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ENDING FEMALE GENITAL MUTILATION/CUTTING

LESSONS FROM A DECADE OF PROGRESS

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This scan of the last decade is dedicated to the memory of Dr. Marjorie Horn, who established the program of support to research and awareness-raising about female genital mutilation/cutting at USAID and was tireless in her commitment to eradication of the practice.

We must also recognize the courageous First Ladies of Africa and all the delegates who met on Feb. 6, 2003, in Addis Ababa to declare a day of Zero Tolerance to FGM.

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Executive Summary

Over the last 20 years, significant efforts have been made at the community, national, and international levels to address the issue of female genital mutilation/cutting (FGM/C). Numerous international and national policy statements have called for an end to FGM/C, which has been recognized as a violation of girls' and women's human rights and an obstacle to gender equality. Program planners have implemented countless interventions to educate and empower communities to abandon the practice. Researchers have conducted important studies and evaluations that have contributed to a better understanding of the prevalence of the practice and the types of procedures carried out, as well as the reasons communities continue to practice it. Research and experience have begun to lift the veil on the intended and unintended impacts of many of the strategies undertaken over the years.

In the first decade of this century progress has been made toward abandonment. Studies have looked at the physical, emotional, and mental impacts of FGM/C. Research has deepened our understanding of the diverse reasons for the continuation of the practice, providing a framework for theories about the origins and social dynamics that lead to its perpetuation. Reflecting the work of dedicated advocates, today most practicing countries have passed laws banning the practice, and prevalence is beginning to decline in some countries.

In September 2000, USAID officially incorporated elimination of FGM/C into its development agenda and created the official U.S. government policy toward FGM/C.

In 2002, the Donors Working Group on Female Genital Mutilation/Cutting formed to convene key international actors, including representatives of UN agencies, European donors, private funders, and USAID.

In February 2003, the Inter-African Committee (IAC) on Traditional Practices Affecting the Health of Women and Children held its landmark conference in Addis Ababa, Ethiopia. Many first ladies of Africa, led by the first lady of Nigeria, officially declared "Zero Tolerance to FGM" to be commemorated every year on Feb. 6. Drawing from this energy, UNICEF's Innocenti Research Centre organized a consultation in 2004, resulting in a seminal publication, *Changing A Harmful Social Convention: Female Genital Mutilation/Cutting*.

In 2008, the Donors Working Group produced *A Platform for Action Toward the Abandonment of FGM/C*. That same year UNFPA and UNICEF formed a strategic partnership

known as the UNFPA-UNICEF Joint Programme on FGM/C's "Accelerating Change." They have been working together, in headquarters and field offices, to develop, fund, and implement policies and programs to accelerate abandonment of FGM/C. The results of this program should inform the work of programs and governments for years to come.

In 2012, the 67th session of the United Nation's General Assembly passed a wide-reaching resolution urging states to condemn all harmful practices that affect women and girls, in particular female genital mutilation, giving the work during this decade a powerful boost forward.

As stated by Berhane Ras-Work, founding president of the IAC and one of 12 experts on FGM/C who were interviewed for this report, "The future is bright. Success has been premised on strengthening conviction, not on using force."

Our vision of the way forward has been sharpened by all the work that has been conducted over the years. As we have now passed a dozen anniversaries of Zero Tolerance Day, it is an opportune time to reflect and build on three key maxims that stand strong:

- First, the centrality of social norms—what communities believe and how they act and expect the members of that community to act—must be addressed.
- Second, a wide range of actors play pivotal roles in the abandonment of FGM/C—men, women, grandmothers, boys, girls, and community, religious, and political leaders.
- Third, not every approach will work in every place, every village, every tribe. But if the approach is too narrow and siloed it will not work anywhere. The focus must be on holistic, integrated, multisectoral approaches that bring together the advocacy, policy-level work, and community-level transformation of social norms.

In the next decade those seeking the end of FGM/C will have to meet some of the same challenges not addressed in the last decade, including:

- Wider support from donors, including recipient governments and organizations.
- Better evaluation of approaches that have been used to date.
- A closer look at how decisionmaking around FGM/C occurs.
- Commitments from the wider gender community to embrace FGM/C as an issue needing attention.
- Responsible health care for women who have been cut.

Introduction

"It is my hope that we can see the abolition of [female genital mutilation/cutting] even sooner than within a generation, but no later than within a generation, and that we also do everything we can to create conditions for every child, girl, and boy, to have the chance to live up to his or her... potential."

—Secretary of State Hillary Clinton, Feb. 16, 2012

In February 2012, at the first-ever Zero Tolerance Day held at the U.S. Department of State, organized by USAID and the State Department, Secretary Clinton spoke passionately about creating conditions for ending female genital mutilation/cutting (FGM/C) so that every child could realize his or her full potential. Advocates must work in the next decade to achieve this goal, and to learn from the years of work of governments, organizations, and brave individuals and communities.

This report is a scan of the last decade—not as an academic exercise but as a means to clarify the lessons and insights learned since 2000 from efforts to end this harmful traditional practice. By looking back, policymakers and advocates will be better able to move forward decisively to create the conditions necessary to allow women and girls around the world to achieve their full potential.

Berhane Ras-Work, founder of the Inter-African Committee (IAC) on Traditional Practices and one of 12 experts interviewed for this report reflected, "The future is bright." She asserted that the taboo around speaking of FGM/C has been broken, and many political and religious leaders around the world have publicly denounced the practice, "Success has been premised on strengthening conviction, not on using force."

A STORY OF PROGRESS AND PARTNERS

Over the last 20 years, significant efforts at the community, national, and international level have addressed the issue of FGM/C. Numerous international and national policy statements have called for an end to FGM/C, which has been recognized as a violation of girls' and women's human rights and an obstacle to gender equality.¹ Program planners have implemented countless interventions to educate and convince communities to abandon the practice. Researchers have conducted important studies and evaluations to enable better understanding of the prevalence of the practice and the types of procedures carried out, as well as the reasons communities continue to practice it. The veil has been lifted on the intended and unintended impacts of many of the strategies that have been undertaken over the years. The lessons learned are shaping programming and community efforts to end the practice. Yet, even with these investments, maintaining global commitment to the issue and gathering evidence on successful approaches to abandonment remains a challenge.

In the first decade of this century in particular progress has been made toward abandonment. Studies have increased our understanding of the physical, emotional, and mental impacts of FGM/C—studies that have helped advocates to advance the case for abandonment. Research has deepened our understanding of the diverse reasons for the continuation of the practice, providing a framework for theories about the origins and social dynamics that lead to its perpetuation. Reflecting the work of dedicated advocates, today most practicing countries have passed laws banning the practice and prevalence is beginning to decline in some countries. Yet all this progress could still be lost if commitments and resources are not continued.

Interventions, research, and thoughtful consultations by many NGOs, funders, and bilateral and multilateral agencies have moved the field forward. Several partners—USAID, the Department for International Development of the United Kingdom (DFID), the Norwegian Agency for Development Cooperation (NORAD), the World Health Organization (WHO), the United Nations Population Fund (UNFPA), and the United Nations Children's Fund (UNICEF)—have been especially visible in this decade, as well as several European and American donors. The IAC, the Gambian Committee on Traditional Practices (GAMCOTRAP), and the Tanzanian Media Women's Association (TAMWA) are a few of the African networks and organizations on the front lines.

In September 2000, USAID officially incorporated elimination of FGM/C into its development agenda. In 2001, USAID funded the Population Reference Bureau (PRB) and PATH to produce the report, *Abandoning Female Genital Cutting: Prevalence, Attitudes, and Efforts to End the Practice*, which presented an overview of the data on prevalence and practice, as well as interventions showing promise and initial success.²

In 2005, the FGM/C Interagency Working Group for USAID commissioned a five-partner report to conduct an in-depth review of interventions around the world addressing FGM/C. The Working Group recognized that a review of evaluated promising approaches to abandonment was needed to move efforts forward. As a result, *Abandoning Female Genital Mutilation/Cutting: An In-depth Look at Promising Practices*, was published after a year of analyses of global FGM/C interventions and responses to a questionnaire distributed in 20 countries. The authors identified three promising interventions in three different countries: The Navrongo FGM Experiment in Ghana, The IntraHealth International Five-Dimensional Approach for the Eradication of FGC in Ethiopia, and the Tostan Community Empowerment Program in Senegal. The publication also identified other approaches that warranted follow up.³

At the same time, many other donors were actively searching for answers: Where was FGM/C occurring, at what rates, and most important, what lessons could be learned about effective approaches in ending the practice? In 2002,

BOX 1

The Innocenti Research Centre (IRC)

The Innocenti Research Centre (IRC), the dedicated research arm of UNICEF, has played a key role over the past two decades in strengthening evidence on issues pertaining to child rights and child protection.

Its 2005 publication, *Changing a Harmful Social Convention: Female Genital Mutilation/Cutting*, highlighted Demographic and Health Surveys (DHS) and Multiple Indicator Cluster Survey (MICS) data, and addressed the complex social dynamics underlying the continued practice of FGM/C and the elements necessary for its abandonment. Building on this work, IRC continues to undertake research to:

- Deepen understanding of the social dynamics around harmful practices (FGM/C, child marriage, and marriage by abduction).
- Develop strategies for galvanizing positive social change.
- Influence policies and programs to abandon the practice.

Given that many of these practices are rooted in gender-inequitable norms, the research also emphasizes strategies for promoting gender equality.

The 2010 publication, *The Dynamics of Social Change: Towards the Abandonment of FGM/C in Five African Countries*, analyzes the experiences in Egypt, Ethiopia, Kenya, Senegal, and Sudan. It highlights promising approaches to support social change and how these strategies are being implemented in different cultural

contexts. The experiences focus on addressing the complex social dynamics associated with the practice and challenging established gender relationships, existing assumptions, and stereotypes. Rather than presenting local culture and traditional behaviors as negative, IRC points out that effective programs propose alternative ways to signal adherence to shared community values and to frame the discussion in a nonjudgmental way.

IRC collaborates closely with UN agencies, including the UNICEF Child Protection Section, Statistics and Monitoring Section, and Regional and Country Offices, and with local development and academic partners. The research has contributed to a systemic approach to stimulate and support large-scale social transformation that benefits children and women reflected in UN policy documents and policy documents of development partners.

Note: Relevant UN policy documents include: *Technical Note: Coordinated Strategy to Abandon Female Genital Mutilation/Cutting in One Generation* (New York: UNICEF, 2007), accessed at www.fgm-cdonor.org/publications/dwg_platform_action.pdf, on Dec. 5, 2013; UNAIDS, UNDP, UNECA, UNESCO, UNFPA, UNHCHR, UNHCR, UNICEF, UNIFEM, WHO, *Eliminating Female Genital Mutilation: Interagency Statement* (Geneva: World Health Organization, 2008), accessed at www.un.org/womenwatch/daw/csw/csw52/statements_missions/Interagency_Statement_on_Eliminating_FGM.pdf, on Dec. 5, 2013; and *Report of the Secretary General on the Girl Child* (New York: UN General Assembly, 2009), accessed at www.crin.org/docs/GIRLREPORT.pdf, on Dec. 5, 2013.

Source: "UNICEF Office of Research," accessed at www.unicef-irc.org/, on Dec. 9, 2013.

the Donors Working Group on Female Genital Mutilation/Cutting was formed to convene key international actors, including representatives of UN agencies, European donors, private funders, and USAID. By 2008, the Donors Working Group would produce *A Platform for Action Towards the Abandonment of FGM/C*.⁴

But 2003 yielded perhaps the most significant breakthrough in making FGM/C a highly visible global concern. In February 2003, the IAC held a conference in Addis Ababa, Ethiopia. At this conference, many first ladies of Africa, led by the first lady of Nigeria, Mrs. Stella Obasanjo, officially declared "Zero Tolerance to FGM" to be commemorated every year on Feb. 6. Since then, this day has been observed around the world. Drawing from this energy, UNICEF's Innocenti Research Centre organized a consultation in 2004 and published a seminal publication, *Changing A Harmful Social Convention: Female Genital Mutilation/Cutting*, that examined where and why FGM/C occurred, as well as some of the actions to date in combating the practice (see Box 1).

Following the 2004 consultation, UNICEF published several landmark publications, including:

- *Female Genital Mutilation/Cutting: A Statistical Exploration* (2005).
- *Coordinated Strategy to Abandon FGM/C in One Generation* (2007).
- *The Dynamics of Social Change: Towards the Abandonment of FGM/C in Five African Countries* (2010).

In 2006, WHO published a report on the health impacts of FGM/C, an important milestone for convincing governments and individuals that this practice seriously affects the health of women and children.

In 2008, UNFPA and UNICEF formed a strategic partnership known as the UNFPA-UNICEF Joint Programme on FGM/C's "Accelerating Change." They have been working together, in headquarters and field offices, to develop, fund, and implement policies and programs to accelerate abandonment

BOX 2

Classification of FGM/C

Complete typology with subdivisions:

Type I. Partial or total removal of the clitoris and/or the prepuce (clitoridectomy). When it is important to distinguish between the major variations of Type I mutilation, the following subdivisions are proposed:

- **Type Ia.** Removal of the clitoral hood or prepuce only.
- **Type Ib.** Removal of the clitoris with the prepuce.

Type II. Partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (excision). When it is important to distinguish between the major variations of Type II, the following subdivisions are proposed:

- **Type IIa.** Removal of the labia minora only.
- **Type IIb.** Partial or total removal of the clitoris and the labia minora.
- **Type IIc.** Partial or total removal of the clitoris, the labia minora, and the labia majora.

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

- **Type IIIa.** Removal and apposition of the labia minora.
- **Type IIIb.** Removal and apposition of the labia majora.

Type IV. All other harmful procedures to the female genitalia for nonmedical purposes, for example, pricking, piercing, incising, scraping, and cauterization.

Note: In French, the term “excision” is often used as a general term covering all types of female genital mutilation; in 2008, WHO slightly revised its classification system noting that ambiguities had arisen since it was first developed in 1995. The revised version attempts to address these shortcomings and includes subdivisions to better capture the variety of procedures.

Source: UNAIDS, UNDP, UNECA, UNESCO, UNFPA, UNHCHR, UNHCR, UNICEF, UNIFEM, WHO, *Eliminating Female Genital Mutilation: Interagency Statement* (Geneva: World Health Organization, 2008).

of FGM/C. The results of this program should inform the work of programs and governments for years to come.

METHODOLOGY

Much of USAID’s work over the last decade has focused on Egypt, Kenya, Ethiopia, Eritrea, Mali, and Senegal. USAID has funded Demographic and Health Surveys (DHS) data collection in FGM/C-practicing countries, as well as the PRB-produced wallcharts on FGM/C in 2008 and 2010.

This report includes a desk review of evaluations, studies, systematic reviews, and donor and project reports since 2000. Web searches included key sites focusing on FGM/C.⁵

Key informant interviews were conducted with a dozen recognized experts in the field, including researchers and representatives of donor organizations active in FGM/C abandonment efforts over the last decade (see Appendices A and B). Interviewees were asked for their views on specific programmatic experience and approaches, and recommendations on where priority attention and resources were most needed. The semistructured interviews focused on promising strategies and approaches, as well as lessons regarding less effective (or ineffective) strategies for addressing FGM/C, gaps in data and programming, and recommendations for strengthening the field.

This review is not exhaustive, but will focus on a few of the key successful approaches and interventions that have had a significant impact on abandonment, identified with guidance from the experts interviewed. This report pulls together the lessons learned from the last decade and crafts a roadmap for how to strengthen programs moving forward.

Defining FGM/C: What and Where

NATURE OF THE PRACTICE

The WHO definition of FGM/C has generally been accepted as the standard. It defines FGM/C as “all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for nonmedical reasons” (see Box 2).⁶ Estimates propose that 100 million to 140 million girls and women worldwide have undergone FGM/C and more than 3 million girls in Africa alone are at risk for cutting each year.⁷ In the past, the practice was commonly thought to occur in some 28 African countries, with a brief mention of Asia and the Middle East. In recent years, the practice has been identified in a wider range of countries, including Indonesia, Iraq, India, and Pakistan.

Attention has been focused on the continuation of the practice among immigrant communities throughout Europe,

BOX 3

Data Collection on FGM/C

The standard approach to estimating prevalence of FGM/C was developed by the Demographic and Health Surveys (DHS) of ICF International (formerly ORC Macro). Using a special module on FGM/C, it has collected data on FGM/C from adult women ages 15 to 49 since 1989, yielding nationally representative estimates of FGM/C in surveyed countries. UNICEF, through its Multiple Indicator Cluster Surveys (MICS), has used a similar module to collect information in selected countries since 2000. Recently, the FGM/C questionnaire used in DHS modules has been changed to ask about the experiences of all daughters.

the United States, Australia, and Canada, although data on the practice in these communities have been difficult to obtain. In the last few years, pressure has intensified in Europe to end the practice among immigrant communities.

The age at which girls are cut is extremely important. In some cultures girls are cut as early as a few days after birth, and in others just prior to marriage. Many experts believe that the age of cutting has gotten increasingly younger in efforts to evade laws and criminal sentences. Generally, it is performed on girls between 4 and 12 years old. In the past, the procedure had typically been carried out by traditional excisors; however, in some countries development experts have been dismayed to see emergence of medicalization, whereby medical professionals are performing the procedure in the name of harm reduction.⁸

A major focus of study has been the religious underpinnings of the practice and the question of whether FGM/C is required by any religion. In fact, a chief motivation for its perpetuation is the strongly held belief that it is mandated by Islam. This mandate has been actively challenged; many Islamic scholars publicly assert that it is not found in Islamic doctrine.⁹

Over the past decade many policy statements have been issued against FGM/C. The United Nations has issued four resolutions condemning the practice, and in December 2012, the General Assembly passed a resolution calling on all countries to end it.¹⁰ As of December 2011, at least 25 countries had enacted laws or decrees criminalizing FGM/C (see Box 9, page 13). While these legal steps are important, many believe that implementation of these laws has been undermined by lack of awareness at the local level and lack of political will of governments to implement them. In a call to all policymakers to end FGM/C, the African Union Representative to the United States, the Honorable Amina Salum Ali, declared that in addition to legal measures,

“public education—raising awareness about its negative consequences—and the support of community leaders are vital in producing behavior change, and have been essential to the success of the campaign to end FGM/C.”¹¹

Important evidence confirms that FGM/C can pose serious physical and psychological health risks for girls and women who have been cut. A widely cited WHO study in 2006 revealed that FGM/C can be linked to increased complications in childbirth and even infant deaths.¹² Other possible side effects that women suffer include severe pain, hemorrhage, tetanus, infection, infertility, cysts, abscesses, urinary incontinence, and psychological and sexual problems. This evidence has helped advocates for ending FGM/C to further the case against the practice, but it has also raised some concerns that focusing only on health outcomes leaves out the gender inequality and human rights aspects of the practice.

PREVALENCE

A decrease in prevalence over the past decade has given hope to those working toward abandonment, although challenges remain in measuring impact in contexts where borders shift: This kind of change takes time. Data on the practice have been collected in 29 countries, mostly through DHS and MICS (see Box 3). Prevalence rates vary significantly across countries—from nearly 98 percent in Somalia to less than 2 percent in Uganda—and even across communities and regions within a country.

Over the last 10 years, a few countries have experienced a decline in overall prevalence (see Box 4, page 7). In addition, comparison of prevalence data between older and younger women in some countries further suggests the practice is being abandoned with younger generations.¹³ It is not all good news, however; in some countries, such as Somalia and Guinea-Bissau, no improvement in prevalence has been observed—although Somalia recently passed a provisional constitution that includes a ban on FGM/C that is hoped to affect that country’s high prevalence. New evidence is still emerging in communities where FGM/C was previously undocumented, such as Iraq.¹⁴

Summary of Findings

Broadly, experts interviewed reflected upon significant progress in strengthening understanding and galvanizing momentum around ending FGM/C over the past decade, in particular advocacy for improved policies and laws. They highlighted efforts aimed at engaging communities, including chiefs, religious leaders, and other community influencers, in support of women and girls’ rights. Many noted the critical need for continued attention to ending the practice of FGM/C, and for holistic, comprehensive approaches that integrate community-level awareness-raising and mobilization with advocacy and training efforts. Researchers and program implementers highlighted the need for additional, rigorous

Decline in Prevalence—Egypt, Kenya, and Sierra Leone

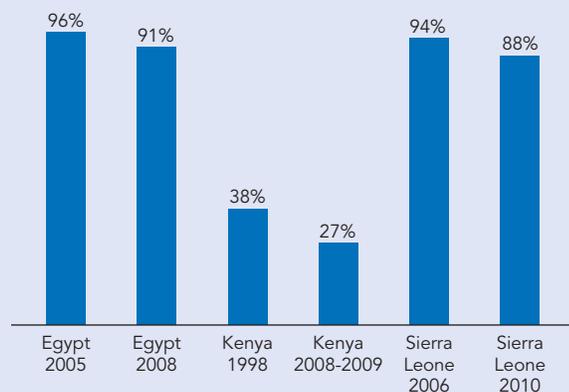
Egypt. The 2008 Egypt DHS for the first time captured the FGM/C status of all women ages 15 to 49 surveyed, compared to only ever-married women ages 15 to 49 in previous surveys, thus providing a more complete picture of FGM/C prevalence in the country. The data show that 91 percent of women surveyed in Egypt have been cut, a decrease in prevalence from 96 percent in the 2005 survey (see figure). The 2008 survey revealed that almost all girls are cut by the age of 15, slightly before or at puberty, and that more than three-quarters of girls ages 0 to 17 were cut by trained medical personnel. The survey asked mothers about all daughters under 18 years of age, capturing both their daughters' current FGM/C status and the mothers' intention to have their daughters cut. While 74 percent of daughters ages 15 to 17 have already been cut, only 45 percent of mothers of 0-to-3-year-olds intended to cut their daughters. This suggests a significant decline in the number of girls who will be cut over the next 15 years, based on mothers' stated intentions. In addition, women's attitudes toward the practice have changed significantly over the last 15 years. Women's support for the practice has decreased from 82 percent in 1995 to 54 percent in 2008.

Kenya. According to the 2008–2009 Kenya DHS, the overall prevalence of FGM/C has been decreasing. Twenty-seven percent of women ages 15 to 49 have undergone the procedure, a decline from 32 percent in 2003 and 38 percent in 1998. The survey revealed that older women are more likely to have undergone FGM/C than younger women, and that 80 percent of women do not see any benefits of circumcision—even among women who have been circumcised, 59 percent said they do not see any benefit. Eighty-two percent of women surveyed believe it should be stopped.

Sierra Leone. While ending FGM/C remains a huge challenge in Sierra Leone, where it is conducted in secret societies,

progress is seen when comparing the 2006 MICS survey to the 2010. In that time period, prevalence decreased from 94 percent to 88 percent among women ages 15 to 49. Among 15-to-19-year-olds, those numbers went from about 81 percent to 70 percent. MICS analysts conclude that real change will not come from passage of legislation in this country but “change will only come when individuals begin to collectively view the practice of FGM/C in a negative light and collectively decide to stop the practice.”

Decrease in Prevalence of FGM/C, Women Ages 15 to 49, Selected Countries



Sources: Charlotte Feldman-Jacobs and Donna Clifton, *Female Genital Mutilation/Cutting: Data and Trends Update 2014* (Washington, DC: Population Reference Bureau, 2014); Fatma El-Zanaty and Ann Way, *Egypt Demographic and Health Survey 2008* (Calverton, MD: Macro International, 2009); Kenya National Bureau of Statistics (KNBS) and ICF Macro, *Kenya Demographic and Health Surveys 2008-09* (Calverton, MD: KNBS and ICF Macro, 2010); and Statistics Sierra Leone and UNICEF-Sierra Leone, *Sierra Leone Multiple Indicator Cluster Survey 2010* (Freetown, Sierra Leone: Statistics Sierra Leone and UNICEF-Sierra Leone, 2011).

evaluations to inform FGM/C programming and the critical gap in information around the complex, nuanced, and multifaceted factors that underlie its continued practice.

LESSONS FROM THE EARLY YEARS

Some of the strategies and approaches thought in the early years to show promise have ultimately fallen short of the mark, but have yielded important lessons for moving forward.

Medicalization, for instance, was once seen by many stakeholders as a way to possibly lessen the health consequences of FGM/C. Likewise, addressing the economic repercussions of abandonment from the perspective of the excisors was an approach that seemed promising at one

point. Evaluations have shown that these strategies are not effective in ending the practice.

Medicalization

Anti-FGM/C campaigns focusing exclusively on the negative health consequences of the practice may have inadvertently bolstered the medicalization of the practice in some areas. Medicalization refers to the performance of FGM/C by health care providers, rather than traditional excisors, for the purpose of physical harm reduction. UN agencies and experts in the field of FGM/C abandonment have condemned the medicalization of FGM/C. Experts estimate that 18 percent of women who have been subjected to FGM/C had

BOX 5

Medicalization in Indonesia

In 2011, the Indonesian Ministry of Health issued guidelines to health professionals on how to perform FGM/C, 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/C mutilation can only be conducted at the request and consent of the person concerned, parents, and/or guardians. These guidelines have been widely criticized.

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

the procedure performed by a medical provider.¹⁶ In Egypt that number jumps to 32 percent or one in three women who have been cut.¹⁷

At one time, advocates believed that allowing trained medical personnel to carry out the procedure would result in a more hygienic environment with less severe cutting. Some proposed this strategy as a first step to abandonment of the practice. However, no evidence supports this strategy, nor does it necessarily make it safer. In fact, sanctioning health care providers to perform the practice can contribute to legitimizing the practice and lead to financial and professional interest by providers to uphold it. Dr. Abelhadi El-Tahir, a physician from Sudan who has worked for abandonment for years, argues that medicalization should be eschewed as it “only validates the practice by providing the veneer of medical approval” while ignoring the human rights violations.¹⁸ Moreover, it has been opposed on the grounds that it is medically unethical and, in most countries, also goes against the law (see Box 5).

Medical personnel, however, can be valuable allies in efforts to abandon FGM/C, since they are highly respected members of the community. Education campaigns aimed at medical personnel should focus on its practice as a violation of human rights and its threat to girls’ and women’s health.¹⁹ Advocates continue to work with governments to ban the practice by medical personnel and, at the same time, with national bodies to develop guidelines and trainings for health care professionals on treating FGM/C complications.

Alternative Incomes for Excisors

Interventions that focused on providing excisors with alternative sources of income have also been disappointing. 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 or underlying community norms around the practice. 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.²⁰ And yet, Nafi Diop, one of the key experts interviewed for this report, cautioned that we have not yet done enough research on the role of excisors—how to reach them and how to make them good allies as one of the voices capable of moving communities away from the practice.

BETTER APPROACHES YIELD CLUES

Some approaches that have been implemented over the last decade have shown promise in certain contexts and offer valuable lessons worth noting, even if they have not proven themselves to be a definitive solution.

Alternative Rites of Passage

The Alternative Rites of Passage (ARP) approach was first introduced in Kenya in 1996 by Maendeleo ya Wanawake (MYWO), a local women’s development movement, as an alternative ritual to FGM/C among the Meru community. In this community, FGM/C had been practiced as part of a coming-of-age ceremony. It was thought that by substituting ARP, the community would stop the genital cutting but maintain the essential components of the passage to womanhood, such as education for the girls on family life and women’s roles, exchange of gifts, celebration, and a public event for community recognition.

The Population Council conducted evaluations of the ARP approach in 2010 and 2011.²¹ The researchers found that this approach is only suited to communities where FGM/C involves a public celebration and where an alternative practice could feasibly replace the traditional rite without the cutting. According to Ian Askew, Population Council’s director of reproductive health and research, the critical factor is the timing of the intervention in the process of change. Is it an effective model for reinforcing or for sustaining the change? According to Askew, one needs to look at activities that preceded the alternative rites. Girls may be attracted to the rite because they are promised something (such as clothes), but was there any community preparation for attitude and behavior change? Another important question: What happens with the next generation?

The 2011 evaluation examined the ARP program implemented in Kuria and Kisii communities as part of a program 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/C is a celebrated public event integrated with

girls' empowerment programs, and supported by intensive community awareness activities through which the local community recognized the graduation ceremony as an alternative to FGM/C. In contrast, in Kuria, where FGM/C is a private, often secret family affair, the ARP concept is less well-articulated. Camps organized during the FGM/C 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 decisionmakers, parents, and village, church, school, and community leaders. The conclusion was that ARP needed to be fully explained and embedded in community education and girls' empowerment programs, which cover health risks and human rights and challenge myths and assumptions.²²

Positive Deviance

The Centre for Population and Development Activities (CEDPA) initially piloted the Positive Deviance approach in the late 1990s with support from UNICEF. This approach was the basis of the FGM/C Abandonment Program (FGMAP) in Egypt, with its focus on identifying individuals within local communities who chose not to practice FGM/C and building on their experiences to encourage other community members to abandon the practice.

In 2008 the Population Council conducted an evaluation of FGMAP's work from 2003 to 2006, using qualitative data. The evaluation sheds some light on the advantages and barriers to the success of this approach. While calling FGMAP "much-needed, both nationally and on the community level, to break the silence around FGM/C," the evaluation emphasized that program activities needed to be integrated as part of a comprehensive developmental approach, and must work with local NGOs to avoid being labeled a "Western conspiracy" against Egyptian traditions and values. It stated that abandonment efforts are most effective when they are integrated into the community and other activities of the local NGOs. In addition, not all the messages from FGMAP reached target families, who remained unconvinced about the negative consequences of FGM/C. While data showed that the number of girls who did not undergo FGM/C increased during the program, in order to amplify that number and reach a larger population, the evaluation suggested including more social networks within communities, as well as religious leaders and doctors who supported abandonment. It suggested adding strong media campaigns and emphasizing child rights in order to achieve the critical mass of people willing to abandon FGM/C and thus create a shift from a convention of cutting to one of noncutting.²³

Safe Houses

Another approach to FGM/C 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/C ceremonies are given a safe place to live and go to school. This strategy is popular with broader gender-based violence programs, but is problematic as this approach 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 examine this approach further to look at the potential long-term implications of removing women and girls from their families and communities, 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. According to Gannon Gillespie of Tostan, "We need more evaluation on the unintended negative consequences of the safe house approach," as well as on sustainability, linkages, and ways to help reconcile girls with their families and communities.²⁴

As part of its multidimensional approach to ending FGM/C in Maasai areas of Kenya, the Tasaru Ntomonok Initiative (TNI), established by Kenyan Agnes Pareyio and supported by Equality Now, includes a residential community-based rescue center offering holistic services for Maasai girls escaping FGM/C and early marriage.²⁵ In addition to a safe house, TNI works with male and female members of the community separately to engage in discussions about FGM/C. Religious leaders and police are involved in the trainings. ARP is one strategy available to girls at the end of their training before they leave the center. One important aspect of the program is that TNI organizes meetings between the girls and their parents and families to facilitate reunion after the girls have been saved from cutting and early marriage. Families must agree to not subject girls to FGM/C or early marriage, and to permit them to complete their education. TNI-trained community monitors are in place for the girls in case they perceive danger.

The Young Women's Christian Association (YWCA) has implemented programs since 2006 encouraging FGM/C abandonment, adopting an ARP approach focusing on the adverse effects of FGM/C and on education, rights, and career choices. The YWCA has established rescue centers that offer training in combating the stigma of noncircumcision, working with schools, parents, and religious and community leaders. Anecdotal information from YWCA indicates that considerable progress has been made in changing attitudes in relation to FGM/C where the program has been implemented. The TNI programs are more recent, although signs of increased abandonment in two communities have been observed.

PROMISING APPROACHES EMERGE

"A process of positive social transformation can occur when programs and policies focus on enabling communities to make a coordinated, collective choice to abandon FGM/C."²⁶

The last decade of research and interventions has yielded valuable lessons on what programs and policies are effective

BOX 6

Case Studies

- Tostan in Senegal
- Working With Religious Leaders in Kenya—The Population Council
- Intergenerational Dialogue—Deutsche Gesellschaft für Internationale Zusammenarbeit (GTZ)
- The Grandmother Project in Senegal
- FGM-Free Village Model in Egypt
- Tanzania Media Women’s Association (TAMWA) in Tanzania

in moving toward abandonment of FGM/C. They fall into three broad categories:

- The centrality of social norms—what communities believe and how they act and expect the members of that community to act—has gained wide recognition as key to FGM/C abandonment.
- A wide range of actors play pivotal roles in the abandonment of FGM/C—men, women, grandmothers, boys, girls, and community, religious, and political leaders.
- The focus must be on holistic, integrated, multisectoral approaches that bring together the advocacy, policy-level work, and community-level transformation of social norms.

The following section describes the main lessons and some recent interventions (with evaluations where available) that underscore these points (see Box 6).

Transforming Social Norms by Empowering Women and Girls

Perhaps the primary lesson from the last decade is that FGM/C is a social norm—the accepted behavior within a society—that requires a nuanced understanding of the reasons for its practice. Moreover, it requires consideration of the role of members of society in maintaining the norm and who has the power to influence and lead change in the community. Community members give many reasons for continuing FGM/C—religious obligation, cultural identity, controlling female sexuality, and hygiene. While fathers and mothers are key decisionmakers in the family, other members of the family and community can have significant influence

on whether or not a girl is cut. Opportunities to publicly discuss this sensitive topic are rare in most communities. As described below, several interventions have sought out the people of influence in order to change the practice.

Empowering women and girls through education and economic opportunities has shown great promise in convincing communities to abandon the practice. One of the early rigorously evaluated interventions, The Navrango FGM Experiment, showed that girls’ education and livelihood training together significantly reduced cutting of girls.²⁷ In fact, much of the gender and development work in the last decade has emphasized the benefits to families, communities, and countries of educating and empowering women and girls.

Tostan

One of the first and perhaps best-known organizations to focus on education, community, and women’s empowerment was Tostan. Established in Senegal in 1991, Tostan, which means “breakthrough” in Wolof, has implemented its Community Empowerment Program (CEP) in thousands of communities in Senegal and expanded to 10 other countries to date. Its three-year program is designed to empower communities through education on human rights, hygiene and health, literacy, and project management, leading to social change (see Box 7, page 11). Tostan uses an organized diffusion approach to maximize the spread of information and ideas from program participants to others within the community and to neighboring communities. Fundamental to the organized diffusion approach is the use of public declarations when communities decide to abandon harmful traditional practices, such as FGM/C and early marriage. Although abandonment of FGM/C was not an original objective of the program, more than 6,000 communities have declared their abandonment of FGM/C.²⁸

Tostan has long believed that the primary reason that people practice FGM/C is that it ensures membership in the community, especially in intermarrying communities. This belief is a basic tenet of the social convention theory of Gerry Mackie, a professor at the University of California San Diego. In 1996, Mackie argued that FGM/C, while centuries old, would end quickly once people began abandoning the practice collectively, as they had with footbinding in China.²⁹ This social convention theory has formed the underpinnings of Tostan’s work for almost two decades, even as Tostan has changed its trainings and audiences to include such areas as youth, gender, and early marriage.

A Wide Range of Actors

Working With Religious Leaders in Kenya

Many communities use religious obligation to justify the practice; particularly in some Muslim countries, Islamic obligation is often cited as a driving force behind the practice.

BOX 7

Evaluations of Tostan

Tostan's approach has undergone several evaluations examining its effectiveness in ending FGM/C. A 2006 evaluation looked at the impact of the Tostan program on age at first marriage, the health status of women and children, and the practice of FGM/C in villages that participated in public declarations between 1997 and 2000. The study compared villages that had participated in the Tostan program as well as the public declaration (group A), villages that had only participated in the public declarations (group B), and control villages where FGM/C was practiced but had not participated directly or indirectly in the program or public declarations (group C). Regarding the practice of FGM/C, the study showed that among the villages that had participated in the Tostan program (group A) and those that had participated only in the public declarations (group B), the proportion of women who had undergone circumcision was 64 percent and 81 percent, compared to 86 percent in the control villages (group C). The evaluation revealed that prevalence of FGM/C for girls 0 to 9 years of age was 15 percent in the Tostan intervention villages and 8 percent in the villages that had taken part in the public declarations, compared to the control villages where 47 percent of girls in this age group were cut. In addition, only

30 percent of women in group A declared that at least one of their daughters had been circumcised, compared to 69 percent in the control villages (group C).

PATH is partnering with a local research group to conduct a rigorous evaluation of the impact of Tostan's Community Empowerment Program specifically on domestic violence, broader gender-based violence (GBV), and women's empowerment outcomes. The four-year (2011 to 2015) evaluation will look at attitudes, perceptions, and behaviors—including around individual and community-level acceptance of and response to GBV. While Tostan has been evaluated for its impact on female genital cutting—as measured primarily through the village-level public declarations—this is the first evaluation focusing specifically on domestic violence and gender-based violence measures. Key to the evaluation will be a newly integrated gender module.

Source: Paul Stanley Yoder, Salif Ndiaye, and Nafissatou J. Diop, "Long-Term Evaluation of the Tostan Programme in Senegal: Kolda, Thiès, and Fatick Regions," working paper (New York: UNICEF, 2008).

FGM/C abandonment efforts have included working with religious leaders to address this perception.

The Population Council developed an innovative approach to engaging Somali communities in the Wajir region of Kenya. FGM/C is practiced by 97 percent of the Somali population of Kenya. The main reasons given by the Somali are that it is a Somali tradition and a belief that it is required by Islam. Infibulation is most commonly practiced as it is believed to ensure female sexual purity by preserving virginity and controlling women's sexual desires. The Population Council approach aimed to generate discussion among community members and a consensus among religious scholars on the practice using Islamic teachings to enable religious leaders to encourage abandonment in the community. Discussion sessions were held with religious scholars at the district, regional, and national levels to discuss FGM/C in Islam and to develop ways to raise awareness and educate the community on FGM/C abandonment. The intervention found that using a religious approach can be powerful in convincing community members to reject FGM/C: Religious leaders can play a powerful role in abandonment of FGM/C at the community level.³⁰

In 2007, at the Global Consultation on FGM/C held in Addis Ababa, religious leaders, including the *grand mufti* of Egypt, agreed that FGM/C is not a religious issue or a test of one's religious observance.

Encouraging Intergenerational Dialogue

Another approach to tackling harmful traditional practices is fostering discussions between older and younger generations. FGM/C is a practice that is embedded in tradition passed

“We are grateful for the information and I am sure we will stop FGM. I want to state here that I have three daughters and nobody will cut them. I will make sure of this.”

—Male at a Youth Forum, April 2008

from generation to generation. As carriers of tradition and key influencers in the family, engaging older members of society is crucial to changing harmful traditional practices. Forums for ongoing intergenerational dialogue between community members, including men and boys, to address topics around cultural-designated values and traditions and gender roles

BOX 8

Intergenerational Dialogue: The Grandmother Project in Senegal

In 2008, World Vision established a three-year 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/C, 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, focus on grandmothers as the entry point, and recognition of FGM/C as a practice that affects all facets of the community.

A 2009 rapid assessment and a qualitative review found that the project strengthened relationships 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/C and early marriage. Some lessons learned that could inform similar interventions in other settings include:

- A holistic approach to promoting girls' health and well-being that addresses all facets of their growth and development is more acceptable to communities than one that narrowly addresses a single problematic aspect, such as FGM/C.

- Explicitly honoring local cultural roles, values, and traditions in community programs responds to a deep-seated and generally unaddressed community concern about the loss of cultural identity and values.
- Recognition and inclusion of senior women (grandmothers) based on their culturally designated role in families and communities validates their central role in the lives of families.
- Inclusion of elders who are viewed as a valuable cultural resource lends credibility. Community groups, especially younger people, stated they are more comfortable with an approach that explicitly involves elders, creating a synergy between the wisdom of the elders and the energy of youth.

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. Because grandmothers and teachers are generally viewed as being committed to ensuring girls' success, they represent entry points for combating teenage pregnancy and early marriage.

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

has allowed communities to develop and publicly commit to a new consensus on the issues, including FGM/C (see Box 8).

The Intergenerational Dialogue approach, promoted by GTZ and implemented in Mali, Kenya, and Guinea, is a participatory approach to engaging members of the community across sexes and generations to feel empowered to change behaviors. The goal of this approach is to build people's communication skills and confidence to articulate viewpoints and learn how to bring about collective change. The Intergenerational Dialogue approach allows communities to engage in the process, identify the specific legal and health improvements needed, and share them at public meetings, demonstrating the peoples' commitment to implement them.³¹ The approach recognizes that change in long-held traditions can be threatening to older generations and, therefore, needs their full engagement. Results from a 2009 evaluation in Mali showed improvements in knowledge, attitude, and behavior among the participating groups. Seventy-nine percent of members surveyed in the community said they were of the opinion that FGM/C is bad, 74 percent said they had taken steps to end FGM/C in the community,

and 94 percent said they would not subject their daughters to FGM/C in the future.³²

Multisectoral Efforts

Anecdotal evidence has presented us with examples of how important it is to work across sectors in order to engage and integrate a broad range of approaches to end FGM/C, including policy work and community engagement, as well as working with media. "We need to merge the advocacy work with broad awareness-raising, social mobilization campaigns, and work to empower women and girls," said Dr. El-Tahir.³³

Public Voices: Pursuing Advocacy and Policy Reform

Much emphasis has been directed toward advocacy efforts to ban FGM/C or to strengthen existing laws and policies at the national and local level. While most countries where FGM/C is practiced now have adopted laws criminalizing the practice, experience has shown that advocacy is needed after the passage of the law to raise awareness at the local level and

to ensure governments follow through with implementation (see Box 9). Lack of awareness by local officials and law enforcement and lack of community buy-in can be serious obstacles to effective implementation. Additional resources for training and awareness-raising after adoption of anti-FGM/C policies are needed.

While laws are important for changing behavior, they are unlikely to result in changes in behavior and social norms all by themselves. Where social norms dictate that people continue the practice as part of social norms, laws without proper interventions at the community level can force the practice underground and communities will be reluctant to stop.³⁴ However, when combined with consensus building and community-level education campaigns that address broader social norms, and with dissemination of the legal information, legal reform can become an effective element in a broader effort to abandon the practice (see Box 10, page 14).

Experience from Burkina Faso 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.³⁵ In the 1990s, the government of Burkina Faso established the National Committee for the Campaign against Excision (CNLPE) to lead the anti-FGM/C effort by actively coordinating with law enforcement, local political and religious leaders, medical personnel, youth, and women's associations. The government committed resources for enforcement of the law and support for families that wished to abstain from the practice. A 2008 analysis following the 20-year government campaign showed that there had been a reduction in support for the practice and an apparent decline in prevalence among girls ages 0 to 10, compared to older girls and women.³⁶ In the 2010 DHS for Burkina Faso, even though the overall prevalence remains high at 76 percent, 90 percent of women think the practice should stop.

Kenya has passed two strong laws around FGM/C—the result of several years of advocacy by community-based groups. A 2011 law passed in Kenya states that anyone subjecting a girl to FGM/C will be sentenced to jail for seven years or fined 500,000 shillings and anyone who causes death in the process could be liable to life imprisonment. In addition, anyone convicted of assisting in the performance of FGM/C could face a prison sentence of three to seven years and a fine of 100,000 to 500,000 shillings. The bill replaced the Children's Act of 2001, which outlawed the practice of FGM/C on girls.

However, questions remain about enforcement of these laws. The 2011 law includes a new clause for those ridiculing girls who have not been cut, but it is not clear how this would be enforced.³⁷ Enforcement of laws is an issue not just in Kenya. In Senegal, the government is working to highlight human rights and promote

BOX 9

Laws and Decrees Related to FGM/C in Africa

Countries With

Benin (2003)
Burkina Faso (1996)
Central African Republic (1966)
Chad (2003)
Côte d'Ivoire (1998)
Djibouti (1995)
DR Congo (2006)
Egypt (Ministerial Decree, 2007)
Eritrea (2007)
Ethiopia (2004)
Ghana (1994)
Guinea (2002)
Guinea-Bissau (2011)
Kenya (revised 2011*)
Mali (2001)
Mauritania (2005)
Niger (2003)
Nigeria (some states, 1999-2006)
Senegal (1999)
Somalia (2012)
South Africa (2005)
Sudan (some states, 2008-2009)
Tanzania (1998)
Togo (1998)
Uganda (2010)

Countries Without

Cameroon
Gambia
Liberia
Sierra Leone

Note: Kenya passed a stronger anti-FGM/C law with the Bill of 2011 in September. It replaces the Children's Act of 2001 that banned FGM/C for children under the age of 18. The new law makes it illegal to practice or procure it or take somebody abroad for female genital cutting. The law even prohibits derogatory remarks about women who have not undergone FGM/C. Offenders may be jailed or fined or both.

Source: UNICEF, *Female Genital Mutilation/ Cutting: A Statistical Overview and Exploration of the Dynamics of Change* (New York: UNICEF, 2013).

Changing Views and Attitudes: The FGM-Free Village Model in Egypt

The FGM-Free Village Model is Egypt's national program to eradicate FGM/C. Launched in 2003, the program is implemented by the National Council for Childhood and Motherhood (NCCM), the United Nations Development Programme (UNDP), and the Donor Assistance Group (DAG). In 2008, the project evolved into a joint initiative under the Ministry of Family and Population. It was initiated in 60 villages and is being scaled up in another 60 villages.

Mobilizing the media, policymakers, activists, and religious and medical communities, the model was designed to create an environment conducive to dialogue and critical thinking on the cultural and social factors that lead to support of FGM/C, focusing on the practice as harmful and a violation of the human rights of girls. The model promoted national dialogue concerning FGM/C and pushed for legal and policy reforms. NCCM mobilized a campaign that led to the issuance of Ministry of Health Decree No. 271 in 2007 banning FGM/C in all clinics, and public and private hospitals, overruling an earlier 1996 decree that allowed the procedure in cases approved by doctors. NCCM advocacy efforts were pivotal in the issuance of a landmark religious fatwa by the *grand mufti* of Egypt condemning FGM/C; and the issuance of the Child Law in 2008, criminalizing FGM/C. NCCM mobilized public declarations, constituting a pledge by village officials, religious leaders, and community members to end the practice.

A 2011 midterm evaluation found that the program was successful in changing views and attitudes toward FGM/C. Close to 80 percent of women in the intervention group retained information about its negative consequences versus 30 percent in the control group. Eighty-one percent in the intervention group stated that the information they received made them reevaluate their views concerning FGM/C, compared with 17 percent in the control group.

And 76 percent in the intervention group who received information and whose daughters were uncircumcised stated that the information convinced them not to circumcise their daughters, whereas only 19 percent in similar situations in the control group had the same response. Similarly, support for the continuation of the practice varied significantly. Only 27 percent of women in the intervention group believed that FGM/C should continue, compared with 77 percent of women in the control group. Finally, women in the intervention group were six times less likely than women in the control group to plan to circumcise their daughters. The evaluation recommended that efforts focus on sustainability of advocacy and awareness-raising, adopting a holistic multisectoral approach in order to maintain impact for future generations.

The evaluation included a number of lessons and challenges:

- The importance of media and campaign messages that resonate with the community.
- The need to formulate opposition to FGM/C within a human rights framework as a matter of bodily integrity.
- The need to engage men and religious leaders.
- The importance of addressing gender-related norms underlying resistance to its end.

The evaluation also warned against focusing only on harmful physical consequences, which can lead to medicalization.

Source: Ghada Barsoum et al., "National Efforts Toward FGM-Free Villages in Egypt: The Evidence of Impact," *Poverty, Gender, and Youth Working Paper* no. 22 (New York: Population Council, 2011), accessed at www.popcouncil.org/pdfs/wp/pgy/022.pdf, on Dec. 9, 2013.

abandonment rather than simply passing the law and arresting violators. Tostan has spearheaded training for government officials at the national and regional level to promote awareness of the law.³⁸

Key opinion leaders emphasized that advocacy efforts must be connected with social mobilization and efforts to empower girls and women at the community level, and that there be sustained government commitment to working with communities to stop the practice (see Box 11, page 15). "It is very important," said Berhane Ras-Work, "to build a bridge between legal frameworks and the community so that rights and obligations under law are understood and owned."

Media's Role in Promoting Change

Media campaigns can play a crucial role in informing communities, promoting dialogue, and changing social norms. They have the most impact when they are part of a larger abandonment effort. Media campaigns supported by public discussions at the community level, especially when led by religious and community leaders, can help individuals confront harmful traditional practices and cultural beliefs.

The Tanzania Media Women's Association's (TAMWA) launched its Stop FGM campaign in 2002. This nongovernmental organization used television and radio spots, posters, and newspaper and magazine articles to

BOX 11

Policy Change: Lessons From Mali

Another critical factor in successful advocacy for legal reform is the political context at the time of the adoption of the law. In 2009, the Health Policy Initiative worked with anti-FGM/C advocates in Mali to develop advocacy tools. Meetings were held with various stakeholders including community and religious leaders, parliamentarians, and other decisionmakers to discuss the negative social, health, and human rights consequences of the practice.

In parallel, a separate policy discussion was taking place about a controversial law—the Family Code—that included a provision that would give men and women equal rights in marriage. Following public protests against the code, particularly by religious leaders, advocates decided that decisionmakers and parliamentarians would be reluctant to support policy change around FGM/C for fear of links to the

highly politicized debates about gender equality. Therefore, advocates did not follow through with the planned meeting by religious leaders with parliamentarians to present the FGM/C advocacy tool.

Despite the unsuccessful attempts to enact a law, stakeholders felt the development of the advocacy tool was useful to create unified messages to advocate against FGM/C, and that the process allowed stakeholders the opportunities for input into materials development and for working together for greater ownership of the advocacy tools.

Source: Elizabeth Doggett and Margot Fahnestock, *Policy and Advocacy Initiatives to Support the Elimination of Female Genital Cutting in Mali* (Washington, DC: Futures Group, 2010), accessed at www.healthpolicyinitiative.com/Publications/Documents/1233_1_Mali_FGC_Final_Report_Final_FINAL_acc.pdf, on Dec. 9, 2013.

mobilize individuals, communities, civil society organizations, and policymakers at all levels to take action to end FGM/C by 2015. TAMWA based its campaign on a series of in-depth surveys and formative qualitative research in several communities with heightened understanding of community-level perspectives around FGM/C; reasons for its continued practice, including perceived benefits; and other factors that influence decisions in this area. The intensive two-year campaign reached a national audience, raising awareness and galvanizing momentum for ending the practice. Notably, the campaign offered critical information to dispel common myths, including that undergoing FGM/C reduces HIV risk. An information kit was produced specifically to sensitize and educate journalists around the issue, and guide them in addressing it with strong but resonant positive and nonjudgmental messages.

TAMWA was officially convened in 1986 with the aim of supporting women journalists and highlighting issues affecting women and children in Tanzania. TAMWA continues to be an important voice for media-based advocacy focusing on women's and children's rights. Over the past 25 years, it has built a reputation for credibility and garnered trust and respect among media professionals, politicians, and activists for its work, especially around gender-based violence. TAMWA's advocacy played a critical role in the campaign to pass the Sexual Offenses Bill in Tanzania.

TAMWA is an active member of a national anti-FGM/C coalition whose efforts have increased attention and action around an issue once considered taboo. Political leaders, including the former president and district commissioners; religious leaders including the Christian Council of Churches,

the National Muslim Council of Tanzania, and the Catholic Diocese of Tanzania; and the highest Council of Maasai Leaders have all issued landmark declarations or statements repudiating the religious or cultural basis for FGM/C. More than 500 former practitioners of FGM/C have stopped the practice as a result of sensitization activities. TAMWA's media activities played an essential role in supporting advocacy and action by keeping the issue alive in community, national, and political discourse.

Ananilea Nkya, TAMWA's executive director, attributes the organization's success to critical coalitions and networks with key partners and allies, and its emphasis on engaging communities integrally in its campaigns. "Media advocacy is critical, but we must work hand-in-hand with grassroots community-level advocates and organizations. We must understand what is happening at the community level, what challenges they are really facing, and how can they be addressed. Media cannot be successful in a vacuum, but must be used to empower communities."³⁹

Lessons Learned

IMPORTANCE OF EVALUATION

The lack of rigorous evaluations of FGM/C interventions challenges our understanding of the promise of and limitations to the various approaches to abandonment. Most interventions targeting FGM/C have been implemented as short-term projects without adequate attention or funding for formative research, rigorous evaluation, and follow-up. Thus, understanding long-term sustainability, effectiveness, and potential unintended negative consequences is lacking.

Research on Decisionmaking in Senegambia

Bettina Shell-Duncan and her partners conducted a study of the dynamics of decisionmaking in the Senegambia with the goal of applying lessons learned to improving theories of behavior change around FGM/C. Using qualitative and quantitative methods, the researchers collected data over a three-year period (2004 to 2007) in the Gambia and Senegal. They found that the age of cutting is declining and that ritual group celebrations are being replaced by individual girls being cut at home, with no significant changes in severity of cutting. They also found that the health risk messages focusing on HIV/AIDS resonated with community members and that the legal prohibition of FGM/C motivated some to abandon the practice, but it did not lead to change for most until the Tostan program initiated community abandonment efforts in the region.

The researchers looked at various factors influencing an individual's opinion of FGM/C over time and concluded that peer pressure and pressure to conform were most strongly associated with abandonment of FGM/C. The researchers looked at the predictions of the social convention theory, a game-theory framework proposed by Gerry Mackie for understanding decisionmaking around FGM/C abandonment. The theory predicts that abandonment will result from public agreement within intramarrying groups to abandon the practice and create a marriage market for uncircumcised girls. The authors found that there were many men from both circumcising and noncircumcising communities who were willing to marry uncircumcised women and that such marriages were not unusual. They concluded that the practice is instead a peer convention in Senegambia which helps to build social capital among younger women and status and power for older women: Being circumcised indicates to other circumcised

women that a girl is obedient, respects the authority of her circumcised elders, and should be included into their network of social support. The authors suggest, therefore, that interventions should:

- Involve interconnected members of social networks.
- Be intergenerational.
- Involve both women and men.

Based on their findings, the authors propose a theoretical model for understanding behavior change regarding FGM/C that suggests that individual readiness to change should be seen as operating along a continuum with broad stages of change characterizing segments of the continuum. They argue that the stages of change described for other behaviors, such as smoking, are not adequate for describing readiness to change for FGM/C as the decision is often a collective rather than an individual one. The authors suggest that the stage of change process is complex and captures motivation, behavior, and elements of the environment in which the decision to change is made. Based on their research, they propose five categories of readiness to change the practice of FGM/C that reflect preference and actual behavior: supporters of FGM/C; reluctant practitioners; contemplators (practitioners considering abandonment); willing abandoners; and reluctant abandoners.

Source: Bettina Shell-Duncan et al., *Contingency and Change in the Practice of Female Genital Cutting: Dynamics of Decision-making in Senegambia* (Seattle: University of Washington, 2010).

Furthermore, experts need to better understand the community perspective on the different factors that lead to continued practice. A huge gap exists in our understanding of decisionmaking around FGM/C. As Stan Yoder of ICF International pointed out, we lack information on how these decisions are made, who makes them, when and in what context, who is involved in those discussions, where do they happen, who initiates them, and what issues or factors are relevant.⁴⁰ This critical issue of decisionmaking has been examined by Bettina Shell-Duncan of the University of Washington and her co-authors in a recent publication, *Contingency and Change in the Practice of Female Genital Cutting: Dynamics of Decision-making in Senegambia* (see Box 12).

Reductions in prevalence in some communities have been attributed to the many advocacy and awareness-raising

efforts, as well as community-level interventions and national laws to stop the practice over the last 20 years. However, population-level evidence of the impact of specific anti-FGM/C interventions remains sparse and it is difficult to draw conclusions of the true impact of the interventions. Conversely, reductions in support for the practice and its prevalence may not be visible immediately from DHS and MICS data, but may indeed be taking place.

GALVANIZING SOCIAL CHANGE

Experience from Tostan in Senegal has shown that the decision to abandon FGM/C can be a byproduct of larger efforts to improve education and the status of women in a community. It has shown that sustained engagement and evaluation is key to program implementation. Together, these factors have allowed Tostan to improve its program based on

experience as well as results from external evaluations. As Askew noted, it is important that interventions be informed by a theoretical model of behavior change that will allow for proper measurement of impact.⁴¹ Tostan's approach is closely informed by Mackie's social convention theory, which has supported the framework of its approach to FGM/C.

Another lesson from Tostan is that when entering a community to attempt to galvanize social change, it is essential to consider potential value judgments imparted. The language used is critical. Tostan maintains its position that the term "mutilation"—a term that has been adopted by many in the advocacy community—can be viewed as a judgmental term and may foster stigmatization and resistance to changing a traditional community practice. Furthermore, Tostan believes that allowing issues of gender and FGM/C to be raised organically by community members, rather than using a Western judgmental approach, is key to getting buy-in and mobilizing communities for change.

ENGAGING BOYS AND MEN

The perception and reality of those driving the practice in the family varies from community to community. Mothers and grandmothers are often considered the drivers that maintain a practice supported by men in the family. Data from some countries show that women, however, perceive men to be drivers of the practice: In fact, men surveyed have indicated that they are less supportive of the practice than women in the community. This finding suggests that fathers can play a significant role in abandonment of the practice. In the 2010 study by Shell-Duncan and her partners, the findings revealed that, while men were very involved in the decisionmaking around FGM/C, 50 percent fewer fathers in Senegal supported FGM/C than did mothers.⁴² Overall, FGM/C is a reflection of the lower status of women in society; therefore, engaging men and boys, while not gender transformative, may be useful in achieving abandonment, according to Berhane Ras-Work and others. In Ras-Work's experience, fathers are often the most protective of daughters when they are informed about the harmful effects of FGM/C. Young men often note that they would willingly marry an uncut woman, weakening one of the foundations of the practice's continuation.

NEED FOR MORE DATA

The biggest gap in data is on decisionmaking around FGM/C—how are decisions made, who makes them, when, and in what context. "It is important to deepen and strengthen this kind of anthropological understanding," as has been started by seminal work by Shell-Duncan.

Another question regarding data arises from the last decade of work: Can prevalence data be considered a barometer of change? Do changes in a community's prevalence reflect recent actions or actions from 10 or 20 years before? Expecting change in numbers immediately may result in

discouraged NGOs and advocates when programs that appear to be taking hold do not immediately reflect a decrease in prevalence. UNFPA's Diop warns that data may not be illustrative of the trends or changes that result from interventions. At the same time, she adds, data are important for encouraging strong government commitment to abandonment.

Recommendations

Based on the expert interviews and this review of interventions in the last decade, several recommendations emerge:

Promising new research and evaluations are still needed. Evaluation is necessary to:

- Ensure that interventions achieve the intended result in the target population.
- Ensure that interventions do not result in unintended negative consequences.
- Document problems as they arise.

Evaluation and research—especially operations research—are needed to document changes in behavior, not just the effect on knowledge and attitudes. It is important to understand the long-term and sustained impact of interventions. Many questions remain, including the sexual, social, and psychological consequences of the practice; the stigma faced by girls and women who are not cut in communities where the practice has not yet been abandoned; and the characteristics and decisionmaking processes of pioneering families that initiate abandonment.

Interventions should focus on holistic, integrated, and multisectoral approaches that bring together the advocacy, policy-level work, and community-level transformation of social norms. Evidence and experience from various interventions show that approaches should be holistic, multisectoral, 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 and implement an approach that appreciates the language, culture, and positive social norms of the community. Julia Lalla-Maharajh of the Orchid Project emphasized holistic models for addressing FGM/C, "One cannot just focus on laws or retraining excisors or working with health service providers alone."⁴³ It is essential that when advocating for legal change at the local level, the willingness and readiness of the practicing communities be taken into consideration. All stakeholders in the community must be engaged, including social influencers (such as religious leaders) and family influencers (such as grandmothers), in order for the community shift to take place. When done well, this community-led and community-owned process has a greater chance of taking hold.

FGM/C must be addressed as part of broader gender efforts. Many advocates of abandonment believe that it must be linked to changing views on girls and the role of women in society. If FGM/C is ever to be eliminated, the interventions must be based on the context of gender equity, and communities must be involved in discussion around the advantages and disadvantages of the practice. According to Tostan's Gillespie, part of the organization's success in Senegal's Kaolack region was that after the workshops, participants reflected a greater willingness to challenge gender norms.⁴⁴

A strong human rights framework should be included in all interventions. A strong human rights framework should be a part of FGM/C abandonment efforts. Interventions that focus only on the negative health aspects of the practice have sometimes led to medicalization of the practice. Recognition of FGM/C as a violation of girls' and women's human rights is essential in FGM/C interventions and discussions with communities.

Empowerment of women and girls is key. 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. Such efforts should be combined with community norm change; otherwise, the girls are at risk.

Evaluation is needed on effectiveness of safe houses. While this approach has been used in Kenya's Maasai region, for example, further evaluation is needed of its long-term consequences and sustainability. Creating a generation of homeless girls would not be a positive impact.

Governments must commit to comprehensive implementation of the law. The implementation of laws banning the practice of FGM/C represents significant progress over the past decade. However, there is an urgent need to galvanize political will and commitment at all levels of government, including ministries of health, justice, women's affairs, youth, and education, to implement the existing laws. Governments must work to educate communities about the law and invest in its implementation at the local level. However, these laws can have a negative impact in some communities, and must be complemented with comprehensive community-level interventions.

Women who have been cut have health issues that need to be addressed. While the focus of this review has been on efforts working toward abandonment of FGM/C, many have called for appropriate health care to address the health problems of women who have been cut. This priority must be included in actions moving forward. Among those who have spoken about this issue are Dr. Nawal Nour of the African Women's Health Center, Brigham and Women's Hospital; and Dr. Atif Fazari of the department of obstetrics and gynecology,

University of Medical Sciences and Technology, in Khartoum, Sudan. While working in different continents, their message is similar: As we move toward abandonment of the harmful traditional practice, advocates must not forget those who have been harmed. Health care providers need to be educated on the health issues related to FGM/C; such efforts could capitalize on the potential of health care providers as key agents of attitude change.

Donors must invest time and resources to produce sustained change. Changing social norms takes time. Short-term projects may only influence the early stages of behavior change. Sustained investment and support for long-term interventions will be the key to full abandonment of FGM/C. Donors should be committed to supporting multiyear interventions and understand that the delivery of results will take time. Furthermore, donor funding should allow for the multisectoral approach to abandonment. Multiple sources of funding will be needed to carry out effective interventions. As this publication goes to press, DFID has announced a large commitment to ending FGM/C in one generation, consisting of 35 million euros to be awarded toward this effort.

Next Steps

Momentum is building from within Africa to address the issue of FGM/C in a comprehensive manner. In 2011, the University of Nairobi agreed to host an African Coordination Centre for FGM/C Abandonment. The center's objectives are to:

- Create networks and knowledge exchange among researchers, practitioners, and communities.
- Support and stimulate research.
- Improve health care for women and children who have undergone FGM/C.
- Accelerate the abandonment of FGM/C.

This center will bring together partners and disciplines from around the world—USAID and the U.S. Department of State have already pledged support, as have WHO, UNICEF, UNFPA, the Population Council's Kenya and Cairo offices, as well as universities from across the globe (several universities from within Africa, as well as the University of Ghent, University of Washington, and the University of Sydney). This pan-African institution is intended to serve as a beacon of commitment and momentum in bringing this harmful traditional practice to an end, as it continues to care for those affected by it.

As program planners, funders, and policymakers continue to distill the hard-earned lessons of the past in striving to end FGM/C, the words of Nafi Diop, coordinator of the UNICEF-UNFPA Joint Programme, resonate, "Where is the innovation in this field?" she asks. "I am seeing a mixture of interventions that start with education, awareness-raising, and then move to cultural acceptance. Is this really the only way? Maybe we need some fresh air."

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Appendix A. Questions for FGM/C Key Informant Interviews

1. What do current data sources highlight with respect to FGM/C trends (prevalence, scope, magnitude, practice)? What do we know about the practice of FGM/C today?
2. What gaps remain in data and information around the practice of FGM/C? What additional research and studies are needed? How reliable are current data?
3. Has your program been evaluated? If yes, what were some of the salient findings? Can you share the report/findings?
4. Do you know of any (other) recent evaluations of FGM/C programs?
5. What are evaluations showing about the effectiveness of different approaches/interventions/strategies being implemented by programs focusing on FGM/C?
6. What new approaches/interventions/strategies have been employed (over the past decade in particular)? By whom? In what context? Where?
7. How has work around FGM/C evolved or changed over the past decade? What kinds of interventions or strategies have shown promise in this field? Why?
8. What lessons have been learned about programmatic interventions and strategies for addressing FGM/C?
9. Are there specific populations that are now being engaged that had not been engaged before?
10. Are there specific populations that should be engaged? If yes, how should they be engaged?
11. What lessons can be gleaned from advocacy, media, and community mobilization campaigns? Are they effective? Why or why not? Which campaigns have been effective?
12. What strategies and which interventions are not working? Why aren't they working? What challenges need to be addressed?
13. Can you point us to other promising programs or interventions? Are there other researchers, practitioners, or policymakers who should be consulted?

Appendix B. Experts Interviewed

Ian Askew, Population Council

Judi Aubel, The Grandmother Project

Nafissatou Diop, UNFPA

Abelhadi El-Tahir, Pathfinder

Gannon Gillespie, Tostan

Sandra Jordan, USAID

Julia Lalla-Maharajh, The Orchid Project

Ananilea Nkya, TAMWA

Nawal Nour, African Women's Health Center, Brigham and Women's Hospital

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