society transforms biological sexuality into a cultural construction, differentiating between male and female to decide gender membership. Gender is a process of the definition of self according to the connection to cultural models historically built on the difference between the sexes. For the most part, they are implicit models in their ways of acting, projecting the difference between the sexes on the cultural level, redeeming them from pure biological belonging. The state of gender in complex societies is subject to continuous negotiation, in the sense that none of the distinctions between men and women is destined to remain the same for long. As such, these distinctions cannot be taken for granted. In traditional societies, on the other hand, gender is better established and, at present, seems fairly unchangeable.

In African societies, the creation of gender identity is first of all physical manipulation of the body. With respect to the ceremonial aspects of the rites of initiation, which take care of the symbolic control of the passage of status, female genital mutilation does something more: it carves the woman’s gender identity onto her body. And it does so in two ways, first, by changing the morphology of her body and then by shaping its expressiveness. Along with manipulation of the woman’s body, mutilation forms the physical appearance, proportion and harmony among the various parts, the exis (final outcome), posture and bearing, giving a woman’s body what anthropologist Marcel Mauss calls “techniques”, those automatic body gestures and movements that, in different ways, represent “femininity” in every culture. This is particularly visible in infibulated women whose lithe, slow gait is a result of the operation that makes a series of movements very difficult. The operation brings the legs closer together, restricting the intermediate space and keeping women from separating their thighs too much. This forces the woman’s body into a carriage and stride that we could define as centripetal. After they are infibulated, the girls are re-educated to use their bodies, choosing certain movements and postures that are compatible with the changes brought by the operation, abandoning others that might compromise its results and reopen the freshly sutured wound. “Careful, don’t run, don’t play ball, you’ll tear,” admonish their mothers. The latter take it on themselves to teach their daughters to discipline their bodies according to rules and models of behaviour inspired by the women’s subordinate role in society and characterized by rigid differentiation and separation of male and female. The operation also ends any form of promiscuity between boys and girls who stop playing with each other, not only because

the operation makes any type of activity we associate with masculinity, like running, playing with balls, jumping, and so forth difficult, but also because the new status of woman forbids it.

The natural body is impure because it is open and violable, exposed to a promiscuity that can contaminate not only the individual woman but her entire family group which would be discredited and shamed. In this scenario, female genital mutilation is the only way of protecting women from the male desire that is always lurking and especially from herself. That helpless body is defended by a cultural construction of bodies that deprives them of all tumescence and excess, making them smooth and innocent after stealing their naturalness and pleasure.

But there are two important relationships at play here: between the sexes and between the generations, mother and daughter in particular, which initiation rites make extremely visible and dramatic. The mother-daughter relationship is much more ambiguous and controversial than that between the sexes, basically an asymmetrical relationship of domination, based on the marital strategy linked to the bride price.

In the mother-daughter relationship, we find psychological rivalries and destructive instincts that are condensed, expressed and neutralized in the period of time required for the ritual performance. This is true from the point of view of the daughters who see in the rite a legitimization of their own sense of guilt at taking over their mothers' position, and from the point of view of the mothers who "betray" their daughters' trust, becoming persecutors and thus expressing their envy for their reproductive capacity. Then, all is forgotten, including torture and suffering, once the "passage" has taken place.

At the rite's end, only the bodies preserve the memory in the form of a scar appointed to represent the sign of membership in one's ethnic group.

* Excerpts from: Pasquinelli, Carla. 2004. *'Anthropology of female genital mutilation'*. In: Proceedings of the Afro-Arab Expert Consultation on Legal Tools for the Prevention of Female Genital Mutilation Cairo, 21-23 June 2003. Cairo: NPWJ. (First published in C. Pasquinelli, *Antropologia delle mutilazioni genitali femminile. Una ricerca in Italia*. Roma: AIDOS, 2000).

Case study n. 2.2:**Sierra Leone: Women's Secret Societies And FGM/C***

The two most salient social organizations, who care for initiation and circumcisions among the Kono, a Mande speaking group of Sierra Leone are Bundu, female "secret societies" and Poro, their male counterpart. Most important, the soko [leader of the Bundu] has the socio-religious authority to create "woman" - that most productive and reproductive asset as far as patriarchy, that is, male-headed families, compounds, villages, and lineages, is concerned. She gives religious, social, and cultural sanction to women's reproductive and productive roles: an initiated or well "trained" woman will fulfil her social responsibilities as mother and as farm labourer. Given the traditional socioeconomic primacy of marriage and motherhood among the Kono, as in most African cultures, and Bundu's paramount historical function of producing marriageable women committed to accomplishing their productive and reproductive roles, the soko is charged with the most credited task in society.

However, the role of Bundu and its leaders in this regard has engendered some controversy among scholars who have criticized female ritual officials as colluding with patriarchy in order to maintain the subordination of women in society. This position, however, misses the point that female subordination is much more complex and situational than Western analysis permits. What Bundu teaches first and foremost is the subordination of young girls and women to female elders: their mothers, future mothers-in-law, grandmothers, older women within the community, and, of course, female ritual leaders. Secondly, novices are taught the art of subservience to some categories of men, that is, their future husbands and other male representatives of those lineages. In the first instance, vis-à-vis female elders - that is, within their own sex group - initiates and younger women are inferior. [...] But ritual leaders do not only teach subservience. They themselves are examples of ultimate female authority: wise, unyielding, and unsentimental. It is the soko's responsibility to see to it that novices are inculcated with the ideals of femininity as laid down by previous ancestresses: stoicism, which must be displayed during excision; tenacity and endurance, which are achieved through the many other ordeals a novice must undergo; and, most important, "dry-eye" that is, daring, bravery, fearlessness, and audacity, qualities that will enable young women to stand their ground as adults in their households and within the greater community. Thus, the soko has a paradoxical responsibility of "creating" dual-natured "woman": a community-oriented and subservient person to be exchanged in marriage, as well as a defiant individual who capitalizes on the bolder qualities ingrained in her feminine identity in defending her own goals, priorities, and stakes within society. Female elders flank the upper echelons of Bundu. The next and most important category of women as far as the continuation of initiation and excision is concerned are the middle-aged grandmothers, whose critical job it is to put pressure on their daughters, who may be wary young mothers. These eminent elders have significant moral and emotional control over their married daughters. New mothers often spend a great deal of time in their natal villages under the supervision of their own mothers, particularly after the birth of and throughout the weaning period of their children. This group of older women are well aware of their importance when it comes to initiation and are often the ones spearheading the organization and orchestration of their granddaughter's ceremonies.

It is incumbent on mothers to initiate their daughters properly, according to ancestral customs, in order for the latter to become legally recognized as persons with rights and responsibilities in society. Thus, there is enormous cultural demand for mothers to conform to the tradition of initiation, no matter how far their travel, the length of their absence from their local communities, and for those who are abroad in Europe or the United States, the intensity of their “Westernization.”

For Kono women living in the diaspora, there is not much difference because many remain very close to their mothers. Although older women and female ritual officials put tremendous social pressure on mothers to “circumcise” their daughters, this pressure does not sufficiently explain why most women adhere to the tradition. [...] The reluctance of women to disengage from female “circumcision” could well be a result of gauging what other women will do - that is, some women may not actually support the continuation of the practice, but they do not want their daughters to be the odd ones out.

Kono women living in the diaspora explain that they want their daughters to enjoy the same legal rights as other women, and even more, they want them to “fit” into Kono society and be respected among their peers and the entire community of women. My own personal experience, which is hardly unusual, is a case in point. I am often reminded by Kono relations that had I not undergone initiation, I would not be able to be involved in meetings concerning “women’s business,” that I would not be able even to speak as a “woman” or on behalf of any women. Moreover, no initiated Kono woman would dare to talk to me about Bundu. In short, I would be ridiculed and maligned as an arrogant *puu moe* [white person] or worse, an “uncircumcised woman”, the ultimate insult against a woman. At the same time, these women do not necessarily believe that their Western-born or -bred daughters will care to be integrated in or accepted by Kono society. In fact, some admit that their daughters, if left to themselves, have no intention of visiting Kono or even Africa for that matter (given the negative image of war and poverty), let alone of marrying Kono men.

Societal coercion and pressure to conform, however, do not explain the eagerness and excitement felt by vast numbers of participants (residents in Kono as well as outside) in initiation ceremonies, including mothers of initiates, even if these same mothers also experience anxiety over the safety of their daughters. It is difficult for me - considering the number of these ceremonies I have observed, including my own - to accept that what appear to be expressions of joy and ecstatic celebrations of womanhood in actuality disguise hidden experiences of coercion and subjugation. Instead, I offer that most Kono women who uphold these rituals do so because they want to they relish the supernatural powers of their ritual leaders over against men in society, and they embrace the legitimacy of female authority and, particularly, the authority of their mothers and grandmothers. Also, they maintain their cultural superiority over uninitiated/uncircumcised women.

* Fuambai Ahmadu, “Rites and Wrongs: An Insider/Outsider Reflects on Power and Excision”, in Shell-Duncan, B. and Y. Hernlund, *Female “circumcision” in Africa. Culture, controversy and change*. Lynne Rienner Publisher, 2000.

Case study n. 2.3:**Why Is FGM/C Such A Strongly Upheld “Traditional Practice”
And Is It “Harmful” Or Useful To Women?***

As an African feminist and physician I have, in the past, been plagued and irritated by the nagging question: why do women in Africa insist on circumcise their girls and why even the educated of them still defend the practice? Studies show that women medical doctors refuse to condemn the practice in a society where infibulation is the norm. It may be easy to lay the burden of the demand for FC/FGM on the shoulders of men or, more accurately, on patriarchal society including the women within it. While such analysis still holds, there is still the unresolved issue of why women defend the practice even when men in their family or their community want to abandon it.

The answer to this question revealed itself while we were conducting an analytical reviewing of major approaches taken against FGM in the past twenty years, which we undertook between 2001-2002. In extracting the elements of what worked and what didn't in persuading people to abandon the practice, we found that projects which focused on changing women's consciousness and, in some cases, their material conditions had a significant effect on accelerating the rate of abandonment. We also found that for the change in women's attitude and behaviour towards FC/FGM to take root and be sustained it must gather sufficient support from power holders in the community such as husbands, health professionals, religious leaders and policy makers.

This finding made us look more carefully at our perceived notion that FC/FGM is harmful to women. On the basis of objective logic and scientific criteria FC/FGM is undoubtedly harmful to girls as it deprives them of vital sexual organs necessary for their health and holistic development. The fact that the cutting happens to minors who have no true powers of consent is a violation of their human rights under the Convention of the Rights of the Child. But these are 'our' logical and rational reasons for condemning the practice which attempt to transplant onto the women who want to preserve the practice. Women living in circumcising communities have 'their' own logic and rational reasons for not readily adopting our logic.

For them living under a strong patriarchal social and economic regime with very few options for choices in livelihood, the room for negotiating a limited amount of power is extremely small. Circumcising your daughter and complying with other certain social norms, particularly around sexuality and its link to the economics of reproduction, is an essential requirement to these silent power negotiations. Women instinctively know this. We may scare them with all the possible risks of FC/FGM to health. We may bring religious leaders to persuade them that the practice is not a requirement. We can try to bring the wrath of the law to bear upon them. But in their desperate hold on the little negotiated power they have known for centuries, they are not willing to let go unless they see a benefit that is equal to or more than what they already have.

* Excerpts from: Nahid Toubia, *“Legislation as a tool for Behavioural and Social Change”*. In: Proceedings of the Afro-Arab Expert Consultation on Legal Tools for the Prevention of Female Genital Mutilation Cairo, 21-23 June 2003. Rome: NPWJ and AIDOS

Activity 2.3: (40 minutes)

Division of labour

Objectives:

The concept of 'gender' is complex. The following activities deepen participants' understanding of the concept of 'gender'. This activity provides them with tools for gender analysis, to understand the concepts of 'division of labour' and 'gender roles'. The ability to analyse the division of labour in a specific social context, including differences in payment between men and women, is a central building block for gender analysis. It allows participants to see that women's work and men's work are valued differently. The undervaluation of women's work is one aspect of women's overall lower social status. The failure of men to share in domestic work means that women often work extremely long hours, especially where they are also engaged in wage work or agricultural activities. The activity allows participants to identify how women's domestic roles give them an unequal and stressful burden to carry, which may have negative implications for their health. The main objectives of this activity are:

1. Identify the different roles that men and women play;
2. Identify the different values associated with these roles;
3. Understand the concepts of division of labour and gender roles

Description:

Step 1: (20 minutes)

Distribute the "24-hour day" template and ask the participants to form groups of about 4 - 6 people. Each group should choose one social group of which they have personal knowledge - such groups may be farmers, poor town dwellers, middle class people where both husband and wife work, etc. Ensure that each group has chosen a different social group.

Ask the group to imagine a typical day in the lives of a wife and husband from the social group they have chosen. Using the framework provided in the

handout, ask the group to list the tasks performed in 24 hours by the wife and husband in a household on a sheet of flipchart paper. The participants need to fill in the activity the person is doing at the time indicated, whether it is paid work, and what the pay is per hour. Once they have filled in the table, they need to calculate the number of hours each person works, and the total pay they receive per day. Put the tables from all the groups on the wall.

Step 2: (20 minutes)

Walk around the room with participants and make a note of common points from the charts on the wall. Bring the groups to plenary. Using the questions below, point out the common points from the tables.

Guiding questions for the discussion:

1. What was your first impression when you saw the woman's and the man's chart?
2. What differences do you notice in the way in which men and women spend their day?
3. What differences do you notice in the way in which men and women spend their spare time?
4. What do you notice about what work is paid and what work is not paid?
5. What are the consequences of this for men's and women's income?
6. What are some of the consequences of these differences for women's health?
7. What are some of the consequences of these differences for men's health?
8. What are some of the consequences for society?
9. Discuss factors that could distribute the workload more evenly and how to address any other imbalances.

Points that may come out from the discussion:

- Women and men do different things during the day.
- Women usually work longer hours.
- Men usually have more leisure time.
- Women have more varied tasks, sometimes doing more than one thing at a time.

- Even when women work outside the home, they do a substantial amount of household work as well.
- Men's work is usually outside the home.
- More of women's work is unpaid compared to men's work.
- Women are usually paid less money than men for the paid work that they do

Main conclusions to be drawn:

In concluding this section, you should introduce participants to the concept of the '**division of labour**'. This refers to the different socially constructed roles of men and women. Thus women taking responsibility for cooking, and men for cattle, is an example of a 'division of labour', which is normative in many societies. The different tasks that are considered 'men's work' and 'women's work' are called 'gender roles'. Girls are raised expecting to perform such gender roles as cleaning the house, while boys are raised expecting to perform such gender roles as fixing cars or looking after cattle.

In contemporary society, people often make the distinction between '**productive**' and '**reproductive**' roles. 'Productive' work refers to work, which is outside of the home and contributes to the economy; 'reproductive' work refers to work which allows people to grow up and contribute to the economy. This means not only the work of raising children, but the daily work of cooking, cleaning, ironing and the like which are necessary to allow workers to go out each day to produce. While women increasingly do productive work as men do, they still take most of the responsibility for reproductive work.

The division of labour into **gender roles** is not only about differences between what society expects men and women to do. It is about the social understanding of the value of the roles that women and men play. The division of labour between women and men in most cultures is unequal; gender roles are not equally valued. Men's roles are considered more important than women's roles. This is

reflected in the fact that many of women's roles are not paid for and that even in the workplace, women's work tends to be paid less than men's work.

Thus gender roles are a part of the overall cultural values of a society and hence one aspect of gender norms. The long hours that women work, and the lack of acknowledgment of the value of this work, can undermine both women's physical and mental health. This suggests that it is time for men to start sharing reproductive work, that is, domestic tasks and care of children, with women.

Point out that the division of labour between women and men in most cultures is unequal, so much so that women's excessive workload has a negative impact on their health. That is, unequal gender roles are damaging to women's health.

Materials:

- Flipcharts;
- Markers;
- Adhesive tape;
- Printed handout n.1: "The 24-hour day".

Handout n. 2.1:
The 24-hour day

	MEN'S ACTIVITY	PAID OR NOT	WAGE PER HOUR		WOMEN'S ACTIVITY	PAID OR NOT	WAGE PER HOUR
1 am				1 am			
2am				2am			
3 am				3 am			
4 am				4 am			
5am				5am			
6am				6am			
7am				7am			
8am				8am			
9am				9am			
10am				10am			
11 am				11 am			
Noon				Noon			
1 pm				1 pm			
2pm				2pm			
3pm				3pm			
4pm				4pm			
5pm				5pm			
6pm				6pm			
7pm				7pm			
8pm				8pm			
9pm				9pm			
10pm				10pm			
11pm				11pm			
12pm				12pm			
TOTAL:							
		TOT. HOURS WORKED	TOT. DAY'S EARNINGS			TOT. HOURS WORKED	TOT. DAY'S EARNINGS

Social Group:_____

Activity 2.4: (40 minutes)

Access and control over resources

Objectives:

This activity identifies how men and women, having different roles, have different access to resources - whether economic, political / decision-making, informational, internal, or of time. It explains how different types of resources, as a result of gender norms in society, are distributed in favour of men, and thereby limit women's ability to develop to their full potential and in many cases actually undermine women's health. The main objectives are:

Describe the range of resources people use;
Identify the different impacts of having access to a resource as opposed to control over resources.

Description:

Step 1: (5 minutes) Introduction

Ask for two people, preferably a man and a woman, to volunteer to do a role-play. Take them to one side and give each of them their role and ask them to think about how they will play this role. Do not let other participants know the roles. Tell the actors that they will have about 5 minutes for the role-play.

Then tell the group that they will be watching a role-play. Remind them that a role-play is when participants act different parts. They are not presenting their own views, but the roles that they have been asked to play.

Step 2: Role play (15 minutes)

Ask the actors to perform the role play. Do not allow them more than 5 minutes.

Ask the actor playing the woman: 'How did you feel playing this role?' and let him/her answer.

Ask the actor playing the man: 'How did you feel playing this role?' and let him/her answer.

Ask the group: 'Is this a real situation? Do things like this happen?' and let them answer.

Run a short plenary discussion asking the group: 'In the role play, what resources were being contested?'

Bring out from the role-play which resources the man has control over and which, if any, the woman has control over. At this stage participants may not be familiar with the language of 'access and control', which you will introduce in the next step, so keep the points simple.

The sorts of points which may come out of the role-play include:

- She did not have the right to ownership or control over the vegetables she grew on the land.
- Although she usually sold the vegetables and kept the money, her husband had the right to sell them and keep the money if he wanted to because he owned the land.
- As a gender norm, in their community men had control over decision-making at home. So the man had the right to decide what to do with the revenues made selling vegetables.
- The man had access to information about where selling the vegetables would be more profitable which the woman may not have had, since she was based at home and did not move around as the man did.

Step 3: Plenary discussion (20 minutes)

The issues which came up in the role-play give you an entry point for this step, in which you guide participants in a more formal way through understanding one of the central reasons why the social construction of gender is about discrimination rather than just difference.

Begin by discussing the meanings of 'access' and 'control' and why having access to a resource is different from controlling it.

Access is the ability to use a resource.

Control is the ability to make binding decisions about the use of a resource

The distinction between access to and control of certain resources is important because the ability to use a resource does not necessarily imply the ability to make decisions about the use of that same resource. For example, a woman may use land to grow food on. But the land may belong to her husband who decides whether to keep or sell the land, and who owns the products of his wife's agricultural work on that land. A woman may have access to a donkey for transport, but if she does not decide who can use the donkey and when, then she does not have control over it. If, for example, she needs to go to a clinic using the donkey, but her father-in-law who owns the donkey wants to use it to go to visit friends, then the woman's needs may be ignored - thus she has access to the donkey, but not control over its use.

Indicate that the fact that women and men are socially assigned different roles and responsibilities (the division of labour between women and men) has direct implications for the level of access to and control over resources they have, which in turn affects their health and their ability to access health services.

Use Handout n. 2.2 ("Relationship between control over resources and power"), to make the point that people who control resources have greater power in society than those who do not. Indicate that one feature of the gendered division of labour is that different roles are associated with different access to and control over resources. It is predominantly men who have control of most resources, and women who do not, although the actual way this works differs among societies.

These overall resources include those necessary for the promotion and protection of one's health as well as the health of others. Go on to look at the different types of resources (see table below).

Take participants through each dimension of the handout n. 2, leaving time for them to give examples of the different types of resources. The capacity to have access to and control over resources develops and strengthens internal resources that can enhance personal development; hence these resources have been included.

Kinds of resources	
Economic	Job, credit, money
Political	Leadership, decision making positions, opportunity for consensus building
Information/Education	Formal / informal education, opportunities to exchange opinions
Time	Hours of the day available for discretionary use, flexible paid hours
Internal	Self esteem, self confidence, the ability to express one's own interests

Materials:

- Printed Handout n. 1 (one copy) and Handout n. 2 (one for each participant);
- Flipcharts;
- Markers.

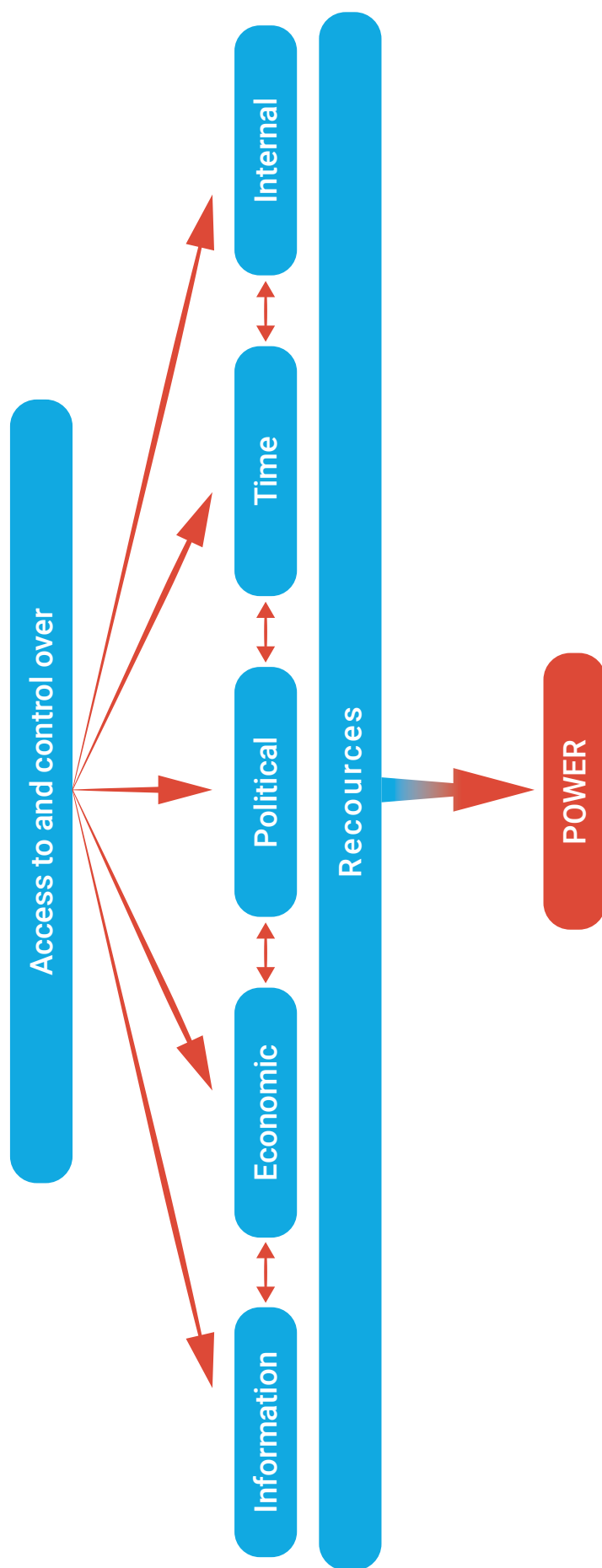
Handout 2.1:**Role Play On Access To And Control Over Resources****Role 1:**

You are a woman. You work on your husband's land growing vegetables for the family to eat. Your husband does not work on the land. He works in the village. Your family eats some of the vegetables and the rest you sell at the market and this gives you some spending money. Otherwise you have no money of your own. Your husband does not give you money; he simply brings food and other necessities from the village. You need to have some money available, so that you can buy small things for your children or for yourself, or pay for the clinic when you need to go. Your husband comes home and tells you that a friend of his has offered to sell your vegetable crop in a bigger town.

Role 2:

You are a man. You have a job in the village. Your wife grows vegetables. A friend of yours has offered to sell the vegetables in a bigger town for good money. You want to do this because you need more money to buy a gift for your best friend's wedding.

Handout n.2:
Relationship between control over resources and power



Activity 2.5: (40 minutes) FGM, power and empowerment

Objectives:

The term **empowerment** has been widely used within development literature. It has mostly been used to refer to the end impact of developmental projects. Empowerment is increasingly acknowledged as an approach to development practice.

The aim of this activity is to brainstorm with the group about the different meanings of empowerment as used in development projects and discuss how FGM is related to the concepts of power and empowerment.

Description:

Step 1: (10 minutes)

Brainstorm around the concept of empowerment: ask participants to define empowerment. Use the flipchart and ask one of the participants to note down the participants' contributions. Definitions might include:

- Autonomy of women;
- The improvement of their political, social, economic and health status;
- Equality with men in decision making processes;
- Full participation and partnership with men in development activities, including productive and reproductive life;
- Sharing responsibilities for the care and nurturing of children and maintenance of the household;
- Policy and program actions that seek to overcome gender inequality;
- Improving women's access to secure livelihoods and resources;
- Full expression of women's capacities and potential;
- Elimination of inequality through laws enacted by the government.

Step 2: (30 minutes)

Distribute "Definition of Power" and allow sufficient time to read it individually. Then divide the participants into three groups. Assign a specific stakeholder to each group:

- Women
- Grandmothers/elders
- Fathers/husbands

and ask each group to outline how a specific stakeholder uses FGM to achieve all these perceptions of power. Each group should answer the following questions:

- Who has the most to gain from FGM?
- Who is more likely to resist ending FGM?

Notes for the discussion

Power is not unidirectional, nor is it quantitative. It is multidirectional, complex and qualitative. This is to say that people (including women) attain different 'kinds' of power, using different negotiating mechanisms. FGM is a potent power gaining tool as well as a 'negotiating tool' for women. Women are the main sufferers of FGM. They are also its main beneficiaries. This is why in so many contexts women are its main perpetrators. It is only through the understanding of this contradictory and sometimes conflicting role of women in sustaining the practice that we can begin to address appropriate interventions to end it. Thus, they stand to gain the most by perpetuating it and lose the most by abandoning it. Until women can achieve the same gains that are traditionally acquired through FGM through other channels, they will be resistant to abandoning FGM. In order to design appropriate and effective women's empowerment inputs that would lead to the abandonment of FGM, we need to know what the perceived 'gains' of FGM are to the women in the specific context where the project/program will be implemented, looking at the broader development agenda.

Materials:

- Flipcharts;
- Markers;
- Printed copies of Handout n. 1 "Definition of power" (one for each participant).

Handout n.2.1:

Definition of power

In order to fully understand the issue of “empowerment” within the context of FGM and its relation to designing effective programming frameworks, we need to look at its root concept: that of “power”.

Power over:

It concerns the decisions/decision making process over which there is observable conflict. It describes the ability to take the decisions that one wishes. It understands power as the capacity to make decisions, acquire new skills and solve problems. It underpins most “women in development” projects and policies and is built on the assumption that women will have a higher decision making power / will be empowered where/when they have greater access to/control over resources, in particular economic resources, hence the focus on income generating activities and the like.

Power to:

A broad view of power that captures not only the enactment of decisions, but moves to include areas that are not customarily thought of as “subject to decision”: i.e. what lies outside the area of the direct observable decision making process. Thus it focuses on the less visible institutionalised forms of advantage and disadvantage that actually empower particular individuals/groups and impose their views of reality on others. Gender roles can be considered one of these forms of power to... do / be.

Both these interpretations of power involve a dichotomy of domination/subordination where one side holds absolute power over a completely disadvantaged partner. These interpretations of power have informed many theories in the social sciences and in development practice as well.

Power with:

This refers to the collective efforts of communities to achieve common goals. In particular it concerns the ability to negotiate with wider social actors as well as the ability and capacity to mobilize and seek support from wider social, political and economic actors.

Power within:

This is perhaps a more holistic interpretation of power. It involves increasing self-awareness, confidence and consciousness. It refers to the ability to understand the complex operation of power on the individual in everyday life as well as at the institutional level, and the ability to effect change. It questions the assumption that power and conflict are necessarily linked: i.e. where there is no direct, observable conflict, consensus prevails. In fact, interests might be unarticulated or unobservable and, above all, people might be mistaken about or unaware of their own interests.

Activity 2.6: (40 minutes) Women's empowerment and community consensus inputs

Objectives:

In the previous sections we have discussed the different meanings of the term empowerment.

This activity is aimed at understanding the relation between FGM, social change and women's empowerment, and also the importance of building the consensus of the community towards women's empowerment, thus renewing gender roles and power dynamics within society, while continuing to bear in mind that the specific local conditions will determine which ones are more appropriate and may lead to additional ones.

Description:

Project the Handout "The relation between FGM, social change and women's empowerment" and read and comment with the participants the four-hypotheses.

Remind participants of the power dynamics that have been explored during the previous activities, and in particular of the fact that in the majority of societies in the world women do not have access to and control over the resources that lead to power, and very often there are other social actors that take decisions for them, including their husbands, the elders in their families, ultimately the elders in the community, etc. If FGM facilitates their affiliation to those "power structures", they can hardly abandon the practice without the feeling of putting their daughters at risk of not accessing any form of participation in power and decision-making.

Conclusive remarks:

Experience gained over the years has led to the four hypotheses previously presented: it is only by changing women's consciousness, material conditions (access and control over resources) and decision making ability, that we can shift the power base and female social identity away from the need for FGM.

But changing women's consciousness will prove ineffective and will only lead to frustration and may even be detrimental, eliciting violent reactions by partners/families/communities, unless there is community consensus and support for women's empowerment and the abandonment of FGM.

In order to involve the community, it is important to address its **priority development concerns**, as FGM abandonment is otherwise perceived as a threat to community cultural values and traditions, an unrequested interference with social mechanisms and family relationships, including economic exchanges such as the bride price, or at the least as an irrelevant development issue, as it is considered a "women's issue" and women are given only very little value in society, and this value is linked completely to what FGM is there for, namely marriage and legal childbearing.

Why empowerment of women may stop FGM

Women use FGM as a power-gaining tool.

By changing women's consciousness, material conditions and decision making ability, we shift their power base and female social identity away from the need for FGM.

Changing women's consciousness will prove ineffective, and may be even detrimental, unless there is community support and consensus.

Behavioural and social change is a cumulative non-linear process. Catalysing and sustaining it requires supportive inputs at the institutional level of society (laws, policy, education, etc).

Materials:

- Flipcharts;
- Markers;
- Handout n.1: "The relation between FGM, social change and women's empowerment".

Handout 2.1:**The relation between FGM, social change, and women's empowerment**

The relation between FGM, social change and women's empowerment

Hypothesis 1

Women use FGM/C as a power-gaining tool. They forego their sexual organs in exchange for social acceptability, material survival (marriage) and other freedoms such as mobility, choice and education. Therefore women protect and practice FGM/C.

Hypothesis 2

By changing women's consciousness, material conditions and decision-making ability, we shift their power base away from the need for FGM/C.

Hypothesis 3

- Shifting women's power base will be ineffective (and maybe detrimental) unless community support and consensus is built around them.

Hypothesis 4

- Behavioural and social change is a cumulative non-linear process
- To catalyse and sustain it requires supportive inputs over the longer term (laws, policies, investment in education, etc).

Source: Toubia, N., "Legislation as a tool for Behavioural and Social Change".

In: Proceedings of the Afro-Arab Expert Consultation on Legal Tools for the Prevention of Female Genital Mutilation Cairo, 21-23 June 2003. Rome: NPWJ and AIDOS.

MODULE 3: FGM AS A DEVELOPMENT ISSUE

Module three describes FGM as a development and girls' and women's human right issue, by exploring past and present approaches and tools adopted by UN agencies, NGOs, governments and other actors which have been developed and tested in order to enable the ending of FGM including the main monitoring and evaluation systems used. The module also mentions the human right based approach as a framework to tackle FGM and therefore the main legal and policy instruments developed at international, regional and national level and their actual use and role.

Finally, main lessons are presented; these are extracted from more than 20 years of experience in this field, and should be considered when designing and implementing programmes and projects addressing FGM.

LEARNING OBJECTIVES

General objective

Highlight key elements of FGM as a development issue and the different approaches and tools developed by UN agencies, NGOs, governments and other actors to enable the ending of FGM

Specific objectives

1. Contextualize FGM in the frame of development interventions and highlight main actors involved at international, regional and national level;
2. Provide an overview of the different approaches

applied by FGM programmes over the last 20 years and analyse success factors and weaknesses of these approaches and tools;

3. Extract lessons from good practices, which can be applied to improve trainees' projects and programmes addressing FGM.

List of activities:

Activity 3.1. Review of past and present approaches

Activity 3.2. Good practices and lessons learned from projects and programmes addressing FGM

Activity 3.3. Monitoring and evaluating projects and programmes addressing FGM

FGM AS A DEVELOPMENT ISSUE AT A GLANCE

1. FGM and development

With an estimated 200 million girls and women living with FGM in 30 countries where the practice predominates and an estimated 3 million girls at risk of undergoing female genital mutilation every year, FGM is one of the key areas for development, as it concerns gender equality, girls and women's reproductive health, child mortality reduction, universal basic education and human rights.

Communities affected by FGM also have other development concerns such as improving access to and quality of health, education, technology, infrastructure, water and food security, and so on. Such development concerns could be an entry point to start addressing the issue of FGM.

As a matter of fact, FGM and development are strictly connected and can be considered from a double-sided perspective: on the one hand development can have a positive impact on attempts to reduce the practice of FGM, particularly when educational programmes that raise awareness about FGM issues are included in development projects. On the other hand, FGM can prevent or delay the successful implementation of development projects because of the negative impact that the practice has on girls' and women's health and lives.

1.1 From MDGs to SDGs

The link between FGM and other development issues is particularly clear in relation to both the Millennium Development Goals (MDGs) and the Sustainable Development Goals (SDGs). The MDGs are eight international development goals set for the period 2000 to 2015 which were agreed upon by all 198 United Nations member countries in 2000. The new Sustainable Development Goals,

and the broader sustainability agenda, go much further than the MDGs, addressing the root causes of poverty and the universal need for development that works for everyone. They are meant to be a set of universally applicable goals that balances the three dimensions of sustainable development: environmental, social, and economic.

On 25 September 2015, world leaders adopted the 2030 Agenda for Sustainable Development, which includes a set of 17 Sustainable Development Goals (SDGs) to end poverty, fight inequality and injustice, and tackle climate change by 2030 (available at <https://sustainabledevelopment.un.org/topics>).

Of the eight MDGs, four in particular highlighted the connection between development and FGM and therefore the fundamental importance of addressing the issue of FGM in any development project. The third MDG focused on promoting gender equality and empowering women by aiming to eliminate gender disparity in all levels of education by 2015. The fourth MDG aimed to reduce child mortality by two-thirds between 1990 and 2015. The fifth MDG aimed to reduce maternal mortality by 75% between 1990 and 2015.

Finally, the sixth MDG was made up of three aims, two of which are directly tied to FGM. The first is to reduce the spread of HIV/AIDS by 2015, and the second is to get universal access to treatment for HIV/AIDS by 2010. Research shows that FGM can increase the risk of transmitting HIV to girls and women through cross-infection when carrying out the procedure on multiple girls at the same time, as well as through increased risk of creating wounds or tears during sexual intercourse. There is also the increased risk of difficulties during pregnancy and childbirth which make the likelihood of blood transfusions being needed higher – yet another increased risk of getting HIV.

The needs of adolescent girls as well as child, early and forced marriage and more in general violence against women were absent from the MDGs, which

directly hindered the achievement of six of them. While the SDGs are supposed to be a holistic set of goals and targets to be considered together in order to maximise impact and avoid the isolated approach that would take the “sustainable” out of them. They are supposed to be a longer and more complex framework that addresses the structural causes of gender discrimination and inequality rather than a shorter set of goals.

This is why the international community has committed “to work for a significant increase in investments to close the gender gap and strengthen support for institutions in relation to gender equality and the empowerment of women at the global, regional and national levels” and for a systematic mainstreaming of a gender perspective in the implementation of the Agenda. At the same time, there is a stand-alone Goal (Goal 5) dedicated to achieving gender equality and empower all women and girls where FGM is included as follows:

- 5.1 end all forms of discrimination against all women and girls everywhere;
- 5.2 eliminate all forms of violence against all women and girls in public and private spheres, including trafficking and sexual and other types of exploitation;
- 5.3 eliminate all harmful practices, such as child, early and forced marriage and female genital mutilations;

The idea is that gender equality is more than a goal in itself, it is the precondition for ending poverty, building peaceful societies and achieving sustainable development, yet women are still subjected to discrimination and violence and harmful practices such as child marriage and FGM and they carry out most of the domestic and unpaid care work. The goal is to give women a say in the decisions that inform their lives and decide freely on matters relating to their sexuality, participate fully in the economy and have access to technology. For this, laws, policies and services that ensure a level

playing field for women are needed.⁽⁵⁵⁾

As an example to show the holistic approach of the SDGs framework and its possible impact on ending FGM we can look at SDG 4 “Ensure inclusive and equitable quality education and promote lifelong learning opportunities for all”, considered to be a core prerequisite for gender equality and women’s rights, as it includes the revision of school curricula and policies to counteract gender discrimination and violence against women which may (should) include harmful practices such as child/forced marriage and FGM where relevant.

Similarly, the SDG 3 “Ensure healthy lives and promote well-being for all at all ages” with its focus on:

- “...reduce the global maternal mortality ratio...” and
- “...ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes

is directly linked to FGM, as it aims to improve the provision of health services for women and girls, including survivors of violence. The entity strives to end practices that endanger women and girls, such as child marriage, female genital cutting, dietary restrictions and others.

The question is how these broad targets will then be adapted to suit the country and regional context, how this complex framework will be implemented and above all how it will be monitored and evaluated. To this end an Inter-Agency Expert Group on SDGs Indicators (IAEG/SDGs) developed global indicators for the sustainable development agenda, including indicator 5.3.2: Percentage of girls and women aged 15-49 years who have undergone FGM/C, by age group.

55. <http://tinyurl.com/hqwxvvs>

1.2 Impact and costs of the practice on development

Given that many women and girls can suffer from a variety of health problems associated with FGM, this can have a negative impact on economic sectors that rely on female labour, both within the household (where women tend to do the bulk of the work) and the wider economy. For example, women carry out almost half of agricultural work globally and in developing countries,⁽⁵⁶⁾ on top of housework and childcare. Health problems related to FGM, ranging from chronic infections and pain to back ache or difficulties conceiving or giving birth, can prevent women from fully participating in the work force, thereby harming the economy as well as putting a strain on the health system,⁽⁵⁷⁾ not to mention the psychological strain this places on women themselves.

A WHO study which examined the obstetric costs (pregnancy, childbirth, and postpartum period) associated with FGM in six African countries found that a huge proportion of women and girls experiencing FGM would later go on to incur a range of costs to the health system as well as possible death from obstetric complications.⁽⁵⁸⁾ The study concludes that funding for programmes that aim to reduce FGM in practicing communities could be largely paid or off-set by savings from reduced numbers of healthcare complications.

Health complications resulting from FGM may lead to the death of a woman and/or a girl. It also increases mortality of infants of mothers who have been subjected to FGM, causing a cost in terms of life loss.

Very recent estimates by WHO, UNICEF, UNFPA,

56. FAO. 2011. 'The Role of Women in Agriculture'. ESA Working Paper No. 11-02. Rome: Food and Agriculture Organization.

57. Hilary Burrage. 2014. 'The Global Economics of Female Genital Mutilation (FGM)'.

58. D. Bishai, Y. Bonnenfant, M. Darwish et al., 2010. "Estimating the obstetric costs of female genital mutilation in six African countries", *Bulletin of the World Health Organization*, vol. 88, no. 4, pp. 281–288.

The World Bank and the United Nations Population Division reveal that most of the high FGM prevalence countries also have high maternal mortality ratios. Two high FGM prevalence countries are among the four countries with the highest numbers of maternal death globally. Five of the high prevalence countries have maternal mortality ratios of 550 per 100,000 live births and above, while four have maternal mortality ratios of between 400 and 430 per 100,000 live births⁽⁵⁹⁾.

FGM has a cost and constitutes an obstacle to education of girls. In some regions in Africa, FGM is part of an initiation ritual that continues over a period of months, hence during this time girls go to school late or not at all. After this interval, they have trouble catching up with the rest of the class. Furthermore, many girls suffer from health problems, pain and trauma following the FGM procedure. There are indications that girls enrolled in school are often absent or less attentive in class for these reasons. This leads to poor performance, interruptions and premature termination of schooling⁽⁶⁰⁾. As a consequence girls who are excluded from (basic) education suffer a number of disadvantages such as the denied opportunities accruing from the acquisition of knowledge – for instance, about health, nutrition or legal rights.

The issue of FGM is deeply tied up with the social and economic realities of communities that maintain this practice, representing also a cost for the family and the community in general. In some of these communities, girls are considered as a form of property to be purchased by husbands in exchange for bride price. For these families, "selling their daughter" is a way to cover the cost of raising her to marriageable age. In some communities, FGM ceremonies are expensive rituals and

59. WHO, UNICEF, UNFPA, World Bank and United Nations Population Division. 2014. *Trends in maternal mortality: 1990 to 2013*. Geneva: WHO.

60. Nancy, Luke and Kaivan Munshi. 2011. 'Women as Agents of Change: Female Income and Mobility in India'. *Journal of Development Economics* 94 (1): 1-17

parents invest in them knowing they will eventually get economic security for both the girl undergoing the ritual as well as themselves.⁽⁶¹⁾ While a 'cut' girl is marriageable and can offer an economic return to her family, an 'uncut' girl may be seen as unclean, unmarriageable, and even a non-adult. This can result in families failing to receive bridewealth, as well as being ostracized from their community. High celebration expenses impose further pressure on the family to marry off a girl early, and as a consequence it may entail early pregnancies for her. Some studies and research have explored possible links between early marriage and FGM; and it is possible that by reducing early marriage rates FGM rates will also decrease.⁽⁶²⁾

Reducing early marriages through economic incentives, Ethiopia.

An example of using economic incentives to create a change in social norms with relation to early marriages comes from Ethiopia. Programmes in this country have been piloted to change the custom of early child marriage by using economic incentives, such as providing school materials and goats to help delay girls' marriage. This project is based on the idea of increasing the value of education and confronting the fact that poverty is a strong driver of early marriage⁽⁶³⁾ - because marriages help households to create bonds and build social capital which will help them deal with economic shocks and uncertainty.

Last but not least, FGM also has relationship costs, since trauma caused by FGM can generate interpersonal and marital problems, as well as isolation

and stigmatization of those girls who have not been circumcised by their families. The individual costs can involve emotional – physical costs (such as pain, shock, PTSD, anxiety, phobias etc.) as well as sexual – reproductive costs (infertility, complications when giving birth, maternal and infant mortality)⁽⁶⁴⁾.

1.3. A story of progress and partners: key actors and stakeholders

Over the last 20 years, significant efforts at community, national and international level have addressed the issue of FGM. Numerous international and national policy statements have called for an end to FGM; amongst these at least the UNGA Resolution approved by the UN General Assembly in 2012 calling on all countries to eliminate the harmful practice of FGM should be mentioned.

Moreover, there have been significant efforts made at national, cross-border or regional and international level to address the issue of FGM through legal frameworks as well as education campaigns and development programmes. There has also been an increase in the amount of research on the impacts of FGM, which has helped advocates in their own work of raising awareness and changing behaviours. The overall rates of FGM have declined in a number of countries, but there are concerns about the increased medicalization of FGM as well as fears that progress could be lost if government commitments and resources are no longer made available.⁽⁶⁵⁾

A number of organizations, funders and development agencies have been particularly active in the field of FGM reduction. Among these the UNFPA-UNICEF Joint Programme on FGM, the European Union, USAID, the Department for International Development of the United Kingdom, the Norwegian Agency for Development Cooperation,

61. Hilary Burrage. 2014. 'The Global Economics of Female Genital Mutilation (FGM)'.

62. Equality Now. 2007. 'Protecting The Girl Child: Using the Law to End Child, Early and Forced Marriage and Related Human Rights Violations'. London: Equality Now; World Vision. 2014. 'Exploring the Links: Female Genital Mutilation/cutting and Early Marriage'. London: World Vision.

63. Rebecca Calder. 2012. 'Pathways' Perspectives on Social Policy in International Development'.

64. Please refer to Factsheet n. 4 "FGM: The Development Costs" available at: <http://tinyurl.com/zx4rbwh>

65. PRB. 2013. 'Ending Female Genital Mutilation/cutting: Lessons from a Decade of Progress'. Washington, DC: Population Reference Bureau.

the World Health Organization, the United Nations Population Fund, and the United Nations Children's Fund have done a large amount of work to put FGM on the international development agenda. There are also a number of African, Asian and Middle Eastern organizations doing significant work in this field, together with international NGOs and networks and campaigns such as the ENDFGM European Network, the Girl Generation Campaign and the Stop FGM in the Middle East campaign among others⁽⁶⁶⁾.

Some pioneer African networks and CSOs started to raise their voices to promote the abandonment of FGM: in 1984 the Inter-African Committee on traditional practices affecting the health of women and children (IAC) was formed with the objective of preventing and eliminating traditional harmful practices, including FGM. IAC was one of the first African regional umbrella body to address FGM and other harmful practices at a time when female genital mutilation was highly controversial and a 'sensitive' issue for discussion⁽⁶⁷⁾.

A Donors Working Group (DWG) on Female Genital Mutilation was established in 2001, bringing together governmental and intergovernmental organizations committed to helping with the abandonment of FGM.

The table (p.72) shows all current signatories to the DWG Platform for Action.⁽⁶⁸⁾

Most FGM reduction programmes rely on a wide range of actors and stakeholders for successful implementation. The table above gives an indication of some of the actors working at international level. Of course, these actors also work closely with regional, national and local level actors to ensure that programmes are sensitive to local concerns and therefore more effective in the long term.

66. <http://www.stopfgmmideast.org/>

67. For more info please see: <http://tinyurl.com/qhld7d4>

68. DWG on FGM. 2015. 'The Donors Working Group on Female Genital Mutilation/Cutting: A Matter of Gender Equality'.

Table 1: Signatories to the DWG Platform for Action

Countries	International organizations
Austria – Austrian Foreign Ministry	European Commission (EC)
Finland – Ministry of Foreign Affairs	International Organization for Migration (IOM)
Germany – Federal Ministry for Economic Cooperation and Development (BMZ), Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ)	Office of the High Commissioner for Human Rights (OHCHR)
Ireland – Irish Aid	Joint United Nations Programme on HIV/AIDS (UNAIDS)
Italy – Directorate General for Development Cooperation	United Nations Children’s Fund (UNICEF)
Netherlands – Ministry of Foreign Affairs	United Nations Development Programme (UNDP)
Norway – Ministry of Foreign Affairs and Norwegian Agency for Development Cooperation (NORAD)	United Nations Economic Commission for Africa (UNECA)
Sweden – Swedish International Development Cooperation Agency (SIDA)	United Nations Educational, Scientific and Cultural Organization (UNESCO)
United Kingdom – Department for International Development (DFID)	United Nations Population Fund (UNFPA)
United States – U.S. Agency for International Development (USAID)	United Nations High Commissioner for Refugees (UNHCR)
	United Nations Foundation (UNF)
	United Nations Volunteers (UNV)
	United Nations Entity for Gender Equality and the Empowerment of Women (UN Women)
	Wallace Global Fund
	The World Bank
	World Health Organization (WHO)

2. LEGISLATION AND FGM

2.1 The role of the law in ending FGM

“The debates around FGM, within the African community, are symbolic of the tension between attempts to preserve an inherited social order which seemingly worked for years, and the search for a new and viable one that can withstand the new challenges they now face.”⁽⁶⁹⁾

69. Toubia Nahid, “Legislation as a tool for Behavioural and Social Change”. In: Proceedings of the Afro-Arab Expert

The history of FGM legislation traces its roots to 1946 when the British colonial administration created legislation in Sudan to prohibit infibulation (FGM Type 3). Since the British were considered an occupying force and did not have support among the local population, the law actually resulted in an increase in FGM rates. This story serves as an important lesson by showing how legislation can lead to

Consultation on Legal Tools for the Prevention of Female Genital Mutilation Cairo, 21-23 June 2003. Rome: NPWJ and AIDOS.

a negative impact if it comes from a government or authority that is somehow unrepresentative of the communities and traditions within that country.

Legislation can be a powerful tool for changing behaviour, but there are important considerations when evaluating the possibility of passing laws to criminalise FGM. These include:

- The possibility that passing laws can cause a deep-rooted and widespread practice like FGM to go underground and be carried out in a less safe manner;
- Organizations calling for legislation might need to be aware that not all communities and societies speak of individual (girls') rights in the same way as in other countries;
- Legislation, which criminalises FGM, may result in family or community members also breaking the law by not reporting criminal acts. Conversely, family or community members who do report criminal acts may cause irrevocable damage to the social relations within their community;
- The importance of analysing the impacts of legislation, which has already passed, and the lessons learned from these, to help improve future laws.⁽⁷⁰⁾

In many of the countries that have passed legislation making FGM a crime, FGM rates may nevertheless remain high.

Therefore, legislation that criminalizes the practice of FGM is one of the most controversial aspects of FGM-abandonment movements.

Critics of legal measures argue that legislation can:

- Drive the practice underground, making it harder to address;
- Discourage treatment by trained health care

providers and institutions in cases of medical complications, due to fear of being reported;

- Cause underreporting of FGM in national surveys because respondents are unwilling to report having done or intending to carry out an illegal act.
- Lead to community opposition to coercive top-down directives.

Advocates insist that legislation:

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

Lessons learned:

- Legislation is not enough to change cultural practices: a culture of gender equality needs to be created to ensure that differences between men and women are not equated with social inferiority of women;
- Laws alone are unlikely to change traditions. To have an impact, they must be complemented by multifaceted programmes at the community level;
- To be successful, laws prohibiting FGM must come to be seen as an expression of popular will. As Nahid Toubia explains, criminalization and regulation "are only effective once a substantial body of public opinion has been raised against the practice.";
- Legislation should be presented as a protective measure and promoted through a delicate balance of law enforcement, public education, and dialogue.

70. Nahid Toubia. 2003. 'Legislation as a Tool for Behavioural and Social Change'. In Proceedings of the Afro-Arab Expert Consultation on Legal Tools for the Prevention of Female Genital Mutilation Cairo, 21-23 June 2003. Rome: NPWJ and AIDOS.

Legislating Change? Responses to Criminalizing Female Genital Cutting in Senegal 2014: Bettina Shell-Duncan, Katherine Wander, Ylva Hernlund, Amadou Moreau

This study examines the range of responses in rural Senegal where a 1999 anti-FGM law was imposed on communities in which the practice was being actively contested and targeted for elimination. The study analyses responses in relation to two leading theories on social regulation, which make differing predictions on the relationship between social norms and legal norms. Among supporters of FGM, legal norms ran counter to social norms, and did little to deter the practice, and in some instances incited reactance or drove the practice underground. Conversely, where FGM was being contested, legislation served to strengthen the stance of those contemplating or favouring abandonment. The authors conclude that legislation can complement other reform strategies by creating an “enabling environment” that supports those who have abandoned or wish to abandon FGM⁽⁷¹⁾.

2.2. A right-based approach to FGM

Because laws alone cannot change social behaviour the international community has adopted a right-based approach to FGM which places the practice within a broader social justice agenda that emphasises the responsibilities of governments to ensure realization of the full spectrum of women’s and girls’ human rights⁽⁷²⁾.

Addressing FGM as a violation of human rights places a responsibility on States. They have a duty to refrain from violating rights but also to ensure protection and fulfilment of human rights in their jurisdictions and policies. Therefore, States can be held responsible for failing to take steps to enable women and girls to enjoy and secure their human rights. The State’s duty has its foundations in the provisions of international human rights treaties, but it is more elaborated upon in the so-called ‘soft law’ instruments.

There are therefore a large number of legal

71. <http://tinyurl.com/zq37vnp>

72. It is internationally recognised that the international human rights violated by FGM are: the right to be free from gender discrimination; the right to life; the right to physical and mental integrity, including freedom from violence; the right to the highest attainable standard of health; the right not to be subjected to torture or inhuman or degrading treatment or punishment; the rights of the child; the rights of persons with disabilities; other international human rights.

frameworks that address the issue of FGM.⁽⁷³⁾

This section outlines the most important frameworks at international, regional and national level, including non-binding recommendations and declarations⁽⁷⁴⁾.

International instruments

There are many international legal frameworks, which deal either directly or indirectly with the issue of FGM. Here just some:

The **Beijing Declaration**, signed in **1995** by participating governments at the United Nations Fourth World Conference on Women, outlines a set of principles concerning the equality of men and women. For example, Article 14 states that “women’s rights are human rights” and Article 29 states that governments are determined to “prevent and eliminate all forms of violence against women and girls”. Although there are no specific references to FGM, this was an important UN resolution, which influenced all subsequent resolutions and legal frameworks.

The **UNGA Resolution** was passed in **2012** by the General Assembly of the United Nations and

73. UNFPA. 2014. ‘Implementation of the International and Regional Human Rights Framework for the Elimination of Female Genital Mutilation’. New York: UNFPA.

74. See Annex 1

constituted the first worldwide FGM ban adopted by all UN members. The full text of the UNGA Resolution highlights the extent to which previous declarations, resolutions and frameworks had all played a part in building the political momentum for a worldwide ban on FGM. It calls on countries to “enhance awareness-raising and formal, non-formal and informal education and training in order to eliminate...all forms of female genital mutilations.”⁽⁷⁵⁾ It also calls on countries to “strengthen advocacy and awareness-raising programmes, to mobilize girls and boys to take an active part in developing preventive and elimination programmes to address harmful practices, especially female genital mutilations” to “condemn all harmful practices that affect women and girls, in particular female genital mutilations” and to “complement punitive measures with awareness-raising and educational activities”.⁽⁷⁶⁾ Although it is not a binding instrument it represents an international political will to end the practice.

Regional instruments

Two of the main regional legal instruments that directly address FGM are: the Maputo Protocol to the African Charter on Human and Peoples’ Rights (the Banjul Charter) and the Convention on Preventing and Combating Violence against Women and Domestic Violence (Istanbul Convention).⁽⁷⁷⁾

The **Maputo Protocol**, also known as The Protocol to the African Charter on Human and Peoples’ Rights on the Rights of Women in Africa, was signed in **2003** by most countries in the African Union. The Protocol addresses a number of rights for women including the right to social and political equality with men as well as control over reproductive health and an end to FGM. It makes specific reference to FGM in Article 5 ‘Elimination

of Harmful Practices’ where it states that all countries “shall take all necessary legislative and other measures to eliminate such practices...”.

The **Istanbul Convention**, also known as the Convention on Preventing and Combating Violence against Women and Domestic Violence, was signed in **2011** by 37 members of the Council of Europe. It is the first European convention specifically focusing on the issue of violence against women including FGM. The Convention has been effective since August 2014 thereby legally obliging signatory countries to increase measures to prevent FGM, and protect and support FGM-affected women and girls.⁽⁷⁸⁾ It also covers issues related to migration and asylum such as obliging countries to acknowledge gender-based asylum claims.

Within the EU, there are multiple legislative and policy documents that deal with FGM. To name some: the EU Charter of Fundamental Rights and Freedoms provides the basis for strong condemnation of FGM as a human rights violation; FGM is also explicitly addressed in the EU Strategic Framework and Action Plan on Human Rights and Democracy, which was adopted by the Foreign Affairs Council in 2012, where FGM is included in the section ‘Protection of the rights of women, and protection against gender-based violence’. The action plan states that Member States need to take actions to support initiatives, which prevent harmful traditional practices like FGM from taking place.⁽⁷⁹⁾

On 25 November **2013**, the **European Commission** released a **Communication**⁽⁸⁰⁾ to the European

75. United Nations. 2013. ‘Resolution Adopted by the General Assembly. 67/146. Intensifying Global Efforts for the Elimination of Female Genital Mutilations’.

76. Ibid.

77. UNFPA. 2014 ‘Implementation of the International and Regional Human Rights Framework for the Elimination of Female Genital Mutilation’. New York: UNFPA.

78. Council of Europe. 2014. ‘The Council of Europe Convention on Preventing and Combating Violence against Women and Domestic Violence’.

79. EIGE. 2013. ‘Female Genital Mutilation in the European Union and Croatia’. Vilnius: European Institute for Gender Equality.

80. European Commission. 2013. ‘Communication from the Commission to the European Parliament and the Council: Towards the elimination of female genital mutilation’. Brussels, 25.11.2013 COM (2013) 833 final.

Parliament ‘**Towards the elimination of female genital mutilation**’ on the International day of elimination of violence against women. It calls for more data in Europe, better training of health and legal professionals, funding for civil society, exchange of good practices within the EU and much more. In its external relations, the EU is urged to raise the issue of FGM in annual dialogues and in its work with the African Union. Although it is a non-binding instrument it’s a powerful tool with a detailed plan of Action that the EU is implementing and monitoring. Also at political level the European Parliament has released several resolutions on FGM⁽⁸¹⁾.

National laws

Twenty seven countries in Africa and the Middle East where the practice is concentrated have prohibited FGM by law or constitutional decree. The majority of these countries enacted laws against FGM in the 90s and in the 2000s, while some did so as early as 1965 (Guinea) or as late as 2015 (Nigeria). There has been an on-going debate on how governments should address the problem and whether or not it is correct to criminalize a practice that is carried out by such a high percentage of the population. It is generally agreed that law alone is not enough to change behaviours, and that it should always be accompanied by sensitization programmes, media campaigns, and other interventions promoting the abandonment of FGM.

Also, 33 countries outside Africa and the Middle East have adopted laws banning FGM.⁽⁸²⁾ They often include an extraterritoriality clause, meaning that parents can be prosecuted for subjecting daughters to FGM even if they do it outside of the country they live in.

National laws, combined with international and regional instruments, add additional layers of pressure on different actors to help prevent FGM.

81. See Annex 1

82. UNICEF. 2013. ‘Female Genital Mutilation/Cutting: A Statistical Overview and Exploration of the Dynamics of Change’. New York: UNICEF.

In Kenya for example, the Prohibition of Female Genital Mutilation Act of 2011 makes FGM illegal and anyone who performs FGM liable to a prison sentence. When combined with education, the development of alternative economic opportunities for women, and other approaches previously mentioned in Section 2, national laws can play an important role in creating a shift in attitudes towards FGM.

2.3 The challenge of implementing legal tools to eliminate FGM

As UNFPA points out in its report “Implementation of the international and regional Human Rights Framework for the elimination of Female Genital Mutilation” (November 2014), despite numerous developments and progresses, FGM prevalence is still at an unacceptable level and the lack of accountability for violations experienced by girls and women is the rule rather than the exception in many countries. Globally, Member States have acknowledged that FGM is a human rights violation. However, this acknowledgement has not yet led to the adoption of necessary solutions that are coherent and sustainable, and which would lead to elimination of the practice.

A set of **Challenges and recommendations** for future action on implementation of the international and regional human rights framework have been identified. They represent possible areas of intervention, especially at advocacy level for NSA and LA involved in projects and programmes addressing FGM.

Challenges and recommendations as possible areas of intervention for NSA and LA

Source: UNFPA, 2014. “Implementation of the international and regional Human Right Framework for the elimination of Female Genital Mutilation”.

1. Ratification of legal instrument and reporting obligation of States

The Maputo Protocol has not yet been ratified by all the concerned countries, without the ratification by all African States, the protocol’s pledges cannot

be fully realized. In addition, many African States do not respect their obligation, under article 26 of the protocol, to indicate in their periodic reports on fulfilment of the African Charter on Human and People's Rights, the measures undertaken for full realization of women's rights. The same issue exists with regard to the UN human rights treaty monitoring bodies: each State party is obligated to submit regular reports on implementation of the rights to the relevant treaty body, late reporting or failure to report presents serious challenges to the monitoring system.

2. Criminalization of FGM

Many countries have passed criminal laws that include penalties for participation in the practice or provide protections and remedies for those who have undergone the procedure or are at risk of doing so but limited impact. This is due to the **lack of consultation and participation of people** during the process and the **lack of dissemination and understanding of the law**, including by civil servants. To effect such profound social change, government action should take multiple forms and be part of a long-term process of guaranteeing human rights for all, particularly women and girls."

3. Stronger enforcement mechanisms

The challenge faced by many governments is **how to effectively implement and enforce legislation**. National laws should be better monitored and court cases regarding FGM should be better reported. Moreover, capacity-building initiatives to prevent and respond to incidents of FGM should reach all professionals working with and for children. This is an area where NSA and LA should and could be involved. Consensus to end FGM must be taken into account when discussing the effectiveness of legislation's effectiveness. **Public support**, by necessity, must be won in order to facilitate legislation implementation. Women and girls must not be seen only as victims, but as agents of change and equal partners in ending discrimination and violence. Engagement with men and boys is necessary. Through dialogue and education men and boys are strong catalysts to change gender

stereotypes, attitudes and beliefs. Additionally, international human rights frameworks and the provisions of human rights treaties and documents as well as national laws are little known or accessible by citizens. **People need to be educated** about international human rights standards and national legislation, policy and laws.

4. System strengthening

Capacity development of legal, health, judicial, gender and social development personnel is crucial. However, the institutionalization and strengthening of services need to be addressed holistically by developing a multisectoral sustained model of prevention, protection, punishment, provision of care and reparations. There is urgent need for guidance to integrate FGM into sexual and reproductive health services for prevention of FGM and repair of injuries; mainstreaming it into legal and judicial services; and developing information management and referral systems for FGM cases. The lack of cultural sensitivity and gender responsiveness can be a barrier to realizing substantive protection for women and girls. Community, legal and health services need to be interlinked with bridges and a functional referral mechanism. Monitoring and evaluation systems, which would include data collection, and indicators, among others, do need to be in place to assess effectiveness and also the impact of measures and intervention adopted

5. Cross-border approach

FGM permeates national borders which creates challenges when implementing the international human rights framework and national legislation. For example, Burkina Faso is surrounded by six countries (Benin, Côte d'Ivoire, Ghana, Mali, Niger and Togo), only one of which (Mali) has laws against FGM. Ghana's law even forbids FGM abroad. But when it comes to enforcement of these laws, Burkina Faso's record is far better than that of its neighbours. This means that Burkinabés who are intent on having their daughters cut can easily slip across the nearest border to have the practice performed. Adding to this problem is inadequate

coordination among national authorities in border areas and insufficient cooperation among the police and justice systems in these countries. Cooperation with neighboring countries is therefore crucial, as acknowledged by the treaty monitoring bodies. The Committee on the Rights of the Child called on Burkina Faso to “reinforce cooperation with neighboring countries in the region to combat FGM” and recommended that Sudan “continue and strengthen its efforts to end the practice of female genital mutilation and to seek cooperation with other countries in the region with a positive experience in combating this harmful practice.” The African Union might need to facilitate a harmonization process. As recommended to Burkina Faso during the Universal Periodic Review, States need to “share best practices with other countries regarding female genital mutilation.

6. Capacity

Unfortunately, insufficient resources are allocated for implementation of the international human rights framework aimed at abandonment of FGM. Governments have relied heavily on the assistance of the international community. However, national governments are responsible for reinforcing institutional frameworks and must be invested in the implementation and enforcement of laws on FGM.

7. Political will

Political will at national, regional and community levels play a crucial role. If political leaders are not engaged and if there is no political support to change the practice, it is almost impossible for the international human rights framework to have an impact. Political will is needed to continue to accelerate and sustain efforts to put an end to FGM. The Inter-African Committee has also argued “political will is at the center of achieving zero tolerance to FGM.” Political leaders have publicly advocated for the abandonment of FGM but remain exception. However where political leaders have called attention to FGM a greater engagement of religious and traditional leaders follow and has facilitated the enactment and enforcement of the law.

8. Litigation and social accountability

Quoted from National NGOs and public interest litigation groups need the skills to activate the application of national laws on FGM before national courts and other protection mechanisms. Beyond the prosecution of specific FGM perpetrators, public litigation can be a tool to compel governments to discharge their human rights obligations. For instance, these groups can litigate cases before courts to oblige States that have ratified the Convention on the Rights of Persons with Disabilities (CRPD) to provide rehabilitation services to women living with a disability resulting from FGM or to ensure the provision of treatment for FGM injuries. In the area of social accountability, governments must ensure accessibility to public information. To better ensure monitoring of policy and programme implementation, civil society organizations need to request that national strategies are accompanied with plans that define the responsibility of different State agencies, benchmarks, and timelines and budget allocations. This information allows the monitoring of policy and programme implementation. Specific mechanisms for social participation and accountability need to be established in the context of these policies and programmes, and affirmative measures need to be taken to ensure participation by the groups of women and girls most severely affected by FGM.”

WHAT PROGRAMME MANAGERS MUST KNOW

The relationship between legislation, human rights and positive social change is complex. Gaining a better understanding of the mechanisms that address changes in social, political and legal norms is crucial to end FGM. Addressing those complex interactions when planning a project with an FGM component is necessary for positive, sustainable change. Capacity building for professionals in charge of implementing such frameworks, and or advocacy towards governments to ratify specific legal tools may be some of the activities that can be planned to contribute to the implementation of the human rights of women and girls.

Human rights can help to accelerate the changes needed to achieve gender equality and end the practice, but they must not only exist on paper, they need to become a reality in the daily lives of women and girls.

3. Tools and approaches to supporting the abandonment of FGM

There have been many tools and approaches used in programmes aimed at reducing the incidence of FGM in the last 30 years. Without any pretension of being exhaustive, this section outlines a range of approaches, including past approaches as well as more recent and promising ones, in order to provide an overview of some of the main typologies of interventions addressing FGM adopted by several development actors in different countries.

Some of these approaches are used in combination amongst them, depending on the scale of the project and the promoting organizations; at the same time, some have been demonstrated to be more effective than others. For instance, two approaches that were popular in the past - such as medicalization and providing an alternative income to excisors or cutters - are now considered to not have been as effective at ending FGM as it was initially thought.

Finally, the lessons learned have been compiled based on the learning of more than 30 years of programme implementation in order to provide suggestions and recommendations for the design and implementation of future programmes and interventions addressing FGM as a key area for development.

3.1 Tools and approaches

Health risk information:

Involvement of medical and paramedical personnel (obstetricians, nurses, social workers and other local professionals) in providing information on the health risks connected to the practice, both

immediate and long term. The idea is that this kind of information will automatically lead to abandonment of the practice, once the seriousness of short- and long-term health risks is fully understood. This approach was and is extensively used in awareness raising activities by agents of local NGOs and CBOs (community based organizations) in villages, with groups including women, village leaders, and young people.

Training of medical personnel as “agents of change”

Medical personnel may use the particular moment of medical consultation to persuade their patients of the need and importance to abandon the practice, given the authority these professionals have in local communities.

This came out of the consideration of the multiple roles played by medical personnel in developing countries with respect to the practice. If, on a personal level, every doctor is called on to resolve the conflict caused by membership of an ethnic group where FGM is practiced with respect to WHO prohibition, at the community level, the physician also plays other roles. It is the doctor to whom the family first turns in the case of complications from an excision or infibulation, or the women/couples in the case of problems, especially in sexual relations, for example frigidity/sterility, which might be a result of the practice. This is a very important, fertile moment of contact with the community. Having what is recognized as “superior” training, the physician ends up in the role of opinion leader, which puts him/her in the best possible position for promoting change in behaviours in his/her patients.

Medicalization

The medicalization of FGM emerged as a strategy for reducing the health damages that occur with traditional FGM. While FGM carried out by medical professionals may be perceived as less harmful from a point of view of health, the focus on medical procedures and health ignores the fact that FGM

violates the human right to health and freedom from cruel, inhumane or degrading treatment. FGM is medically unethical, and in many countries is illegal. UN agencies and experts have condemned the medicalization of FGM.

Furthermore, there is some evidence that programmes which have focused on highlighting the negative impacts of FGM on health may actually have encouraged the medicalization of FGM. In other words, instead of traditional excisors or cutters performing FGM, some people have turned to health professionals – doctors, nurses and midwives.

According to some estimates, 18% of women who have had FGM have actually received it from a health professional or medical provider rather than a traditional excisor.⁽⁸³⁾ In some countries, the number is even higher. In Egypt, for example, an estimated one in three women have been cut by a medical professional or healthcare worker. In Sudan, almost half of all mothers in one study had undergone FGM by a health professional. There is also evidence that FGM medicalization is increasing particularly among mothers with secondary education.

Part of the reason for this growth of FGM medicalization is that people think that FGM will be less dangerous and will cause fewer health complications when a medical professional performs it. The challenge for anti-FGM organizations is to highlight that medicalized FGM is not necessarily less severe, nor conditions more sanitary, and there is no evidence that medicalization reduces obstetric or other long-term complications associated with FGM, including potential loss of sexual function and problems during pregnancy and childbirth, no matter who carries out the procedure and above all that it is a matter of girls' and women's human rights which can't be solved simply through health solutions.

83. PRB. 2013. 'Ending Female Genital Mutilation/cutting: Lessons from a Decade of Progress'. Washington, DC: Population Reference Bureau.

Medicalization in Indonesia

In 2011, the Indonesian Ministry of Health issued guidelines to health professionals on how to perform FGM, reversing a government ban on its practice by medical personnel issued in 2006. The new regulation directs providers not to cut the genitals but to "scrape the skin covering the clitoris, without injuring the clitoris." It states that FGM can only be carried out at the request and with the consent of the person concerned, her parents and/or guardians. These guidelines have been widely criticized⁽⁸⁴⁾.

Alternative income-generating activities for traditional practitioners

Some anti-FGM programmes have focused on providing an alternative source of income to traditional excisors. Many of these programmes have been unsuccessful in reducing FGM rates because families continue to want to carry out FGM on their daughters and therefore seek out excisors who are still practicing it. A study in Mali showed that excisors lacked social status within the community, which meant that - if they stopped practicing FGM - this would have little impact on the rest of the community and the social norms that support the practice continuing.⁽⁸⁵⁾ In West African societies, much of the power to influence social norms lies in the hands of community chiefs and elders, rather than the excisors themselves.⁽⁸⁶⁾ Anti-FGM work therefore needs to focus on the people who can influence a change in social norms thereby reducing demand for the practice. The WHO has in the past mentioned the need to include excisors in any anti-FGM work but has also pointed out that

84. Source: Amnesty International. 2011. "Indonesia Must Repeal Female Genital Mutilation Law," Amnesty International, June 24, 2011, accessed at <http://www.amnesty.org.au/news/comments/26036/> on Dec. 9, 2013.

85. PRB. 2013. 'Ending Female Genital Mutilation/cutting: Lessons from a Decade of Progress'. Washington, DC: Population Reference Bureau.

86. Mustafa Rogaia Abusharaf. 2013. 'Female Circumcision: Multicultural Perspectives'. Philadelphia: University of Pennsylvania Press.

“finding alternative income for excisors should not be the major strategy for change.”⁽⁸⁷⁾

Alternative income for excisors, Mali

An evaluation of interventions in Mali aimed at converting excisors showed it to be an ineffective approach, as families continued to seek out excisors to cut their daughters. The evaluation found that excisors did not have sufficient social status in the community to lead the community to abandon the practice, especially where this was used as a stand-alone method without focusing on the demand for the practice or underlying community norms around it. Furthermore, it found that the community recognition the excisors received was a key motivation, in addition to the income they earned, to continue their work⁽⁸⁸⁾.

Alternative Rites of Passage (ARP)

This approach was introduced and popularised in Kenya in 1996 by a local women’s development movement known as Maendeleo ya Wanawake Organization (MYWO). The alternative rite of passage is known as “Ntanira na Mugambo” or cutting through words.⁽⁸⁹⁾ The aim of this rite is to preserve the original meaning of the ritual of FGM but discard the harmful aspects of it. This is done through three stages: community sensitization, education, and the ‘Coming of Age Day’ ceremony with performances, gift giving and public declarations by family members.

The Population Council carried out evaluations of ARP and found that this approach only works well in communities where FGM is already associated

87. Ibid.

88. Population Council and Centre National de la Recherche Scientifique et Technologique (CNRST). 1998. ‘Evaluation of the Strategy to Retrain Excisors for the Eradication of Female Genital Mutilation in Mali’. Bamako (Mali): Population Council and Republic of Mali, Ministry of Secondary and Higher Education and of Scientific Research.

89. Kyung Sun Lee. 2008. ‘Female Genital Mutilation: Multiple-Case Studies of Communication Strategies Against a Taboo Practice’. Retrospective Theses and Dissertations. Paper 15452.

with a public celebration, which could be replaced by an alternative one. It would be less successful in communities where FGM takes place more privately and even secretly.⁽⁹⁰⁾

Alternative Rites of Passage in the Kuria and Kisii communities, Kenya

The 2011 evaluation examined the ARP programme implemented in the Kuria and Kisii communities as part of a programme involving awareness-raising, working with schools, health providers and religious and community leaders. The research found that ARP has been successful in Kisii, where FGM is a celebrated public event, and where it was integrated with girls’ empowerment programmes, and supported by intensive community awareness activities through which the local community recognized the graduation ceremony as an alternative to FGM. In contrast, in Kuria, where FGM is a private, often secret family affair, the ARP concept is less well-articulated. Camps organized during the FGM season included ARP graduations and training on health risks and human rights, but there was limited recognition of these elements by the Kuria community. The evaluation found that the success of ARP depended on local understanding and acceptance of the concept, particularly by decision makers, parents, and village, church, school, and community leaders⁽⁹¹⁾.

Positive Deviance

The Positive Deviance approach was developed in the 1990s by the Centre for Population and Development Activities with the support of UNICEF. It aimed at identifying individuals within a local community who had chosen not to carry out FGM on their daughters and to work with these people to

90. PRB. 2013. ‘Ending Female Genital Mutilation/cutting: Lessons from a Decade of Progress’. Washington, DC: Population Reference Bureau.

91. Jane Njeri Chege, Ian Askew, and Jennifer Liku. 2001. ‘An Assessment of the Alternative Rites Approach for Encouraging Abandonment of Female Genital Mutilation in Kenya’. New York: Population Council.

support other local people to also abandon the practice. Critics of this approach have pointed out that the approach needs to be integrated more fully into a wider development programme to avoid being seen as a 'Western conspiracy' against traditional values and practices. It has also been suggested that the positive deviance approach, while helping to break community silence about FGM practices and support individuals who are trying to break with tradition, needs to include religious leaders and doctors as well as the media in order to create the sort of community shift that is needed to change social norms.⁽⁹²⁾

Safe houses

One approach foresees the use of 'safe houses', where girls who want to avoid experiencing FGM can escape to and be protected. Although this practice is helpful in protecting girls who face FGM, it does not deal with the underlying social norms, which promote the practice. It may also have implications for the girls being removed from their communities as they will face difficulties reintegrating into their families and communities in the future.

Tasaru Ntomonok Initiative, Kenya

In the Maasai areas of Kenya, the Tasaru Ntomonok Initiative (TNI) has created a residential community-based centre that provides housing and support to Maasai girls who have escaped from FGM and the possibility of early marriage. The TNI works with the families of the girls who escape and engages them in discussions about FGM; it also facilitates meetings between girls and their families to make it possible for both to eventually be reunited. Training is also provided to local religious leaders and other members of society. Although TNI is a relatively new initiative, there are already signs that rates of FGM have fallen as awareness has spread.⁽⁹³⁾

92. Ibid.

93. Ibid., 9.

Empowering women to transform social norms

It is widely understood that FGM is above all a social norm and therefore requires a deep understanding of the reasons for the continued existence of the practice. In communities that continue to practice FGM, people emphasise a wide range of social factors that influence this social norm including religious and cultural factors, controlling female sexuality and marriage, and notions of health and hygiene. It has been shown that there are key decision makers – within the family but also within the wider community – who have an influence over whether a girl receives FGM or not. Women play an important part in this process of decision making and it has been shown that educating and providing economic opportunities to women can have a significant impact on rates of FGM within communities. In other words, by empowering women, communities can be encouraged to abandon the practice.

Navrango Health Research Centre, Ghana

In a programme carried out by the Navrango Health Research Centre in northern Ghana, girls were provided educational opportunities and livelihood training. These 'problem-focused' education strategies resulted in a 93% reduction in FGM rates relative to places where there had been no specific programmes focusing on FGM carried out.⁽⁹⁴⁾ Combining livelihood training with educational opportunities resulted in similar rates of reduction, which suggests that livelihood training has little additional impact.

Deir el Barsha, Egypt

The village of Deir el Barsha in Egypt ended the practice of FGM in 1992 without the intervention of government, NGOs, or medical professionals. With the encouragement of local women's groups,

94. P. Adongo et al. 2005. 'Community-Based Interventions Can Change Detrimental Social Norms: Experience from the Navrango Female Genital Mutilation Experiment'. Presented in : Poster Session 6: Applied Demography, Methods, Health and Mortality. Princeton: Princeton University.

an agreement was made between village leaders, local religious figures, and various practitioners of FGM, to end the practice and tell others to end it too.⁽⁹⁵⁾ This was the culmination of over ten years of work by women's groups and a gradual shift in gender relations through the increased social and political participation of women in local society. As one Hadi (2006) put it, "women's empowerment enabled them to articulate their critique of female circumcision and to persuade village leaders to use their influence to abolish the practice".⁽⁹⁶⁾ Deir el Barsha has become a pioneering example of community-led social change and continues to influence wider Egyptian society, which has some of the highest rates of FGM in Africa.⁽⁹⁷⁾

Community led approach - The Tostan human rights-based Community Empowerment Program (CEP)

Tostan is probably one of the best-known examples of a successful intervention aimed at empowering communities through a holistic and educational approach. Tostan is now an international NGO with activities in over 450 communities in six countries in West Africa including Senegal, Mali and The Gambia.⁽⁹⁸⁾

The rationale behind Tostan is that although people say they carry out FGM because of marriage prospects, religion, and preservation of virginity, the real reason is to ensure membership in the community, especially in intermarrying communities. As such, the practice will only end once people in intermarrying communities collectively begin to abandon the practice.

The Tostan human rights-based Community Empowerment Program (CEP) "approach" encourages dialogue around FGM and other practices that communities feel hinder their vision for their community's development. Participants, Community Management Committee (CMC) members, and social mobilization teams speak with friends and family as well as travel to other communities to raise awareness about what they have learned. Through this process, many communities decide to end FGC together, some without having directly participated in Tostan classes.

Fundamental to the organized diffusion approach is the use of public declarations when communities decide to abandon FGM and/or early marriage. According to the founder of Tostan, the strength of the approach is that "Tostan's programme is holistic — it addresses many issues, from human rights to health, and from literacy to small projects. It doesn't start with or focus on FGM."⁽⁹⁹⁾ Ideas of gender equity are promoted throughout the programme and each module explores the issue of gender from a different perspective.

Lessons learned include the importance of educational programmes and awareness raising being carried out over a long time with the involvement of the whole community. Time and space are needed to allow people, and women in particular, to reflect on and analyse information before taking action. Classes related to literacy, management and economic empowerment are only included at a later stage (in the second year), once participants are more confident, active and engaged.⁽¹⁰⁰⁾

95. Amal Abdel Hadi 2006. 'A Community of Women Empowered: The Story of Deir El Barsha'. In: Abusharaf, Mustafa Rogaia (ed.) 2013. *Female Circumcision: Multicultural Perspectives*. Philadelphia, Pennsylvania: University of Pennsylvania Press.

96. Ibid.

97. Mohammed A. Tag-Eldin et al., 2008. '2008. 'Prevalence of Female Genital Cutting among Egyptian Girls'. *Bulletin of the World Health Organization* 86 (4): 269–74.

98. Tostan.org. 2015. 'Mission & History'. Dakar: Tostan.

99. UNICEF. 2007. 'Coordinated Strategy to Abandon Female Genital Mutilation/Cutting in One Generation: A Human Rights-Based Approach to Programming'. *Leveraging Social Dynamics For Collective Change*. New York: UNICEF.

100. Ibid., 37.

Evaluation of Tostan⁽¹⁰¹⁾

Tostan's work in Senegal has undergone a number of evaluations, including: by FRONTIERS from 2000 to 2003, by the Government of Senegal in 2004, by the Swiss Tropical Institute in early 2006, and by UNICEF and Measure DHS/Macro, with Population Council/FRONTIERS and the Center for Research on Human Development. This last evaluation, has measured impact in the communities of the Kolda and Thies regions of Senegal where the first declarations were held several years ago. While shedding some much-needed light on the long-term impact of the Tostan approach, it has also measured the impact of an approach and content that has changed considerably over the last eight years.

Involvement of religious leaders

In some countries, anti-FGM programmes have started working with religious leaders to try and address the belief that there is a religious obligation to carry out FGM.

This approach has had some success, particularly because religious leaders play an important role in the propagation and persistence of the practice of FGM. Importantly, a large meeting of religious scholars – including the Grand Mufti of Egypt – was held in 2007 in Ethiopia on the subject of FGM, and it was agreed that FGM was not a practice required by Islamic law.⁽¹⁰²⁾

Working with religious leaders of the Somali population, Wajir Region, Kenya

The Population Council worked with Somali communities in Kenya where the rates of FGM among women and girls are 97%. They created discussion between the community and religious scholars aimed at enabling religious leaders to encourage

101. For a more in-depth results of different evaluations of Tostan's work, please see: PRB. 2006. Abandoning Female Genital Mutilation. An in-depth look at promising practices, pp. 40-43.

102. PRB. 2013 'Ending Female Genital Mutilation/cutting: Lessons from a Decade of Progress', Washington, DC: Population Reference Bureau.

the abandonment of FGM in the community by showing that Islam does not require it.

Intergenerational dialogue

Another approach to support the abandonment of FGM has been encouraging dialogue between older and younger generations within communities where FGM practices are prevalent. Since FGM is so embedded in the culture and tradition of a local community, it is therefore passed on from generation to generation.⁽¹⁰³⁾ Intergenerational dialogue is therefore an important way for the younger generation to share its own ideas and opinions with the older generation. Through facilitated dialogue, a new consensus about traditional practices can be reached. This approach has been used in Mali, Kenya and Guinea by the German development agency GIZ. An evaluation of the programme in Mali showed that there had been improvements in knowledge and attitude towards FGM as well as an increased number of people opposed to FGM practices.

Intergenerational Dialogue: The Grandmother Project in Senegal

In 2008, World Vision established a three-years Girls' Holistic Development Project in southern Senegal with technical support from the Grandmother Project (GMP). The project's goals were to strengthen positive cultural values and practices; promote adoption of positive community attitudes and social norms regarding FGM, early marriage, and corporal punishment; and reduce teen pregnancies. GMP developed an innovative approach, involving intergenerational dialogue in community and school-based activities and the active participation of elders, especially grandmothers. The strength of this approach is its broadness, the focus on grandmothers as the entry point, and recognition of FGM as a practice that affects all facets of the community.

A 2009 rapid assessment and a qualitative review found that the project strengthened relationships

103. Ibid., 12.

and communication between all ages and sexes; increased appreciation of positive cultural traditions by children, adults, and elders; and appeared to be changing community attitudes toward harmful traditions, including FGM and early marriage.

Results from a recent assessment indicate that grandmothers are seen as an invaluable untapped resource and potential agents of change because of their role and influence in the family and the community.⁽¹⁰⁴⁾

Advocacy for improved policies and legislation

Many of the countries where FGM is still practiced have passed laws criminalising it. But there is nevertheless a gulf between the existence of laws and awareness of them at a community level. Once laws are passed at state level, efforts need to be made to raise awareness about these laws among the population, religious leaders, local government officials and the police.

It is widely considered to be important that legal frameworks and government commitments are combined with social mobilization and efforts at the community level to increase awareness about the negative impacts of FGM. Passing laws alone is not enough (particularly since laws related to FGM are not always enforced – and some of them are hard to enforce, e.g. the clause in Kenyan law that aims to prevent un-cut girls from being ridiculed), and local awareness-raising programmes also have their limitations.

Legislating and campaigning to abandon FGM, the case of Burkina Faso

In Burkina Faso, the government established a committee to campaign against FGM in the 1990s. This campaign involved getting women and youth groups, medical professionals, religious and political leaders and the police to work together to

104. Grandmother Project, "Grandmother Project: Change Through Culture," accessed at www.grandmotherproject.org/, on Dec. 10, 2013; and expert interview with Judi Aubel.

enforce the law and support families that wanted to stop practicing FGM.⁽¹⁰⁵⁾ They used a combination of community education, media campaigning, and developing support services to encourage the abandonment of FGM. After 20 years, FGM rates had dropped in the younger generation, and although the rate remains around 76%, around 90% of women surveyed believe the practice should stop.⁽¹⁰⁶⁾ The Burkina Faso experience has demonstrated how a combination of long-term political will, community education involving many sectors of society, mass media campaigns, and establishment of support services can lead to a reduction in support for the practice.

Multi Media campaigns

Media campaigns play an important role in changing people's attitudes and social behaviours. There is good evidence that mass media campaigns have had a significant impact on health behaviours such as smoking, and on reductions in drinking and driving (although media campaigns to reduce alcohol intake across the population have been less successful).⁽¹⁰⁷⁾ Large-scale media campaigns in various countries aimed at preventing heart disease have also been successful in reducing blood pressure and cholesterol rates. Generally, mass media campaigns are considered to be able to create positive changes and reduce negative changes in health-related behaviours.⁽¹⁰⁸⁾

In relation to FGM, media campaigns often play an important part in helping to change social norms and promote dialogue, but they are always more effective when they are part of a wider campaign to change attitudes and behaviours. It is extremely important that value-neutral non-judgemental language which is simple and straightforward is used

105. PRB. 2013 'Ending Female Genital Mutilation/cutting: Lessons from a Decade of Progress', Washington, DC: Population Reference Bureau.

106. Ibid.

107. Loken Wakefield et al., 2010. 'Use of Mass Media Campaigns to Change Health Behaviour'. *Lancet* 376 (9748): 1261–71.

108. Ibid.

to discuss FGM. This applies both within media campaigns and in community-based programmes aimed at raising awareness and educating people about the issue.

Media magnify the message. The UNICEF-UNFPA Joint Programme on FGM and its partners has supported multiple, mutually reinforcing media channels—radio, television, print and social media—in spreading credible information about the practice, its legal status, its negative health effects and efforts to promote its abandonment. The strategy to encourage and inform national conversations about FGM using local media took off in 2014⁽¹⁰⁹⁾.

AIDOS project 'Abandoning FGM/C on FM!'

Using radio to promote the abandonment of female genital mutilation/cutting

See video at AIDOS YouTube channel

<https://www.youtube.com/watch?v=3t-lp2HiZEI>

Radio is the most widespread, all-encompassing and effective media in Africa, especially in rural areas. It is therefore a crucial instrument in the promotion of social change. Based on this assumption AIDOS adopted the audio documentary as a tool to support the abandonment of FGM in its project "Abandoning FGM/C on FM!", in several African countries under the Unicef/Unfpa Joint Programme on FGM/C. The project encompassed the organisations of training workshops addressed to African radio journalists on how to produce and use audio documentaries on FGM/C and the production of two supporting training guides. The training workshops were held both in English-speaking and French-speaking African countries (Burkina, Senegal and Kenya) with the participation of radio journalists coming from several neighbouring countries.

During and after the two training workshops participants from different countries and backgrounds

109. UNFPA-UNICEF. 2015 "Voices of Change. "2014 Annual report of the UNFPA-UNICEF Joint Programme on Female Genital Mutilation/Cutting: Accelerating Change".

had the chance to **meet, share ideas, reinforce their technical and editorial skills and work together**, producing several audio documentaries, in French, English and local languages, which are now being broadcast by **community radios**, as well as used to animate **public debates**. The journalists were trained to look for their own stories, let the communities speak for themselves, and use **a sensitive and respectful language**. The result is a series of audio documentaries that listeners do not perceive as external sensitizing campaigns, but as stories that really concern them.

Sustainability challenge: commercial radios have a larger audience but are reluctant to broadcast programmes for free.

Opportunities: a mix of commercial and community radios were targeted in order to reach a larger audience and involve more interested people.

Main Lessons learned: Audio documentaries could be effectively used in large community-based programmes and be produced by communities themselves in local languages. This would promote community ownership and dialogue, thus facilitating the abandonment of FGM/C. Audio documentaries are financially and logistically easy to integrate into larger development programmes. Moreover, they can be adapted to other issues such as child, early and forced marriage.

"Stop FGM/C!" campaign

The "Stop FGM/C!" campaign was launched in 2002 by the International NGOs No Peace Without Justice and AIDOS - Italian Association of Women for Development, to foster the abandonment of female genital mutilation by a better involvement of the media in all their forms: printed, broadcast and web based, with a particular attention to changes at community level.

As part of this campaign, in Tanzania, the Tanzania Media Women's Association (TAMWA) initiated a national campaign in 2002. They used television and radio, public posters, newspaper and

magazine stories to engage individuals, communities, other NGOs, and the government, to help reduce FGM rates across the country. In combination with the media campaign, the organization used surveys and qualitative research to improve their understanding of community perspectives on the issue of FGM, and also produced information to educate journalists about the issue. The impact of the organization's efforts – combined with the wider coalition of anti-FGM organizations – has been considerable. More than 500 FGM cutters have stopped their work, and a large number of organizations and religious groups have issued statements in opposition of FGM.

Therefore, the evidence shows that media campaigns can be powerful in changing perceptions and behaviours but they must work together with community-based organizations and advocacy groups. As the director of TAMWA puts it, “media cannot be successful in a vacuum, but must be used to empower communities”.

The Saleema Campaign, Sudan

The Saleema Campaign is a Sudanese media campaign, which calls for the end of FGM. The word Saleema in Arabic means ‘whole’ or ‘undamaged’ and the campaign makes no direct reference to FGM, focusing instead on emphasizing that a girl should remain ‘whole’. The campaign aims to create discussion at family and community level about FGM, with the broader aim of “promoting wide usage of new positive terminology to describe the natural bodies of girls and women”.⁽¹¹⁰⁾ Hundreds of communities, as well as religious leaders, have joined the campaign, pledging to boycott the practice of FGM. The campaign makes use of mass media to communicate its message, and is readily identifiable through its uniform – a bright coloured scarf that both men and women wear as a sign that they are engaged in discussing FGM and the message of Saleema. The strategy of the campaign is to stimulate

community decision-making and encourage communities to make public declarations in support of the abandonment of FGM.⁽¹¹¹⁾

There are also risks that media can be counter-productive if incorrect information is made available on a huge scale. For example in Senegal in 2010, reporting on FGM was at times biased and incorrect and led to widespread debates both nationally and internationally. This eventually had a negative impact on the implementation of a UNICEF programme targeting FGM.⁽¹¹²⁾

Value Centered Approach

This approach identifies key local leaders who are interested in being involved in community programmes addressing sexual and reproductive health and rights. These leaders participate in a training programme that runs for three and a half years and examines the physical, psychological, social and economic effects of FGM. It also encourages reflection on underlying structures and gender relations that support the practice. Knowledge is shared on issues concerning sexual and reproductive health and rights, anatomy, hygiene, HIV and AIDS prevention, human rights and other subjects that are important to individuals, families and communities.

This approach is based on the belief that ideas must not be “forced upon” participants. Through open dialogue, participants are encouraged to make their own informed choices in a non-coercive environment. The objective is to create a safe environment that supports individuals to make their own decisions to abandon FGM, free from judgement and social pressure, in order to bring about cultural change. Community leaders and citizens, as well as girls who have been cut, are fully involved in the process, allowing them to be

110. UNICEF. 2010. ‘In Sudan, Saleema Campaign Re-Frames Debates about Female Genital Cutting | Sudan | UNICEF’.

111. UNICEF. 2010. ‘In Sudan, Saleema Campaign Re-Frames Debates about Female Genital Cutting | Sudan | UNICEF’.

112. UNFPA-UNICEF. 2011. ‘UNFPA-UNICEF Joint Programme on Female Genital Mutilation-Cutting: Accelerating Change’. New York: UNFPA-UNICEF.

vocal and effective promoters of the transformation taking place in their community. Through the strategy of engaging social networks, the sphere of change expands from the individual level to the wider community⁽¹¹³⁾.

Center for PROFS and Vivid Communication with Women in Their Cultures: The experience in Mosocho Division, Kenya

With approximately 130,000 inhabitants, Mosocho is one of seven divisions within the Kisii Central District in Nyanza Province. Before activities to abandon FGM were introduced in the area, the practice was almost universal among the Kisii ethnic group and was usually performed on girls between the ages of 3 and 8.

The Fulda-Mosocho Project was launched in 2002 by two organizations based in Fulda, Germany, that were conducting activities in Kenya: Vivid Communication with Women in Their Cultures, and the Center for Practice-Oriented Feminist Science (Center for PROFS), Fulda University of Applied Sciences, a research institute that developed the 'Value-Centered Approach' to promote personal development, change attitudes and facilitate community-wide abandonment of FGM. In 2002, the Kisii community was considered to be one of the most resistant in the division to the abandonment of FGM. In the first educational programme organized, about 210 teachers and school directors (50 per cent male and 50 per cent female), from all 70 schools in the division, were invited to participate in the project's training programme. Despite the long-standing resistance, by 2009 evidence indicates that approximately 16,500 girls at risk of undergoing FGM had not been cut and thousands of families had expressed their commitment to end the practice. This willingness to deviate from the long-standing practice shows that the social norm surrounding the practice in the community had changed; individuals and families realized that

113. UNICEF.2010. 'The dynamics of social change: toward the abandonment of female genital mutilation and cutting in five African countries' Florence: UNICEF, Innocenti Research Centre.

there was broader support for their decision not to cut girls and that they would still be accepted members of the community. ⁽¹¹⁴⁾.

Holistic approaches

The international community has engaged in holistic programmes to address FGM, thereby adopting measures that include prevention, protection, legislation and provision of support services. The holistic approaches used in attempts to facilitate collective abandonment of FGM are based upon the social convention theory.

UNFPA and UNICEF address FGM in a holistic manner by funding and implementing culturally sensitive programmes for abandoning the practice of FGM, advocating for legal and policy reforms and building national capacity to stop all forms of FGM. by partnering with government ministries, non-governmental organizations, community groups, and faith-based organizations through culturally aware methods. Steps to prevent FGM include collaborating with religious leaders to promote education and discussion, supporting legal framework, empowering community leaders, creating alternative practices, and encouraging gender equality movements.

This approach also promotes the provision of treatment and care to women and girls suffering from its immediate or long-term complications.

The "culture lens" approach of UNFPA is an approach promoted by UNFPA that can advance the goals of programming effectively and efficiently with strong community acceptance and ownership. It is an analytic programming tool that helps policymakers and development professionals to understand and utilize positive cultural values, assets and structures in their planning and programming processes, so as to reduce resistance to the ICPD Programme of Action, strengthen programming effectiveness and create conditions for ownership and sustainability of UNFPA

114. Ibidem.

programmes, especially in the areas of women's empowerment and promotion of reproductive health and rights.⁽¹¹⁵⁾

Building bridges

FGM has emerged as an issue in Europe and in the so-called "Global North" due to migration from countries affected by the practice - the migrants' countries of origin - and is now practiced within several communities residing in the EU, which have strong transnational linkages both within the EU and beyond.

FGM abandonment programmes can be challenged by migrants returning to their countries of origin. In some cases migrants may encourage people to maintain traditional practices like FGM, sometimes through lack of awareness of the social changes that have occurred since they were away, other times as a reaction to not being included in a community process which led to the abandonment.⁽¹¹⁶⁾ At other times though, migrant associations, as well as migrants who return to their communities, can play an important role in showing how people can shift away from FGM practices without losing their sense of belonging and cultural identity.

Therefore, the practice must be addressed in bi- and multilateral discussions among countries and stakeholders and requires the development of measures with a cross-border dimension and collaboration among European authorities and with partners in third-party countries.

The IOM's Comprehensive and Human Rights-Based Approach to FGM⁽¹¹⁷⁾

The IOM, which joined the Donors Working Group (DWG) on FGM in 2008, brings together good practice, social science, and a human rights perspective to address the issue of FGM within migration. The main strategy of the IOM is based on four key elements. Firstly, recognising the role of **community empowerment**, creating empowering activities for women and recognising the central role that women can play in promoting a human rights perspective on FGM. Secondly, focusing on the **capacity-building of relevant professionals** who can build important relationships with families and communities including medical professionals, teachers, social workers and the police. Thirdly, raising awareness in the **destination countries** where people migrate to, particularly within government, but also in international agencies, NGOs, community groups and within the media. Finally, **building bridges** so that members returning to their communities as well as members who are abroad but continue to provide financial support back home, do not have a negative impact on community-level processes of change. But also so that migrant groups abroad can have a positive impact on change by challenging traditional power hierarchies in the home communities.

The "Building bridge" approach is still in its early stages of implementation. At regional level some attempts to coordinate policies have been made within Europe and among several African countries, yet cross-border mechanisms to protect girls at risk of FGM are still poor both in Europe and in Africa and a wider cross-border mechanism between Europe and African countries affected by the practice has still to be discussed. At community level some pilot projects have been implemented in partnerships between European and African NGOs, but these need to be scaled up and evaluated in order to inform possible similar projects in the future. Building bridges means going beyond the traditional line between

115. Khadija Hashi, and Leyla Sharafi. 2007. 'A Holistic Approach to the Abandonment of Female Genital Mutilation'. New York: UNFPA.

116. IOM. 2008. 'Supporting the Abandonment of Female Genital Mutilation in the Context of Migration'. Geneva: International Organization for Migration. Geneva: International Organization for Migration.

117. Ibidem.

international cooperation projects and domestic ones. To this end, the international community and the national actors involved in the abandonment of the practice, including donors, need to better understand the importance of addressing the issue from a building bridge perspective and therefore finance projects and programmes that form such links. This approach, which foresees activities both in countries of origin and of migration, has become known as the “building bridge” approach.

Protecting the Next Generation Project, Equipop

The French NGO **Equilibres & Populations (Equipop)** implements a pilot project entitled “Protecting the Next Generation” for the abandonment of FGM in 100 communities in the Kayes region of western Mali. The project aims to reach a total of 250 villages. Since 2006, Equipop has been developing a strategy to involve migrants living in France who come from the project area. The Kayes region is a key emigration region; from which 80% of Malians living in France originate. The migrants, through the financial support they regularly send to their families in Mali, can have a strong influence on their community. Involving them in the abandonment process of FGM is necessary so that they agree with the final decision made in their villages of origin, or at the very least, to secure their neutrality so that they do not challenge the decision.

Migrants are identified in the field with the help of AMSOPT, the Malian NGO in charge of the activities in Mali. In France, the Paris-based association “Entraide et Espoir”; is in charge of mobilizing the associations of migrants originating from the villages involved in Mali, and organizing debates and awareness-raising sessions on the issue of FGM.

The project brought together around 10 migrants who are actively involved in the abandonment of FGM. A delegation of these migrants travelled to Mali in 2009 to show their support for the abandonment of FGM in their communities. Back in France, debriefing sessions were organized to raise further awareness on the issue of FGM among the Malian diaspora.

In 2013/2014, this specific group of migrants, called “migrants-relais”, was kept regularly informed about activities implemented in Mali and helped to inform other diaspora members about the consequences of FGM. Equipop intends to develop training activities for this group of migrants in order to give them tools that they can use to mobilize and inform the Malian diaspora about FGM.

The plans are to organize another journey to Mali for the migrants in order for them to attend a ceremony of abandonment of FGM and participate in debates organized in villages in the Kayes region. Once back in France, new debriefing sessions will be organized with the other members of the Malian diaspora living in the Paris region. For now, migrant associations sign a **Charter** showing their support for the abandonment of FGM in the villages that they represent in France. A copy of this charter will be given to the villages in Mali.

Video letter to talk about FGM: Belgium – Senegal project, Gams Belgique

To increase the exchange of information and build bridges, in 2015 GAMS Belgium has begun a video letter project: migrants in Belgium are interacting with the women and men in their villages of origin through video, where they will address the topics of FGM and broader issues related to the condition of women and girls.

The video letter project was born from the following observation: migrant men and women, in order to remain in contact with their relatives in their country of origin, regularly use different communication media: letters, audio cassettes, emails, international calls, videos ... Thus the idea came to produce videos with migrants and with the communities in their country of origin in order to strengthen the exchange of information between them on the chosen topics. This had been done on HIV with SIREAS, a partner association of GAMS, but never yet on FGM. The method is very simple: a group of men and women, members of the Fulani community in Belgium, met in Antwerp. With the assistance of a facilitator from GAMS they exchanged views on their perception of FGM,

on its consequences and its reasons, in a video addressed to the Fulani community in Vélingara in Senegal. In Belgium the video tour was edited and verified by the group before the mission in Senegal. Two GAMS facilitators left for Senegal: they filmed the immediate reactions of the people of Vélingara during the projection of the film and then a debate followed the film (the debate was also filmed). Video equipment was left in Vélingara for the next video exchange. Back in Belgium, the part filmed in Senegal was edited and added to the Belgian part. This video lasting 26 minutes will now serve as a support for awareness-raising in the two communities in Belgium and in Senegal. The filmed letters have helped to create a first bridge between Europe and Africa starting on a small scale (the Fulani communities in Belgium and Vélingara). This project will allow a community diagnosis to be made in order to develop activities to promote the abandonment of the practice of FGM.

3.2 What works and what does not work

A recent paper on popular approaches for the abandonment of FGM highlights examples of ‘what works and what does not’.⁽¹¹⁸⁾ The article examines some of the most common interventions which have been used to eliminate FGM and outlines the main advantages and disadvantages of each (see table 2, p. 92).

3.3 Lessons learned

There is a distinct lack of research on the impact of interventions to reduce rates of FGM. Many of the interventions which have been carried out were short-term projects and lacked adequate evaluation to determine their successes and failures. Moreover, a lot of details are missing regarding the understanding of decision-making and FGM. For example, who makes decisions about FGM, when and where these are made and who are the

important players in the decision-making process.

Generally, evidence suggests that social change is the result of a combination of larger-scale efforts to educate and improve the status of women in practicing communities, together with sustained efforts over a longer period of time to engage people at community level. Interventions may be more successful if they are inspired by a specific model of behaviour change, if they are able to avoid using critical language – such as the term “mutilation” – and if concerns related to gender and FGM are raised by the community itself rather than being imposed: this helps to achieve ‘buy-in’ (active support and participation in the process).⁽¹¹⁹⁾

While there are a myriad of approaches, which have been used by various organizations,⁽¹²⁰⁾ there are a number of recommendations and lessons, which show up regularly. These include:

- **Community based approach:** A non-coercive and non-judgemental approach able to understand the community perspectives and decision making around FGM in which the focus is fulfilling human rights and empowering girls and women: “Despite taboos regarding the discussion of FGM, the issue emerges because group members are aware that the practice causes harm. Community discussion and debate contribute to a new understanding that girls would be better off if everyone abandoned the practice.”⁽¹²¹⁾

119. PRB. 2013. ‘Ending Female Genital Mutilation/cutting: Lessons from a Decade of Progress’. Washington, DC: Population Reference Bureau.

120. Ibid., 16–17; UNICEF. 2007. Coordinated Strategy to Abandon Female Genital Mutilation/Cutting in One Generation: A Human Rights-Based Approach to Programming’. Leveraging Social Dynamics For Collective Change. New York: UNICEF; UNICEF. 2010. ‘The Dynamics of Social Change: Towards the Abandonment of Female Genital Mutilation/cutting in Five African Countries’. Florence: UNICEF, Innocenti Research Centre.

121. UNICEF. 2007. ‘Coordinated Strategy to Abandon Female Genital Mutilation/Cutting in One Generation: A Human Rights-Based Approach to Programming’. Leveraging Social Dynamics

118. R. Johansen et al., ‘What Works and What Does Not’. A Discussion of Popular Approaches for the Abandonment of Female Genital Mutilation’. *Obstetrics and Gynecology International* 2013.

Table 2

Approach	Advantages and potential successful results	Risks and disadvantages	Measures to overcome risks and disadvantages
Health risk info	(i) Stimulate resistance to FGM among lay people, religious leaders, politicians, and health providers (ii) Improve health care for females who suffer complications	(i) Medicalization (ii) Change type of FGM (ii) Disbelief (iv) Inadequate quality of information (v) Defensive reactions (vi) Social norm overrules health risks	(i) Ensure health information is locally adapted, communicated non-judgementally by a reliable source
Conversion of excisers	(i) Reduce availability of excisers (ii) Easy success indicators (iii) Media coverage providing visibility to issue	(i) Does not reduce demand for FGM (ii) Continue secretly or with apprentices (iii) Others take over task (iv) Ex-excisers unreliable sources against FGM (v) Alternative income may not motivate abandonment	(i) Ensure that work with excisers is only an aspect of a wider approach adapted to their roles in the particular community. (ii) Do not expect it to reduce the demand for FGM
Training of health professionals	(i) Improved quality of care (ii) Refrain from performing FGM (iii) Provide information and counselling (iv) Build local evidence of health consequences	(i) Resistance to work against FGM (ii) Inadequate content of training (iii) Lack of time and resources to implement	(i) Comprehensive training for prevention and management in standard curricula (ii) Training to target potential acceptance of the practice. (iii) Ensure an enabling environment for implementation of knowledge
Alternative rites	(i) Facilitate community ownership and support, as it maintains key cultural practice (ii) Increased knowledge and empowerment of girls (iii) Publicity about change through community celebrations	(i) Only viable in communities in which FGM is a part of a rite of passage (ii) Limited integration of the whole community (iii) Insufficient adaptation into the specific sociocultural situation of each community	(i) Use only where fits into local culture (ii) Include the whole family and community (iii) Consider alternative measures if the actual cutting is done at other times (iv) Ensure community ownership for sustainability
Community-led	(i) Community own problem and solution (ii) Broader support, less resistance (iii) Addressing underlying causes (iv) Reduce/remove FGM as a social norm, facilitating and stimulating change	(i) The community might decide to change, rather than to abandon, the practice. (ii) Failing to ensure community participation and resorting to traditional "lecturing"	(i) Ensure community ownership and adaptation (ii) Ensure long-term support to secure viable and broad change, reaching reluctant abandoners and neighbouring communities

Public statements	(i) Create a sense of social change among a group (ii) Facilitate and stimulate abandonment among group members	(i) Public statements by sub-groups only, lack of community ownership (ii) “Fake” opinions and/or lack of authority	(i) Ensure community-wide support (ii) Having legislation and policies in place provides support to people ready to change (iii) Further research is needed to investigate the effects of public statements from single groups, especially religious leaders
Legal measures	(i) Create an enabling framework (ii) Discourage FGM	(i) Practice can go underground (ii) Fear of seeking health care if there are complications	(i) Ensure community support for the law (ii) Ensure regulations that guarantee care if there are complications.

- **Galvanizing social change:** Communities must be able to feel that change is in their best interest: “Of the experiences studied, the most successful programmes did not bring outsiders into communities to initiate a discussion on FGM, but instead, engaged respected community members to promote transformation, including religious and local leaders, representatives of local women’s and youth associations, and others. When communities were provided with information from credible sources and with possibilities to reflect, discuss and act, they were encouraged to find viable alternatives.”⁽¹²²⁾
- **Importance of evaluations:** improving the quality of evaluations and research on FGM programmes: “Most interventions targeting FGM have been implemented as short-term projects without adequate attention or funding for formative research, rigorous evaluation, and follow-up... experts need to better understand the community perspective on the different factors that lead to continued practice.”⁽¹²³⁾
- **Holistic and multi-sectorial approaches:** Ensuring that interventions adopt holistic and multi-sectorial approaches, so that they integrate advocacy, policy and community-level work to create social change: “Evidence and experience from various interventions show that approaches should be holistic, multi-sectorial, long-term, and owned by the community. Stand-alone approaches are not able to create the change needed at the individual or community level. Communities should drive the intervention, allowing for buy-in, and design.”⁽¹²⁴⁾
- **Engaging with media:** “The media, as well as traditional forms of communication, such as music, poetry and drama, are powerful tools to instigate social change. They can portray a new vision whereby girls and women can maintain their traditional values without being cut.”⁽¹²⁵⁾
- **Gender equity and empowerment of women and girls:** Ensuring that FGM work is always part of a larger project addressing gender equity: “If FGM is ever to be eliminated, the interventions must be based on the context

For Collective Change. New York: UNICEF.

122. UNICEF. 2010. ‘The Dynamics of Social Change: Towards the Abandonment of Female Genital Mutilation/cutting in Five African Countries’. Florence: UNICEF, Innocenti Research Centre.

123. PRB. 2013. ‘Ending Female Genital Mutilation/cutting: Lessons from a Decade of Progress’. Washington, DC: Population

Reference Bureau.

124. Ibid.

125. UNICEF. 2010. ‘The Dynamics of Social Change: Towards the Abandonment of Female Genital Mutilation/cutting in Five African Countries’. Florence: UNICEF, Innocenti Research Centre.

of gender equity, and communities must be involved in discussion around the advantages and disadvantages of the practice.”⁽¹²⁶⁾ Moreover ensuring that efforts are aimed at empowering women and girls, through education, economic opportunities, and increased capacity to take decisions and be actors of change: “Interventions should empower women economically and girls through education. In Kenya, an NGO-led education and awareness-raising campaign resulted in a number of girls refusing to be cut and marching through the community demanding access to education and an end to cutting.”⁽¹²⁷⁾

- **Including a human rights framework in all interventions:** “Recognition of FGM as a violation of girls’ and women’s human rights is essential in FGM interventions and discussions with communities.”⁽¹²⁸⁾
- **Implementing and enforcing laws against FGM:** “Governments must work to educate communities about the law and invest in its implementation at local level. However, these laws can have a negative impact in some communities, and must be complemented with comprehensive community-level interventions.”⁽¹²⁹⁾
- **Work beyond national borders:** “Fostering links across national borders can enable the positive social change to extend across members of the ethnic group, including those living in countries of immigration.”⁽¹³⁰⁾
- **Working beyond the short-term:** “Changing social norms takes time. Short-term projects

may only influence the early stages of behaviour change. Sustained investment and support for long-term interventions will be the key to full abandonment of FGM.”⁽¹³¹⁾

- **Involve multiple actors:** All relevant actors, international agencies, governments, parliamentarians, professional organizations, NGOs, community groups and media professionals should join forces to make national policies and legislations work for an effective abandonment of FGM, to develop a holistic child protection

Monitoring: To assess the process and progress of programme implementation

Evaluation: To assess the effect or impact of a programme

framework and to secure health care, social and psychological support for women and girls who have already undergone FGM⁽¹³²⁾.

4. Monitoring and evaluation of programmes addressing FGM

4.1 Measuring FGM interventions

Monitoring and evaluation is a crucial component of developing programmes and interventions addressing FGM.

Monitoring (outputs) is aimed at measuring the performance of the process and show the success of the programme’s performance at different levels (quality, quantity, time).

The evaluation (outcomes) is more episodic and it is not undertaken on a regular basis as a “routine” activity of the programme; it looks at the impact of the programme’s intervention on a more long-term basis.

126. PRB. 2013. ‘Ending Female Genital Mutilation/cutting: Lessons from a Decade of Progress’. Washington, DC: Population Reference Bureau.

127. Ibid.

128. Ibid.

129. PRB. 2013. ‘Ending Female Genital Mutilation/cutting: Lessons from a Decade of Progress’. Washington, DC: Population Reference Bureau.

130. UNICEF. 2010. ‘The Dynamics of Social Change: Towards the Abandonment of Female Genital Mutilation/cutting in Five African Countries’. Florence: UNICEF, Innocenti Research Centre.

131. Ibidem.

132. IOM. 2008. ‘Supporting the Abandonment of Female Genital Mutilation in the Context of Migration’. Geneva: International Organization for Migration.

In order to understand the impact of interventions aimed at reducing the rates of FGM, it is very important to determine the successes and failures of the different typologies of intervention. The understanding of decision-making related to FGM is crucial. For example, who makes decisions about FGM, when and where these are made and who the important players in the decision-making process are.

In the past, the most widely used methodology for impact assessment of programmes addressing “social change” within communities was that of measuring the knowledge, attitude and practice (KAP) or behaviour (KAB), with the underlying assumption that by providing factual information, usually through information, education and communication (IEC) campaigns, a change in the knowledge base will be engendered, which will lead to a change in attitude, which will then translate into a change in practice or behaviour⁽¹³³⁾.

KAP/KAB impact assessment relies too heavily on the assumption that human behaviour has an exclusively rational basis, and doesn’t take into account the more complex psychological and social dynamics that underlie such behaviour. It also assumes that change in knowledge automatically guarantees a change in attitude, one that is sufficient for taking the risk of changing a practice or behaviour. It does not take into consideration the fact that change, in particular when it is not yet perceived as a needed and beneficial modification, is not always progressive nor coherent, and that other social, economic, cultural or psychological factors must be envisioned to facilitate a positive and irreversible change in behaviour⁽¹³⁴⁾.

In the FGM field, evidence shows that many communities have acquired the knowledge of the harmful effects of the practice, but have failed

to change attitudes and/or behaviours. Lessons learned from HIV research confirm this, in particular when it comes to adopting safe sexual behaviours. Similarly, the decision making process around FGM involves a wide range of actors and is influenced by a number of external contingency factors.

The most crucial questions in developing evaluation and monitoring indicators is how to define success. The only acceptable success or outcome indicator is the proof of the irreversible abandonment of the practice in a family or a community, which can only be measured over time. A decrease in incidence can be measured through community monitoring, repeated national surveys, independent local pre- and post-intervention survey or through case control studies.

4.2 Defining indicators to measure results and impacts

Currently, the principal source of data and data analysis on FGM is provided by the DHS, Demographic and Health Surveys, administered by Macro International and funded by USAID, and the MICS, Multiple Indicator Cluster Surveys, carried out by UNICEF. Both are used with large samples of the population, and include a questionnaire on FGM (the number of women aged 15 to 49 who have been subjected to the practice), and the trend towards its possible abandonment (number of women aged 15 to 49 who have at least one daughter circumcised). Thanks to these surveys a comparable set of data is available for a large number of African FGM-practicing countries. Together, DHS and MICS construct a joint portrait of FGM in individual countries. This portrait has programmatic implications, because it needs to be taken into consideration when designing strategies and programmes to end the practice in specific countries where the programme will be implemented.

In 2003, the UNICEF Programme Division, Child Protection Section, and Division of Policy and Planning, Strategic Information Section,

133. AIDOS, RAINBOW. 2006. FGM/C as a development issue, programming tools to mainstream the abandonment of FGM/C into development programmes and projects. Rome: AIDOS.

134. Ibidem.

organized a “Global Consultation on Indicators” with partners that included UN agencies and non-governmental organizations.

Participants in the consultation discussed how an FGM component should handle such issues. There was, for example, agreement that **physical examination of girls is unethical** for survey purposes and should be done only in hospital settings, during antenatal care or in other situations associated with medical services.

The discussions led to a consensus on the five following main indicators to measure impact over countries and over time, at national and subnational levels.

1. Prevalence of FGM by age cohorts 15-49;
2. FGM status of all daughters: This indicator refers to FGM prevalence for all daughters of mothers aged 15 to 49;
3. Percentage of “closed” FGM (infibulation, sealing) and “open” FGM (excision). This simplified category is introduced to help overcome the difficulty of identifying the specific type of FGM a woman or her daughter has undergone;
4. Performers of FGM;
5. Support of, or opposition to FGM by women and men aged 15-49.

During the consultation, it was noted that at the local level, where programmes were implemented, there were no indicators that take into account different paradigms for FGM abandonment. FGM abandonment is not an individual or family matter, but rather a community, cultural group and inter-village (on a zonal level) concern. Thus, it was considered important to include indicators that might enhance understanding of this concept and to limit their number to **three general indicators** to be applied in any circumstances:

- **Public declaration of intent:** Questions should capture individual, community and village intentions of abandoning FGM. Forms of public declaration include village declarations, public written statements, public lists

for subscription, alternative rites of passage and positive deviance.

- **Community-based monitoring mechanisms to follow up on girls at risk of FGM** should be gathered from the community through the health and school systems, youth groups and other monitoring mechanisms chosen by the community.
- **Drop in prevalence** This is the ultimate quantitative measure that demonstrates progress towards the abandonment of FGM and the effectiveness of programmes already in place. This figure can be obtained through various research methods at local level, over a minimum period of five years and where a baseline survey has been conducted.

A fourth indicator was proposed for **‘government commitment’**, a combined indicator including legislation, national plan of action and resources allocated for FGM prevention activities.

A number of issues remained unresolved after the Global Consultation and moreover some of the indicators highlighted by the Consultation have been criticized. With regard to Public Declarations, for instance, since they do not constitute by themselves proof of an effective abandonment of the practice in the local communities, and they only apply where social units are cohesive enough to reach joint decisions and if there is evidence of genuine debate around the issue before the declaration is made.

As a matter of fact, indicators for evaluating programmes addressing FGM should consider that variations are idiosyncratic and vary by community; actually, typical outcomes of FGM abandonment should consider more broadly the **changes in the decisional capacity and empowerment of girls, women and communities and the concrete impact on the reduction in the practice** at community, regional, national and international level. Typical outcomes of FGM abandonment also include other related issues such as:

- Abandonment of early and forced marriages;

- Increase in vaccination rates;
- Increase in systematic pre- and post-natal consultations;
- Increase in activities promoting birth spacing and good nutrition;
- Increase in organization of health services in the community;
- Systematic birth registration;
- Campaigns to enrol girls in school;
- Regular community clean-up activities;
- Active peace committees for conflict resolution;
- Improved communication among all members of the community;
- Changes observed in the community as regards to gender roles;
- Women emerging as influential leaders⁽¹³⁵⁾.

It is important to consider how a decision to abandon the practice is not taken by only one individual, but it is a decision taken on behalf of a minor that may involve several individuals including the mother, father, grandmother, aunts, religious leaders and community leaders.

Collection of data on projects outputs and outcomes can follow quantitative and/or qualitative methods. Qualitative methodologies can include interviews (structured and semi-structured), focus groups discussion, social mapping, and collection of success stories from the programme. Researches is also a useful tool to better understand change in behaviour and impacts on the abandonment of the practice.

Evaluation of the UNFPA-UNICEF Joint programme on FGM/C

An example of a recent evaluation is the one undertaken on the UNFPA-UNICEF Joint Programme in its first phase of implementation; the programme addressed 15 programme countries

(2008-2012). The evaluation provides an opportunity to learn about methodologies and indicators applied by a large-scale and holistic programme for the acceleration of the abandonment of FGM. For more information please visit: <http://tinyurl.com/hgesvzh>

135. UNICEF. 2007. Technical Note: Coordinated strategy to abandon female genital mutilation/cutting in one generation, New York, UNICEF.

READINGS

- Abusharaf, Mustafa Rogaia. 2013. 'Female Circumcision: Multicultural Perspectives'. Philadelphia: University of Pennsylvania Press.
- ACHPR. 2015. 'Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa'. Banjul (The Gambia): African Commission on Human and Peoples' Rights. <http://tinyurl.com/oxa22pt>
- D. Bishai, Y. Bonnenfant, M. Darwish et al., 2010. "Estimating the obstetric costs of female genital mutilation in six African countries," Bulletin of the World Health Organization, vol. 88, no. 4, pp. 281–288 <http://tinyurl.com/pmq7ll7>
- Adongo, P., E. Jackson, L. Abokyi, R. Naik, E. Feinglass, and J. Phillips. 2005. 'Community-Based Interventions Can Change Detrimental Social Norms: Experience from the Navrongo Female Genital Mutilation Experiment'. Presented in Poster Session 6: *Applied Demography, Methods, Health and Mortality*. Princeton: Princeton University. <http://paa2005.princeton.edu/papers/51279>
- AIDOS, RAINBOW. 2006. *FGM/C as a development issue, programming tools to mainstream the abandonment of FGM/C into development programmes and projects*. Roma: AIDOS.
- Amnesty International. 2011. "Indonesia Must Repeal Female Genital Mutilation Law," Amnesty International, June 24, 2011. <http://tinyurl.com/z63ucbt>
- Amnesty International Ireland, and End FGM - European Campaign. 2010. 'Ending Female Genital Mutilation to Promote the Achievement of the Millennium Development Goals'. Brussels, Belgium: Amnesty International Ireland and End FGM - European Campaign. <http://tinyurl.com/nklkmf5>
- Baden, S, and H. Reeves. 2000. 'BRIDGE Report 57: Gender and Development: Frequently Asked Questions'. Brighton, UK: Institute of Development Studies. <http://tinyurl.com/pwm9ylx>
- Beijing Declaration. 1995. 'Beijing Declaration and Platform for Action: The Fourth World Conference on Women'. <http://tinyurl.com/yf48vhq>
- Bradshaw, S. 2013. 'Women's Role in Economic Development: Overcoming the Constraints'. New York: Sustainable Development Solutions Network. <http://tinyurl.com/ln5w9os>
- Burrage, Hilary. 2014. 'The Global Economics of Female Genital Mutilation (FGM)'. <http://tinyurl.com/jo7sa5g>
- Calder, Rebecca. 2012. 'Pathways' Perspectives on Social Policy in International Development'. <http://tinyurl.com/qx6ofy6>
- Council of Europe. 2014. 'The Council of Europe Convention on Preventing and Combating Violence against Women and Domestic Violence'. <http://tinyurl.com/jo7sa5g>
- DWG on FGM. 2015. 'The Donors Working Group on Female Genital Mutilation/Cutting: A Matter of Gender Equality'. <http://tinyurl.com/q7txrqf>
- EIGE. 2013a. 'Gender Equality Index'. Vilnius: European Institute for Gender Equality. <http://tinyurl.com/zcckd5t>
- _____. 2013b. 'Female Genital Mutilation in the European Union and Croatia'. Vilnius: European Institute for Gender Equality. <http://tinyurl.com/jcraypf>
- End FGM European Network. 2014. 'Repositioning

- FGM as a Gender and Development Issue - Position Paper'. End FGM European Network. <http://tinyurl.com/otf469e>
- Equality Now. 2007. 'Protecting The Girl Child: Using the Law to End Child, Early and Forced Marriage and Related Human Rights Violations'. London: Equality Now. <http://tinyurl.com/lyoqanh>
- European Commission. 2013. 'Communication from the Commission to the European Parliament and the Council: Towards the elimination of female genital mutilation'. Brussels, 25.11.2013 COM (2013) 833 final. <http://tinyurl.com/gsha9ja>
- FAO. 2011. 'The Role of Women in Agriculture'. ESA Working Paper No. 11-02. Rome: Food and Agriculture Organization. <http://tinyurl.com/m4uy9pv>
- Girls Not Brides. 2015. 'Post-2015 Advocacy Toolkit'. London: Girls Not Brides. <http://tinyurl.com/zbfbk5eq>
- GTZ. 2009. 'Female genital Mutilation and Education', Eschborn: GTZ. <http://tinyurl.com/nbdaaq4>
- GTZ. 2013. 'Empowering the next generations to abandon female genital mutilation (FGM) Integrating the topic FGM into school education in Burkina Faso', Eschborn: GTZ. <http://tinyurl.com/h6aoofd>
- Hadi, Amal Abdel. 2006. 'A Community of Women Empowered: The Story of Deir El Barsha'. In: Rogaja Mustafa Abusharaf (ed.), *Female Circumcision: Multicultural Perspectives*, Philadelphia, Pennsylvania: University of Pennsylvania Press.
- Hashi, Khadija and Leyla Sharafi. 2007. 'A Holistic Approach to the Abandonment of Female Genital Mutilation'. New York: UNFPA. <http://tinyurl.com/pg7ym2o>
- IOM. 2008. 'Supporting the Abandonment of Female Genital Mutilation in the Context of Migration'. Geneva: International Organization for Migration. <http://tinyurl.com/k6efs3o>
- IMOW. 2015. 'Economica: Young Women Speaking the Economy'. San Francisco: IMOW. <http://tinyurl.com/p82t7v8>
- Johansen, R. Elise B., Nafissatou J. Diop, Glenn Laverack, and Els Leye. 2013. 'What Works and What Does Not: A Discussion of Popular Approaches for the Abandonment of Female Genital Mutilation'. *Obstetrics and Gynecology International* 2013. <http://tinyurl.com/od7f4v3>
- Lee, Kyung Sun. 2008. 'Female Genital Mutilation: Multiple-Case Studies of Communication Strategies Against a Taboo Practice'. A thesis submitted to the graduate faculty in partial fulfillment of the requirements for the degree of Master of Science. Iowa State University. Ames, Iowa. <http://tinyurl.com/okw8ay2>
- Njeri Chege Jane, Ian Askew, and Jennifer Liku. 2001. 'An Assessment of the Alternative Rites Approach for Encouraging Abandonment of Female Genital Mutilation in Kenya'. New York: Population Council. <http://pdf.usaid.gov/pdf/docs/Pnacm865.pdf>
- Population Council and Centre National de la Recherche Scientifique et Technologique (CNRST). 1998. 'Evaluation of the Strategy to Retrain Excisors for the Eradication of Female Genital Mutilation in Mali'. Bamako, Mali: Population Council and Republic of Mali, Ministry of Secondary and Higher Education and of Scientific Research.
- PRB, 2006. 'Abandoning Female Genital Mutilation,

- An in-depth look at promising practices'. http://www.prb.org/pdf07/fgm-c_report.pdf
- PRB. 2013. 'Ending Female Genital Mutilation/cutting: Lessons from a Decade of Progress'. Washington, DC: Population Reference Bureau. <http://tinyurl.com/myjm7rc>
- Tag-Eldin, Mohammed A., Mohsen A. Gadallah, Mahmoud N. Al-Tayeb, Mostafa Abdel-Aty, Esmat Mansour, and Mona Sallem. 2008. 'Prevalence of Female Genital Cutting among Egyptian Girls'. In: Bulletin of the World Health Organization 86 (4): 269–74. <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2647417/>
- The Grandmother Project. Girls and Grandmother Hand in Hand, Dialogue between generations for community change, Rome, 2012. <http://tinyurl.com/neaag8g>
- The Guardian. 2014. '10 Reasons Why Our FGM Law Has Failed – and 10 Ways to Improve It'. <http://tinyurl.com/okcx7zr>
- Tostan.org. 2015. 'Mission & History'. Dakar: Tostan. <http://www.tostan.org/about-us/mission-history>
- Toubia, N. 2003. 'Legislation as a Tool for Behavioural and Social Change'. In Proceedings of the Afro-Arab Expert Consultation on Legal Tools for the Prevention of Female Genital Mutilation Cairo, 21-23 June 2003. Rome: NPWJ and AIDOS. <http://tinyurl.com/nvzrca8>
- TROCAIRE. 2010. 'Gender Mainstreaming Resource Pack: a Practical Guide for Programming'. Maynooth, Co. Kildare: Trocaire. <http://tinyurl.com/js7y5d4>
- UN Development Group. 2015. 'Transforming the world: the 2030 Agenda for Global Action'. (Final draft of the outcome document for the Post-2015 Development Agenda). New York: UNDG. <http://tinyurl.com/h4snzxi>
- UNFPA. 2014. 'Implementation of the International and Regional Human Rights Framework for the Elimination of Female Genital Mutilation'. New York: UNFPA. <http://tinyurl.com/os6ln8g>
- UNFPA-UNICEF. 2011. 'Joint Evaluation. UNFPA-UNICEF Joint Programme on Female Genital Mutilation-Cutting: Accelerating Change. 2008-2012'. New York: UNFPA-UNICEF. <http://tinyurl.com/nohj9zw>
- UNFPA-UNICEF. 2015 "Voices of Change. "2014 Annual report of the UNFPA-UNICEF Joint Programme on Female Genital Mutilation/Cutting: Accelerating Change" <http://tinyurl.com/z27nnem>
- UNICEF. 2007. 'Coordinated Strategy to Abandon Female Genital Mutilation/Cutting in One Generation: A Human Rights-Based Approach to Programming'. Leveraging Social Dynamics For Collective Change. New York: UNICEF. <http://tinyurl.com/yjk2kha>
- . 2010a. 'In Sudan, Saleema Campaign Re-Frames Debates about Female Genital Cutting | Sudan | UNICEF'. <http://tinyurl.com/pxy758u>
- . 2010b. 'The Dynamics of Social Change: Towards the Abandonment of Female Genital Mutilation/cutting in Five African Countries'. Florence: UNICEF, Innocenti Research Centre. <http://tinyurl.com/qbhmw4u>
- . 2013. 'Female Genital Mutilation/Cutting: A Statistical Overview and Exploration of the Dynamics of Change'. New York: UNICEF. <http://tinyurl.com/lmpg6a9>
- United Nations. 2013. 'Resolution Adopted by the General Assembly. 67/146. Intensifying Global Efforts for the Elimination of Female Genital Mutilations'. <http://tinyurl.com/nas63go>

Wakefield, Loken, Melanie A., Barbara Loken, and Robert C. Hornik. 2010. 'Use of Mass Media Campaigns to Change Health Behaviour'. *Lancet* 376 (9748): 1261–71. <http://tinyurl.com/q6g48bq>

WEF. 2014. 'Country Rankings'. Global Gender Gap Report 2014. Geneva: World Economic Forum. <http://tinyurl.com/krqmkgn>

WHO. 2014. 'Female Genital Mutilation'. Geneva: WHO. <http://tinyurl.com/yrtjlx>

WHO, UNICEF, UNFPA, World Bank and United Nations Population Division. 2014. Trends in maternal mortality: 1990 to 2013. Geneva: WHO. <http://tinyurl.com/hw64y2v>

World Vision. 2014. 'Exploring the Links: Female Genital Mutilation/cutting and Early Marriage'. London: World Vision UK. <http://tinyurl.com/lerszux>

ACTIVITIES

Activity 3.1: (1 hour 15 mins.)

Review of past and present approaches

Objectives:

obtain an overview of different approaches for prevention and abandonment of FGM and identify positive and negative aspects of those approaches.

Description:

Step 1: Work group discussion (30 minutes)

Divide participants into pairs. Give each pair one of the approaches listed in “Approaches to FGM prevention” (cut the boxes into separate strips beforehand).

Also give them “Questions to guide past approach analysis and presentation”, and read them out to explain how to carry out the exercise.

Step 2: Plenary discussion (30 minutes)

Invite each pair to share their analysis: they should briefly explain which approach they have considered, then how they have replied to the questions, and what the strengths and weaknesses of those approaches are. Invite other participants to share their views and comments.

Ask if anybody has adopted any of the approaches presented and would like to share his/her experience.

Materials:

- “Past and present approaches to FGM prevention” (to be printed and cut up into strips);
- “Questions to guide approach analysis and presentation” (to be printed and given to the groups).

“Past and present approaches to FGM prevention”



The Harmful Practices Approach

Involvement of medical and paramedical personnel (obstetricians, nurses, social workers and other local professionals) in providing information on the health risks connected to the practice, both immediate and long term. The idea is that this kind of information will automatically lead to abandonment of the practice, once the seriousness of short- and long-term health risks is fully understood. This approach was and is extensively used in awareness raising activities by agents of local NGOs and CBOs (community based organizations) in villages, with groups including women, village leaders, and young people.

Training of medical personnel as “promoters of change”

Medical personnel may use the particular moment of medical consultation to persuade their patients of the need and importance to abandon the practice, given the authority these professionals have in local communities. This came out of the consideration of the multiple roles played by medical personnel in developing countries with respect to the practice. If, on a personal level, every doctor is called on to resolve the conflict caused by membership of an ethnic group where FGM is practiced with respect to WHO prohibition, at the community level, the physician also plays other roles. It is the doctor to whom the family first turns in the case of complications from an excision or infibulation, or the women/couples in the case of problems, especially in sexual relations, for example frigidity/sterility, which might be a result of the practice. This is a very important, fertile moment of contact with the community. Having what is recognized as “superior” training, the physician ends up in the role of opinion leader, which puts him/her in the best possible position for promoting change in behaviours in his/her patients.

Alternative income generating activities for traditional practitioners

After sensitization towards the dangerous consequences and related risks of the practice, the programmes aim to substitute the practice of FGM with other income-generating activities – agricultural production, food processing, crafts, trade. To this end they foresee appropriate professional training for the former traditional practitioners, as well as a credit scheme providing funds for the start up of the chosen activity. This approach was adopted in a number of countries, especially in Western Africa (Guinea, Ghana, Mali, Burkina Faso) and in Ethiopia.

Alternative rites of passage

This specific action has been designed and used, in particular in Kenya by the Maendeleo Ya Wanawake Organization (MYWO), as a key element of a community-based approach aimed to raise awareness of the human rights and health implications of FGM, and to involve peer educators, teachers and religious and community leaders in mobilizing for social change. The alternative rite of passage was built on an existing one which is common for girls in some ethnic groups in Kenya where FGM is part of a process to mark a girl's coming of age and prepare her for marriage. The alternative rite of passage promotes positive aspects of culture and passing on of traditional wisdom while educating girls about sexuality, HIV/AIDS, relationships and family life. It culminates in a celebration of the girl's altered social status as a young woman. For girls and their families who have decided to abandon FGM, the programme provides social support to offset the stigmatization that commonly occurs with those who don't follow conventional norms.



Multi Media campaigns

In relation to FMG, media campaigns often play an important part in helping to change social norms and promote dialogue, but they are always more effective when they are part of a wider campaign to change attitudes and behaviours. It is extremely important that value-neutral non-judgemental language, which is simple and straightforward, is used to discuss FGM. This applies both within media campaigns and in community-based programmes aimed at raising awareness and educating people about the issue.

IEC stands for Information, Education, Communication and is very common in first generation programmes aimed at raising the veil that hides the practice, stimulating an open debate in society and promoting a different behaviour on the basis of new information made available. There are a number of studies comparing the production of posters, brochures, leaflets, stickers, and coloured tables to encourage debate and anatomy models, which analyse the messages, graphic design and contents. On the basis of this analysis, WHO lists the most common messages, including the following:

- FGM has a negative effect on the health of women and girls
- FGM is a harmful practice
- Use of the same knife can facilitate contagion with HIV/AIDS
- FGM violates the rights of women and girls
- FGM is not required by Islam
- A non-excised girl is a good wife
- FGM does not prevent sexual promiscuity
- FGM reduces female sexual pleasure
- FGM is contrary to Christian teaching
- Since the age when excision is practiced is constantly lowered, FGM can no longer be considered a rite of passage into adulthood

Involvement of religious leaders

This is an essential element of local programmes, as the conviction that FGM is a religious obligation is widespread. It is therefore not enough to state that neither the Quran nor the Bible requires FGM. They have to be the first ones to abandon the practice (in the case of Imams or Protestant ministers with daughters) and must not tolerate further diffusion among their congregations. For that reason, they need the proper theological knowledge to motivate their own choices, answer questions and doubts, support the individual decisions to abandon the practice made by isolated families and guide the entire community towards a future without FGM.

Intergenerational dialogue

Another approach to support the abandonment of FGM has been encouraging dialogue between older and younger generations within communities where FGM practices are prevalent. Since FGM is so embedded in the culture and tradition of a local community, it is therefore passed on from generation to generation. Intergenerational dialogue is therefore an important way for the younger generation to share its own ideas and opinions with the older generation. Through facilitated dialogue, a new consensus about traditional practices can be reached. This approach has been used in Mali, Kenya and Guinea by the German development agency GIZ.



Positive deviance

This is the name given to an approach that underwent systematic experimentation in Egypt by the Center for Development and Population Activities (CEDPA), but is actually an integral part of all those programmes that intervene at village level, first engaging a few individuals who, once won over by the cause, promote a change in behaviour within their communities, for whom they become a model of behaviour. The experiment in Egypt was aimed first of all at identifying people who had already abandoned the practice, the “positive deviant”. Their motivation, the process followed to reach the decision, the way they resisted community pressure and stuck to the choices made were then the subject of an in-depth qualitative study that revealed the strategies for abandonment developed within the cultural context. Later awareness raising activities within the community were developed in accordance with the study result. The second phase of the project identified girls at risk (at the age for FGM intervention). The positive deviants formed small groups and contacted the families of the girls at risk, gained their trust and gradually induced them to reconsider their decisions regarding FGM. The challenge is to preserve this status at least until the girl is married: if the husband does not insist that she be excised/infibulated before marriage, it is rare for the practice to be carried out afterwards.

Empowering women to transform social norms

It is widely understood that FGM is above all a social norm and therefore requires a deep understanding of the reasons for the continued existence of the practice. In communities that continue to practice FGM, people emphasise a wide range of social factors that influence this social norm including religious and cultural factors, controlling female sexuality and marriage, and notions of health and hygiene. It has been shown that there are key decision makers – within the family but also within the wider community – who have an influence over whether a girl receives FGM or not. Women play an important part in this process of decision making and it has been shown that educating and providing economic opportunities to women can have a significant impact on rates of FGM within communities. In other words, by empowering women, communities can be encouraged to abandon the practice.

Advocacy for improved policies and legislation

Many of the countries where FGM is still practiced have passed laws criminalising it. But there is nevertheless a gulf between the existence of laws and awareness of them at a community level. Once laws are passed at state level, efforts need to be made to raise awareness about these laws among the population, religious leaders, local government officials and the police.

Safe houses

One approach to FGM abandonment has been the use of safe houses for girls and women who want to escape being cut. In Kenya in particular, girls facing FGM ceremonies are given a safe place to live and go to school. This strategy is popular with broader gender-based violence programs, but could be problematic as it may merely remove the girl or woman from the situation rather than address the social norms and pressures driving the practice. It is important to look at the potential long-term implications of removing women and girls from their families and communities, in order to understand what happens to these women and girls once they are in the safe house, and what happens with their relationship with their families and communities.

Questions to guide the analysis and presentation of the approaches:

1. What kind of reasons does the selected approach address:
 - **Socio-cultural reasons:** if the approach addresses FGM as part of a girl's initiation into womanhood and/or as an intrinsic part of a community's cultural heritage;
 - **Religious reasons:** if the approach targets religious leaders and/or involves them as key actors;
 - **Socio-economic reasons:** If the approach addresses FGM as a question of empowerment of women and communities, changes in gender roles, and addresses the role of excisors (for instance their income);
2. Which key actors participating in the decision making process concerning FGM are involved in the selected approach?;
3. Could you list the success factors and/or weaknesses of the approach?

Activity 3.2: (1.5 hours)**Good practices and lessons learned from projects and programmes addressing FGM****Objective:**

Identifying good practices in current approaches and extract lessons applicable to programmes and projects addressing FGM.

Description:

The trainer will identify some good practices implemented by IOs as well as by NGOs, which deserve to be better analysed in order to extract general lessons learned for the design and implementation of project interventions. It is suggested to choose at least three good practices featuring different approaches, and which are relevant for the trainees. The suggested approaches to consider are the following:

- Community-based approaches;
- Migration and building bridges;
- Holistic programmes.

Step 1: (40 minutes)

The trainer will project some selected videos (or extracts of videos), and/or provide some brief project descriptions focusing on 3 good practices, which he/she intends to analyse deeply during the training. The trainees will be divided into different groups; each of these will focus on one specific good practice. A suggestion for the good practices to be analysed is provided below according to different typologies of interventions:

Community based approaches:

1. Tostan: Empowering Communities to Abandon Female Genital Cutting (2010)
<https://www.youtube.com/watch?v=JcX32btTU48>
2. Tostan: Tostan Declaration Ceremony to end FGM in Senegal (2015)
<https://www.youtube.com/watch?v=YsKz8EldhNw>
3. Fulda Mosoch project and the Value Centered approach (2013):
<https://www.youtube.com/watch?v=3pQ3AJNhWcc>

Community and building bridges approaches

1. Equipop: "Protecting the next generation"
Video "FSM The Roads to Abandonment" (2010)
<https://www.youtube.com/watch?v=QJfKLrRXWis>

Holistic Programmes:

1. Joint UNICEF – UNFPA Programme on Female Genital Mutilation
<https://www.youtube.com/watch?v=vcDXTt9eN9M>

Step 2: (20 minutes)

After the projection of the selected videos and/or the reading of the project descriptions, ask a rapporteur (spokesperson) of each working group to provide a summary of their analysis by following the guiding questions below.

Guiding questions:

What kind of approaches did you recognise in the videos?

Can you identify the activities implemented by the project?

What do you think the success factors are?

Can you identify any weaknesses?

Have you tested some similar approaches with your organization?

Step 3: (30 minutes)

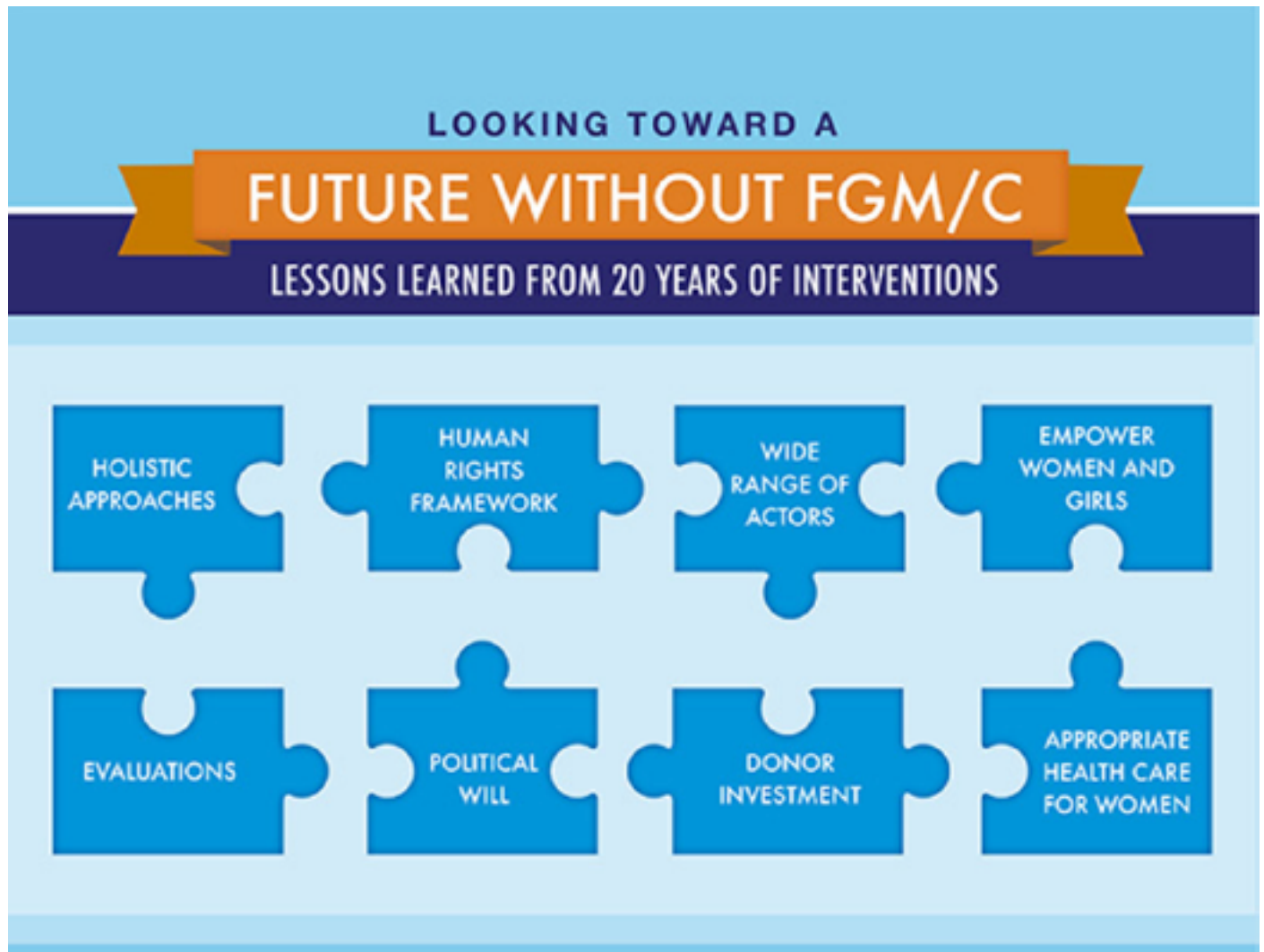
Through a group discussion extract lessons on the different approaches; which can be applicable to all kinds of interventions addressing FGM. You can facilitate the discussion by projecting the Handout n. 1 “Lessons from 20 years of intervention”.

Materials:

- Laptop;
- Projector;
- Internet connection;
- Notebook and pens;
- Flipcharts;
- Markers;
- Handout n. 1: “Lessons from 20 years of intervention” PRB.

Handout n.3.1:

Lessons from 20 years of intervention



Activity 3.3: Monitoring and evaluating projects and programmes addressing FGM

Objective:

Identify indicators for monitoring and evaluating projects with a focus on FGM.

Description:

This activity is linked to the previous one. The trainer will divide the participants into three groups (they can be the same group as per the previous activity), which will focus on three different approaches, for instance: 1. Community-based; 2. Advocacy and holistic programmes; 3. Community-based and Building Bridges.

Each group will have to develop a sample of specific activities for each typology of project and then identify indicators for monitoring (outputs) and evaluation (outcomes); including, if possible, different methodologies of measurement.

Finally, each group will present the results of the group work and a plenary discussion will follow, aimed at providing the groups with specific suggestions for the creation of appropriate indicators according to their kinds of projects.

Some examples of indicators, which may be considered according to different kinds of interventions, are as follows:

Education programmes:

- Number of girls completing education;

Community-led interventions:

- Number of families upholding the decision not to circumcise their girls;
- Number of young men stating to be ready to marry uncircumcised women;
- Increase in age at marriage of girls;
- Number of public declarations;
- Significant awareness of human rights;
- Significant increase in knowledge of

contraceptive methods;

- Significant decrease in women who think that FGM is necessary;
- Significant decrease in women who approve FGM;
- Significant increase in women who share information on FGM with others;
- Significant decrease in women who will cut their daughters in the future;
- Significant increase in discussion about FGM in involved communities;

Media campaigns:

- Media and articles published in the media;
- Radio programmes circulated within communities;
- Number of women/men and girls and boys reached by media campaigns;
-
- Advocacy for improved laws and legislations:
- Ratification of new laws addressing FGM;
- Number of policies that actively support the elimination of FGM;
- Number of countries implementing a comprehensive legal and policy framework to address FGM;
- Increased resources of national governments to implement policies and legislation to eliminate FGM;.

Training of health professionals:

- Could name any type of FGM/C;
- Could name at least three types of long-term FGM/C complications ;
- Wished to play a role in educating the population who visited their health facilities about FGM;
- Number of health personnel involved in training focusing on FGM complications;.

Treatment and care of women and girls who have undergone mutilation:

- Perception of improved health conditions of women and girls within involved communities;
- Number of women who have been assisted by

health professionals;

- Increased access to health services by women and girls of affected communities.

Building Bridges:

- Number of migrant associations involved;
- Number of awareness raising events addressing FGM prevention organised by migrant associations;
- Number of migrants who have been exposed to FGM awareness raising activities implemented in their countries of origin;
- Number of migrants who have interacted with their families and community members involved in FGM programmes through other means.

ANNEXE 1

IMPROVE YOUR PROJECTS AND PROGRAMMES

Objective:

This transversal activity is aimed at improving participants' currently ongoing programmes and projects which focus on FGM and /or which focus on other development sectors but may include an FGM component. It is a transversal activity to be proposed during the 3 days of training in order to facilitate discussion amongst the trainees on their currently implemented projects and to generate improvements and/or adoption of new strategies and tools.

Description:

Introduce this transversal activity to the trainees and guide them in the selection of one currently implemented project focusing on FGM. If the trainees' organizations are not currently working on FGM, the trainers will facilitate the trainees in the selection of one currently ongoing project which may include an FGM component in the future.

Step 1:

Presentation of your ongoing projects

The trainer will ask the trainees to identify one ongoing project and then will give twenty minutes for individual work aimed at preparing a concise presentation of the selected project. The presentation should include the following: name of the project, country of implementation, context, target groups, activities implemented, actors involved, outputs and outcomes, M&E indicators.

Step 2:

Develop your projects and programmes

The trainer will ask the trainees to work individually to organize new ideas and approaches, which can be applied by the trainees' organizations in order to improve and/or include an FGM component in their projects. After the individual work, a plenary discussion will follow in order to share ideas and inputs for the improvement of ongoing projects and/or the design of new interventions focusing on FGM. In the final discussion, trainees should focus on: new learning acquired; approaches and tools which may be adopted by their organizations in order to facilitate the abandonment of the FGM practice; synergies and partnerships amongst participants and the organisations they are working for.

Materials:

- Flipcharts;
- Markers;
- Adhesive tape.

ANNEXE 2

INTERNATIONAL AND REGIONAL INSTRUMENTS

International instruments

International legal frameworks which deal either directly or indirectly with the issue of FGM include:

- The Universal Declaration of Human Rights, 1948
- The Convention relating to the Status of Refugees, 1951
- The International Covenants on Civil and Political Rights and on Economic, Social and Cultural Rights, 1966
- The Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), 1979
- The Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, 1984
- The Convention on the Rights of the Child, 1989
- The Vienna Declaration and the Programme of Action of the World Conference on Human Rights, 1993
- The Programme of Action of the International Conference on Population and Development (ICPD), 1994
- The Platform for Action of the Fourth World Conference on Women, 1995
- Key Actions for the Further Implementation of the Programme of Action of the International Conference on Population and Development, 1999
- Further Actions and Initiatives to Implement the Beijing Declaration and Platform for Action, 2000
- Commission on the Status of Women Resolution on ending FGM, 2007
- Commission of the Status of Women Resolution 54/7 on ending FGM, 2010
- The Fifty-sixth session of the Commission on the Status of Women draft decision, "Ending female genital mutilation." (E/CN.6/2012/L.1), 2011
- UN. Report of the Secretary-General "Ending Female Genital Mutilation", 2011
- World Health Assembly Resolution WHA61.16 and Progress Report 2011 (A64/26), 2011
- Beijing Declaration and Platform for Action of the Fourth World Conference on Women, 1995
- UN Convention relating to the Status of Refugees and its Protocol relating to the Status of Refugees (1967)
- UN General Assembly (UNGA) Declaration on the Elimination of Violence against Women, 1993
- UN General Assembly (UNGA) Resolution on intensifying global efforts for the elimination of female genital mutilations, 2012
- UN General Assembly (UNGA)
- The Human Rights Council Resolution "Intensifying global efforts and sharing good practices to effectively eliminate female genital mutilation." 2014

Regional instruments

Other regional legal and political instruments that directly or indirectly address the issue of FGM are:

- African Charter on the Rights and Welfare of the Child, 1990 <http://tinyurl.com/hcprmyr>
- Inter-American Convention on the Prevention, Punishment and Eradication of Violence against Women (Convention of Belem do Para), 1994 <http://tinyurl.com/jyx8f5j>
- The Banjul Declaration on violence against women, 1998 <http://tinyurl.com/j4t48fk>
- The Ouagadougou Declaration of the Regional Workshop on the Fight against Female Genital Mutilation, 1999

- Charter of Fundamental Rights of the European Union, 2000
<http://tinyurl.com/367mr2>
- The Protocol to the African Charter on Human and Peoples' rights, on the rights of women in Africa (Maputo Protocol), 2003
<http://www.achpr.org/instruments/women-protocol/>
- Council of Europe Convention on preventing and combating violence against women and domestic violence (Istanbul Convention), 2011
<http://tinyurl.com/z7newx7>
- African Union Assembly/AU/Dec. 383(XVII) decision, 2011
<http://tinyurl.com/hmajl64>
- European Parliament Resolution of 14 June 2012 on ending female genital Mutilation <http://tinyurl.com/jqvhjqp>
- The Addis Ababa Declaration on Violence against Women 2013
<http://tinyurl.com/z8c2s3s>

ANNEX 3

INFOGRAPHIC SOCIAL NORM



ANNEX 4

EXAMPLES OF TRAINING AGENDAS

Agenda 1:

Training of trainers "Addressing Female Genital Mutilation in development projects and programmes"

organized by AIDOS with the participation of European Members of the End FGM European Network, 22nd - 24th July 2015

Day 1			
Time	Module	Activities	Contents and objectives
09.00 – 10.30	INTRODUCTION	Welcoming to the training course (10 minutes)	Welcoming speech
		ACTIVITY 1. Getting to know the issue and each other (20 minutes)	To get participants comfortable and create a relaxed atmosphere
		ACTIVITY 2. Participants and trainers' presentations and expectations (40 minutes)	Introduce participants and trainers and give the opportunity to raise participants' and trainers' expectations about the course
		ACTIVITY 3. General presentation of the course (20 minutes)	Introduce the objectives of the course, the agenda, the modules and the manual
10.30 – 11.00	Coffee break		
11.00 – 12.00	MODULE 1	ACTIVITY 1. Introduction to FGM	Introduce what, how, why and where FGM through video projection and guided discussion.
12.00 – 13.00	MODULE 1	ACTIVITY 2. Myths and realities behind the practice	Explore the broad range of reasons for the persistency of FGM
13.00 – 14.00	Lunch		
14.00 – 15.00	MODULE 1	ACTIVITY 3. Is FGM a women's issue?	Understand the complexity of FGM and why women continue the practice
15.00 – 15.15	Coffee break		
15.15 – 16.45	Improve your projects and programmes	State of art of your organization	Presentation about current projects focusing on FGM and/or other projects which may include an FGM component
16.45 – 17.00	Conclusion	Wrap up of the day	Summarize main contents of the day.

Day 2			
Time	Module	Activities	Contents and objectives
09.00 – 10.00	MODULE 2	ACTIVITY 1: Differentiating between sex & gender	Understanding differences between sex and gender, and recognise that norms can be changed
10.00 – 10.40	MODULE 2	ACTIVITY 2: Division of labour	Identify the different role that men and women play and identify the different values associated with these roles.
10.40 – 11.00	Coffee break		
11.00 – 11.40	MODULE 2	ACTIVITY 3. Role play: access and control over resources	Describe the range of resources people use Identify the different impacts of having access to a resource as opposed to control over resources
11.40 – 12.20	MODULE 2	ACTIVITY 4: FGM, Power and Empowerment	Brainstorm about the different meanings of empowerment and discuss how FGM is related to the concepts of power and empowerment.
12.20 – 13.00	MODULE 2	ACTIVITY 5: Women's empowerment and community consensus inputs	Understand the relation between FGM, social change and women's empowerment
13.00 – 14.0	Lunch		
14.00 – 15.15	MODULE 3	ACTIVITY 1: Review of past and present approaches	Obtain an overview of different approaches for prevention and abandonment of FGM and identify positive and negative aspects of those approaches
15.15 – 15.30	Coffee break		
15.30 – 16.45	Improve your projects and programmes	SWOT Analysis of your programmes	Identify main strengths, weakness, opportunities and threats of participants' projects
16.45 – 17.00	Conclusion	Wrap up of the day	To summarize main contents of the day
Day 3			
Time	Module	Activities	Contents and objectives
09.00 – 10.30	MODULE 3	ACTIVITY 2: Good practices and lessons learned from projects and programmes addressing FGM	Identifying good practices in current approaches and extract lessons applicable to programmes and projects addressing FGM
10.30 – 11.00	Coffee break		
11.00 – 13.00	Improve your projects	Develop your programme	Improve your project intervention focusing on FGM and/or address FGM in development projects which have other focus of intervention

13.00 – 14.0		Lunch	
14.00 – 15.45	Improve your projects	Present your programme	Briefly present your project to the rest of the group and receive their feedbacks
15.45 - 16.00		Coffee break	
16.00 – 17.00	Conclusion and evaluation of the course		Evaluate the training course and conclude the training course by providing inputs for the next implementations

Agenda 2:

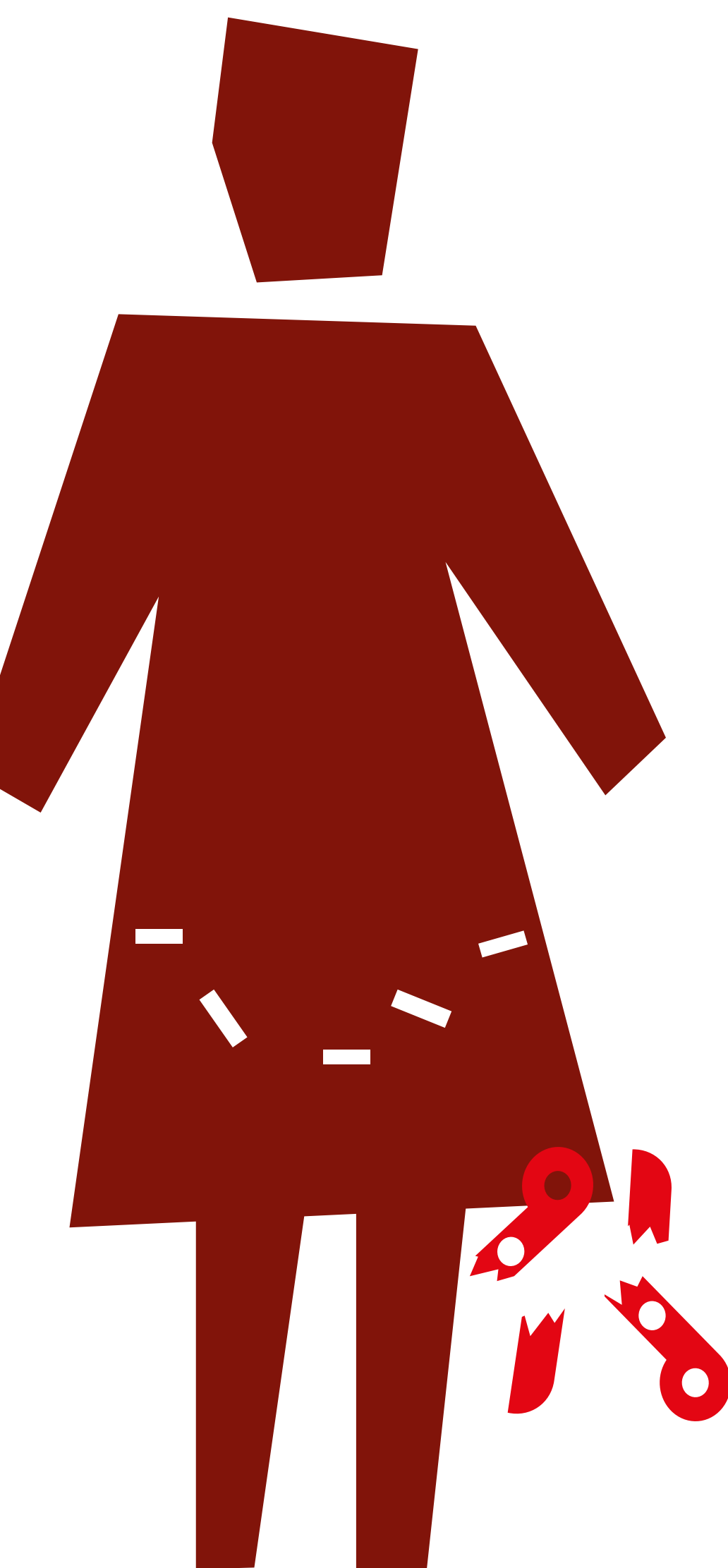
“Addressing Female Genital Mutilation in development projects and programmes”

with the participation of Italian Civil Societies Organizations and Local authorities, organized by AIDOS, 11th – 13th of November 2015

Day 1			
Time	Module	Activities	Contents and objectives
09.00 – 10.30		Registration	
09.00 – 10.30	INTRODUCTION	Welcoming to the training course (10 minutes)	Welcoming speech
		ACTIVITY 1. Getting to know the issue and each other (20 minutes)	To get participants comfortable and create a relaxed atmosphere
			To get participants comfortable and create a relaxed atmosphere
11.00 - 11.30		Coffee break	
11.30 - 12.45	MODULE 1	ACTIVITY 1. Introduction to MGF	“FGM: what where and how many?, video projection and guided discussion”
12.45 - 13.45		Lunch	
13.45 - 14.45	MODULE 1	ACTIVITY 2: The reasons behind the practice and the consequences on the health of women	Analyse the reasons and through video projection and guided discussion
14.45 - 15.30	MODULE 1	ACTIVITY 3. Understanding the reasons for and consequences of the practice through the life stories of migrant women dealing with FGM	Analyse the reasons and consequences of FGM in a migration context
15.30 - 16.00		Coffee break	
16.00 - 17.00	MODULE 1	ACTIVITY 4. Myths and realities behind the practice: the social norm theory	Explore the broad range of reasons for the persistency of FGM and introducing the social norm theory
17.00 - 17.45	Improve your projects and programmes	Presentation of participant’s on-going projects	Working group: Presentation about current projects of participants’ organizations focusing on FGM and/or other projects which may include an FGM component

Day 2			
Time	Module	Activities	Contents and objectives
09.00 - 09.45	MODULE 2	ACTIVITY 1: Differentiating between sex & gender	Understanding differences between sex and gender, and recognise that norms can be changed
09.45 - 10.45	MODULE 2	ACTIVITY 2. MGF & Gender: Is FGM a women's issue?	Understand the complexity of FGM and why women continue the practice
10.45 - 11.15	Coffee break		
11.15-11.45	MODULE 2	ACTIVITY 3: FGM, Power and Empowerment	Brainstorm about the different meanings of empowerment and discuss how FGM is related to the concepts of power and empowerment.
11.45 - 12.45	MODULE 2	ACTIVITY 4: Women's empowerment and community consensus inputs	Understand the relation between FGM, social change and women's empowerment: the 4 hypothesis (N. Toubia)
12.45 -13.45	Lunch		
13.45 -14.30	MODULE 3	ACTIVITY 1. MGF and development	Introduce and contextualize MFG as a development issue
14.30 - 15.45	MODULE 3	ACTIVITY 2: Review of past and present approaches including programmes across Europe and Africa (Building Bridges)	Obtain an overview of different approaches for prevention and abandonment of FGM and identify positive and negative aspects of those approaches
15.45 -16.15	Coffee break		
16.15 - 17.30	MODULE 3	ACTIVITY 3: Good practices and lessons learned from projects and programmes addressing FGM	Identifying good practices in current approaches and extract lessons applicable to programmes and projects addressing FGM

Day 3			
Time	Module	Activities	Contents and objectives
9.00 - 9.45	MODULE 3	ACTIVITY 4: Monitoring and evaluation of projects and programmes addressing FGM	Group work: Identify indicators for monitoring and evaluating projects with a focus on FGM
9.45 - 10.30	Improve your projects	Develop your programme	Group work: How to improve participants' project interventions focusing on FGM and/or how to include an FGM component in other development projects which are not focusing on FGM
10.30 – 11.00	Coffee break		
11.00 - 12.30	Conclusion	Final discussion and evaluation	Final Q&A session to clarify any issues as requested by participants and evaluation of the course



PARTNERS



COORDINATOR



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