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Female Genital Mutilation

Programmes to Date: What Works and What Doesn't

A Review

Department of Women's Health
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Executive Summary

Although the adverse effects of female genital mutilation (FGM) have been documented for years by women's organizations, health professionals, colonial administrators, social workers, and human rights campaigners, serious attention to this practice by governments and bilateral development agencies is more recent. Over the past two decades, FGM elimination has gained increasing recognition as a health and human rights issue among governments, the international community, and amongst professional health associations. As a result of concerted efforts by individuals, non-governmental organizations, and the United Nations, a global, regional, and national consensus against FGM has gradually emerged. With the support of bilateral development agencies, private foundations and trusts, concerted efforts are being taken in countries to prevent and eliminate FGM. However, little attention has been given to the status of FGM programming, the types of behaviour change strategies being implemented, their successes and failures, what lessons have been learned, and what support and strategies are required if the elimination goal is to be achieved.

To document the current status of and trends in FGM programming, and to identify crucial elements that need to be prioritized for future support, the World Health Organization commissioned the Program for Appropriate Technology in Health (PATH) to undertake a review of FGM programmes in countries in the WHO African and Eastern Mediterranean Regions.

This review is designed to serve as a programming tool and/or a baseline for monitoring the evolution of FGM elimination efforts. It is also designed to serve as a programming tool for donors and policymakers trying to understand FGM and behaviour change, and non-governmental groups implementing anti-FGM programmes. Governments and countries are confronted with complex and culturally entrenched beliefs on FGM, referred to in the review as "the mental map".

This mental map incorporates myths, beliefs, values, and codes of conduct that cause the whole community to view women's external genitalia as a potentially dangerous, that if not eliminated, has the power to negatively affect women who have not undergone FGM, their families, and their communities. To make sure that people conform to the practice, strong enforcement mechanisms have been put into place by communities. These include rejection of women who have not undergone FGM as marriage partners, immediate divorce for unexcised women, derogatory songs, public exhibitions and witnessing of complete removal before marriage, forced excisions, and instillation of fear of the unknown through curses and evocation of ancestral wrath. On the other hand, girls who undergo FGM are provided with rewards, including public recognition and celebrations, gifts, potential for marriage, respect and the ability to participate in adult social functions.

In spite of the above pressures, the findings of the review are encouraging. There is no doubt that there is an emergence of a large-scale information campaign against FGM in countries. There is increased willingness and commitment from a large number of non-governmental organizations working in family planning/reproductive health, those dealing with women, youth and human rights issues, as well as individuals, donor and development agencies, to prevent FGM through advocacy, programme implementation and/or financial

support for programme implementation. The findings also present a wealth of information on the reasons for the continuation of FGM; ways to reach the communities from the national, regional and local levels; elements of success; and pitfalls to avoid in prevention programmes on FGM. Governments' involvement in FGM prevention is increasing. Laws on FGM have been passed in at least five countries over the past few years. Experience is being gained in law enforcement issues in countries such as Burkina Faso. More involvement by people on FGM prevention brings about increased programming and results in more people being exposed to information, which in turn discourages the perpetuation of the practice of FGM. Several community-based programmes are showing promising results in ways to stop girls from undergoing FGM.

However, the findings also indicate that much work remains to be done. Agencies and groups working on FGM prevention are reaching only a small percentage of the people for whom FGM is a traditional practice. There is need to re-orient the communication strategies from awareness raising to behaviour-change intervention approaches. Current strategies on FGM prevention are based on the message that FGM is a harmful traditional practice that has negative health consequences for women and girls. This message does not address the core values, the myths, or the enforcement mechanisms that support the practice.

If success is to be achieved, anti-FGM programme implementers must focus on understanding and dismantling "the mental map", tailoring their programme strategies, information, messages, and activities to their audiences, while keeping in mind how far the target audience has proceeded on the stages of behaviour change.

I. INTRODUCTION

It is estimated that over 130 million girls and women have undergone female genital mutilation. It is also estimated that 2 million girls are at risk of undergoing some form of the procedure every year. Most of the women and girls affected live in more than 28 countries in Africa although some live in the Middle East and Asia. Affected women and girls are also increasingly found in Europe, Australia, New Zealand, Canada and the USA, primarily among immigrant communities from Africa and southwestern Asia. Female genital mutilation will continue indefinitely unless effective interventions are found to convince communities to abandon the practice. Many campaigners, development and health workers from the communities where FGM is a traditional practice recognize the need for change, but do not know how to achieve such an extensive social transformation.

Box 1: Definition and classification of FGM

Definition
Female genital mutilation comprises all procedures that involve partial or total removal of the female external genitalia and/or injury to the female genital organs for cultural or any other non-therapeutic reasons.

Classification
- Type I - Excision of the prepuce with or without excision of part or all of the clitoris;
- Type II - Excision of the prepuce and clitoris together with partial or total excision of the labia minora;
- Type III - Excision of part or all of the external genitalia and stitching/narrowing of the vaginal opening (infibulation);.
- Type IV - Unclassified: Pricking, piercing, or incision of the clitoris and/or labia;
  Stretching of the clitoris and/or labia;
  Cauterization by burning of the clitoris and surrounding tissues;
  Scraping (angurya cuts) of the vaginal orifice or cutting (gishiri cuts) of the vagina;
  Introduction of corrosive substances into the vagina to cause bleeding or herbs into the vagina with the aim of tightening or narrowing the vagina;
  Any other procedure that fall under the definition of female genital mutilation given above

II. OBJECTIVES, METHODOLOGY AND ANALYTICAL FRAMEWORK

To document the current status of and trends in anti-FGM programming and to identify crucial elements that need to be prioritized for future support, the World Health Organization commissioned PATH to undertake a review of anti-FGM programmes in countries in the WHO African Region and parts of the Middle East. The work was carried out in three phases:

- **Literature Review:** During the first phase, anti-FGM programme documents, including proposals, reports, evaluations, conference papers, and educational materials, were reviewed. The findings from the literature review were used to guide the development of a survey questionnaire and were used to support interpretation of data collected.

- **Survey of Programmes:** A structured questionnaire was developed to collect information in the following categories: programme approaches, funding sources, staffing, target audiences, materials developed, evaluation approaches, constraints, and overall lessons learned. The questionnaire was mailed to 365 national and international organizations, of which 102 were returned. The data from 88 agencies that had current anti-FGM programmes were assessed statistically to yield generalizable information about anti-FGM programmes (See Annex 1 for profiles of these organizations). The survey captured a snapshot of the status of FGM elimination programmes in Africa. (See Annex 2 on details on how the survey was conducted.)

- **Field Assessments:** The third phase entailed visiting five countries with strong programmes. Information gathered through these country assessments was compared with the survey findings and was used to derive innovative approaches and to provide a general perspective on national-level programmes. The countries include Burkina Faso, Egypt, Ethiopia, Mali, and Uganda. Several case studies were also reviewed but only programmes from Senegal are discussed in the review.

Data is presented as follows: the foundations needed to support successful and sustainable participatory behaviour change programmes and their status in countries; approaches to behaviour change; research and evaluation; country assessments; and successful projects. In each of the first three sections, key recommendations are presented. The survey data is used to show what organizations are currently doing. This is followed by a discussion of issues highlighted by the country assessments. The final two sections present details from the country and project assessments and include country specific recommendations.

The analysis of the data is based on a behaviour-change perspective. FGM is a deeply imbedded cultural practice. Its elimination requires an understanding of the culture, the perceptions, and the beliefs that have sustained FGM through the millennium. Culture is defined as the body of learned beliefs, customs, traditions, values, preferences, and codes of behaviour commonly shared among members of a particular community. Taken as a whole, this learned knowledge acts as a "perceptual filter" for information and "a road map" or

"mental map" for surviving in the world. These "mental maps" tell people where they are in relation to the world and its inhabitants. They provide people with both general direction and very specific details as to the behaviour required in their interactions with others. They also determine the boundaries between men and women, young and old, powerful and powerless. People within the same culture generally share similar "mental maps", but these vary and evolve according to education, life experiences, exposure to other cultures, and isolation from or connection with mass media (Mohamud, 1992).

Irrespective of where and when FGM was initiated, whether it was instated together with male circumcision, or whether it started as a response to a health problem - "filariosis of the external genitalia" - as some anthropologists contend, it is clear that the people who practise FGM share a similar "mental map" that presents compelling reasons why the clitoris and other external genitalia should be removed (Mohamud, 1992). As shown in figure 1**,** all the reasons fit into an elaborate belief system that operates on different levels - all targeting the external genitalia of women and girls. The three overlapping reasons for the practice at the center of figure 1 - spiritual and religious reasons, sociological reasons, and hygienic and aesthetic reasons - seem to indoctrinate society into the practice without explicitly addressing women's sexuality. According to these reasons, the clitoris and external genitalia are believed to be ugly and dirty, and if not excised can grow to unsightly proportions. In addition, they are purported to make women spiritually unclean. Their removal is thus required by religion. The clitoris is also believed to prevent women from reaching maturity and having the right to identify with a persons age group, the ancestors, and the human race. According to the numerous myths associated with this set of beliefs, the external genitalia have the power to make a birth attendant blind; cause infants to become abnormal, insane or die; or cause husbands and fathers to die (Mohamud, 1997).

However, once people are educated about the reasons mentioned in the paragraph above, larger, more encompassing psycho-sexual reasons emerge that directly focus on the sexuality aspects of the external genitalia and the dangers that may befall the girl, her family, potential husbands, and society in general if the genitalia are not eliminated. From this perspective, a young woman's sexuality has to be controlled to ensure that she does not become over-sexed and lose her virginity, thereby disgracing her family and losing her chance for marriage. In fact, it is believed that because an "uncut" clitoris will become big, activities like riding a bike or a horse, or even wearing tight clothing will arouse an unexcised woman, who may then rape men. It is believed that such a woman is likely to be promiscuous and therefore cannot be trusted by potential suitors. The entire community is threatened by the "actions" of an unexcised woman.

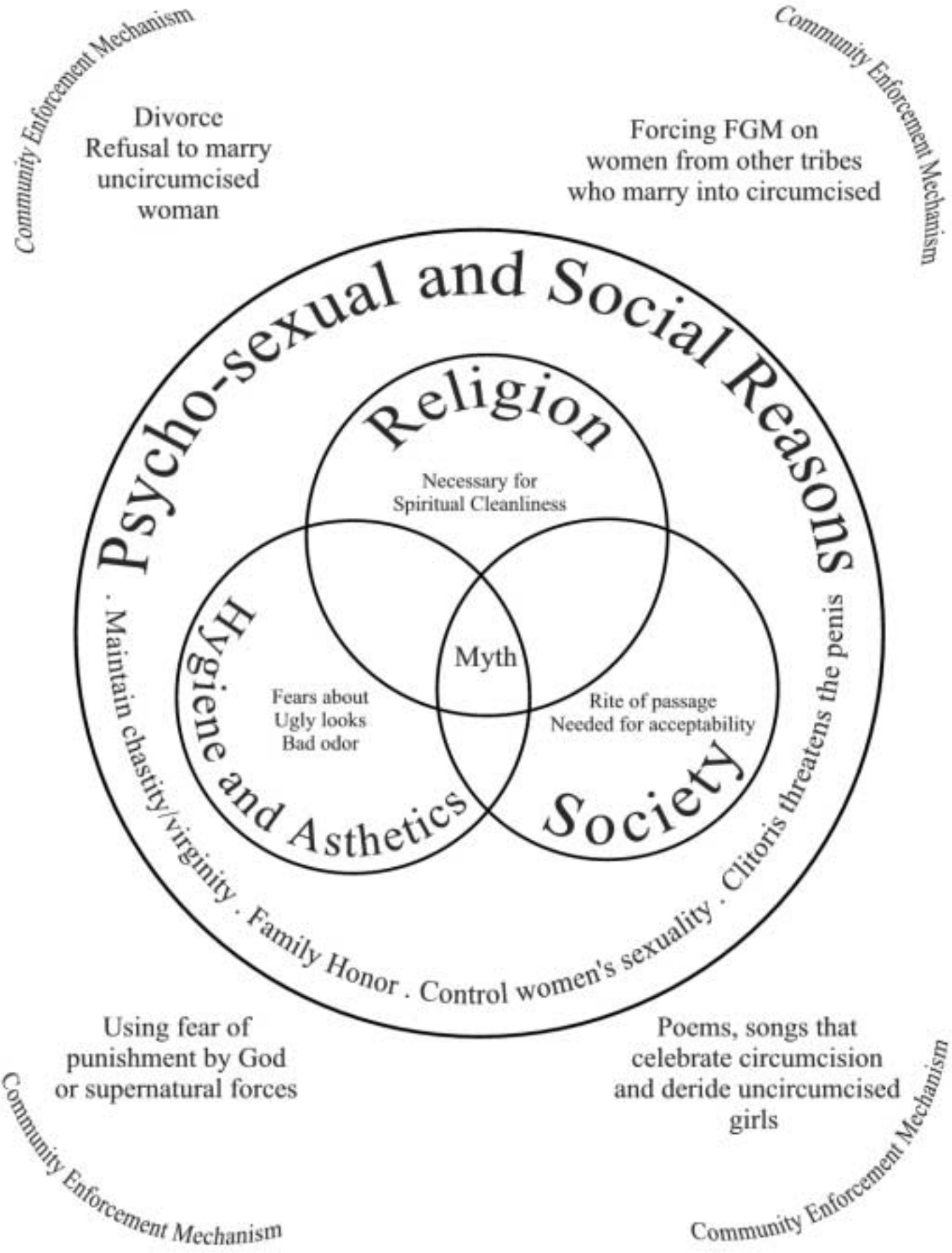
At the community and at the family level, strong pressure is brought to bear on women and girls to ensure continuation of the practice of FGM. Women who are not excised face immediate divorce (Somalia), or forcible excision (most communities). As initiates, girls are sworn into secrecy so that the pain and ordeals associated with the procedure of FGM will not be discussed, especially with unexcised women (Kenya and Sierra Leone). Songs and poems are used to deride unexcised girls (most communities). The fear of the unknown through punishment by God, ancestral curses, and other supernatural powers is instilled in them.

While the overall "mental map" is similar in most of the countries which practise FGM, some reasons are more prominent in certain countries than others. For example, Muslim countries tend to associate the practice with tradition as well as with Islam; some communities emphasize the rite of passage from childhood to adulthood (Burkina Faso, Ethiopia, Kenya, and Sierra Leone) or to humanity (some Eritreans); and others emphasize the mythological aspects (e.g., in Nigeria some people believe that if the head of the baby touches the clitoris, the baby will die). Understanding the different components of "the mental map" and their relative strength is crucial for any intervention strategy.

Like other social behaviours, the practice of FGM derives from varied and complex belief systems. It is tempting to simplify matters by isolating a piece of the behaviour and explaining it as a separate item, for example, "FGM has negative health consequences". Yet it is crucial to see the big picture - the connections among all aspects of the behaviour. The challenge of taking the whole picture into consideration may seem daunting, but social behaviour involves a vast range of influences - defined by culture. Culture acts as a lens or filter through which people view, understand, and interpret the world. Each culture is selective in what is filtered out and what reaches the human consciousness. Some things may pass unchanged (basic human needs) while others may undergo subtle shifts in emphasis. The filter effect of culture has great importance for health communication programmes.

Because culture is not static and changes constantly and because of the inherent functions of culture, it is important for health care providers and community workers to strive towards gaining cultural competency by assessing their own values and biases - their own "filters" and "mental maps" - and by respecting the values, culture, and biases of others. In this document, FGM elimination programmes are reviewed according to how well they incorporate "the mental map" in the communities they are committed to assist; whether the implementers are culturally competent; and whether they are adequately prepared to assist communities to bring about sustained behaviour change.

Figure 1: Why the Practice of FGM Continues: Mental Map



III. THE FOUNDATIONS FOR FGM ELIMINATION EFFORTS

Bringing an end to the practice of FGM is a long and arduous process, requiring long-term commitment and establishment of a foundation that will support successful and sustainable behaviour change. That foundation includes:

- strong and capable institutions implementing anti-FGM programmes at the national, regional, and local levels;
- a committed government that supports FGM elimination with positive policies, laws, and resources;
- mainstreaming of FGM prevention issues into national reproductive women's health, and literacy development programmes;
- trained staff who can recognize and manage the complications of FGM;
- coordination among governmental and non-governmental agencies; and
- advocacy that fosters a positive policy and legal environment, increased support for programmes, and public education.

Although implementing innovative behaviour change interventions is at the heart of FGM elimination, these foundations have to be in place for successful interventions. The following section reviews data from the survey and country assessments to provide a glimpse of the foundation that is currently in place to support anti-FGM endeavors.

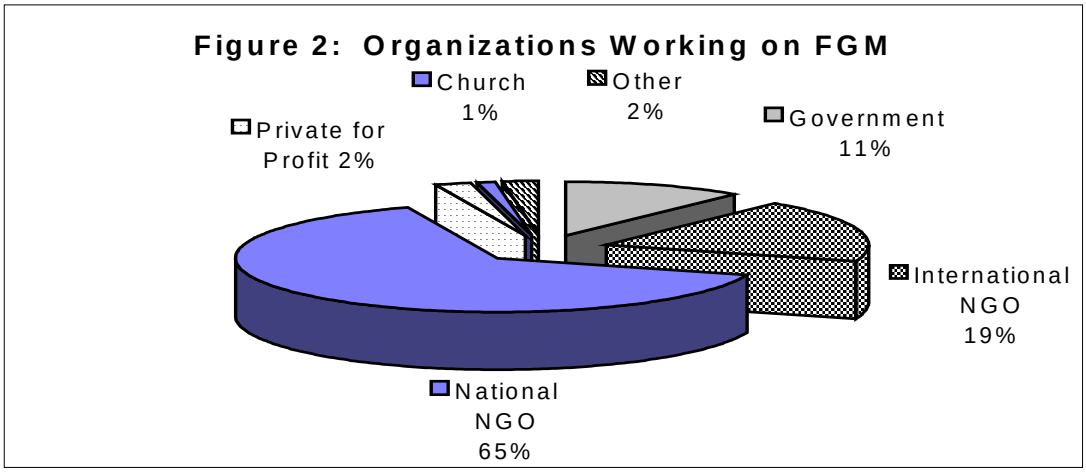
Recommendation 1: Governments and donors should continue to foster the groundswell of agencies involved in FGM elimination by providing technical and financial support.

Data from the survey and the country assessments provide an overview of the agencies implementing anti-FGM programmes. Among the organizations that responded to the survey[1], non-governmental organizations (local, national, and international) implement the majority of FGM elimination programmes; they represent 84 percent of those who responded to the survey (see figure 2). Government agencies represent 11 percent of the respondents. Slightly more than half of the programmes are implemented at the national level, while 44 percent are regional and 36 percent are district-level programmes. The country assessments revealed that there are three distinct ways anti-FGM activities are being carried out: 1) national level programmes, the majority of which are those run by National Committees of the Inter-Africa Committee on Harmful Traditional Practices (IAC) (see box 2); 2) non-governmental organization (NGO) networks, like the example in Egypt; and 3) smaller scale, community-based programmes (See Section VIII for examples of successful programmes). Each of these models has strengths and weaknesses that will be

[1] 102 organizations returned questionnaires; however, the survey data present throughout this report are from 88 of those responses - the organizations currently carrying out FGM programming. The other respondents were groups who said they planned to initiate anti-FGM activities.

highlighted throughout the review. Generally, there is a trade-off between the reach of national and network programmes, i.e. how many people they can influence, and the intensive behaviour change orientation of the community-based activities.

FGM programmes are predominantly implemented by non-governmental organizations.



Box 2: The structure of IAC chapters

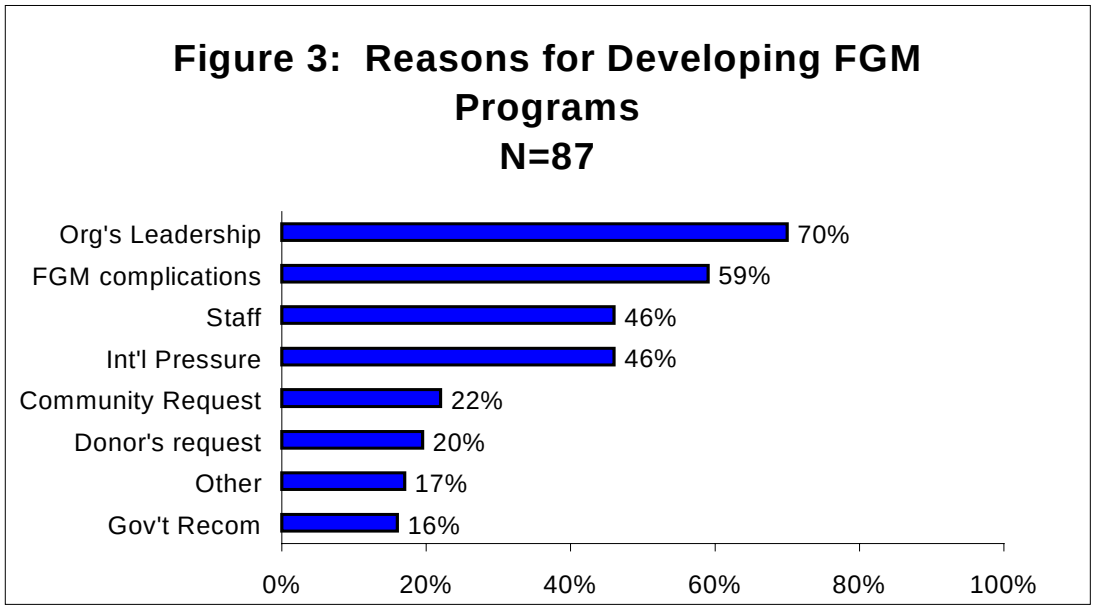
According to the IAC, which was established in 1984, there are at least 26 national chapters that are campaigning against harmful traditional practices (HTP), including FGM. Some of these chapters have small programmes (Mali), have never implemented any anti-FGM activities (Kenya), or have been overshadowed by stronger agencies (Egypt) (IAC, 1997). Others are more dynamic; in Burkina Faso and Ethiopia, anti-FGM programmes have been successfully implemented by national IAC chapters. The following IAC organizational and programme model is used:-

- **Formation of a national committee.** The National Committee on Traditional Practices of Ethiopia (NCTPE) and the Committee National De Lutte Contre Le Pratique De Excision (CNLPE) in Burkina Faso are inter-agency committees that include representatives from government, the United Nations, other donors, non-governmental organizations, and development agencies. They coordinate all FGM elimination activities in the two countries.
- **A permanent secretariat.** Both country committees have permanent secretariats that plan and implement national programme activities. The Burkina Faso secretariat, for example, has 12 employees, including four social workers, one sociologist, and one police officer. The permanent secretariat organizes an annual general assembly as well as regional or sub-committee meetings and is responsible for development of national, regional and sub-regional action plans.
- **Provincial or Regional Committees.** In each country, regional programme activities are implemented by provincial or regional sub-committees. In Ethiopia, the NCTPE established 10 regional sub-committees in 1995, after a mid-term evaluation indicated the need to strengthen programme activities at the regional, district, and community levels. Similarly, the CNLPE has established 30 provincial committees, drawing its membership of 750 from regional-level civil servants as well as representatives of development agencies and traditional chiefs.
- **A trained group of resource persons**. Both committees have trained a group of resource persons, drawn from non-governmental and governmental agencies at national, regional/provincial and community levels. To date, NCTPE has trained 198 resource persons and CNLPE has trained 826 people to support programme activities at all levels.

The survey highlights the reasons why the respondents started to carry out anti-FGM activities. FGM programme development was prompted by the organizations' leadership (70 percent) and by concern about the high rates of FGM-related medical complications

(59 percent). However, increased international awareness and pressure, as well as staff visits to the anti-FGM programmes of other organizations and attendance at seminars and workshops were also important reasons for programme initiation. The category "other" includes requests from the local community and donors, government recommendation, the death of two baby girls, the spread of HIV/AIDS, and in one case, personal experience with FGM and its related complications (see figure 3).

Commitment from the organizational leadership and concerns about the complications of FGM prompted initiation of most FGM programmes.



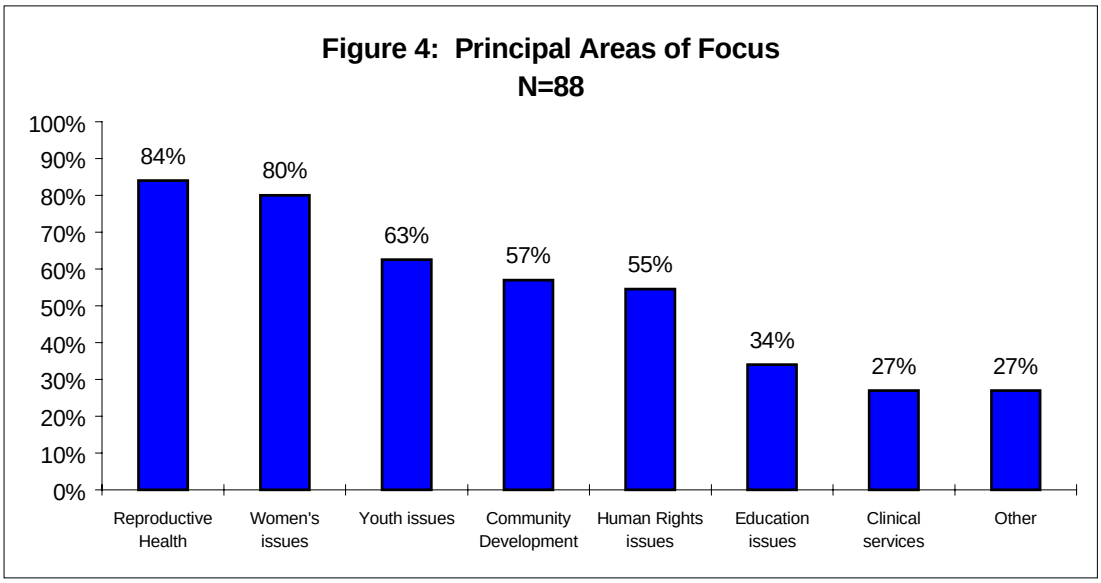
The majority of the survey respondents indicated that they had initiated their FGM elimination programmes within the past three years. This underscores the expansion of anti-FGM activities after the Beijing and Cairo Conferences, especially by agencies working on the topics of women, youth, and human rights. Still, a significant number of agencies started their programmes more than 3 years ago (26 percent), and some as long ago as 16 years (16 percent). The older agencies are more likely to be national committees that have been active in the field since the establishment of the IAC in 1984.

Despite the increase in the number of organizations, programmes are not yet reaching all the FGM practising communities. The 46 organizations that responded to a question on how many people their programmes reached reported audiences of about 20.5 million individuals. The national programmes from Burkina Faso, Ghana, Guinea, and Tanzania reported reaching respectively six, close to five, four, and one million individuals, which represents more than three-fourths of the estimated total population reached. Among the remaining respondents, 41 percent reported reaching only between 10 and 100 thousand individuals, and 26 percent between 101 and 500 thousand.

The organizations working on FGM were asked to categorize the principal focus of their programmes. Most specified that they have multiple mandates. The data shows that the vast majority of organizations focused on reproductive health and family planning

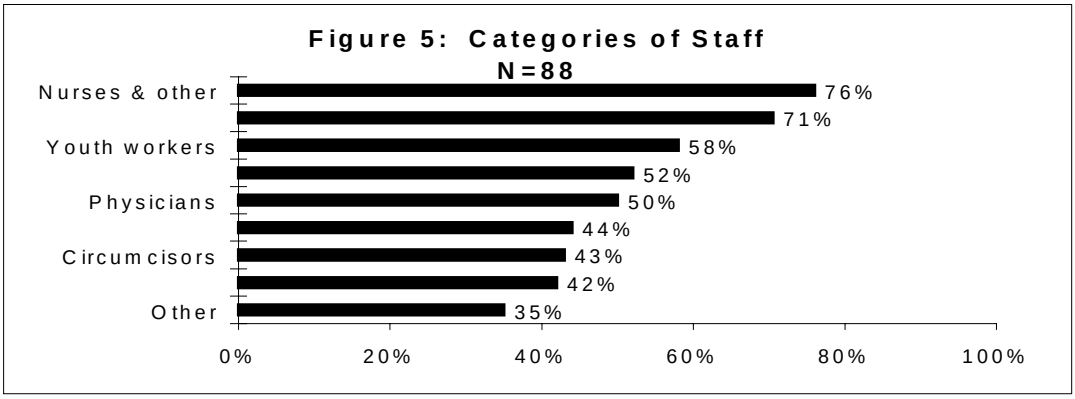
(84 percent), followed by women's and youth issues (80 percent and 63 percent respectively). In addition, more than half of the organizations also focused on community development and human rights (see figure 4).

Agencies involved in FGM elimination efforts are most likely to have family planning/reproductive health, women, or youth issues as their primary focus.



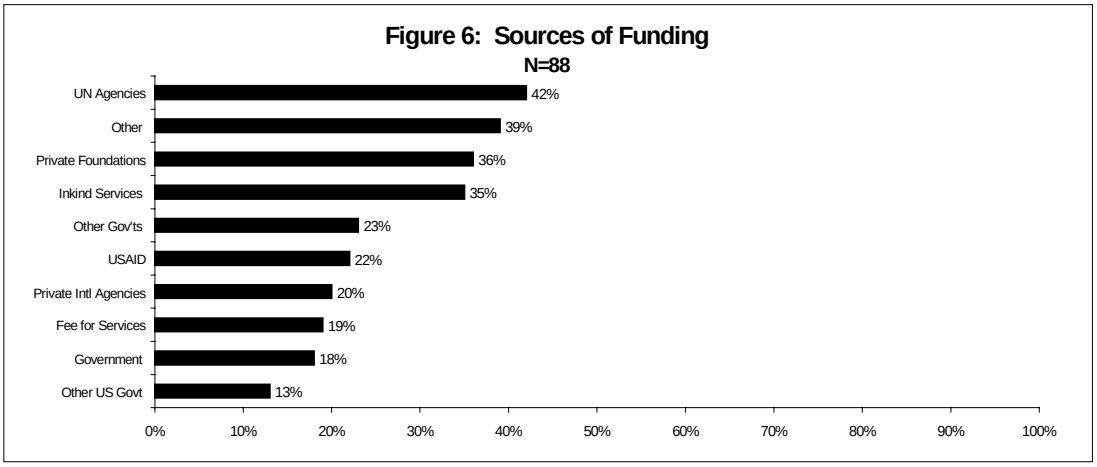
Most of the organizations involved in FGM elimination are relatively small and rely heavily on volunteers: two-thirds of the organizations have fewer than 20 part-time or full-time employees, while more than half recruited at least 20 volunteers. It is worth noting that nine organizations reported that they carry out their work entirely on a volunteer basis. Three-quarters of the agencies employed nurses for their anti-FGM work, while 71 percent employed counsellors/social workers, and 58 percent relied on youth workers. In addition to nurses, more than half of the agencies reported involving medical doctors and community health workers. One-fourth of the organizations recruited peer counsellors, researchers, and excisors for programme activities. The category "other" includes religious and community leaders, human rights' advocates, journalists, and policemen (see figure 5).

Programmes are most likely to use nurses, counsellors or social workers, and youth to carry out their activities.



The survey respondents reported receiving funding from a variety of sources, including the United Nations (42 percent), various US agencies (35 percent), and the foreign assistance agencies of other countries such as GTZ (Germany) or Canadian CIDA (23 percent). (See annex 3 for information about the multilateral agencies priorities.) Only 18 percent of the agencies reported that they received funding from national or local governments. However, 35 percent reported receiving in-kind contributions. The country assessments indicated that most of that in-kind support came from government sources and included office space, vehicles, or staff time. Nineteen percent of the agencies reported that they received money from fees, an important source of income if programmes are to become sustainable (see figure 6).

Most organizations rely on foreign funding for programme support.

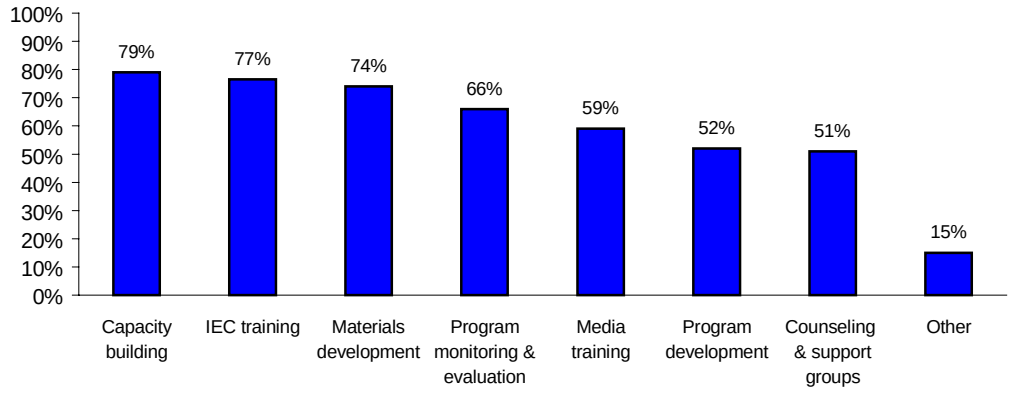


Except for some of the international agencies and a few successful IAC Chapters, most of the agencies have limited funds to support their FGM elimination efforts. Only 57 organizations provided information about their annual budgets. Among these, 12 percent have an annual budget of between $1,000 and $10,000, 40 percent between $10,001 and $50,000, 11 percent between $50,001 and $100,000, and 28 percent between $100,001 and $500,000 dollars. A few organizations (9 percent) stood out with annual budgets of more than a million dollars; these include both African-based and international non-governmental organizations. Forty-eight organizations provided further information on how much they spend on anti-FGM programmes specifically. Close to half of these (46 percent) have allocated between $500 and $10,000 to FGM programmes, while 23 percent have allocated between $10,001 and $50,000, 13 percent between $50,001 and $100,000, and 14 percent between $100,001 and $800,000. Again, the latter are mostly international non-governmental organizations and the successful IAC Chapters.

The survey asked agencies what type of technical assistance they most needed to strengthen their programmes. The respondents identified three inter-related areas: capacity building, IEC training, and materials development. Other areas included, in order of importance, programme monitoring and evaluation, media training, programme development, and counselling and support groups (see figure 7).

Agencies implementing FGM elimination programmes identified a need for technical assistance in the areas of capacity building, IEC, materials development, and programme monitoring and evaluation.

Figure 7: Need for Technical Assistance
N=85



The country assessments also indicated that most anti-FGM-implementing agencies could benefit from technical assistance in specific areas including advocacy, behaviour change communications, and programme monitoring and evaluation.

In sum, there is a positive trend towards increased involvement of non-governmental organizations in FGM elimination efforts. Several of these organizations had been working on this issue for between 3 and 10 years and have, therefore, accumulated significant experience. Others, motivated by the high profile that FGM received at the Cairo and Beijing conferences, initiated their work more recently. While most of the organizations are health-related, it is important to note that both the survey data and the country assessments highlighted the increased involvement of human rights non-governmental organizations.

The increasing number of non-governmental organizations working on this issue means that more people will be reached with anti-FGM messages at the national and local levels. However, the survey data and country assessments indicate that most programmes are fairly small and rely heavily on volunteers and funds from foreign donors. While the agencies and their staff are committed to their work, they generally needed institutional capacity building and technical assistance in IEC, including materials development, media training and advocacy, as well as programme monitoring and evaluation.

A critical mass of organizations is needed to bring about positive change in the anti-FGM campaigns; the data shows that a groundswell of organizations are now working on FGM elimination. These organizations represent an array of national-level programmes and focused community-based programmes. A foundation has been established, yet many organizations still need assistance in shaping their skills and expanding their reach.

Recommendation 2: Governments must enact, and/or use anti-FGM laws to protect girls and educate communities about FGM.

Passing anti-FGM legislation is one of the most controversial aspects of the FGM elimination movement. Many persons working on FGM elimination acknowledge the need for a strong governmental stand against FGM - a stand reflected by a law. Thirteen percent of the organizations responding to the survey reported that the passage of an anti-FGM law was a contributing factor to the success of their programmes.[2] Respondents mentioned that anti-FGM legislation provides an official legal platform for project activities, offers legal protection for women, and ultimately discourages excisors and families fearing prosecution.

However, enforcement of anti-FGM laws in countries that have them is poor. It is common to find that in most FGM-practising communities there is little difference in practise between the educated (who might be aware of anti-FGM legislation) and the non-educated. While two-thirds of the survey respondents said that anti-FGM legislation would have a positive impact on their programmes, 15 percent felt it would have a negative effect. The biggest concern, expressed by supporters and opponents, is the possibility that such a law would drive FGM underground. Younger girls might be clandestinely excised, leading to more severe or fatal complications - complications that might go unreported for fear of prosecution. Even those who supported legislation against FGM suggested that it was risky to impose such a law on a community. Clearly, the best approach is that enactment of a law should go hand-in-hand with community education.

To date, at least eight African countries (Burkina Faso, Central African Republic, Djibouti, Egypt, Ghana, Guinea, Ivory Coast, Senegal, and Sudan) have passed laws or decrees prohibiting FGM (See Annex 4 for the status and summary of laws in FGM-practising countries). Other countries have a variety of decrees or general medical legislation that can be used to regulate or prohibit FGM (see Box 3). An assessment of the laws and decrees revealed that they do not all have provisions that protect women and girls from all forms of FGM. Many of the laws have loopholes that lead to the medicalization of the practice.

Box 3: Anti-FGM legal provisions

The laws and decrees have a variety of provisions that can be used to regulate or ban FGM:

- Prohibit all forms of FGM (Burkina, Guinea, Ivory Coast, and Djibouti), or only the more drastic types (Sudan).
- Provide for imprisonment and/or fines for both those who perform the procedure on a woman/girl and those who request, incite, or promote an excision by providing money, goods, or moral support (Burkina Faso, Ivory Coast, Ghana, Djibouti).
- Forbid performing excision on females either in hospitals or public or private clinics, except for medical indications and only with the concurrence of a senior obstetrician. The decree also forbids excision from being performed by non-physicians (Egyptian Ministerial Decree).
- Other laws prohibit injury that impairs the function of the body (Penal Code, Egypt), cruel and inhumane treatment (Penal Code, Guinea), and outlaws assault and grievous bodily harm (Penal Code, Mali).

[2] Note: many of the respondents were from countries that have no anti-FGM legislation.

In most countries with anti-FGM laws, the practice of FGM continues unabated. Except for Burkina Faso and Ghana, laws are not enforced, thus girls and women are not protected against damaging operations. In Burkina Faso and Ghana, however, perpetrators have been brought to justice: 36 in Burkina Faso and two in Ghana. Burkina Faso's National Committee educates the public about the law and uses public service announcements (PSAs), called "SOS Excision" to ask people to anonymously denounce pending cases of FGM. Law enforcement agents are often tolerant with first time offenders, choosing to educate them about the harmful effects of the practice, but repeat offenders face a prison term of several months and/or fines. The Committee believes that enforcing the law is crucial for an effective campaign against FGM. In Ghana, several local non-governmental organizations and watchdog committees throughout the country are prepared to intervene to stop excisors by going to the police. Some of these groups even offer refuge to women who fear they are about to be subjected to the procedure.

In countries that enforce the law, it is difficult to find the right balance between enforcement, community education, and dialogue. During the country assessment in Burkina Faso, the natural tension arising from the need to gain the trust of the communities and educate them about the harmful effects of FGM and the need to protect girls under the law was evident. In an interview meeting with school girls, for example, several girls who work with the Provincial Committee mentioned that FGM was being carried out clandestinely in their communities. Soon after this testimony, some of the older members of the Committee asked the girls why they had not reported these cases. The girls responded that they had only heard about them from others, and did not know who was performing the procedures.

Similarly, messages from the "SOS Excision" PSAs come across as threatening: "You do FGM and I will tell on you"! In order to avoid this threatening approach, which can stifle genuine dialogue, it is important that committee members and project volunteers generally support but disassociate themselves from the law enforcement aspect of the work - leaving this to the police. It is also important to present the law as a protective measure for all communities rather than as an instrument of punishment.

Even though anti-FGM laws have some disadvantages, activists and grassroots non-governmental organizations generally agree that a law provides a back-up to their work by empowering them with legal support and by the extension of support of their governments. (See Box 4 for an interpretation by one law enforcement agent that the law in Burkina Faso is an "instrument for demarcating the right from the wrong.")

Ultimately, protecting the rights of each and every citizen is the responsibility of national governments. Both the survey and the country assessments indicated that while governments provided some political support to the elimination of FGM, the hard work of dealing with its sensitivities and funding anti-FGM activities was left to the non-governmental organizations. In essence, governments needed to do more to develop and implement support policies and laws.

Box 4: To pass a law or not to pass a law? Perspectives from the Chief of the Military Police in Ouagadougou, Mr. Issa Kabré (June 1998).

In my opinion, the law should be a complement to the educational efforts, because those who say they need to sensitize without arresting people will never be able to stop excision. All forms of FGM pose a major risk to the health of little girls. Even though many girls die each year, we are not informed. However, those responsible for the death of two little girls in Bobo Dialasso recently went to jail. If these deaths had taken place in a country that has only sensitization, the girls would have died for no reason. Persons responsible for death of innocent girls have to be brought to justice! My own mother was an excisor. After I got involved in the struggle against excision in 1984, I told her that if any of the girls she excises die, I would have no alternative but to arrest her. I asked her to stop carrying out this criminal activity. She stopped and that saved me some anguish.

The story of an excisor will illustrate my point. An excisor was notified in 1986 to stop excising and notified again in 1991. After she continued to excise, the NC trained her in 1995. She promised, in a televised interview, that she would abandon the practice and educate her peers and community. She was caught excising in 1997 and was taken to jail. You can educate excisors to death but they will not stop unless they are afraid of repercussions.

In Banfora in Western Burkina, between 20 and 50 girls are excised at the same time, as a rite of passage before marriage. The grooms carry the newly excised girls on their shoulders and dance around with them; sometimes with blood spilling all over their bodies as a sign of bravery. The girls often faint in the process. When we learned that the excision ceremony was coming up, we notified all involved including the traditional chiefs that the marriage can take place but excisions are not permitted. The chiefs, community police and elders all insisted that stopping the practice will be a disgrace to their community and culture. They went ahead and authorized the excisions. Seven community leaders are currently in jail.

Similar cultural practices practised in the past are no longer tolerated and were stopped with the law. For example, in the past, if a young man wanted to marry, he could not ask the hand of a girl until he showed that he can provide for his family during hard times. In order to prove this, the young man had to steal cattle from other families without being caught. Today, this practice is not tolerated, and has completely stopped. People know that they can go to jail for such an offense. Those who excise girls, take away parts of their body, put them in immediate and long-term risk.

Only the law can protect girls and clarifies what is wrong from right. The fact that the law can protect girls if properly applied is illustrated in the case of an official in Ouagadougou, who was planning to send his two daughters to their grandparents in the rural areas for excision. The girls informed their friends who in turn notified the National Committee on Excision. The gendarme (military police) notified local police and health care providers in the rural village who contacted the grandparents and warned them not to attempt excision. When the girls arrived in the village, the grandparents were asked to present the girls for examination before they returned to their father. They complied and excision was prevented. In this case, having a law in place gave the police, committee and health professionals the legitimacy to intervene.

Recommendation 3: Governments need to be active in both policy and implementation.

National governments are providing political and in-kind financial support to non-governmental organizations working on FGM elimination activities. As Figure 6 indicates, while only 18 percent of the survey respondents reported receiving funding from governments, 35 percent reported receiving in-kind contributions towards their FGM elimination efforts. The country assessments indicated that the non-governmental organizations carry out their FGM elimination activities independently but with strong support from relevant ministries. For example:

- The **Ethiopian** National Committee has the strong support of the Ministries of Health and Social Affairs. In addition, Committee members include staff from many relevant ministries, non-governmental organizations and donors.

- **The Burkina Faso** National Committee is similarly supported by the Ministry of Social Action and Family, which houses its employees, provides vehicles and some staff support, adopts its documents as official government documents, and has enacted a law following the Committee's lobbying and advocacy activities. On one occasion, the Ministry of Social Action and Family sent out a circular directing the military to educate its personnel and their families on the harmful effects of FGM and the anti-FGM law.

- The **Egyptian** Taskforce operates under the auspices of the National non-governmental organization Commission for Population and Development. While there is no anti-FGM law in Egypt, there have been a series of ministerial decrees forbidding the practice in government hospitals and clinics.

- In **Mali**, the Ministry of Women, Children, and the Family (MWCF), with the involvement of the NGO Network and all donor agencies, recently developed a national plan of action aimed at reducing the prevalence of FGM by the year 2002 and eliminating FGM in all its forms by the year 2007. Non-governmental organizations and the Ministry are still working to develop a mechanism for cooperation and coordination.

Nonetheless, despite some degree of governmental support for the activities of the Committees, the relevant ministries often implement only limited anti-FGM activities themselves. For example, in Ethiopia, where most government agencies are members of the National Committee and their policies include prohibition of harmful traditional practices (HTPs), each agency sees the Committee's work as their own, and they do not have specific activities aimed at elimination within their national programmes. This indicates that except for a few countries, governments are either silent on the issue or leave the responsibility of eliminating FGM to the non-governmental organizations. A quarter of the respondents also mentioned that lack of government support is a major constraint to their activities. In addition, public pronouncements about FGM by high-level policymakers can backfire if taken out of context. In the case of Kenya, when President Daniel Arap Moi made a statement in the early 1990s, his remarks were met with opposition and had the unexpected effect of

forcing more girls to be excised at earlier ages and at unconventional times - midnight, for example.

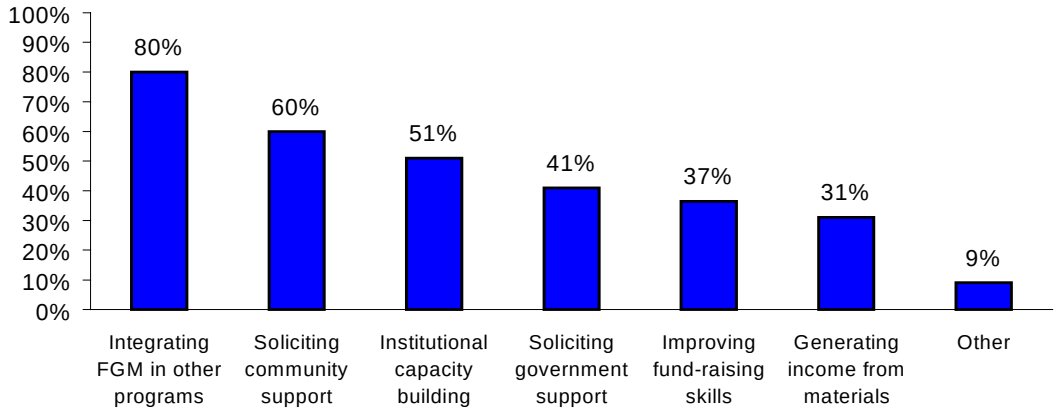
The country assessments highlighted that while government involvement at the policy level was already underway, the task of implementation by all tiers of government was just starting. A key role for governments, as the momentum to eliminate FGM increases, is to "scale-up" anti-FGM activities. There are now excellent implementation models that have, in general, been carried out on a pilot or localized basis by non-governmental organizations. These need to be expanded, either by direct government interventions or by increased support for networks such as those in Egypt and Mali.

Recommendation 4: To sustain programmes, FGM elimination activities must be institutionalized or mainstreamed, primarily into relevant government ministries programmes.

To achieve sustainability, the majority of survey respondents reported working to integrate FGM issues into other programmes, soliciting community support, and working to build institutional capacity. Other important sustainability efforts include soliciting government support, improving fundraising efforts, and generating income from programme materials (see figure 8).

Anti-FGM programme implementers use a variety of techniques to develop sustainable programmes.

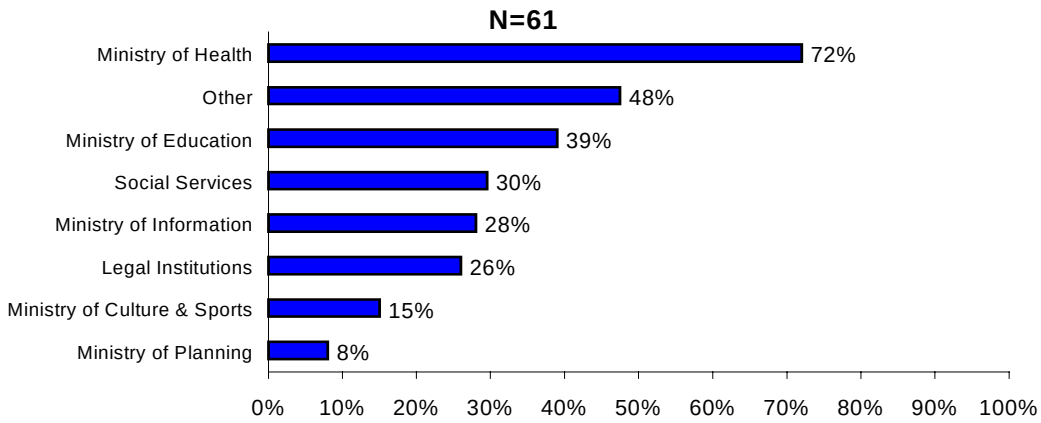
Figure 8: Sustainability Efforts
N=85



Among the groups that reported working on integration, nearly three-quarters mentioned working with Ministries of Health, and about one-third reported working with Ministries of Education, Information, and Social Services. The "other" category for integration includes universities, women's rights services, immigration services, religious institutions, and the work of other non-governmental organizations (see figure 9).

Anti-FGM programme implementers have made some progress towards integrating FGM issues into government programmes, but much more needs to be done.

Figure 9: Other Agencies Receiving Integration Assistance



Similarly, the country assessments indicated that anti-FGM programme implementers have made some progress in integrating anti-FGM activities into various governmental programmes. For example:

- In **Burkina Faso**, the National Committee promotes institutionalization of FGM through participation in national events such as the international day of population, the national culture week, and the day of the child. The Committee has also developed plans to integrate FGM elimination into all the relevant ministries and has taken some steps towards that goal, including: training media professionals on how to report on FGM issues; training teachers and incorporating FGM in the natural sciences in pilot schools; initiating awareness-raising activities in universities; training different levels of health care providers (including midwives, obstetricians and gynaecologists); and reaching out to religious groups and the police through support committees. The Committee is currently negotiating with the Ministry of Education to include FGM in the Family Life Education (FLE) programme.

- The **Egyptian** Taskforce advocates for increased anti-FGM programming at the national, regional and local levels by working with government agencies and other private, educational, or religious institutions. In addition, its grassroots sub-committee trains local non-governmental groups on FGM issues and assists them to access funding from donors - thus building a groundswell of agencies which are capable of implementing anti-FGM programmes.

- In **Ethiopia**, one of the National Committee's strategies is to integrate elimination of harmful traditional practices into the work of its member organizations including local and international non-governmental organizations, churches, and government institutions. The Committee has integrated information campaigns into the activities of the Ministry of

Agriculture's rural development agents and encouraged the Ministry of Education to include FGM in school curricula.

Despite some success, the country assessments also highlighted how difficult it is to mainstream anti-FGM programmes:

- In **Mali**, while a commitment to the elimination of FGM has been expressed by various ministries, activities have not yet been mainstreamed, especially in programmes carried out by the Ministry of Health. FGM is not included in the standard pre-service training programmes for health staff - for example, the teaching curricula of the main medical schools in Mali do not include FGM as an adverse health practice (The Population Council, 1998a). Staff at health care facilities have not yet been fully involved in many anti-FGM efforts with only very few clinics (18 out of 82 community health centers and district level rural health centers in Mali) having included this topic in their routine IEC sessions (The Population Council, 1997; The Population Council, 1998a).

- In **Egypt**, human sexuality - including the functions of the female external genitalia - is not taught as part of educational protocols in medical schools or any other school/colleges (CIHRS, 1998).

- In **Ethiopia**, the findings from a 1996 Safe Motherhood Assessment, carried out by the MOH, illustrate the limited integration of FGM elimination into government agencies' programmes (Family Health Department, 1996). When trained and untrained TBAs working in 96 health facilities were asked about the educational messages and the advice they give to their clients after delivery, neither group mentioned providing information on HTPs, (Harmful Traditional Practices) such as FGM, despite the fact that most girls undergo excision during infancy. The same study assessed the types of IEC material available at the 96 clinics: 14 percent had no materials, and the others only had posters, none of which were on HTPs, including FGM.

The data showed mixed success with mainstreaming of anti-FGM activities into existing programmes. The organizations were doing a good job in fundraising, have initiated efforts to integrate anti-FGM activities into government and civil society programmes (Burkina Faso, Egypt, and Ethiopia), and have begun to solicit community support. However, none of the programmes seemed to be sustainable in the long term. Programme implementers need to continue to work on mainstreaming anti-FGM efforts into existing programmes, including community-based programmes that have the potential for changing social norms.

Recommendation 5: Health care providers at all levels need to receive training to manage FGM complications and to prevent FGM.

A key foundation for anti-FGM work is to raise the awareness of health care providers to FGM-related complications and to provide them with the skills and resources to manage these complications. In a recent report by Macro International, among all women between the ages of 15 and 49 in Central Africa Republic, Egypt, and Eritrea, more than 1 million had experienced FGM-related complications (Carr, 1997). High levels of complications are likely

in any FGM-practising country, especially those communities where the more severe forms are common. For example, in Ethiopia, health care providers who participated in the 1996 health facilities assessment confirmed that they encountered adverse effects and complications arising from many harmful traditional practices. The most adverse effects follow uvulectomy[3], milk tooth extraction, and female excision. Similarly, in a survey of 55 health care providers in one Kenyan district, almost half of the service providers reported encountering women with chronic FGM-related complications, including bleeding, infections, and delivery complications (Abwao, et al., 1996).

Health care providers often encounter women with FGM-related complications, yet equally often they do not have the skills to treat and counsel these women, nor to prevent recurrence of FGM. There was limited training on the clinical management of FGM complications. There are no evidence-base tested protocols for delivering infibulated or excised women. There was no counselling for women suffering from psychological or sexual problems related to FGM. Excised women therefore lack access to high quality and relevant services in most countries. Excised infibulated women (Type III FGM), who live in countries where most people practise clitoridectomy or excision, are especially at a disadvantage since they may be subjected to unnecessary caesarean sections. A recent report on the position of Egyptian physicians on FGM highlighted the problem. The data indicated that most physicians have not studied sexual health, and those who had, studied it in a limited fashion. Further, the approval level of physicians for the continuation of FGM was similar between those who had studied sexual health and those who had not (52 percent and 46 percent respectively). Even more worrying was the fact that about 79 percent of the physicians who support FGM believe that they can counsel women about sexuality issues. The report further indicated that some medical school professors had written to newspapers saying that FGM is necessary for 30 percent of Egyptian women (CIHRS, 1998). This further demonstrates the lack of knowledge and training among physicians.

In contrast to the situation in many countries, Burkina Faso's National Committee has made substantial progress in mainstreaming the clinical and psychological management of FGM complications by forming an alliance with Dr Michel Akotionga, an obstetrician and gynaecologist at one of the main hospitals in Ouagadougou. Through this collaborative effort, 95 doctors have been trained on how to manage FGM complications. Referral guidelines have been developed, and the hospital now serves as a referral center and receives women from all over the country for various complications including lacerations, fistula, or delivery of women with Type III FGM. Fistula repairs are performed by an obstetrician/gynaecologist and a urologist. Lack of simple medications such as anesthesia, however, hampers work in this area.

[3] Uvulectomy is the cutting of the uvula, the pendent fleshy lobe in the middle of the posterior border of the soft palate. Complications of this practice include infections and meningitis, among other diseases.

According to a prominent Burkina Faso physician, more young educated women are experiencing psychological complications of FGM. They feel that their lack of sexual satisfaction is due to FGM. "Many of them are very angry at their parents and society", said Dr Akotionga. He cited the example of a newly married, 18-year-old daughter of a medical doctor, who was excised at an early age, reportedly by grandparents while her father was abroad for studies. Because sexual encounters with her husband were very difficult, she felt that her father, educated and a medical doctor, could have saved her from this brutal culture. The young woman was extremely upset and angry with her parents.

Health care providers need pre-service training, continuing education forums, special in-service training, treatment and counselling guidelines for all complications. In Mali, Plan International, an international non-governmental organization, is supporting continuing education for health professionals, medical students, and non-governmental groups on FGM and other health issues, through seminars co-organized with the Faculty of Medicine, Pharmacology, and Dentistry and the Malian Society of Medicine. At one such continuing education session held in June 1998, faculty members presented slides showing different types of complications including delivery problems, urinary retention, secondary infibulation, and a case of vitiligo where the vulva lost its natural color after the trauma of excision. A strong case was made for all health care providers to stand up against the practice.

FGM is being increasingly medicalized in Africa, in part by parents' desire to reduce complications of FGM and fear of HIV/AIDS if traditional excisors perform the procedure (see Box 5), and in part because many health care providers still support the practice. For example, in Egypt, girls are three times more likely to be excised by physicians (55 percent) than were their mothers (17 percent) (EDHS, 1996). Similarly, according to the Mali Demographic Health Survey (DHS), only two percent of women were excised in hospitals or other health care facilities, while five percent of their eldest daughters were. It is clear that excision is becoming a source of income for health care providers and hospital cleaners (who pose as health care providers) to the community. Consequently, many health care providers are on the one hand treating or referring the immediate and long-term complications of FGM to the hospitals, while at the same time excising girls, including their own.

Women also need to be educated to come forward with FGM-related complications, and a referral system needs to be put in place to provide essential services. Many women suffer serious complications that affect their entire lives, but they have never been able to come forward for services. For example, a 50-year-old Malian woman recently confided to a member of ASDAP - a non-governmental organization working on FGM - that she had a problem that she thought might be related to her excision. After being examined, it turned out that she had a cyst that she had tried to cut off over the years by pulling it away from her body, and it was now dangling between her legs. This woman never mentioned a word to anyone even though the cyst affected her most of her life. She had withdrawn herself from sexual life until she learnt the reasons for her problem from ASDAP.

Box 5: FGM and HIV/AIDS

Besides the many documented immediate and long-term complications of FGM, the possible role of the FGM operation in spreading HIV/AIDS infection is of increasing concern. This is because girls are usually excised in groups (for example, up to 50 girls are excised together in some parts of Burkina Faso) using the same instruments, without any kind of cleaning between operations of initiates. Although scientific data is not available, the FGM operation itself may facilitate the transmission of HIV/AIDS in cases where:

- An infant born with the HIV virus is excised together with uninfected infants using the same blade; or
- A young girl infected with the HIV virus through early sexual intercourse is excised with uninfected girls using the same instrument. In addition, FGM may contribute to the spread of HIV/AIDS among married women, since excised women may have a scarred or dry vulva[4] that can be easily torn through sexual intercourse. This makes it easier for a woman to be infected with HIV if her partner is infected.

Anti-FGM implementers have been responding to the threat of HIV/AIDS. According to the survey, 81 percent of the agencies reported that the "performance of FGM with the same instrument may facilitate the spread of HIV/AIDS infections". This is one of the key messages of their programme.

Recommendation 6: Governments, donors, and non-governmental organizations must continue coordination with all agencies working on the elimination of FGM.

Findings from the field assessments revealed an impressive array of efforts to coordinate activities and facilitate exchange of information and resources among non-governmental organizations, governmental institutions, donors, and funding organizations. The agencies generally invite each other to policy-related and research dissemination workshops, and training activities. For example, 50 percent of survey respondents mentioned involving staff from collaborating agencies when developing messages for their programmes. Examples of collaboration are shown below:

- In **Burkina Faso**, the National Committee enjoys excellent collaborative relationships with government institutions, donors, and civil society organizations in the country. The agency operates under the auspices of the Ministry of Social Action and Family, which legitimizes its programme while at the same time allows it to operate autonomously. Consequently, it has been able to carry out intensive lobbying efforts, resulting in endorsements by the Head of State and his wife (who is the Honorary President of the Committee), identification of excision as a public health priority, fundraising with potential donors, and the adoption of its reports as official government documents.

- In **Ethiopia,** the National Committee's network of collaborators is similar to the National Committee in Burkina Faso. They have also been successful in collaborating with and receiving funding from a variety of donors, each of which supports one or several regions of the country without overlap.

[4] FGM alters the normal mucosa of the vulva since lubricating glands may have been removed. This causes dryness of the vulva area.

- In **Mali,** coordination and information sharing among non-governmental organizations occurs via the NGO Network, which is coordinated by the Ministry of Women, Children and Family (MWCF). Several seminars held during 1997 and 1998 facilitated this coordination, which led to the development of a national action plan. The Network has also assisted local non-governmental organizations to access funding from donors, including European donors, United Nations agencies, and international development agencies such as the Population Council and Plan International.

- In **Egypt,** the FGM Taskforce has the role of coordinating the activities of non-governmental groups. One of the Taskforce's major strategic objectives is to build alliances with health, human rights, and development groups. The Taskforce hosts monthly meetings for its members, and the minutes are used to understand membership needs, avoid duplication of efforts in research or campaign activities, disseminate information, and share lessons learned. The Taskforce also assists members to share materials and access funding.

While all the agencies strive toward increased coordination of activities, competition for funding, disapproval of each others' strategies, and personality conflicts sometimes impede collaborative efforts. However, these obstacles should not discourage anti-FGM groups from continuing to collaborate and build on each other's strengths.

Recommendation 7: Given the importance of advocacy, international agencies must help non-governmental organizations to develop their advocacy skills.

> **"**When trying to eliminate FGM, it is important to involve everyone in the dance," Traditional Chief, member of Burkina Faso's Support Committee on Excision

Advocacy is essential to ensure that FGM elimination programmes are funded, implemented, and maintained, until FGM becomes a thing of the past (Advocates for Youth, 1998). Advocacy involves making a case in favor of a particular issue or a cause, using skillful persuasion and/or strategic action. The components of a successful advocacy campaign include utilizing the power of numbers to achieve goals through coalition building, promoting goals to the public, influencing the legislative process to support FGM elimination, and educating and involving programme beneficiaries.

As the survey data indicated, 69 percent of the respondents identified advocacy as one of their programme components. This emphasis on advocacy was confirmed during the country assessments. The Egyptian Taskforce, which became more active in response to a crisis during the Cairo Conference when the Ministry of Health issued a decree allowing FGM to be carried out in hospitals, operates under a typical advocacy framework to achieve its goals:

- Utilizing the power of numbers through coalition-building: The Taskforce recruits, supports and maintains a coalition of like-minded organizations and individuals. It provides a forum that is open to all interested parties to exchange information and experiences, and build partnerships. Without encroaching on member organizations' mandates and activities, the Taskforce

informs, motivates, monitors, and maintains the coalition and its activities through monthly meetings and public education materials.

- Influencing legislation: The Taskforce has been successful in mobilizing its membership, including human rights groups, the media and policymakers, to defeat the decree medicalizing FGM and later to overturn the court case that tried to revoke the 1996 decree that prohibited FGM.

- Public education through campaigns: The Taskforce has a grassroots sub-committee that is responsible for grassroots mobilization. Since 1995, it has organized and participated in several workshops throughout the country, from Alexandria to Upper Egypt. These workshops were either organized by the Taskforce, or by other organizations who invited the Taskforce to coordinate one or more sessions about FGM. The workshops focus on networking and building links between concerned parties in their respective communities. They also focus on building the capacity of these groups to do advocacy work and increase their sense of empowerment to enable them to elicit change within their own communities.

- Documentation and information dissemination: The Taskforce has a resource center that collects research and evaluation data and disseminates this information to the general public through workshops, newspaper articles, and periodic meetings of its membership.

Other countries have employed a variety of successful advocacy strategies. In Mali**,** members of the NGO Network, the MOH, and the MWCF formed a strong coalition against any medicalization of the practice, as had been suggested by the National Union of Muslim Women of Mali (UNAFEM) during their convention in December 1997. Government officials and non-governmental members were interviewed by the press and they explained their opposition to the position of the Muslim women and educated the public about the negative effects of medicalization. Countering negative propositions right away is an excellent strategy; however, it is not enough. It is also important to study the opposition's reasoning, and to develop specific activities to reach them.

In other countries, some of the agencies have used testimonials from women affected by the practice. This is an effective but under-utilized strategy for lobbying and public education purposes. There are many women whose daughters have died or suffered severe complications or who themselves have suffered severe complications. It is important to first educate them about FGM and then to speak out against FGM.

The anti-FGM movement received a big boost from the United Nations conferences held in Cairo in 1994 and Beijing in 1995. Many more groups have become involved in the anti-FGM campaign and are using advocacy strategies to make a difference. However, many of these groups need to have a better understanding of advocacy, and how to best use it to eliminate FGM. Groups should see their work as an effort to save girls from excision, and their actions should be centered around prevention of "the event of excision".

IV. COMMUNICATION FOR CHANGE

Behaviour change is the goal of all health communication programmes, including those aimed at the elimination of female genital mutilation and other harmful traditional practices. Over time, the field of health communication has evolved from the traditional information, education, and communication (IEC) strategies to behaviour change communication (BCC) to behaviour change interventions (BCI). The evolution in terminology is a reflection of the increased recognition of the complexities and difficulties associated with behaviour change.

Traditional IEC activities focus on promoting, informing, motivating, and teaching. They have contributed to successful efforts in the areas of family planning, child survival, nutrition and HIV/AIDS education. However, programme implementers often conduct IEC activities with a focus on awareness raising rather than behaviour change. This is, in many ways, a response to the length of time it takes to change people's behaviours and the need to focus on short term results. In addition, IEC materials are often not research based or pre-tested appropriately; the production of the materials sometimes becomes an end by itself. The messages, orchestrated without the involvement of the target audiences, are either imposing, such as "stop excising" or "use family planning", scary, as in "AIDS kills", with a picture of a skeleton or skull; demoralizing, such as, "plan your family or you will be poor" with a picture of a large, ill-fed family; or even neutral and thus hard to understand. People who receive the IEC materials may not be taught how to use the materials to support their programme activities. Well-designed IEC programmes may raise awareness and change attitudes - important components of behaviour change - but they are not usually sufficient to change complex behaviour.

In behaviour change communication (BCC), the field of health communication goes beyond developing the right messages for any particular audience to the recognition that behaviour change may also require skill-building, for example, how to resist being pressured to have a daughter excised, and building community support to sustain the change. Behaviour change interventions (BCI) additionally recognize that the desired behaviour change must be feasible and structurally encouraged. Therefore, the role of the socio-cultural environment and the context in which certain behaviours take place become important for project design.

Several behavioural scientists, including Everett Rogers and William McGuire, described the steps an individual must pass through in order to adopt the desired behaviour. These steps include: 1) awareness; 2) seeking information; 3) personalizing the information; 4) examining options; 5) reaching a decision; 6) trying the behaviour; 7) receiving positive reinforcement; and 8) sharing the experience with a larger group.

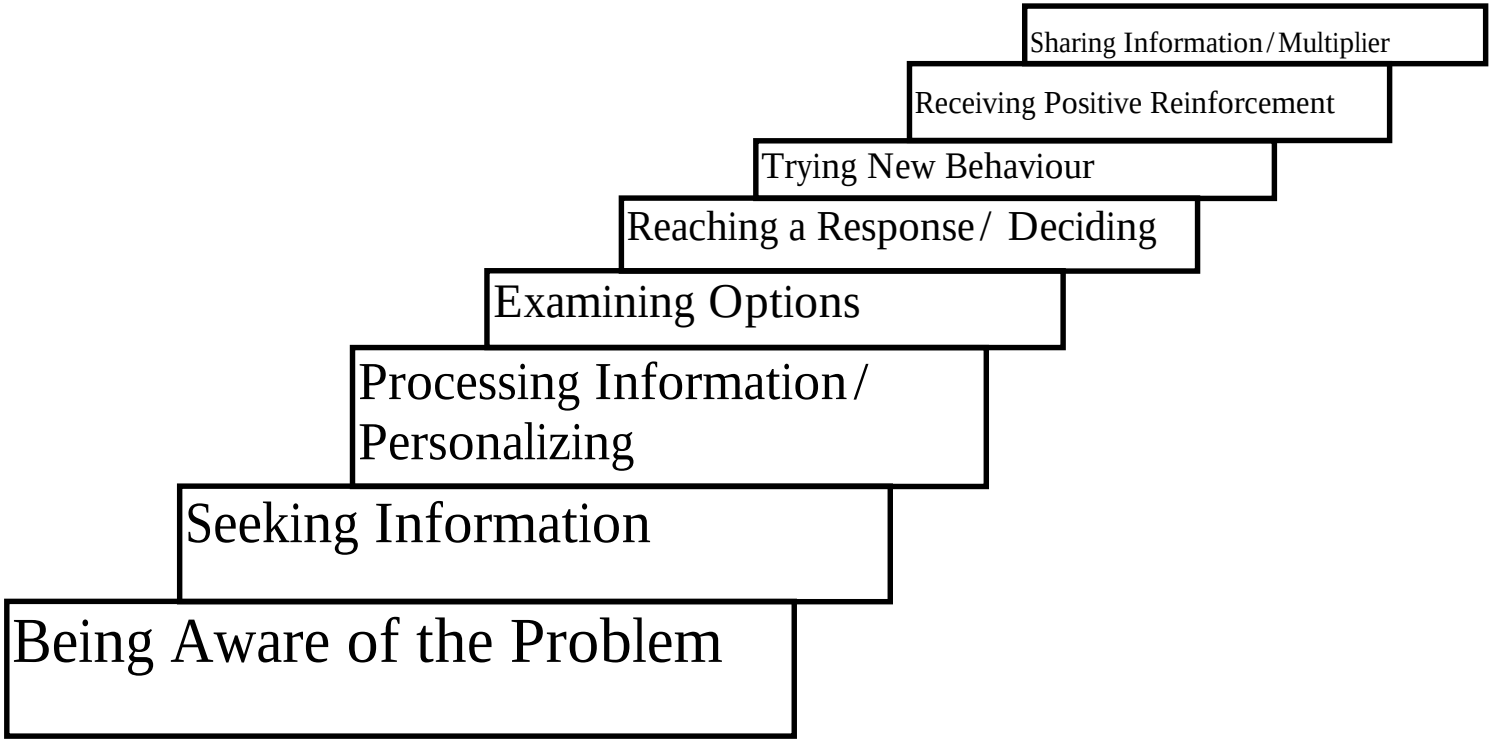
For example, the decision to reject FGM as a mother, grandparent, father, husband, aunt, teacher, older sibling, or a girl involves changes at different levels, including knowing that refusal is an option; finding such a choice desirable; reaching the decision to reject the tradition; figuring out how to put this decision into action; doing it and seeing what happens; and receiving positive feedback that allows the decision to stand. The final stage is the multiplier effect that a positive decision has when someone feels empowered to stand by his or her decision and "go public" with it, thus helping others reach the same decision. At all

levels, there is risk of failure, and individuals must struggle with the personal and community-level repercussions of their choices. (See figure 10 for Stages of Behaviour Adoption.)

Paying attention to the stages of behaviour change ensures that a communication programme will address all the factors that determine whether a message is received and absorbed, and whether the programme is staged to address audience needs as they evolve on the way to behaviour change. In his *Diffusion of Innovations* study, Everett Rogers suggests, for example, that mass media is a quick and effective route to introduce new information or influence attitudes (Rogers, 1983). However, at the point of trial, interpersonal channels are more influential. This means that a communications strategy might consist of using the mass media to introduce a message, providing knowledge, influencing attitudes, and reinforcing behaviour, followed by using the community or interpersonal interventions to teach and encourage the adoption of the behaviour.

While adopting a new behaviour is very difficult in and of itself, making a decision about an issue like excision on an individual basis is quite different to, for example, making an individual decision to adopt a family planning method. In the case of FGM, decisions are often made in a larger group, so even if a parent is ready to decide to stop the practice, it is difficult to hide the "no excision decision" from neighbours and family members as well as from potential grooms and in-laws.

Figure 10: Stages of Behaviour Adoption



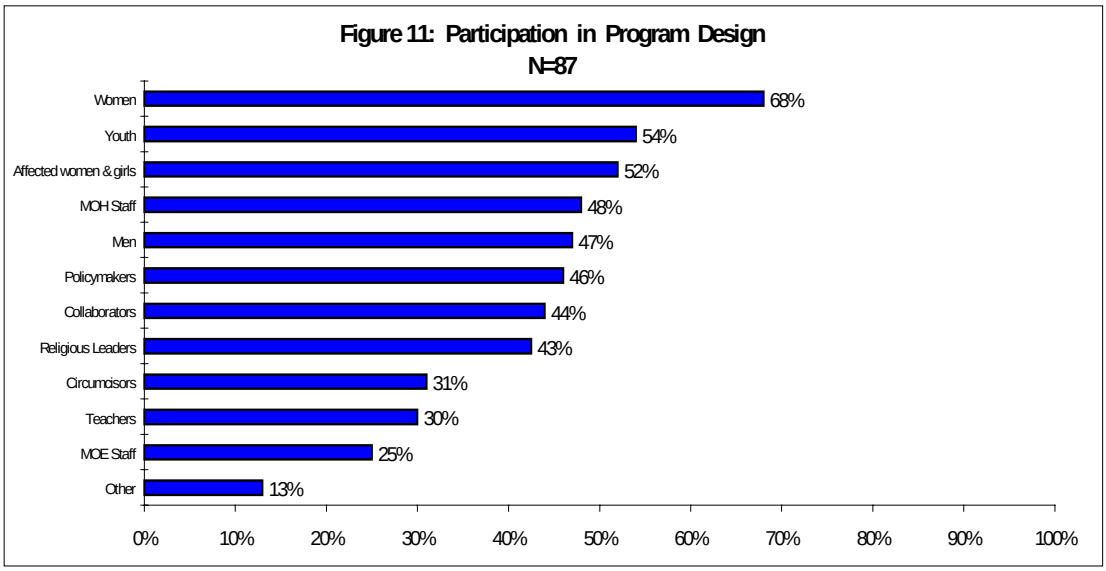
This section of the review assesses the extent to which anti-FGM programme implementers are using effective behaviour change interventions. The following set of questions will be addressed:

- Are programme designs participatory?
- Are a wide range of tailored approaches being used?
- Are youth being actively involved in designing and implementing programmes?
- Are positive community values being assessed and incorporated into programmes?
- Are programmes focusing on girls rather than perpetrators?
- Are IEC materials and messages tailored and research-based?
- Is training comprehensive and guided by the mental map?

Recommendation 8: Anti-FGM programme implementers must include all stakeholders in the design, implementation, and evaluation of programmes.

The survey included a question on whether anti-FGM programmes have been designed in a participatory fashion. Respondents said that they have used participatory approaches. Two-thirds said they involved women in programme design and over half included youth and affected women and girls. Among the professionals, staff from the MOH (48 percent) and collaborators (44 percent) were included. Policymakers and community leaders (46 percent) as well as religious leaders (43 percent) also contributed to programme design. Slightly less than half of organizations mentioned involving men in programme design, while a third mentioned involving excisors. The category "other" includes agents of social promotion, policemen, lawyers and legislators, and media people (see figure 11).

Organizations reported including a wide range of people in the design of their anti-FGM programmes.



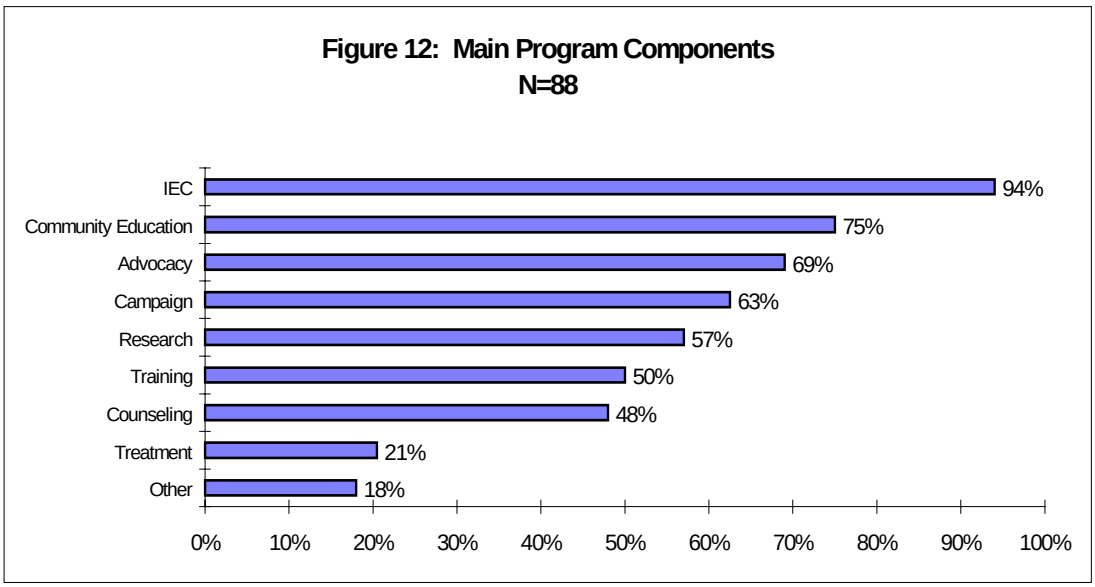
Although most agencies seem to have adopted a participatory approach to programme design, it is not clear whether they misunderstood the question and reported their target audiences instead. The assessment visits suggest that only a few programmes involved the intended beneficiaries in programme design. These include the community-based programmes in Kenya, Senegal and Uganda, as well as in programmes implemented by AMSOPT and Centre Djoliba in Mali. The Burkina and Ethiopian National Committees also ask training participants to assist in the development of their own action plans. More often, programme beneficiaries became involved only after the programme had been fully designed and was being implemented. A non-governmental group in Mali was unable to carry out the participatory, community-based design process it had envisioned because one of its donors required the group to spell out programme activities and strategies before funds were provided.

Recommendation 9: Anti-FGM programme implementers need to tailor their approaches to specific audiences; this requires a variety of programme approaches implemented in a strategic fashion.

To accomplish behaviour change goals, most of the respondents reported multiple programme components. Almost all of the organizations reported having an IEC component, followed by community education, advocacy, and campaigns. About half of the agencies also reported research, training and counselling as significant programme components. The "other" programme components include planning and organization of conferences and seminars, publications, civil and legal action, lobbying and legislation, and providing technical assistance (see figure 12). It is important to note that while 48 percent of the agencies reported offering counselling, only 21 percent reported offering services of clinical management of FGM-related complications. However, in a subsequent question, 56 percent of agencies reported making referrals for women with various FGM-related complications including psychological services (61 percent), medical services (61 percent), and legal services (29 percent).

IEC, community education, and advocacy are the three most frequently used programme components.

Figure 12: Main Program Components
N=88



IEC was also one of the main programme components in all the countries visited. In general, countries with national committees (Burkina Faso, Uganda) had major IEC components, while the community-based programmes (Kenya, Senegal, Uganda) relied mostly on community education techniques and used IEC materials as a support activity. Clinical management of women and girls suffering from FGM complications was more evident in Burkina Faso and Mali. Most programmes claimed that they provided counselling services but in general, counselling did not seem to be an organized part of their work.

The survey respondents were also asked to provide more detail on their specific implementation activities. More than two-thirds mentioned peer education and seminars/workshops for policymakers and community leaders. Respondents also mentioned three strategies that complement each other and are used for general public education: work with the media (65 percent), guided community discussions (63 percent), and campaigns (61 percent). Income generation for women, alternative income for excisors (conversion strategy), and alternative rites of passage strategies were each mentioned by more than a quarter of the agencies (see figure 13).

Figure 13: Implementation Strategies

N=88	**Frequency**	**Percent**
Peer education	59	69%
Seminars/workshops for policymakers and/or community leaders	59	69%
Working with the media (TV, radio, newspapers)	56	65%
Guided community group discussions	54	63%
Campaigns	52	61%
Family Life Education in schools	43	49%
Seminars/workshops for religious leaders	38	44%
Income generation strategies for women	29	34%
Alternative rites of passage ceremonies	25	29%
Alternative income strategies for excisors	24	28%
Other	16	18%

The country assessments also highlighted the fact that agencies involved in anti-FGM programming rely on a variety of approaches to change behaviour. The national committee programmes generally use a strategy called TIC – training, information, and campaigns. Almost all the IAC national chapters follow this TIC programme approach. However, national chapters add their own innovations to the strategy, as was seen in the Burkina Faso programme which has adapted various outreach strategies for its audiences including religious institutions, youth, couples, and the military police.

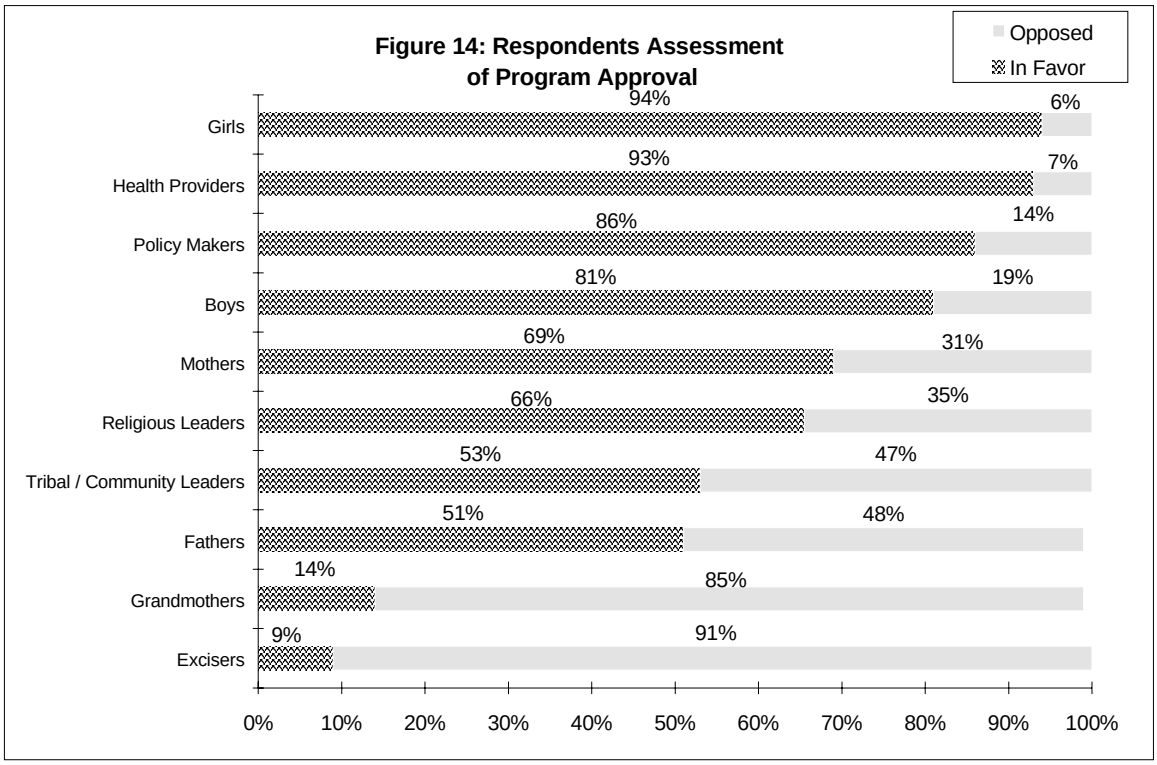
While non-governmental organizations and governments are clearly using a wide variety of techniques, the survey data and country assessments indicate that, in most cases, the choice of interventions is not decided in a strategic way, rather programmes are implemented in a haphazard fashion. Most programmes have not assessed where their target audiences are on the behaviour change continuum and thus are not necessarily using the best messages and approaches to prevent girls from being subjected to FGM.

Recommendation 10: Anti-FGM programme implementers should particularly focus on youth, both as key change agents and potential victims.

Findings from several DHS surveys and other research in countries indicate that a large number of ever-married adolescent girls, aged 15-19, have already undergone excision (Mohamud, 1997). For example, 98 percent of girls, aged 15-19, are excised in Egypt and Somalia, as are 92 percent in Mali, 90 percent in Eritrea, 86 percent in Sudan and 78 percent in Kenya. Furthermore, a large percentage of these adolescents would like to excise their daughters: Egypt, 93 percent; Mali, 92 percent; and Sudan, 77 percent (Carr, 1997).

Despite these alarming statistics, young and educated youth are more likely to disapprove of the practice than their parents. For example, in Eritrea, 41 percent of girls aged 15 to 19 want the practice to continue, compared to 71 percent of women aged 45 to 49. Among the survey respondents, 94 percent reported that girls were in favor of their FGM elimination programmes and 81 percent reported a favorable response from boys (see figure 14). Consequently, programme implementers consider youth as one of the most important target audiences and reach them mainly through Family Life Education initiatives in the school system and/or peer education programmes.

Respondents report that girls, health care providers, policymakers, and boys are most likely to approve of anti-FGM programmes, while excisors and grandmothers are least likely.



The country assessment studies also indicated that programme implementers viewed youth as the most receptive audiences to programme messages. For example:

- In **Ethiopia**, the Committee reached youth through its general IEC strategy and through a one-year radio programme. The committee has recently developed an innovative, more focused child-to-child activity representing a new and exciting initiative.

- In **Burkina Faso**, the Committee already works with several youth associations, and was negotiating with the Ministry of Education to include FGM in the national FLE (Family Life Education) programme. The Committee was also implementing a focused innovative initiative in one high school.

- In **Uganda**, the REACH project trained peer educators, who in turn educated their peers about FGM and conducted community education activities.

- In **Kenya**, MWYO developed a three-day peer educator curriculum and trained a total of 467 peer educators, who in turn reached 200 families each. Kenyan peer educators are a mix of adults and youth, and are responsible for recruiting girls and families for the alternative rites of passage programme.

- In **Egypt**, the new Horizons project targets rural girls (ages 9 to 20 years) with basic life skills and reproductive health information. To date, over 89 New Horizons Girls' Learning Centers have been set up and more than 4000 adolescent girls have completed the programme in four communities in the Minya governorate. At least 131 girls avoided FGM, and 17 families agreed not to impose the practice of bridal deflowering (test for virginity) on their daughters.

Despite all these initiatives, the country assessments indicated that integration of FGM into national Family Life Education (FLE) programmes is a political decision and that many non-governmental organizations have pilot-tested FLE programmes but have not succeeded in mainstreaming the issue. The assessment also indicated that peer education programmes are often not well designed, and that peer educators lack comprehensive information about FGM and the communication skills necessary to deal comprehensively with FGM. For example, one peer educator in Uganda was asked how to deal with the fact that parents sometimes curse their children if they refuse excision. The peer educator answered that the parents are trying to harass the youth. This kind of response, which criticizes parents in front of their children, may lead to parental opposition to FGM elimination programmes. Additionally, peer educators need continuous support, monitoring, and retraining, as well as question-and-answer booklets that address all the difficult questions that may arise during their outreach activities.

Reaching young people through in-school FLE programmes and peer education programmes for both in- and out-of school youth are important steps towards changing the attitudes, knowledge, and future practices of young people about FGM. Both the Kenyan FLE, peer education, and alternative rites of passage programmes try to get commitments from girls to prevent their own excisions and that of their sisters; from boys not to request for their wives to be excised; and both are asked to oppose excision in their families, neighborhoods and communities.

Recommendation 11: Urban elites must be included in anti-FGM programming.

It is important to base a behaviour change intervention on the community's readiness to change, i.e., where they are on the behaviour change continuum. According to the demographic and health surveys (DHS) conducted in Egypt, Mali, Sudan, Central Africa Republic, Ivory Coast and Eritrea, FGM is widespread among all socio-economic groups (Carr, 1997). The findings also indicate that in countries with high prevalence levels (89 %), there are no substantial differences in levels of genital mutilation among women based on education or residence. Similarly, in most of the countries studied, younger women appear nearly as likely to undergo these procedures as their mothers had been.

In nearly all the countries where DHS data on FGM is available, urban and educated women are more likely to oppose continuation of the practice than their rural and less educated counterparts. However, less favorable attitudes towards the practice may not necessarily translate into lower prevalence levels; a significant number of women who are opposed to the practice report having a daughter who has been, or will be, excised. For example, Sudanese women who are opposed to FGM mention that two reasons why the practice continues include "fear of social criticism" and the "insistence of old women."

These data indicate that while urban and educated women may have knowledge about the harmful effects of FGM and may have negative attitudes about the procedure, their daughters are still likely to be excised. DHS data also shows that young girls are more likely to be excised by health professionals than their mothers who were mostly excised by traditional excisors. Perhaps those who are knowledgeable about FGM and its health consequences and who approve elimination but do not know how to break out of the grip of tradition have taken the first step toward change, ironically by choosing medicalization. Under this scenario, FGM elimination implementers will have an easier time persuading these women to move along the stages of behaviour change and make informed decisions to not make their daughters undergo female genital mutilation.

Reaching out to generally urbanized communities and especially to educated women and men seems to be a forgotten agenda in FGM elimination programmes, which focus mostly on youth, rural, and uneducated communities. While developing community-based programmes for the rural and uneducated is a very important aspect of the campaign, it is important to remember that urban elites are still tied to rural communities and are emulated by their relatives in the villages. Decision-making is more individualized and easier also among the urban and educated elites than among the rural communities where collective decisions are more likely to take precedence.

Recommendation 12: Non-governmental organizations and other organizations working at the community level need to assess and build on the positive community values that underpin FGM, while working with the population to eliminate the practice.

Discontinuation of FGM is largely a matter of social, rather than individual change, thus it must be addressed primarily by the communities where it is practised, rather than by policymakers, educators, or health professionals. Traditional societies have always had mechanisms for thinking about, discussing, and resolving matters of importance in a

community context. These same mechanisms can be used to eliminate FGM by tapping local potential and animating the interest of the community with a new way of looking at an old practice.

These are the ideals advocated by Paolo Freire, an adult educator and advocate for the poor and powerless, who described the process of "conscientisation" in which the community articulates and solves its own problems (Hope et al., 1984). Many anti-FGM programmes have adapted parts of this philosophy (according to the survey, 63 percent of agencies mentioned using guided community group discussions as a strategy for community education) but several organizations have adapted it for effective communication-for-change projects. TOSTAN in Senegal, CEOSS in Egypt, MYWO in Kenya and the REACH project in Uganda, are all using effective strategies based on community empowerment, consensus building, and collective decision-making. (See Section VIII below for a detailed description of each of these projects.)

- TOSTAN (Breakthrough), a 10-year old Senegalese non-governmental organization, implements a community-based, basic education and literacy programme in rural areas of Senegal. TOSTAN conducts a year-long modularized education programme that covers such topics as sanitation and disease transmission, child health, women's health, human rights, project planning and implementation, and book-keeping techniques. The core of its programme is to teach women problem-solving skills, self-awareness and assertiveness through guided group discussions and outreach (Walt, 1998).

  A dramatic result of TOSTAN's activities was that a group of village women, after participating in the training - particularly the sessions on Women's Health and Human Rights - decided to take up the issue of FGM. Consequently, these women have mobilized all the people in their villages to declare that they will stop practicing FGM. Since September 1996, when the village of Malicounda Bambara pledged to refrain from FGM, an event known as the "Malicounda Commitment", 29 other villages - some of which have marriage ties - decided that they would ban excision from their communities.

- The core of the Coptic Evangelical Organization for Social Services (CEOSS) anti-FGM programme is to segment the community according to the number of leaders available, with each taking responsibility for a defined geographic area. Each community leader is required to monitor approximately ten girls per year using specially designed monitoring charts. Information about each girl, including questions as to whether a girl has undergone excision or not, is noted on these charts. If a girl reaches the age of 13 and remains unexcised she is considered out of risk of excision and, therefore, a successful case.

  This system of monitoring is complemented by seminars, meetings with religious leaders and training courses to educate the villagers. In these settings, any topics that require reinforcement are discussed, particularly religion. Refresher training courses are held the year round for local leaders, who may request to have the programme changed so as to include other issues of interest.

By focusing the programme on young girls, who are most at risk, relying on local community leaders who are active participants in community life, setting realistic targets to be achieved by the end of each year, and targeting all members of the family, the CEOSS approach has been both participatory and successful.

Another strategy for building on and indeed celebrating, community values is the alternative rite of passage. The idea of creating alternative initiation ceremonies, in which girls do not undergo the mutilating FGM operation but retain all the information and privileges associated with the traditional coming-of-age ceremonies, began with the initiation of the anti-FGM movement. However, implementation strategies for such programmes are more recent. Since 1996, two programmes implemented alternative rites of passage:

- Maendeleo Ya Wanawake Organization (MYWO), and its partner, Programme for Appropriate Technology in Health (PATH) decided to develop an alternative rite of passage after baseline research indicated that girls appreciated being part of the initiation ceremonies and enjoyed the associated information, gifts, food, merrymaking and the respect, maturity, and peer recognition gained from the event.

- Similarly, the findings from a survey conducted among Sabiny students in Uganda in 1994 revealed that the majority of youths supported FGM due to peer and parental influence, cultural beliefs, and fear of mockery and harassment by the community.

While these two projects use different methodologies - MYWO identifies families with girls that are eligible for excision and then educates and recruits them for modified ceremonies. The REACH project in Uganda works with the community to stop the practice - both celebrate, in a modern-day format, the cultural values for which elders are nostalgic. Both showed that the excisions can be eliminated from the dances, merrymaking and rites of passage in ways that are acceptable to the community.

Alternative coming-of-age ceremonies are a viable solution towards the elimination of FGM in communities where traditional adolescent initiation ceremonies are or used to be the norm. These ceremonies conducted in the community or school system can also be used to introduce sexuality education and life planning skills to girls with the full consent and participation of their parents and community. Alternative coming-of-age ceremonies can also be adapted in other settings; for example, in areas where girls are excised as infants, mothers could participate in a celebration of the birth or naming parties that do not involve excision.

Each of the four projects described above has been successful, but each could also benefit from adapting successful approaches from other projects. For example, TOSTAN and the REACH projects could complement their community decision-making approach with specific outreach to families to identify "at-risk girls", allay fears, foster family decision-making, and build self-esteem and confidence as was done by the MYWO project in Kenya. All the agencies could also learn from CEOSS's scheme to monitor "at-risk girls" until they are out of risk.

These projects should also start identifying all the families who are likely to stop the practice and recruit them as peer educators or support groups and continue to increase the critical number of families who have stopped the practice for good. Building the self-esteem of individual girls and their families is a necessary step, at least at the beginning. This approach will help girls and women avoid accepting excision later, when they are about to be married, due to pressure from in-laws and grooms, as was reported in Uganda.

The Kenyan and Senegalese projects used simple legal literacy to raise awareness about legal and human rights issues, including the Convention on the Rights of the Child. Learning about human rights in a non-threatening manner allowed project participants to take power into their own hands and make positive decisions for their daughters. This aspect of empowerment is important if change is to be sustainable in the communities.

The community decision-making or consensus-building approach has significant potential for rural communities where collective decision-making is still valued, and the authority of the traditional chiefs has not been politicized and eroded. Because many ethnic groups live on both sides of national borders, for example: the Bambara in Mali, Burkina-Faso, and Senegal; the Peuls in Guinea and Senegal; the Somalis in Djibouti Ethiopia, Kenya, and Somalia; and the Kswahili speakers in Kenya, Uganda, and Tanzania, there is a need to develop cross-border programmes and to foster information exchanges among groups. It is also important to organize information exchanges between similar groups who practise and others who do not. Some Malians who visited similar but non-practicing ethnic groups in neighboring countries were quick to share their experiences in Mali and become early acceptors of change.

This set of programmes shows that focused community-based programmes that use interpersonal approaches to educate the public, while at the same time empowering leaders to analyze issues of concern and devise acceptable solutions, is an effective approach towards FGM elimination. Above all, these project examples demonstrate the need to focus the agenda on the girls for which the programmes have been designed and to start moving away from widespread initiatives that provide dispersed information which may raise awareness but never move people up the stages of behaviour change.

Recommendation 13: While excisors should be included in programming, finding alternative income for excisors should not be the major strategy for change.

Although urbanized parents are increasingly taking their daughters to modern health care providers for excision, FGM is still predominantly being performed by "traditional female excisors": 91 percent in Cote d'Ivoire, 95 percent in Eritrea, and 88 percent in Mali (Carr, 1997). These excisions are typically performed with sharp stones, broken glass, scissors, or unsterilized razor blades, without anesthesia (Hosken, 1993). The resulting health complications, including the HIV threat, has convinced many anti-FGM implementers to reach out to traditional excisors as one of the main target groups of their projects. Excisors have also been targeted because of their opposition to FGM elimination programmes. For example, 91 percent of the survey respondents reported that excisors are opposed to the FGM elimination programmes.

Projects that work with excisors are usually referred to as "conversion strategies," because they are designed to "convert" them to other forms of employment. They unfold in three phases:

- Identifying excisors and training them on normal female genitalia and its functions; the harmful effects of FGM on women's health; reasons why FGM is practised; and the role they play in perpetuating the practice.

- Training excisors as change agents and motivating them to inform the community and families that request FGM about its harmful effects.

- Orienting the excisors towards alternative sources of income and giving them resources, equipment, and skills to allow them to earn a living.

In **Mali**, some agencies implemented all three phases (e.g. APDF), while others implemented only the awareness-raising phase (AMSOPT, ASDAP), or proceeded to train excisors to become change agents (The Population Council, 1998b). Cooperative de Femmes pour l'education, la Sante Familiale, et l'Assainissement (COFESA) indirectly raised the awareness of excisors through their IEC programme about adolescent sexual and reproductive health. However, some Malian groups disagreed about the relative importance that this strategy has had, noting that when local excisors were "removed from the market", others, sometimes from as far away as Burkina Faso, come to the communities to conduct the operation.

In **Ethiopia,** the NCTPE together with the Inter-Africa Committee (IAC), implemented an alternative employment opportunity project for excisors. It involved 25 to 30 excisors who promised to "lay down the blade" if they were able to participate in an alternative employment programme. In an IAC evaluation of this programme, many of the women said that they never excised girls; this clearly raised questions on whether they had actually never excised anyone, but wanted to take advantage of the project or were instead denying their earlier "excisor status" since they are aware of its complications and unpopularity.

In **Uganda,** traditional birth attendants and excisors have been educated about the harmful effects of FGM, but the programme has not succeeded in developing an alternative income for excisors as of yet.

In **Kenya**, discovering alternative income sources for excisors is not a major strategy, however, excisors are educated and recruited as change agents. In fact, when two excisors put down their tools and became change agents, the programme assisted them to sell sugar and cigarettes as an alternative income. **(Caution: WHO is opposed to smoking and the selling of cigarettes as an alternative income strategy.)**

In **Burkina Faso**, the military police identifies, educates, and monitors known excisors. However, the programme does not offer alternative income to excisors but educates them about the harmful effects of FGM to overall health.

Box 6: Have excisors changed?

In Burkina Faso, an 80-year-old excisor stated in a community meeting that she had completely abandoned the practice of excision since she realized that it is harmful to the health of girls. Later, the reviewers learned that she went to jail for seven months after the last girl she excised died. When asked how many girls she excised in her life, the women responded, "not less than 500." However, she denied that any of those girls died or suffered any complications related to FGM.

In a community in Kenya called Materi, where a group of women, *Ntanira Na Mugamb,* were implementing an alternative rites of passage programme called "excision by words," a 60-year-old excisor found herself without a job. She subsequently abandoned her trade and joined *Ntanira Na Mugambo*. As a proof that she had stopped excising girls, she brought her youngest and unexcised daughter to participate in the alternative rites of passage programme! She confessed during the ceremony that she has been excising girls for 40 years, that she has been opposed to the programme for a long time, and that she has come to learn that what she has been practicing was quite harmful. She vowed that she would be an active supporter of Ntanira Na Mugambo.

In Senegal, Aissa Tou Sarr, a woman in her fifties, had been the ritual excisor for decades in the rural village of Diabougou. Using a razor blade, she performed the procedure, a trade inherited from her grandmother, on about 200 girls every rainy season. The trade had provided her with a decent living: about $8.60, lunch, and a bar of soap for each operation. When Sarr's village joined the other villages in banning the practice of FGM, Sarr found herself depending on her brother's charity and resigned herself to near-destitution. Sarr's hardship is one of the harsh and sad realities of rebelling against an old-standing practice. When TOSTAN worked on rehabilitating Sarr (through their education programme), she became a convert. She stated "When I learned that this might cause sterility and infections, I didn't want to be the cause of all that."

Educating excisors about the harmful effects of FGM, recruiting them as change agents, and providing them with an alternative income lead to the empowerment instead of vilification of prestigious members of the society. There are, however, obstacles that hinder the effectiveness of the alternative income strategy. These include:

- Income generation and loan programmes require resources and time commitments for them to succeed. These also divert resources from other project activities.
- Excisors who put down their tools may not be able to maintain their promise since excision is a lucrative business (Burkina Faso).
- Other excisors may replace those who are taken out of the market (Mali).
- Since there is a demand from the community for excisions, excisors will try to comply with the demand.
- Focusing on the excisors sometimes promotes their role as an important one and does not expose it as a profession that is harmful and needing to be counteracted.

In both Ethiopia and Mali, the alternative employment pilot projects do not seem to have achieved the goal of saving girls from FGM, and may be diverting resources from other project activities. However, identifying, educating, and monitoring the activities of the excisors is an essential element of FGM elimination programmes in several countries, especially in Burkina Faso. The benefits of this strategy require in depth evidence, evaluation, and discussion in the future.

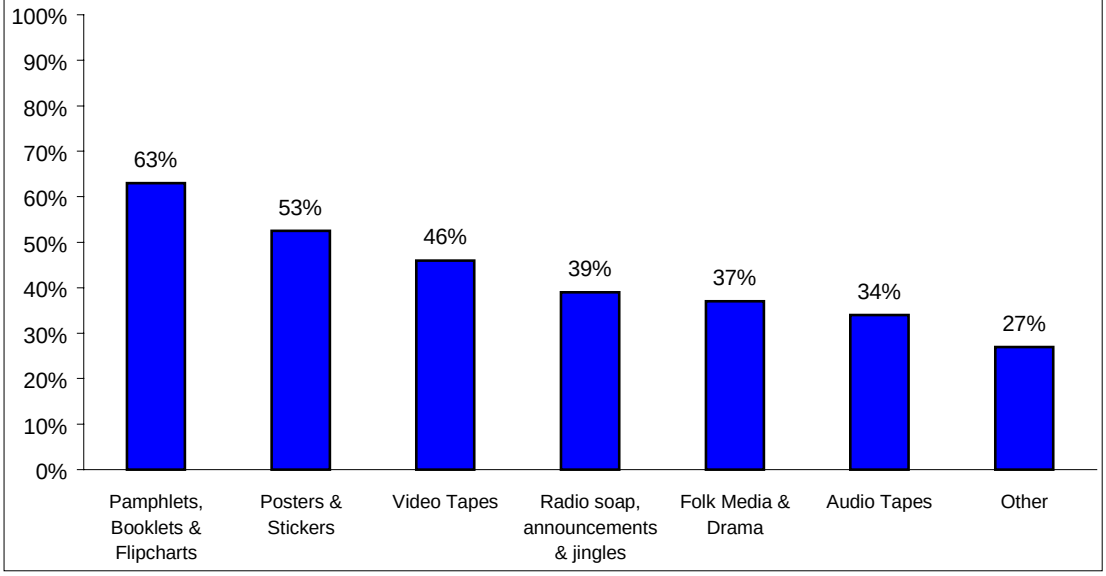
> As one national committee member in a province in Burkina Faso said, "The thief does not need to be compensated for articles he stole"!!

Recommendation 14: IEC materials need to be research-based, and targeted to specific audiences and communities instead of mass produced.

The agencies surveyed and those visited indicated that a relatively large number of IEC materials have been produced to support programme activities. Of the fifty-nine organizations that responded to the survey question on whether they had developed FGM-related IEC materials, 69 percent reported that they had produced such materials. Sixty-three percent produced pamphlets, booklets, and/or flipcharts, 53 percent mentioned posters and/or stickers, and 46 percent video tapes. Between 30 and 40 percent of the agencies produced both traditional and modern educational programmes intended to be used by the media. These include audio tapes, radio soaps, public service announcements and jingles, and folk media and dramas. Additional materials developed include newsletters, factsheets, newspaper articles, calendars, songs, hats, T-shirts and puppet shows. Interestingly, e-mails and web-sites were also mentioned as channels for information dissemination (see figure 15).

The survey respondents reported producing a wide array of IEC materials.

Figure 15: IEC Materials Developed
N=59



The field assessments also confirmed that large numbers of IEC materials were produced and used for public education campaigns. For example:

- **Burkina Faso's** National Committee was very active in its IEC materials production - even though the agency seemed to have fallen short of its own expectations. Between 1990-1997, the Committee successfully produced 87,150 pieces of IEC materials including leaflets, stickers, caps, posters, T-shirts, brochures, and locally designed anatomical models adapted from the IAC model manufactured in Geneva. They also produced two songs in the two most popular languages, radio and television public services announcements, four film documentaries, and two videos (one adapted and one original). In addition, some of the active provincial committees were able to produce their own materials, including 300 posters in local languages, stickers and anatomical models.

- The **Ethiopian** National Committee was also successful in producing relatively large quantities of IEC materials including a calendar, posters, leaflets, brochures, T-shirts, songs, dramas and videos. Materials are first produced in English or Amharic and then translated into 6 to 9 other major languages (such as Harari, Afar, Oromia, Tigrinya, Somali).

- In **Mali**, the Centre Djoliba has produced materials including a mannequin (anatomical model), pictures for a flannel board, videos, audio-cassettes and a poster. IEC and training materials are always shared with their trainees, students and colleague non-governmental organizations. One recent poster supported by UNICEF was a collaborative project between all non-governmental organizations belonging to the anti-FGM Network. UNICEF also developed a small booklet on FGM for its literacy programmes. ASDAP, with the support of the Population Council, is working on a flipchart on FGM and its complications for health care providers. APDAF has also developed materials on women and children's rights.

- In **Egypt**, several members of the Taskforce produced IEC materials including booklets, a calendar, a flipchart and posters. Other materials produced for advocacy purposes include newsletters, position statements and other easy-to-read manuals.

- In **Kenya**, the three main non-governmental organizations working on FGM - MYWO, Seventh Day Adventist Rural Health Services, and the Family Planning Association of Kenya - have produced a variety of IEC materials targeted to the general public or specific audiences. These include two videos, factsheets for policymakers and religious leaders, booklets for girls, pamphlets for mothers, peer educator bags, T-shirts, and posters for religious parents, health care providers, parents, and the general public.

In addition to the materials seen in the countries visited, materials received from other countries (posters, pamphlets, stickers, and video tapes) were reviewed. Although a substantial amount of material has been produced, the messages conveyed by visual images

and written text are in general fairly limited and focus mostly on the harmful health effects of FGM, with exhortations to stop "circumcising". For example:

- In **Ethiopia**, most of the visual images identified all the major harmful traditional practices. Since this is a complex message, it is quite difficult to convey them graphically. Other posters, produced in different languages, show a young girl being held by several women and excised in what seems to be a very matter-of-fact way. In each poster, special attention has been paid to the way each community dresses. In most cases, there are drops of blood on the knife and on the girl. While the visual was probably intended to shock people, in reality it only shocks westerners since an excision is a normal event and thus neutral for most Ethiopians. The message text refers to the negative health consequences of FGM, including HIV/AIDS.

- The messages and visual images were slightly different in **Burkina Faso,** focusing on the fact that excision represents bad culture, has negative consequences including difficulty in childbirth, and is against the law. The materials say that excision should be stopped totally and that excision cases should be denounced. Visual images include a naked young girl hiding her genitals; an ugly, old excisor with a knife trying to reach for a girl while the parents are pulling the girl away and jointly saying "no" to the old woman. Other materials show a rose and a razor blade (the National Committee logo). According to the National Committee, posters showing a naked girl, particularly when her legs were wide open, offended the public and had to be replaced. However, those developed later seemed to demonize excisors and may not be credible since parents are the ones who ask for the services of excisors rather than excisors forcing their services and knives on families.

  Burkina Faso also has radio and television public service announcements (PSAs), "SOS excision" to support enforcement of the anti-FGM law. One PSA shows an old man who sees a young girl being excised. She is crying and bleeding. He nods his head and starts dialing "SOS excision" to denounce the case. More information is given on "SOS excision" and that the denouncer's identity will be kept confidential. Overall, the messages have threatening undertones and compound the fear of the law.

- Printed materials in **Mali** follow the same design as those in Burkina Faso (a young girl being held down by several people and being excised), and giving similar messages including "We should stop excising. Excision harms women." Again, the visual depicts a routine event for most Malians.

- An **Egyptian** reproductive health training manual included a chapter on FGM in which it was called "the black day" and used words such as "butchering" for the practice. Another booklet called FGM "a useless torture," while yet another used very judgmental and disrespectful words while trying to stimulate dialogue about the issue.

The survey also sought information on the content of the messages the various organizations were conveying in their IEC and public information activities. Almost all the agencies conveyed that FGM "has negative health consequences for women and girls" (92 percent). Three other messages were conveyed by at least 80 percent of the agencies: "FGM is a harmful traditional practice," "performance of FGM with the same instrument may facilitate the spread of HIV/AIDS infection", and "FGM violates the rights of women and girls". At least 60 percent of the agencies address cultural issues such as "FGM is not required by Islam" and "unexcised women are marriageable" (see figure 16).

Figure 16: Main Key Messages		
N=85	**Frequency**	**Percent**
FGM has negative health consequences on women and children	79	92%
FGM is a harmful traditional practice	70	81%
The performance of FGM with the same instrument may facilitate the spread of HIV/AIDS infections	70	81%
FGM violates the right of women and young girls	69	80%
FGM is not required by Islam	55	64%
"Unexcised" women are marriageable	53	62%
FGM does not prevent promiscuity	50	58%
FGM reduces a woman's sexual enjoyment	49	57%
FGM is against Christian teachings	41	48%
Since girls are being 'excised' at a younger age, 'excision' as a rite of passage has lost its significance	38	44%
FGM curtails chances of girls to further their education	29	34%
Other	12	14%

It is important to note that at least 57 percent of the agencies used messages that focus on sexuality, namely "FGM does not prevent promiscuity", and "FGM reduces women's sexual enjoyment", which is a bit surprising, considering sex is a taboo topic in most African societies. Several of the IEC materials reviewed also had sexuality messages; for example, in Burkina Faso, additional messages from the programmatic side included, "Excision causes frigidity in women", and "Excision violates the rights of women and girls" etc. Similarly in Mali, two of the non-governmental groups, Centre Djoliba and AMSOPT, routinely discuss the effect of FGM on women's sexuality in their training and guided group discussions. In addition, several groups pass the message that FGM violates girls' and women's rights.

Addressing women's sexuality is a positive trend towards demystifying one of the core beliefs of the practice - the outer circle of "the mental map" (refer to figure 1). However, including an isolated message about the fact that FGM reduces women's sexual enjoyment is not likely to change people's practise. In fact, many people - men and women alike - want to reduce women's sexuality, something of which they are uncertain and afraid. Supporters of the practice still hold beliefs that an unexcised woman will "run wild", "rape men", or "be unfaithful to her husband". For example, one legislator who was studying the possibility of drafting a law to ban the practice in his country asked, "Are you sure that unexcised women will not be unfaithful to their husbands?" In a survey of 55 health care providers in Kenya,

"FGM reduces a woman's libido" was given as a reason for supporting the practice as well as a reason to stop the practice (Abwao, et. al., 1996).

Educators need to avoid including superficial information about what excision does to women's sexuality. They need to address the similarities and differences between male circumcision and female excision, discuss why anti-FGM implementers are opposing one and not the other, emphasize that all women, whether excised or unexcised, normally want to have sex and will be attracted to men, and that the main difference is that excised women will be less likely to be satisfied with their sexual encounter. Unexcised women may, on the other hand, be satisfied and thus not look for other men. Also, unexcised women are equally moral and faithful to their husbands. A woman in Burkina Faso said, "except for the African woman, no other female animal is clitoridectomized, excised and/or infibulated. Even the female elephant is intact!"

The majority of the organizations based development of their key messages on a combination of research and staff experience. Indeed, 51 percent of the agencies reported carrying out their own research while 54 percent used findings from research carried out by others. However, staff knowledge of and experience with the issues surrounding FGM was instrumental to the development of those messages. Other resources included deep knowledge of the cultural environment and collaboration with non-governmental organizations. When asked who was involved in developing their key programme messages, the agencies reported an all-inclusive approach with the agency staff serving as the main resource (81 percent). Programmes involved professionals who are either knowledgeable about the issue (staff from collaborating agencies - 50 percent and from ministries of health - 38 percent) or have artistic expertise (45 percent). More than a third mentioned involving the intended audiences, including tribal, community and religious leaders.

The above findings indicate that the agencies made some effort to segment their audiences, base their messages on research, and involve knowledgeable people and artists in the design of the messages and materials. However, only about a third mentioned involving the target audience, and none mentioned involving researchers or communication specialists.

The country assessments and materials reviewed also reveal that, except in a few cases, the IEC materials were not research-based or audience-specific; used symbols that might not be understood by low-literate audiences; employed ineffective, offensive or neutral visual images; conveyed judgmental or threatening messages; included very limited information; and seemed to be outdated. Most programmes still seemed to be using messages appropriate for awareness raising campaigns rather than supporting the next stages of behaviour change.

Despite the short-comings of the IEC materials, agencies valued the materials they produced, and considered them as crucial to the success of their programmes and a validation of their efforts. Materials were used to support all programme activities implemented by the national, provincial/regional, support committees, and resource persons in IAC countries, while in the other countries such as Mali, Egypt and Kenya, the materials were used by the originating agencies and shared with other colleague agencies, sometimes from other countries.

Recommendation 15: Information campaigns must be designed in a strategic, systematic way and include all stakeholders.

National IAC chapters use information campaigns for their public education initiatives. In **Ethiopia,** for example, the information campaigns modeled after the regional IAC programme design, usually follow seminars and workshops designed to sensitize policymakers and community and religious leaders.

In 1995, **Burkina Faso's** National Committee modified its information campaign format after an evaluation of its previous five-year programme indicated that a large proportion of the population either still considered excision a good practice or were undecided. The evaluators recommended involving and mobilizing different sectors of the population at the local level. Below is a summary of Burkina Faso's very systematic community education programme that one traditional chief called, "involving everyone in the dance".

The National Committee (NC) has successfully segmented and prioritized its audiences and developed special outreach initiatives for each group through appropriately trained resource people, and the provincial and support committees. Sensitization activities take various forms, including three-day training sessions, film and video shows in village squares, discussions and debates, and outreach at places where specific audiences congregate, such as churches, mosques, police stations, residences, and schools. The National Committee's priority target audiences are traditional leaders, Islamic associations, churches and pastors, women's associations, and youth groups, health professionals, birth attendants, police, teachers, youth, and the press/media. Trained resource persons from each group receive support for developing outreach strategies and resources for implementation, including manuals and IEC materials. Illustrated below are outreach activities for several audiences:

- Outreach through Traditional Leaders (saturation strategy): The rationale for involving the traditional leaders came from the evaluation results that indicated both supporters of and opponents to the elimination of excision suggested that the entrenched nature of the tradition was the main impediment to its elimination. Consequently, the NC organized a training and strategy development workshop which led to the development of the saturation strategy - conducting successive sets of awareness sessions at the canton, village, community, and family level, reaching at least 2 million people.

- Outreach through Religious Groups: Trained religious resource persons developed strategies to educate their own followers through regular prayers, special sermons and religious events (Friday and Sunday prayers, baptism, etc.). As of June 1998, about 205 preachers have been trained and are working with the NC. Protestant leaders are seen as the most supportive and have been credited with reducing the practice among their congregations.

- Outreach through Youth: The National Committee prioritizes youth because they are tomorrow's parents, are not wed to old traditions and can be influenced easily with sound arguments about the harmful effects of excision.

The Committee therefore reaches out to youth through formal systems, especially schools (primary, intermediate, secondary and university) and the informal sector, through youth associations. Special innovative activities include in-school activities, competition through sports (i.e. soccer cup), and radio call-ins.

- Outreach through the Military Police (Gendarmes) and Police : Involving the police force and other legal professionals is quite essential for Burkina Faso's programme since a law was passed in 1996 that bans the practice and penalizes its perpetrators. The Ministry of Defense authorized education of all military personnel and their families through work and residential places. Consequently, 60 members of the military police and regular police were trained and established as a support committee for the National Committee. The mission of the gendarmes is to educate the population about social problems, maintain security, and protect citizens. Based on this mandate, the gendarmes were selected as the principle change agents for educating the community about excision and protecting girls. Despite these mandates, the gendarmes face many constraints in their community education programme, including the fact that the more comprehensive initiative is limited to Ouagadougou and that regional activities are sporadic. Lack of sufficient training materials and paper supplies to write reports; and lack of transportation and per diem costs when police officers go out into the community to resolve conflicts related to excision and to protect girls etc. are examples of some of these constraints.

Burkina Faso's programme is showing increased maturity. Its outreach approach is more systematic and targeted to specific sub-populations. It reflects modifications made based on an evaluation conducted after five years of programming. For example, when this evaluation report indicated that only 17 percent of women and 22 percent of men reported discussing FGM issues with their partners, the Committee began a "couples' initiative" aimed at recruiting and educating couples about FGM, thus creating dialogue and joint decision-making against the practice.

Similarly in 1995, after MYWO outreach workers in Kenya mentioned that community members were getting bored with programme messages dealing only with the harmful effects of FGM, and that they were being asked difficult questions that they could not answer, the project adopted a more systematic implementation approach and developed strategies to reach various project audiences. These included an FLE strategy for in-school youth, a peer education strategy for mothers and youth (boys and girls), an advocacy strategy for policymakers, and a community outreach strategy for the general public. Additionally, the project initiated a "minimum intervention approach" aimed at ensuring that programme beneficiaries receive a comprehensive amount of information addressing the various aspects of FGM (health, human rights, culture, etc.) from project staff. For example, outreach workers provide information about six topics using a series of discussion guides with various audiences. The project therefore became more systematic in designing its strategies, both in terms of audiences and content. Most of the difficult questions can now be answered using a discussion guide series, which is currently being produced in a flipchart format.

Unfortunately, many of the country-level outreach activities identified by the survey and country assessments are carried out in a haphazard fashion with short-term, periodic campaigns that include information addressing only one or two dimensions of FGM. The examples from Burkina Faso and Kenya show the clear advantage of strategic and systematic approaches to educating specific audiences or the general public.

Recommendation 16: Anti-FGM programmes should build on and expand their work with the mass media, particularly creative areas such as folk media and drama.

Over the past several years, media coverage of FGM issues has increased dramatically, both within Africa and in the West. The media has the power to reach various segments of society with accurate information that raises awareness and reinforces positive decisions. Accurate media coverage desensitizes the issues of FGM and promotes dialogue. Anti-FGM programme implementers in almost all the countries visited reported that they worked with the media by training personnel on gender issues and ways to report on FGM. According to the survey, for example, 65 percent of the agencies had "working with the media" as a programme strategy. The country assessment visits also confirmed similar targeting of the media:

- In **Burkina Faso,** for example, the National Committee reached out to all media groups, whether public or private, radio speakers, journalists or television broadcasters for training on FGM complications, the rationale for its elimination, and ways to report on it through their programmes. The Committee emphasized coverage of new stories, such as interception of an excision case, by interviewing the excisors and family members, various committee members, and women and girls who had an unusual experience with the practice. They also formed partnerships with the radio and television programmes to run SOS excision public service announcements and anti-FGM songs.

- In **Egypt**, a controversial television report depicting a nine-year-old girl being excised, which was aired during the 1994 International Conference on Population and Development (ICPD) in Cairo, brought about a major controversy and also a dialogue on the issue in Egypt. The anti-FGM Taskforce has a media sub-committee focused on sensitizing the media by developing a network of media personnel that enters into alliances with non-governmental groups and offers them support in their work. The Taskforce has produced factsheets to provide accurate information to the media. This project is in its preliminary stages; building such a network will require negotiations with the government and other powers, given that most media channels in Egypt are under government control.

- In **Mali,** the NGO Network educates the media about FGM issues, and Centre Djoliba monitors media reporting on FGM to track changes in the volume, accuracy, and sophistication of media reports. Similarly, **Kenyan** advocacy agencies monitor media reporting on issues related to gender, FGM and adolescent reproductive health.

- In **Ethiopia**, the National Committee has collaborated, over the years, with the Educational Mass Media (EMA), the Ethiopian Radio Agency, and Ethiopian Television, to disseminate information on the harmful effects of FGM and other practices. NCTPE's most successful work in mass media was a joint programme with the EMA to produce entertaining radio and television programmes and audio-visual materials for in-school students and distance learners on a variety of subjects, including health, civic duties, agriculture, rural development, and teaching methods. The programme produced a total of twenty-eight, one minute radio spots that were broadcast between 1995 and 1997. Each spot covered a theme, such as consequences of FGM or early marriage, and was broadcast in schools twice weekly throughout the school year. The programme was very popular with the school system and seemed to educate students, teachers and the general public. However, it was discontinued due to lack of funding.

The African community is an oral society, and story-telling, dramas and poetry are part of the local heritage in each community. For example, 30 to 40 percent of agencies surveyed mentioned producing both traditional and modern educational programmes including folk media and dramas. Similarly, all the country programmes visited used dramas and poetry and songs as a way of educating the public about FGM issues. An area that has not been exploited as much is that of story telling - used creatively and in conjunction with dramas, songs and poetry, this method could be used to examine the beginnings of tradition or the myths that surround FGM in a non-threatening and entertaining way.

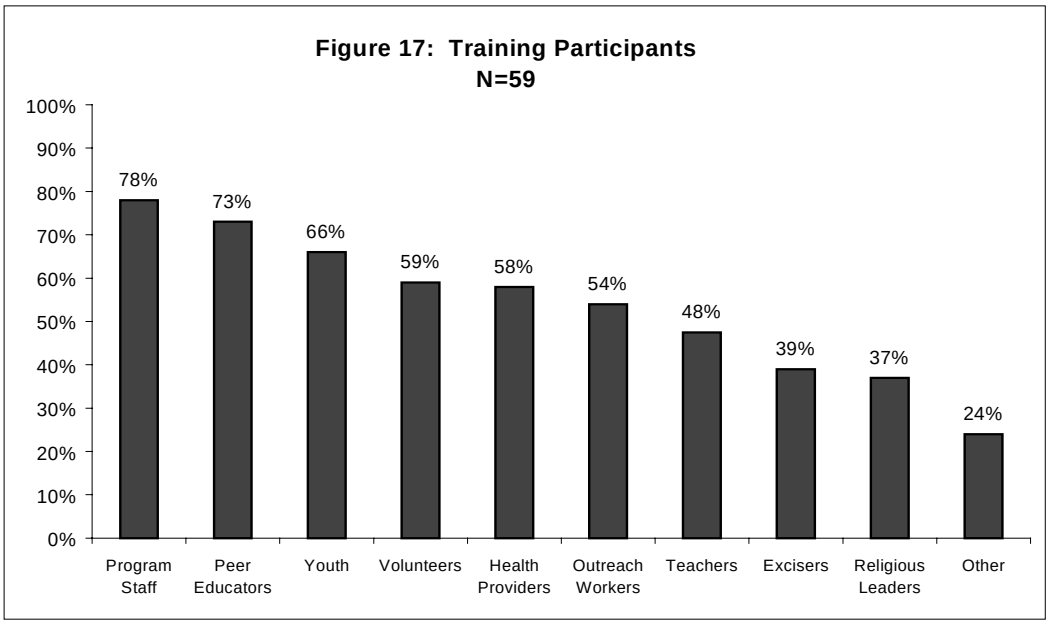
Recommendation 17: Anti-FGM implementers need to design training programmes that are comprehensive both in the range of people they train and in the range of topics they cover.

> *Not to know is bad. Not to wish to know is worse.* Nigerian Proverb.

Competency-based training is an essential element of FGM elimination programmes. Training is needed to build the capacity of programme implementers to design, implement, evaluate, and monitor multi-faceted national and community-based behaviour change, advocacy initiatives, fundraising, and the establishment of an infrastructure for sustainable programmes. Training is also needed to expand the programme vision, goals and objectives at various levels by supporting work of programme implementers. The quality of the training philosophy, content, methodology, and skills to be mastered by trainees will also determine whether they in turn follow sound communication principles, are culturally competent, and implement programmes that lead to sustainable social change.

During this programme assessment, types of training, and their content, quality and methodologies were reviewed through the survey, country assessments and review of training curricula. Sixty-seven percent of survey respondents reported carrying out training activities. Most agencies (78 percent) prioritized training for their own staff, possibly to build and/or strengthen their institution's capability to implement anti-FGM programmes. Other groups who received training were peer educators (73 percent), youth (66 percent), volunteers (59 percent), and health care providers (58 percent). Additionally, agencies trained outreach workers, excisors, teachers, religious leaders and women's unions (see figure 17).

Almost all programmes reported that they carried out training activities, mainly for their own staff and programme volunteers.



About half (48 percent) of the agencies developed their own training materials. Among these, 64 percent reported designing manuals, 52 percent videos, and 30 percent curricula. Other training materials included discussion guides, federal legislative drafts, guidebooks, anatomical models, photographs, and protocols for management of health consequences. When designing training materials, 65 percent of the agencies sought assistance from collaborators to either develop them from scratch (54 percent) or adapt existing materials (33 percent).

The country assessments also highlighted the importance of training for the development and sustainability of programmes. Almost all non-governmental and other organizations involved in FGM elimination carry out some form of training for their staff and to reach their many target audiences and stakeholders. These include:

- Training conducted by national chapters of the IAC: In **Burkina Faso** and **Ethiopia**, training sessions are provided for a wide range of audiences, and consequently vary in length, content and format. Typically, there are 5 to 10-day Training-of-Trainers courses for resource persons, 2 to 3-day awareness raising sessions for influentials at the regional, district or community levels, and one-day orientation seminars for community leaders, policymakers, journalists, artists, students and teachers and refresher courses for previous trainees.

- Community-based, participatory training: Many non-governmental organizations carry out community-level, participatory training. For example, the Centre Djoliba and AMSOPT in Mali use a training method called the "GRAAB". The training emphasizes that the trainees, and later the community, need to identify their own problems, whether health related or otherwise, and encourages them to come up with their own solutions.

- Because of the empowerment-through-problem-solving philosophy inherent in the GRAAB method, this training programme is very popular among local associations, youth-serving organizations and government employees in the social sector.

- Training to strengthen advocacy: National-level organizations play a key advocacy role and reinforce that role by providing advocacy training. For example, the **Egyptian** Taskforce offers advocacy workshops to its member organizations throughout Egypt, from Alexandria to Upper Egypt. The workshops aim to: a) foster networking and building links among members; b) build knowledge and skills of non-governmental groups in designing and implementing grassroots advocacy strategies, including coalition-building, media advocacy, development and use of lobbying tools, and public education; c) encourage members to carry out research to support their advocacy efforts; and d) link organizations with sources of funding.

- Communication for Change Training: Several of the community-based projects began their efforts with intensive training for the programme implementers; for example, in **Kenya** MYWO and PATH-Kenya provided a comprehensive 3 to 4-week course for programme implementers, health care providers, and other resource persons. The overall goal of this training is to equip participants with the knowledge, attitudes, and skills necessary to plan and implement a successful participatory anti-FGM programme.

- Media and materials development training: This training is a sub-component of the communication for change training offered for project staff, artists and intended audiences in the **Kenya** projects implemented by MYWO and the Seventh Day Adventist Rural Health Services with technical assistance from PATH-Kenya. Outputs from this training in Kenya include posters targeting health care providers ("FGM violates the rights of the girl child; do not earn from it") or religious parents (a little child praying and saying "God, please give my parents the wisdom to prevent me from being excised"), poems, songs, information sheets, factsheets and other materials.

- Operations research training manual developed by IAC: The Regional IAC developed a manual on how to apply operations research in anti-FGM programmes. The manual is in draft form and is available for national IACs in the region.

During the country assessments, a crucial training weakness became apparent. While programme staff stated that they did receive training on FGM, the majority of them said they received only basic knowledge on the immediate health hazards and the historical, religious, and social context of FGM. For example, the cultural, sexual, legal, human rights and ethical dimensions of FGM, as well as how to effectively communicate and elicit behaviour change among members of their community, were not adequately addressed.

This finding was reconfirmed in a review of training curricula, the majority of which provided very limited information about FGM, mostly covering harmful traditional practices and the negative health consequences of FGM, some of the reasons why people practise FGM, facts about religion and FGM, the need to eliminate FGM and how to develop action plans. Although tradition and culture are the main reasons why FGM is practised, few of the curricula provided acceptable information about culture and its evolution. Similarly, many agencies use human rights messages such as FGM violates the rights of the girl child and women but their training does not include easy-to-understand information about rights, the human rights conventions and what rights the community needs to safeguard. Although, medicalization of the practice is a major concern in most countries (Egypt, Mali, Ethiopia etc.), ethical and legal issues are not included in the training curricula used routinely by programmes, even though health care providers are the number one target group when integrating or mainstreaming anti-FGM programmes into existing programmes. While fear about women's sexuality and promiscuity are some of the basic reasons why FGM is practised, the curricula and training materials gloss over these issues and do not try to demystify sexuality in ways that can be understood by the community. Messages that FGM is being used "to control women" or that it is "a form of violence against women" or "torture" do not resonate with the community since their underlying reasons and values are not being addressed.

Most training programmes follow a general IEC strategy and seem to train people on how to raise awareness through training, information and campaigns, and do not address behaviour change adoption processes so that trainees can have a goal in mind while educating the community, since awareness raising is not the ultimate goal for FGM elimination.

> *He who learns, teaches.* Ethiopian Proverb.

There are several innovative and/or more comprehensive training materials available: the GRAAB training method, PATH's Communication for Change and Family Life Training modules, and TOSTAN's training modules. However, these materials are usually only available to the originating agency, may not be available in local languages, and may not be printed in a format that can be easily shared. There are also no mechanisms for sharing training materials other than through the occasional international conference attended by some of the programme implementers. Clearly, a mechanism for disseminating and sharing state-of-the-art materials is needed.

V. RESEARCH AND EVALUATION

Given that FGM elimination programmes are relatively new and have to deal with such a sensitive and culturally embedded practice, it is crucial that programmes develop strategies based on a deep understanding of community values, beliefs, practices, and rules of interaction. This kind of information can be derived from formative research or community assessment methodologies, both quantitative and qualitative. It is also important to carry out periodic operations research studies to better understand the proposed strategies and their relative effectiveness. The crucial role of built-in evaluation and monitoring systems cannot also be overemphasized. The survey and country assessments provide insight into the kinds of research data anti-FGM programme implementers use to design their programmes, strategies that they believe to be effective, how much evaluation they have been able to carry out, and their assessment of keys to success and pitfalls to avoid.

Recommendation 18: Anti-FGM programme implementers should ensure that programme design and implementation are based on sound formative research.

When anti-FGM programme implementers were asked what sort of information was used to design their programmes, most reported using a variety of sources of information, including survey research (74 percent), international research data (52 percent) and community health assessments (43 percent). Twenty percent of agencies mentioned basing their programmes on anecdotal information. Other sources given included visits to villages, consultation with other non-governmental organizations, and interviews with women suffering from FGM complications.

The findings from the country assessments confirm that, except for few community-based programmes, formative research was not conducted before a particular programme had been designed. Alarmed by the problem of FGM and using data available from international agencies, most groups designed and implemented their anti-FGM elimination programmes without more specific information. For example, both the Burkina Faso and Ethiopian programmes were not preceded by formative research nor were many of the programmes visited in Mali. Except for Egypt and Mali, the latest demographic and health surveys did not include an anti-FGM module which could establish the actual prevalence of the practice, as well as other critical information for planning. However, it was quite evident that all the agencies realized the need for accurate information and were either carrying out or advocating for increased research in the various aspects of FGM. For example:

- In **Burkina Faso** research activities remain at an embryonic stage. To remedy this the National Committee has sponsored at least six papers and studies carried out by university students, and carried out one national-level study on excision in collaboration with the National Institute of Statistics and Demography in 1996.

- In **Mali**, the assessment identified three types of studies on FGM which have been conducted over the years. The first were ethnographic studies; the second group of studies was carried out by health care providers and documented the types of FGM and its complications; and the third group of

studies was done by anti-FGM programme implementers, including non-governmental organizations and women's groups. During the past several years, anti-FGM organizations encouraged students to carry out more research on the types of FGM and their complications, and health and human rights issues related to FGM. Centre Djoliba, one of the anti-FGM agencies, also conducted several studies to serve as a baseline for their ongoing programme.

- In **Egypt,** most programmes were not based on formative research. However, a significant amount of information is available at the national level, including the 1995 EDHS; a collaborative study between the Population Council and the Egyptian Fertility Care Society (EFCS), which validated EDHS findings regarding prevalence of FGM types; and a study conducted by the Cairo Institute of Human Rights, which determined the factors that influence physicians to support the practice of FGM. The Population Council, the Ford Foundation and the Egyptian Taskforce have been instrumental in supporting availability of basic national level information for all agencies to use and supplement with more focused studies.

Most studies conducted to date have been quantitative in nature. In general, programme implementers have not been trained in qualitative community assessment methods that could have assisted them to better understand the cultural context of the practice and to develop and modify their IEC and training materials. Except for few operations research (OR) studies that have been conducted by the Population Council in Mali, Egypt and Burkina Faso, OR studies are also quite rare.

When survey respondents were asked whether there is a need for additional research in their countries and if so, to specify the topics, 84 percent of the survey respondents recognized the need for more research studies on the prevalence of FGM and its related complications. More specifically, they mentioned research on the knowledge, attitudes, and practices related to FGM, on the morbidity and mortality related to the practice, on the social, religious, cultural, and mythical reasons for the practice. This response reflects the lack of reliable national level quantitative data, which could be provided by including an anti-FGM module into the periodic demographic and health surveys and qualitative type information for in-depth understanding of contextual factors.

Respondents also identified the need for research on the effectiveness of various programme strategies: alternative rites of passage, alternative sources of income for excisors (conversion strategy), as well as the relationship between FGM and the spread of HIV/AIDS, and the role of male involvement in FGM elimination programmes.

It is encouraging to note that many of the topics mentioned by the survey respondents matched well with the research being planned in the countries visited for the assessments.

For example:

- In **Egypt,** a study exploring the role of men in perpetuating FGM, including assumptions made about men, their sexuality, and their perceptions about women's sexuality, is being planned. Similarly, a follow-up study to investigate the direct relationship between FGM and maternal morbidity and mortality is being planned by the Egyptian Fertility Care Society and the Population Council.

- In **Mali**, the Population Council is planning an operations research study to assess the effectiveness of excisors conversion strategies.

- In **Kenya**, PATH-Kenya/MYWO is conducting an exploratory study to assess the feasibility of implementing a scaled-up alternative rites of passage programme throughout the country. In partnership with FORWARD International, it is also conducting a study on male attitudes towards FGM and female sexuality as a baseline for an educational programme aimed at men.

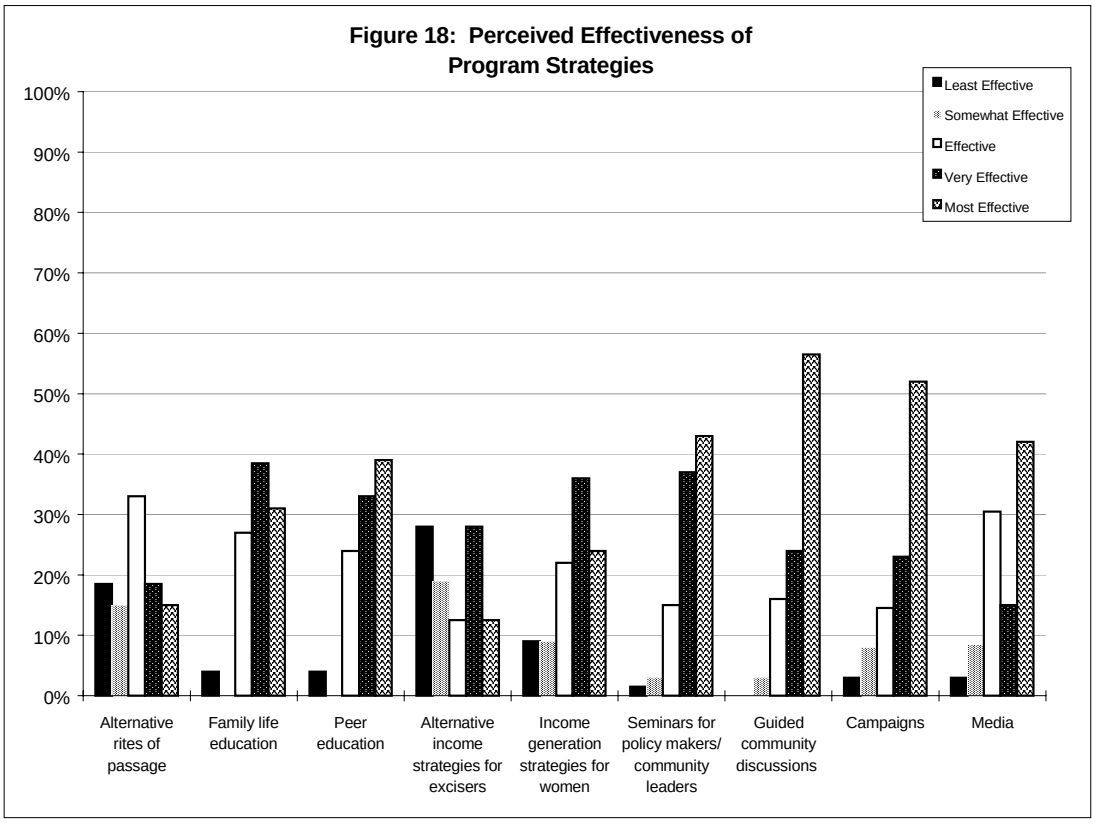
Several countries have reliable national level data, and programme implementers are advocating for increased research on all aspects of FGM. However, agencies need to base their programmes on the perspectives and needs of the intended audiences; advocate for the inclusion of a comprehensive anti-FGM module in their country's demographic and health survey; build their agencies' expertise in carrying out qualitative community assessment research techniques; and encourage periodic operations research type studies to support their programmes.

Recommendation 19: To increase the effectiveness of their programmes, anti-FGM programme implementers should prioritize and implement both process and impact evaluations.

To better understand the perceived effectiveness of the various strategies that are being used in the field, programme implementers were asked to rate their activities on a scale of 1 (least effective) to 5 (most effective). The majority of organizations perceived guided group discussions, campaigns, seminars for policy-makers and community members, and working with the media, including use of film and videos, to be the most effective programme strategies. Thirty to forty percent of the agencies also perceived peer education and Family Life Education to be either most effective or very effective. More than a third of the agencies thought income generation for women and alternative income for excisors were very effective strategies. However, one third of the organizations rated the alternative income strategies for excisors as least effective, indicating opposing views on the strategy. Similarly, alternative rites of passage received a mixed reception, with one third perceiving it as an effective strategy, while close to 20 percent perceiving it as ineffective (see figure 18).

Survey respondents rated guided community discussions, campaigns, and policy seminars as the most effective strategies.

Figure 18: Perceived Effectiveness of Program Strategies



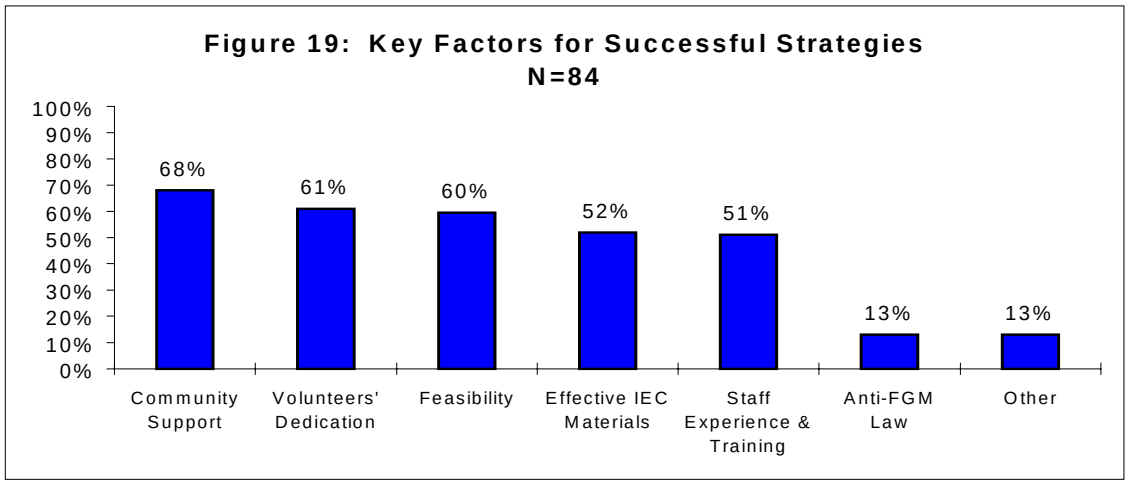
The country assessments confirm these data and highlight that most agencies are likely to rate highly the strategies most known to them. For example, the various overlapping public-education methodologies being used in the countries visited matched with the highly rated activities mentioned above: guided group discussions, campaigns, seminars for policymakers and community members, and working with the media. Further, those non-governmental groups visited mentioned these strategies to be successful. Peer education and Family Life Education strategies were also becoming increasingly popular in the countries visited.

The alternative rites of passage strategy was used only in Kenya and a version of it was used in Uganda and seemed to have brought down the incidence of excision in the communities implementing it. However, this successful strategy was not known in places like Burkina Faso, where it could have saved several community leaders from jail when they refused to stop excision celebrations preceeding the marriage celebrations in a community in Banfora (See Burkina Faso Report). If applied well, this strategy could allow the communities to celebrate the coming-of-age ceremonies while eliminating the mutilation aspects of these rituals.

When agencies were asked to identify the key factors that contributed to the success of their strategies, staff commitment (74 percent) and community support (67 percent) were identified as the most important factors, followed in order of importance by volunteers' dedication, feasibility of the programme approaches, effective IEC materials, and staff experience and training. Only 13 percent of the agencies identified the passage of an

anti-FGM law as a key factor contributing to the success of their strategies (see figure 19). These are probably agencies working in countries where an anti-FGM law or a ministerial decree has been passed (e.g. Burkina Faso, Ghana, and Egypt). Other key factors include effective training materials, international support, empowerment of youth and women, work of trained village facilitators, courage of certain members of the community and in one instance, the commitment of the government of Burkina Faso.

Staff commitment, including volunteers and community support are key factors for success.



While most of these agencies were able to identify key factors that led to the success of their programmes, effective rigorous evaluation is seldom available to help improve and expand their programmes. For example, the survey showed that the majority of organizations (71 percent) have not evaluated their programmes because of lack of funds (80 percent) and/or lack of expertise (23 percent). Some respondents mentioned that they had no interest in evaluation or that their programmes were young, informal in nature, or were integrated into other programmes and thus difficult to evaluate.

The majority of the evaluations were conducted within the past two years, suggesting increased understanding of the value of evaluations, donor support, or pressure to show results. When asked who evaluated the programmes, agencies reported they were conducted by external evaluators (76 percent) and/or evaluation specialists within the organization (56 percent). The rest of the evaluations were carried out by programme staff (28 percent) and donor consultants.

The country assessment visits also confirmed that except for a few programmes (MYWO's Project in Kenya, and AMSOPT's one-year Pilot Project in Mali), most were not preceded by a formative research and did not have an in-built evaluation. However, evaluation was becoming increasingly important as donors and the international community asked organizations to justify the effectiveness of their programmes. For example, the national committees of Burkina Faso and Ethiopia, and Mali's Centre Djoliba carried out research aimed at both documenting impact and serving as a baseline several years after they began implementing their programmes. However, since they did not have a baseline research/study, they had difficulty attributing findings to their programmes or understanding the level of change. Nevertheless, good information gleaned from this research assisted them

to change their strategies. For instance, the Ethiopian programme increased its activities at the regional level; the Burkina Faso programme started specialized outreach activities for various sectors of the society and began a couples initiative, and Mali's Centre Djoliba organized a national seminar to establish an anti-FGM network and assist in the development of a national anti-FGM action plan in collaboration with the Ministry of Women, Children and Family.

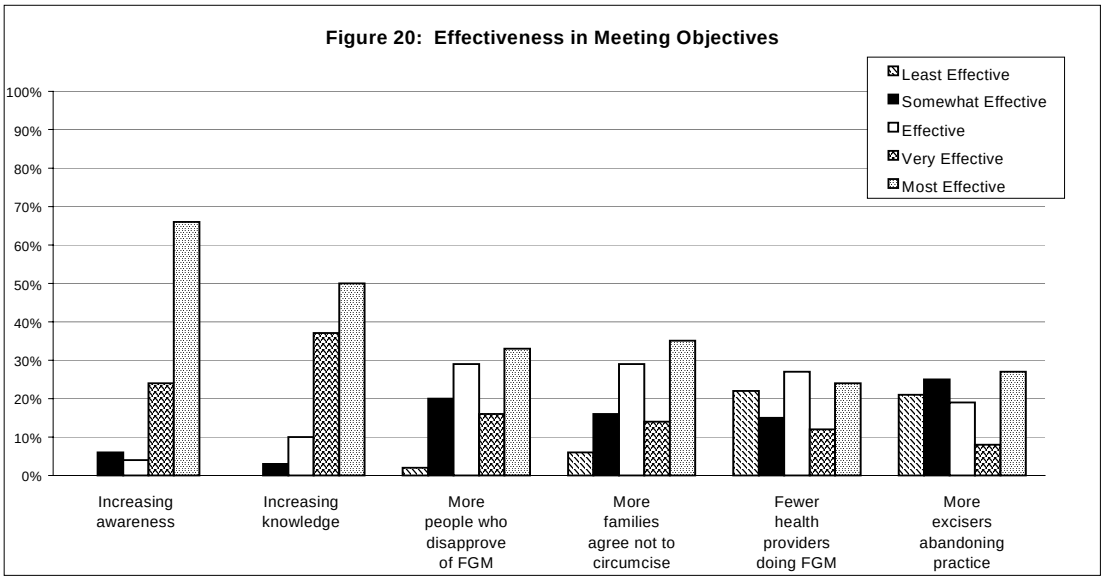
Similarly, the Egypt Taskforce recommended and supported the evaluation of a number of non-governmental groups in 1997 to assess the efficacy of past and ongoing programmes. Findings were used to provide better training and support to the leadership of its member agencies, and to recommend that messages be credible, scientific and easily accessible; media campaigns be given strong consideration; and men be targeted in awareness-raising campaigns.

Sixty-two percent of the agencies responded to the question asking what indicators they used to evaluate their programmes. Although only 29 percent of the respondents said they had conducted formal evaluations of their activities, many agencies keep track of numerical programme outputs, such as the number of IEC materials produced, the number of training courses conducted, and number of newspaper articles placed, etc. Among these organizations, the two main indicators used are "the number of people reached" (70 percent) and "the community's openness to discuss FGM" (68 percent), indicating that breaking the silence on FGM is a very important first step. Sixty percent of the agencies also reported using "the number of seminars conducted" and "the number of families who agree not to excise their daughters" as evaluation indicators. "Reduction in the prevalence of FGM" and "reduction in prevalence of FGM complications" were used by nearly 40 percent and 23 percent of agencies respectively.

It is important to note that a minority of the organizations (25 percent) mentioned "number of boys who will no longer marry 'unexcised' girls only" as an indicator used. This indicator and those related to "the number of families who agree not to excise their daughters" and/or "the number of mothers who no longer excise their daughters" are important process and impact indicators. These newer generation of indicators show a move towards monitoring intent and decision-making within the family and during marriage.

The survey also asked the agencies to subjectively rate the effectiveness of their programmes in bringing about behaviour change, using a scale of 1 (least effective) to 5 (most effective) (see figure 20). Sixty-six percent of the agencies felt that they have been most effective in raising awareness about the harmful effects of FGM, while 40-to-50 percent felt that they had been either most or very effective in increasing knowledge about the health effects of FGM. However, only about a third of the agencies reported that they have been most effective or effective in "increasing the number of people disapproving of the practice" and "increasing the number of families deciding not to excise".

Respondents report being more successful at awareness raising then changing behaviour.



Country assessments support the non-governmental organizations' perceptions of the effectiveness of their programmes in bringing about change. Indeed, the agencies have contributed to the emergence of a new attitude toward FGM in their communities. However, most of their achievements only contribute to the beginning stage of the full behaviour change continuum. For example, in almost all the countries visited for this study:

- FGM is no longer a taboo subject and opinion; religious and traditional leaders are offering their support for its elimination.
- More sectors of the civil society are getting involved in addressing the issue of FGM.
- There is increased media coverage fostering public education and dialogue.
- The agencies addressing the issue are becoming more sophisticated in several ways, including how to advocate for their cause, how to implement their programmes and what messages and materials are appropriate.
- The rationale for eliminating the practice is evolving from one of only harmful traditional practice and one that affects women's and children's health to one that violates human rights, affects the sexual and mental health of women, is a public health burden, and affects the development and advancement of women, communities, and countries as a whole.
- Laws have been passed and enforcement mechanisms established in Burkina Faso, and other countries have decrees banning the practice. Human rights agencies and judiciary groups are advocating for and studying possibilities of passing specific laws.

In addition to these achievements, several community-based projects have shown that change is possible and have led to behaviour-change breakthroughs that may guide anti-FGM activities in the future.

Despite the lack of rigorous evaluation data, there is a growing body of evidence on the impact of anti-FGM activities. Following are some specific examples of impact in the countries visited and projects:

- In **Burkina Faso**, an impact evaluation of the Committee's seven years of struggle against FGM has not been conducted to date. However, a national study conducted in 1996 gave some insights into the Burkina Faso programme. When asked whether people heard about the Committee's work, remember programme messages, or have negative attitudes towards the practice, the study indicated that more than 50 percent of the population had heard about the existence of CNPLE, that FGM is a "bad thing", and either received the message positively or believed it to be true. At least a quarter of women and a third of men heard that FGM has multiple consequences including haemorrhage, tetanus, frigidity, difficulty of labor and injury. In spite of this, 43 percent of those interviewed still believed that FGM was a "good thing" and 14 percent were undecided about whether it is bad or good. The study also indicated that only 17 percent of women and 22 percent of men reported discussing FGM with their partner.

- In **Mali**, evaluation studies completed by AMSOPT and Center Djoliba revealed an increased level of knowledge about the harmful effects of FGM among population groups reached by their activities. Three villages have declared publicly that they will not excise their daughters. What happens to girls in those villages and whether eleven other villages that have marriage linkages with them will support this action needs to be monitored.

- In **Egypt,** the work undertaken by the FGM Taskforce has not been assessed to date, therefore the overall impact it has had in Egypt, and more importantly on Egyptian non-governmental groups working on FGM elimination activities, cannot be clearly measured. The Taskforce has however, recognized the need to understand what achievements had been made to date by non-governmental groups, and has commissioned a study to critically assess anti-FGM efforts through a systematic, in-depth analysis of the activities undertaken by non-governmental organizations at both the community and national level. Of the seven agencies whose programmes were finally analyzed, only one community-based non-governmental organization - the Coptic Evangelical Organization for Social Services (CEOSS) - succeeded in reducing the rate of excisions in eight of 22 communities in Minya Governorate. According to this assessment, a success rate in FGM elimination of above 70 percent has been achieved in eight of the villages.

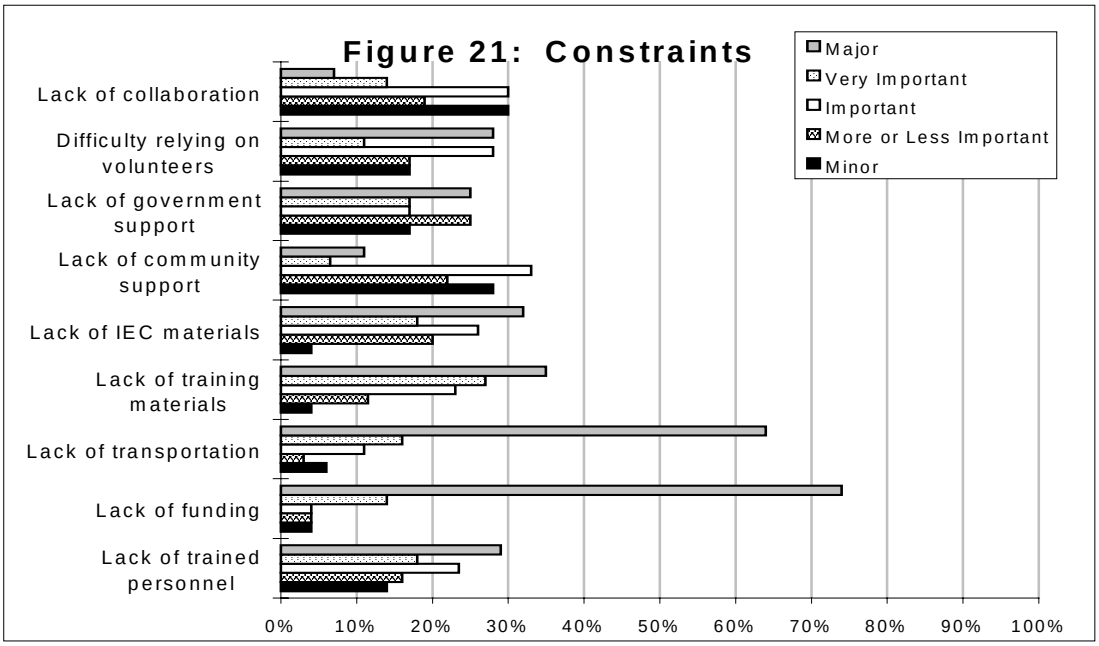
- **In Uganda,** the REACH project recorded a marked decrease in the practice of FGM since its inception in January 1996. According to statistics compiled by the REACH office, 36 percent fewer girls and women underwent the procedure as compared to1994 figures (544 girls/women were excised in 1996 as opposed to 854 girls/women in 1994). The reduction in FGM was even greater in sub-communities where the programme activities were intensified - Kaserem: 90 percent, Kabei: 60 percent, and Sipi: 43 percent.

- In **Kenya**, final evaluation of the community-based MYWO programme has not yet been conducted, although between 1996 and 1998, about 500 girls had been initiated into adulthood without excision in two districts of Kenya (Tharaka Nithi and Kisii). The number of girls saved through other programme components such as the Family Life Education (FLE) programme are estimated to be in the hundreds but the actual number is not known.

- In **Senegal**, at least 29 villages - some of them from intermarrying groups- declared publicly that they would not excise their daughters following basic education and health literacy, human rights and problem solving training for women. The impact of this public intention to stop the practice on actual individual girls and their excision status is to be monitored.

Despite the tremendous groundwork that has been established, the FGM elimination movement is still fragile and is faced with many constraints. When survey respondents were also asked to identify the constraints that their programmes faced, and to rate how these constraints affected their programmes on a scale of one to five (ranging from minor to major constraints - see figure 21), the majority of organizations identified lack of funds (74 percent) and lack of transportation (64 percent) as the two major impediments to the success of their programmes. Four other constraints pinpointed as major constraints are, in order of importance, lack of training materials, lack of IEC materials, difficulty relying on volunteers, and lack of trained staff and government support.

The survey respondents viewed issues like lack of funding and transportation as more significant constraints than lack of community or governmental support



Overall, many of the existing programmes have not been rigorously evaluated due to lack of resources and/or technical expertise. In addition, most programmes did not carry out any baseline research that is needed to conduct effective evaluations. Consequently, programme planners rely on their perceptions to judge the effectiveness of programme strategies. Despite these facts, there is a trend towards increased evaluation of programmes - a move that needs to be supported and strengthened.

Pitfalls to Avoid

The field of FGM elimination is a very sensitive and sometimes controversial subject as one begins to question age-old wisdom that communities have relied on. Differentiating the mutilating outcome of the practice from the socializing, maturing, belonging, preparing and bringing to adulthood intention of the practice becomes difficult. Individuals from non-practicing communities, whether from the same country, Africa, or elsewhere, and even individuals from practising communities whose families have abandoned the practice are often shocked by the unjustified burden that it places on women and girls. It is then easy to judge, to condemn, and to want to order people to stop, but this will not work. Anti-FGM programme implementers have learned this the hard way. For example, the survey respondents cited the pitfalls to avoid as condemnation, value judgment, disrespect for the community's cultural and traditional beliefs, and a failure to involve excisors in all project phases. Other pitfalls included the use of foreign concepts as key messages because of the risk of alienation, the adoption of a confrontational attitude with community, religious and tribal leaders and excisors. Furthermore, the agencies cautioned against devising complicated IEC and advocacy materials, a heavy reliance on volunteers and the use of provocative and abusive language during communication. All agencies and individuals working in this field should challenge their own assumptions beliefs and practices and work towards becoming culturally competent - that is, avoiding looking at these communities with their own filtered view of community reality.

VI. COUNTRY ASSESSMENTS

BURKINA FASO

INTRODUCTION

Burkina Faso, one of the Sahelian countries in West Africa, has an estimated population of 10.3 million (1979). The population is mostly rural and has high infant and maternal mortality rates. Female literacy is very low, estimated in 1997 to be only 7 percent. Burkinabe society is strongly attached to its traditional and cultural values, including those that support the practice of female genital mutilation.

THE PRACTICE OF FGM

Data compiled by Fran P. Hosken estimate that 70 percent of women in Burkina Faso have undergone excision, regardless of class, religion, and ethnic group (Hosken, 1993). People offer a wide range of reasons for the practice: it is considered a custom and tradition; it is a religious requirement; it facilitates child birth; it ensures fidelity; and it is a rite of passage girls need to undergo to become women. The age of excision varies from early childhood, to just before marriage, to before the birth of the first baby. Excision (Type I and Type II) is the most common type of FGM in Burkina Faso, however, many cases of unintended infibulations (Type III) and shrunken vaginas due to scarring are seen in medical facilities[5].

FGM ELIMINATION EFFORTS

Awareness-raising and FGM elimination activities began in Burkina Faso as early as 1975, through a radio campaign. Numerous seminars, meetings and campaigns followed, eventually leading to a presidential decree authorizing the establishment of a National Committee to fight against the practice of FGM in 1990 - the Comite National De Lutte Contre La Pratique De L'Excision (CNLPE).

CNLPE*:* Since 1990, all FGM elimination activities in Burkina Faso have been implemented with the oversight of the CNLPE. The Committee, which is Burkina Faso's national chapter of the Inter African Committee (IAC), operates under the auspices of the Ministry of Social Action and the Family. It is, however, autonomous and functions independently. The CNLPE has four levels of organization:

- The permanent secretariat with 12 permanent staff including four social workers, one sociologist, and one police officer.
- The National Committee, which draws its membership (of 45 people) from government ministries; professional associations such as the Burkina Faso Midwives Association and Nurses Association; women's and youth groups;

[5] Many cases of excision that when healed result in infibulations or shrunken vaginas (caused by tightness and/or in-elasticity of the vulva area). Both conditions make childbirth difficult.

religious organizations; and human rights agencies such as the Burkina Faso Movement for Human and People's Rights.

- Thirty provincial committees drawing their membership of 750 from provincial administration; representatives of provincial-level ministries of health, education, and social action and women; development agencies; and traditional chiefs.

- A subsidiary group of 826 trained resource persons who support NCLPE's programme activities from the national to the village levels, as needed.

The National and Provincial Committees are supplemented by 33 special support committees, which include Muslim, Christian, Traditional Chiefs, Military Police (Gendarmerie) and Police Force committees, and civil and human rights associations. Each support committee has sub-committees at the provincial, canton and village levels. These sub-committees are established as programme activities are expanded into new communities.

Programme Goals and Objectives: The National Committee developed a 1992-1995 plan of action to carry out FGM elimination activities in Burkina Faso; however, due to funding delays, the plan was implemented during 1994 to 1997. The main objectives highlighted in this plan of action were to:

- Strengthen the structure of the CNLPE.

- Improve the skills and competence of the National Committee and the resource people in the areas of IEC and management.

- Increase qualitative and quantitative research to support programme implementation.

- Raise awareness that the criminal activity of FGM occurs among two-thirds of the population.

A follow-on plan of action for the next 4 to 5 years was developed in January 1998 and is currently being finalized.

Programme Activities

Training: Training is the principle programme area of the National Committee. The Committee organizes and conducts two types of training - five-day Training-of-Trainers courses for resource people who will support programme implementation at all levels, and three-day awareness raising courses for targeted audiences among the general population. Training manuals for both the five-day and three-day sessions were developed by the National Committee to guide the activities of the resource people.

The content of the five-day training is based on IAC's training module for resource people. The National Committee prioritizes resource people from the health, education and media sectors and from the police.

The training covers the following topics:

- Harmful traditional practices and the anatomy of female genitalia.
- The history of FGM and its cultural significance.
- The consequences of FGM.
- Information, education, and communication techniques.
- An overview of the National Committee's plan of action and activities.
- Interpersonal communication and counselling (IPC).
- Information about the national law against excision.
- Instructional and informational audiovisuals (produced by IAC).
- Training techniques using debates, role plays and evaluation.

The three-day awareness-raising sessions for the general population focus on the harmful effects of FGM, the work of the National Committee, different strategies to combat the practice, and the role trainees need to play in educating their communities. Many of these training sessions are targeted to specific audiences to include information that enhances the work of these particular groups, and enables them to become change agents within their communities. Examples of such training sessions include:

- Training for excisors that emphasizes knowledge of the anatomy of women's genitalia, the law prohibiting excision, and the consequences of excisors' actions.
- Training for law enforcement agencies, including the military police, magistrates and public and private lawyers, that emphasizes understanding and applying the penal law on FGM, and informing about the harmful effects of FGM.
- Training for religious leaders that focuses on the use of religion, specifically Islam, as a reason for the continuation of the practice, and the role of religious leaders in eliminating FGM.
- Training for men that emphasizes the effect of FGM on sexuality.

Information, Education, and Communication or Sensitization (IEC): Another major programme area of the National Committee is IEC, carried out mainly through sensitization campaigns. The focus of these campaigns took a decisive turn in 1995 when an overall evaluation of the programme revealed that a large proportion of the community either still considered FGM to be a good practice or were undecided. The evaluation recommended mobilizing different sectors of the population at the local level. To follow up, the Committee successfully segmented and prioritized its audiences and developed special outreach initiatives for each group through appropriately trained resource people and the provincial and support committees. Sensitization activities range from the three-day awareness-raising training sessions, to film and video shows in village squares, discussions and debates, and/or outreach activities at churches, mosques, police stations, residences, and schools.

The National Committee focuses on the following target audiences: traditional leaders, Islamic associations, churches and pastors, women's and youth associations, health professionals, birth attendants, police officers, teachers, youth, and the media. Trained resource people from each of these groups receive support from the Committee, including a supply of manuals and IEC materials, to develop outreach strategies and resources for implementation of activities.

Examples of types of outreach activities carried out by resource people in different target groups include:

Outreach through Traditional Leaders (Saturation Strategy): The rationale and importance for involving traditional leaders in elimination efforts became clear to the National Committee after the overall programme evaluation revealed that both supporters and opponents of FGM believed that the main reason the practice continues is because it is deeply entrenched in the culture. Consequently, the Committee organized a training and strategy development workshop which led to the development of the *saturation strategy.* This strategy, which reaches at least 2 million people, includes conducting successive sets of awareness sessions at the canton, village, quarter, and family level. Specifically, the traditional leaders' outreach activities are being implemented in the following manner:

- The 45 provincial leaders conduct one-day information and awareness sessions for "canton leaders" (there are 8 to10 cantons in each province).
- The 450 canton leaders conduct sessions with each of the village leaders (there are 20 to 25 villages in each canton).
- The 8000 village leaders then conduct sessions with each quartier (neighbourhood) leader (there are 3 to 4 quartiers in each village).
- The quartier leaders then meet with groups of families, discuss FGM issues, monitor FGM episodes in the community and report back to traditional leaders.

Outreach through Religious Groups*:* Similarly, trained religious resource people develop strategies to educate their own followers through regular prayers, special sermons and religious events (Friday and Sunday prayers, baptism, etc.). As of June 1998, approximately 205 preachers had been trained and are working with the National Committee on outreach activities. Protestant leaders are seen as most supportive and have been credited with reducing the practice of FGM among their followers.

Outreach Through Youth: The National Committee has prioritized working with youth because they are not as wedded to tradition and can be influenced to stop practising FGM by sound arguments about its harmful effects. Outreach activities for youth are carried out through formal systems, specifically schools (primary, intermediate, secondary, and university). Training of education inspectors, school principals, and teachers forms the backbone of in-school youth activities. There are also youth activities in the informal sector, with youth associations. Special innovative in-school activities include competition through sports, such as soccer, and radio call-in shows.

One in-school pilot programme worth noting is called, "The Vacation without Excision Programme" and is conducted by an intermediate school called Lycée Venégré in Ouagadougou. The students are taught about FGM in the natural sciences, and trained youth (peer educators) develop songs, poems, and posters on the topic. The trained youth also conduct outreach activities within their schools and communities. Examples of the outreach activities include organizing dramas, plays and film shows for students and their parents, educating the community about the dangers of FGM, preventing their sisters (if applicable) from undergoing the practice, and denouncing the practice during vacations. Unfortunately, the impact of this innovative pilot project, which is supported by UNICEF, as well as other youth outreach activities, is not known as they have not been evaluated. However, the youth continue to denounce excision actively, and university students seem to be against all forms FGM.

Outreach through the Military Police (Gendarmes) and Police*:* Involving the police force and other legal professionals is considered essential for the Burkina Faso programme, since a law penalizing the perpetrators of FGM (excisors, conspirators and co-conspirators) is on the legal books (Articles 380, 381 and 382 of the Penal Code, enacted in October 1996). (See Appendix 4 for more details on law).

Because the National Committee has strong links with the government, the Ministry of Defence authorized the education of all military personnel and their families about the harmful effects of FGM. Consequently, 60 members of the military police and regular police were trained as a support committee. Given that the mission of the military police (gendarmes) is to educate the population about social problems, maintain security, and protect citizens, it is natural that they were selected as the principle change agents for educating the community about FGM, protecting girls and enforcing the law at the national and local levels.

The National Committee is currently following a two-tiered approach of working with the military police: involving military police and regular police in Provincial Committee activities in all regions (to identify known excisors and carry out outreach activities); and carrying a pilot police outreach project within the Ouagadougou area. Police activities in Ouagadougou include:

- Identifying, informing, and monitoring known excisors.
- Seconding a police officer to the National Committee so that there will be immediate response to denunciation of upcoming excisions through the SOS Excision Hotline.
- Educating other military police and their families through outreach in the workplaces and residential camps.
- Coordinating all police responses related to legal protection.
- Monitoring court cases.
- Educating the community through community rounds, film shows and outreach through religious institutions. Police also counsel individuals and families.

To date, some of the achievements of police involvement include: identification of 328 excisors nationwide and monitoring of their activities; participation in 35 excision interruptions that had been denounced, which saved a large number of girls from undergoing the practice; contribution to awareness-raising about the harmful effects of FGM and understanding the law, thus depicting excision as a criminal rather than a cultural practice.

SOS Hotline*:* The SOS Excision Hotline and community-level denunciations provide the backbone for enforcement of the law. The Hotline instructs people in the regions to go to the provincial committee within their communities for help. Individuals from Ouagadougou are told to call the headquarters of the National Committee for help. Before becoming available to the public, the SOS Excision Hotline was publicized over the radio, with support from RAINBO, for a one year period. The Hotline currently is broadcast on television with support from UNICEF. Most denunciations are made by young people. Unfortunately, many callers hang up the phone before giving the location of the pending excision. In several cases, those who called indicated that the girl had either died or was at risk of death. The callers seem to be afraid of repercussions.

Outreach through the Media*:* The National Committee targets all media groups, whether public or private, for training on FGM complications, the rationale for its elimination, and ways to report on the practice through their programmes. Activities are aimed specifically at radio hosts, journalists, and television broadcasters. The Committee also formed partnerships with the radio and television programmes to run the SOS Excision public service announcements and anti-FGM songs.

IEC Materials*:* The National Committee has produced a wide array of IEC materials to support programme activities implemented by the provincial and support committees and the resource people. These include leaflets, stickers, caps, posters, T-shirts, brochures, and anatomical models adapted from the IAC model manufactured originally in Geneva. Several of the provincial committees have also produced their own materials, including anatomical models and posters, and stickers in local languages. Other IEC materials include two songs in the country's two most popular languages, and radio and television public services announcements of SOS excision, four film documentaries, and two videos (one adapted and one original).

The IEC messages mostly describe FGM as an unnecessary and harmful cultural practice that has negative consequences on the life cycles of women, including difficulty in childbirth and frigidity. Other key messages refer to the law and the consequences of breaking the law. Visual images on posters and brochures are often sensational, including such images as a naked young girl hiding her genitals and asking others to stop excision; an old excisor with a knife reaching for a girl as her parents are pulling her away and jointly saying "no" to the old woman; and a rose and a razor blade together (the IAC national logo).

Mainstreaming FGM into Other Agencies' Work*:* The CNLPE plans to integrate FGM elimination into all the relevant ministries, and has already taken some steps towards this goal. These activities include training media professionals on how to report on FGM issues; training teachers and incorporating FGM into the natural sciences courses at selected schools; initiating awareness-raising activities at the university; training different levels of health care providers (including midwives, obstetricians and gynecologists); reaching out to

religious groups and police through support committees; and including information about FGM activities in national events such as International Population Day, National Culture Week and The Day of the Child. Although the Committee has had some success with mainstreaming FGM into other agencies' work, such decisions have to be approved by the government. For example the Committee is currently negotiating with the Ministry of Education to include FGM in their Family Life Education (FLE) programme.

The Committee has had some measure of success in mainstreaming the clinical and psychological treatment of FGM complications. By forming an alliance with a renowned obstetrician/gynecologist, Dr Michel Akotionga, at one of the main hospitals in Ouagadougou, ninety-five (95) department doctors were trained on how to handle complications of FGM, including third degree lacerations caused by secondary infibulation after excision (unintentional) and "shrunk vulva" (very tight and inelastic vulva that is prone to multiple tears during childbirth). The doctors also received training on how to counsel women suffering from psychological complications of FGM. According to Dr Akotionga, psychological complications are increasingly being seen, especially among young educated females who feel that their lack of sexual satisfaction is due to FGM.

Dr Akotionga's hospital, Le Centre Hospitalier National Yalgado Ouedraogon, serves as a referral center, and receives women from all over the country for various complications for women with Type III FGM, including lacerations, fistula, or complicated childbirth. Fistula repairs are done by an obstetrician/gynaecologist and a urologist. However, lack of basic drugs and medications, such as anesthesia, still hampers work in this area.

Collaboration and fundraising: The National Committee enjoys excellent collaborative relationships with government institutions, donor agencies, and private and civil society institutions. Most notably, the agency operates under the auspices of the Ministry of Social Action, which legitimizes the agency's programme as governmental while at the same time allowing it to operate autonomously. Consequently, the agency carried out intensive lobbying efforts that led to endorsements by the head of State and his wife (who is also the honorary president of the Committee), identification of excision as a public health priority, and adoption of its reports as official government documents.

All the major donors are members of the national committee, and see themselves as partners towards elimination of FGM. They receive project reports and are invited to participate in all major events - this involvement promotes donor ownership of projects and results achieved. UNICEF, for example, developed a booklet on the Convention on the Rights of the Child (CRC), and incorporated messages on eliminating excision and appreciation for the first lady's support for stopping excision.

Research: The Committee has not emphasized research to date. The only substantive research that has been carried out is a national-level study on FGM conducted in collaboration with the National Institute of Statistics and Demography in 1996 (Institute National de la Statistique et de la Demographie, 1997). This study allowed the Committee to improve its programme by developing more focused strategies aimed at involving the different sectors of society. Recently, the CNPLE has sponsored at least six FGM studies by university students.

PROGRAMME ACHIEVEMENTS

Programme Impact: So far, no impact evaluation of the Committee's seven years' work on FGM elimination has been conducted. However, findings from CNLPE's 1996 national study on FGM provided general information about the practice and revealed some insight into the impact of the overall programme:

- Sixty-six percent of the women interviewed had been excised.
- Excision is slightly more prevalent in rural areas than in urban areas (69 percent versus 63 percent).
- More than 50 percent of the population had heard about CNPLE and had either positively received the message that FGM is harmful or believed it to be true.
- At least one quarter of women and a third of men had heard that FGM has multiple consequences, including haemorrhage, tetanus, frigidity, difficulty of labor and injury. However, 43 percent of those interviewed still believed that FGM was a good practice, and 14 percent were undecided
- Only 17 percent of women and 22 percent of men reported discussing FGM with their partners.

These findings indicated that the CNLPE's elimination efforts were successful in increasing people's awareness about the harmful nature of the practice and its multiple complications. However, another study did not reveal any impact on actual behaviour among people. Nonetheless, the programme can be commended for significant programmatic outcomes (CNLPE, 1997a,b).

- Sensitizing at least 4,750,000 people.
- Conducting 87 training sessions that improved the competence of 2700 people.
- Involving a wide array of actors, including the police, religious groups, youth, women, and traditional chiefs.
- Training and mobilizing excisors to stop excising and to participate in community education.
- Lobbying for, and achieving, enactment of a law criminalizing the practice of excision.[6]
- Publicizing the law and establishing the SOS Hotline for denouncing pending cases of FGM, which led to at least 35 denunciations and several cases of imprisonment for excisors and accomplices.

[6] However, this may have led families to practise FGM in secret and suppressed discussion or dialogue.

- Achieving full government and donor support, and increased funding, for anti-FGM activities.
- Improving organizational competency and capacity.
- Gaining international recognition.

Gaps and Weaknesses: Despite significant governmental and donor support, programme growth, and improved programme implementation and technical capacity, the CNLPE still has gaps and weaknesses in the following areas:

- The programme has not reached the communities, especially those in rural areas, which seem to have the most need.
- The programme relies on volunteers for all its implementation activities, and these volunteers often have full-time jobs that make it difficult for them to concentrate on planned programme activities.
- The programme's successful mass mobilization strategy has led to increased awareness and some attitudinal change, but has included few focused community-based activities to target parents and extended families to encourage behavioural change.
- The large number of IEC materials produced by CNLPE depict FGM as a harmful practice and tell people to stop, messages that may have been timely at the beginning of the struggle but now seem too accusatory and intimidating. These materials are not based on any research and are mostly mass-produced at the national level even though there are different beliefs and practices within Burkina Faso.
- The content of the training materials is still based on the negative consequences of FGM, including sexual complications; because it does not address the basic myths and beliefs about FGM, the materials fail to allay people's fears.
- Even though health care providers, teachers and youth are included in the national and local committees and are trained as funds become available, FGM issues have not yet been formally included in the Ministry of Health's pre-service and in-service medical training programmes, teacher training programmes or formative school programmes.
- Except in a few pilot schools, youth outreach has been very limited.
- Although a law has been passed and the Committee and its resource members have had some success in enforcing and educating people about it, emphasis has been placed on the intimidating and punitive aspects of the law rather than on the protection it offers to girls and families.

- Although the Committee has been successful in identifying and setting up referral services for women suffering from complications of FGM, the systems could still be improved. For example, health care providers recommend that pregnant women with secondary infibulation should be referred for cesarean sections. This may increase the number of women subjected to unnecessary cesarean sections, since these women could have normal deliveries with an appropriate episiotomy. Burkina Faso nurses and medical doctors still need to be trained on how to provide services for infibulated women.

RECOMMENDATIONS

The national programme in Burkina Faso is one of the most successful FGM elimination programmes in the region; many of its programme strategies are commendable and need to be continued. However, the programme could be strengthened in several areas:

- The CNLPE programme emphasizes a mass mobilizing strategy. While this is very important, these activities now need to be supplemented by community-based, culture-specific initiatives.
- The national and provincial committees need enhanced skills in the area of behavioural change communications, specifically community assessment techniques and behavioural change adoption models. They also need guidance on how to focus their training materials and IEC messages on addressing community values, perceptions, beliefs, and behaviours. The focus of the current programme needs to be shifted from awareness raising (sensitization) with forced decisions (through the law), to fostering and supporting decision-making at the family and community levels.
- The IEC materials need to be revised. The messages and formats must be research-based and targeted to specific audiences and communities.
- At the community level, people should be educated about human rights and legal issues, including the Convention on the Rights of the Child (CRC) and the Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW). This, coupled with education about the positive aspects of the Burkina Faso law prohibiting FGM, will promote equal protection for all, and hopefully decrease the practice. While it is important to inform people about the current law, presenting it as forced punishment will increasingly drive the practice underground.
- The content of the training curricula must be expanded to include all the dimensions of the practice, including the cultural/mythical, psychological, sexual, human rights, and legal aspects. The current curricula focus only on medical complications. Since there is evidence that the psychological complications are increasing, outreach workers and health care providers should be trained in counselling skills.
- Burkina Faso health care providers who treat FGM complications would benefit from exchange of experience with medical doctors from areas where infibulation is practised. There is a need to revise the treatment and existing referral protocol.

EGYPT

INTRODUCTION

Before the 1995 Egyptian Demographic Health Survey (EDHS), information on the prevalence and practise of FGM in Egypt was based on small-scale studies and anecdotal information. Most of this information was misleading; researchers and others claimed that the prevalence of FGM was on the decline and was practised predominantly among lower class and illiterate Egyptians, mainly out of ignorance. Therefore, the FGM prevalence data from the 1995 EDHS - that 97 percent of ever-married Egyptian women had been excised - surprised the Ministry of Population and Health (MOP&H), non-governmental organizations, donors and other Egyptian groups. Findings highlight that other information about the perpetuation of FGM was also inaccurate. The data show clearly that FGM is not practised only by the poor and ignorant, but among all social classes and educational groups. The perpetuation of the practice is due to political, religious and economic interests, as well as gender roles and power relations between men and women. There is also evidence that physicians are strong advocates of the practice; many physicians, through law suits and public slander via the media, have attacked FGM activists and decision-makers working to eliminate the practice (FGM Taskforce, 1998).

The battle over FGM that followed the 1994 International Conference on Population and Development (ICPD) and the subsequent court cases has shown that more is at stake than the practice itself. Religion is a strong point of reference used by religious advocates and leaders to maintain belief in the practice. According to the 1995 EDHS, 31 percent of people supporting FGM attribute the practice to religion. FGM is also inextricably linked to upholding Egypt's patriarchal society, a link clarified by examining the main reasons people give for supporting the practice: FGM is related to women's honor and marriageability; their chastity and reputation; and their submission to the prevalent gender-based value system. Combating FGM in Egypt can, therefore, no longer focus on targeting the poor, ignorant, and deprived women, but must become a process of changing the social power structures (FGM Taskforce, 1998).

POLITICAL AND LEGAL HISTORY OF FGM IN EGYPT

Egypt does not have a specific law prohibiting the practice of FGM. However, approval and/or performance of FGM is a violation of Act 240, a law that states that any person who injures another person or beats him/her in a way that leads to cutting or severing, or impairing the function of any body part or leads to blindness shall be punished by 3-5 years' imprisonment. In cases of previous deliberate intentions, punishment would be hard labor for 3-10 years.

For doctors, the right of medical intervention, which allows them to injure or cut body parts in surgery, is inapplicable to FGM because it is not considered an intervention to diagnose or treat a disease or stop pain. In addition, FGM cannot be legally justified by parental approval, since parental custody does not involve the right to mutilate the child.

In 1959, a ministerial decree was passed that forbade the practice of FGM and made it punishable by fine and imprisonment. A subsequent series of ministerial decrees allowed certain forms of FGM. At some point, doctors were prohibited from performing FGM in

government health facilities, and non-medical practitioners were forbidden completely from practicing FGM. In 1994, as a result of the public outcry over a television broadcast of the excision of a nine-year-old girl by a barber, the Ministry of Health (MOH) decreed that FGM be performed one day a week in governmental facilities, by trained medical personnel, only if they failed to persuade the parents against the practice. However, this decree was later rescinded (1995) following international outcry and protests deploring the medicalization of the practice.

On July 26, 1996, the Ministry of Health and Population (MOH&P) issued a decree forbidding the practice except for medical indications, and only with the concurrence of a senior obstetrician. The decree (No. 261) states: "It is forbidden to perform excision on females either in hospitals or public or private clinics. The procedure can only be performed in cases of disease and when approved by the head of the obstetrics and gynaecology department at the hospital, and upon the suggestion of the treating physician. Performance of this operation will be considered a violation of the laws governing the medical profession. Nor is this operation to be performed by non-physicians." This decree finally prevented medical practitioners from performing FGM in any governmental facilities or private clinics. However, it still did not legally prevent the performance of FGM by a non-governmental medical practitioner in one's home.

A number of Islamic fundamentalists and medical practitioners who support the practice challenged this decree in court. As a result, on June 24, 1997, an administrative court overturned the decree, declaring it unconstitutional. This ruling later was appealed and sent to a higher administrative court, which reinstated the anti-FGM decree on December 28, 1997, because the court believed the Minister's decree was well within his power, and there was no strong evidence in Islamic texts to suggest that Islam favored the practice of FGM.

While the impact of this last ruling appears to be positive, that it will elicit behavioural change is not guaranteed. The decision to excise a daughter is not likely to be affected by a ministerial decree. Furthermore, while the decree bans FGM from government hospitals and health units, most excisions in Egypt are performed in homes and private clinics by male doctors, traditional birth attendants or in some cases by barbers (EDHS, 1996). The ruling, however, is not pointless since it also helps activists, grassroots non-governmental organizations and other human service organizations by empowering them with legal and governmental support.

FGM ELIMINATION APPROACHES

In addition to the legal technicalities described above, various approaches to eliminate the practice of FGM have been implemented in Egypt, depending on the target population, the implementing agency, and the perceived obstacles, for example, people lacking the correct information about FGM. This section describes these activities.

- **The Health Approach:** The health approach (i.e. using key messages that directly link FGM to health consequences) has been the most popular one. Organizations perceive that a health perspective provides an easy entry point to address an issue as sensitive as FGM. The Egyptian Society for Population and Development (ESPD) and the Center for Development of Population Activities (CEDPA) reviewed the experiences of non-governmental organizations working

towards the elimination of FGM in Egypt. This study revealed that several organizations still recommend and implement their work on FGM within the framework of reproductive health (Katsha et al. 1997). However using the health approach alone has led to a number of problems. First, it has led people to associate the practice directly with medical care and thus to rely more heavily on doctors, some of whom are strong advocates of the practice. Second, using the health approach highlights the complications and side effects associated with FGM. This has led to either disbelief about the harmful consequences of the practice among some excised women who have not experienced any complications, and/or to the medicalization of the practice, since many people believe they can avoid side effects by taking their daughters to health clinics and/or hospitals for the procedure. Last, the health approach used in Egypt has not been comprehensive; the mental and sexual complications of FGM have not been addressed since they are culturally sensitive topics.

- **The Human Rights Approach:** In Egypt, three international conventions - The International Declaration of Human Rights, The Convention on the Rights of the Child, and the Convention Against all Forms of Discrimination Against Women - have been used as lobbying and advocacy tools for FGM elimination efforts. However, many Egyptians do not see themselves as active participants in the international scene and thus do not respond to or are alienated by arguments-based international conventions that forbid the practice of FGM. Therefore, the human rights information must be combined with information that humanizes these conventions and draws on Egyptian history and life to develop a more "audience-friendly" approach.

- **The Cultural Approach:** This approach is still quite new in Egypt. Since the data show that support for FGM in Egypt is culturally based, addressing the practice of FGM from a cultural perspective could be effective. Given that FGM is practised in Egypt to reduce women's sexual desires and to control their sexuality, an in-depth look into the local cultures and forms of expression with regard to this issue may reveal cultural traditions and norms that admire female sexuality and call for its self-expression. For example, traditional wedding songs are a rich source for alternative cultural expectations of a woman's sexual life. Once more data is collected (including geographical and historical data), the cultural approach may be able to complement other approaches.

- **Development/Gender Approach:** The development/gender approach is based on the belief that the country's development cannot occur without the improvement and change among all people, particularly women. In broader terms, development will not be successful if people's health, individual and collective rights, and oppressive aspects of culture, are not addressed. This approach is a wider approach that involves whole communities, and ultimately the whole country, to achieve the welfare of every individual on the basis of justice, equality and democracy. The advantage of the development/gender approach is that it is flexible and allows the use of several entry points based on the situation and/or the groups being targeted. This approach is used by the Egyptian FGM Taskforce (described below).

EGYPTIAN FGM TASKFORCE

A key actor in the FGM elimination movement in Egypt is the Egyptian FGM Taskforce. It was founded in October 1994, under the umbrella of the National NGO Commission for Population and Development (NCPD), an non-governmental support organization created in 1994 to assist in the implementation of the ICPD. Chaired by Dr Marie Asaad, the Taskforce is composed of a diverse coalition of organizations and individuals who share the same objective of eliminating the practice of FGM. The impetus for starting the Taskforce derived from lessons learned from FGM efforts, dating back as far as the 1950s, that did little to eliminate the practice in Egypt. The ICPD provided momentum to anti-FGM activities, and the Taskforce built on that momentum to address FGM and foster change.

The Taskforce's diversity is one of its main strengths, supporting multidisciplinary approaches to the issue of FGM. The Taskforce provides an open forum for all interested parties to meet, exchange information and experiences, and build partnerships, while at the same time supporting and mobilizing the parties. Membership in the Taskforce is open to every person, organization, or constituency that shares its vision and chooses to work in collaboration with others. In addition, the identity of the Taskforce as a coalition of non-governmental organizations and activists against FGM is further enriched by the independent nature of its membership. The role of the Taskforce is that of mutual guidance, coordination and support. Each organization is free to choose its own activities according to its original mandate.

Organizational Structure: Although the Taskforce is affiliated with the NCPD, it works independently. Its main role is to be the umbrella organization for all organizations working to eliminate FGM, through which a mutually beneficial exchange of experiences can occur. For example, many grassroots organizations have expressed a need for user-friendly materials on reproductive health matters for low-literate populations. The Taskforce responded by coordinating the production of such materials through the Resource Center and other non-governmental organizations.

At the start, the Taskforce was divided into three coordinating subcommittees: grassroots mobilization, research, and lobbying. The lobbying group later became the media subcommittee, which is now working on a media strategy to highlight FGM issues in Egypt. A smaller, informal group acts as an "Advisory and Facilitating Committee" to the wider Taskforce. Made up of volunteers based in Cairo, this committee meets regularly. Members discuss urgent decisions, draft documents, facilitate the preparations for events, recruit membership and consultancies, and manage the overall activities of the Taskforce.

All members of the Taskforce are essentially volunteers, with the exception of some staff at the Resource Center. On occasions, Taskforce members may be asked to work full-time on a specific project. They are then provided with an honorarium.

The Taskforce's Resource Center provides information to non-governmental organizations and other organizations in the field, and also collects and documents lessons learned from these same organizations' experiences to enrich its resources further.

Goal and Objectives: The long-term goal of the Egyptian FGM Taskforce is to eliminate the practice of FGM without compromise. The words "without compromise" were

added to the goal because the Taskforce does not accept the suggestions made by some groups to practise a "milder" form of the practice (clitorectomy) or to medicalize the practice.

The Taskforce's overall plan to achieve its long-term goal is based on two strategic objectives:

- To build strategic alliances with health/reproductive rights, human rights and integrated development groups so that FGM can be addressed as an independent issue, using all available approaches, whether development, human rights, and/or reproductive health/rights approaches.

- To gain a better understanding of the social function of FGM - in other words, the general factors and power relations that reinforce the persistence of the practice despite the availability of information and people's wish to stop the practice - in order to be able to address all relevant stakeholders.

Programme Approach: The Taskforce uses the development/gender approach to address the issue of FGM. This broad and comprehensive approach allows the Taskforce to draw on all facets of the issue and to integrate health, gender equity, human rights, culture and the welfare of the nation into their efforts against the practice.

The Taskforce is reluctant to access or use the religion approach in their work because of its ambiguity. The "Islamization" of FGM has given the practice a sanctity which is difficult to shake. It has also produced a variety of irreconcilable religious views, ranging from complete belief in the necessity of the practice, to a total denial that religion promotes the practice. This approach has only served to confuse people and convolutes, rather than clarifies the issue.

Programme Activities: To achieve its goals and objectives, the Taskforce carries out and/or supports several activities. These activities are designed for a variety of target groups and therefore have different points of emphasis:

- Conduct research on FGM, its impact, peoples' knowledge, attitudes and practices, and other topics, to provide crucial information about the social aspects of the practice and assist the Taskforce and other groups in developing long and short-term plans to address peoples' needs and the issue. Research findings are used to help guide non-governmental organizations and other organizations in their work. For example, the Taskforce is initiating research on male perceptions of their own, and women's sexuality. This research will explore the assumptions that have been made about men, their sexuality, their sexual insecurities and misperceptions etc. It has usually been assumed that men prefer an excised wife; however, surveys have not directly asked men this question, nor have men been asked their view of the difference between excised and unexcised women.

- Document and evaluate experiences of non-governmental organizations: In 1997, the Taskforce recommended and supported the evaluation of a number of non-governmental organizations. The motivation to conduct the research came from the Taskforce's need to assess the initiatives already under way and to plan

ahead by assessing the efficacy of past and ongoing programmes. The main findings and recommendations of the evaluation were: the messages disseminated about FGM need to be credible, scientifically based, and easily accessible to be effective; more training and education needs to occur at the leadership level; to increase awareness media campaigns need to be given strong consideration; and men need to be targeted in awareness-raising activities.

- Conduct consciousness-raising and education through workshops and written materials. The Taskforce helps build awareness among people about the harmful practice of FGM. By educating others about the facets of FGM - explaining what the practice of FGM is and what the Taskforce is trying to do - the foundation on which FGM is built can be questioned and hopefully dismantled.

- Conduct health-related training in order to spread the message against the practice of FGM effectively. The Taskforce believes that researchers, social workers, and health care providers, especially doctors working in the field, need to be trained and sensitized about the different aspects of FGM. In many cases, people who are aware of the harmful aspects of the practice are not able to communicate this message further. The Taskforce supports and/or conducts training workshop and seminars for all the above groups. In addition, to increase awareness about the harmful aspects of FGM at the community level, the Taskforce also created and trained groups of community-based trainers who are trusted in their communities and can communicate with people about sensitive issues. The Taskforce also supports and/or conducts counselling training for counsellors and other relevant health care providers whose skills need to be improved and updated so that they can offer good counselling service about FGM and related issues to their clients.

- Support capacity-building for groups that want to advocate, campaign, or research. One of the Taskforce's key areas is grassroots mobilization. Since 1995, the Grassroots Mobilization Subcommittee, coordinated by Dr Magdy Helmi, has been organizing and participating in workshops throughout Egypt. The workshops have either been organized by the subcommittee or by organizations who have invited the subcommittee to coordinate one or more sessions about FGM. These workshops focus on networking and building links among concerned parties in their respective communities. They also focus on building the capacity of these groups to carry out advocacy work and increase their sense of empowerment to elicit change within their own communities. Grassroots organizations are also offered support to conduct research that could help with their advocacy work. The Taskforce Grassroots Mobilization Subcommittee provides interested organizations with a letter of introduction and recommends various donors that might support their work.

- Carry out advocacy, campaigning, and public mobilization. The Taskforce believes that mobilizing the public is key to eliminating FGM. Advocacy needs to be carried out in as many segments and levels of society as possible. By working at the grass-roots level, with the media, and with decision-makers,

the Taskforce hopes to win as many allies as possible and get the public to question the practice. The grass-roots mobilization subcommittee plays a crucial role in this area, disseminating information about FGM in accessible formats via newsletters, workshops, and easy-to-read manuals.

- Network. To avoid duplication of effort, whether in research or campaigning, the Taskforce supports individuals and organizations by providing the forum to build a strong networking system, to learn from each other's mistakes and experiences. The Taskforce, through its Resource Center, also facilitates the dissemination of information.

- Lobby. The Taskforce has worked with several non-governmental organizations to transform their information, research and experience into lobbying tools that can be used at conferences and/or meetings with influentials. In 1995, the Taskforce and NCPD organized a workshop, under the auspices of the MOH & P, for decision-makers, media representatives, social scientists, doctors and non-governmental organizations to discuss and address the issue of FGM. Since then, conference presentations have been supported to sensitize people about violence against women and FGM.

- Develop informational and educational materials. The production of educational and communication materials is seen as an integral part of spreading the Taskforce's messages. In response to a need expressed by many non-governmental organizations, especially at the grass-roots level, the Taskforce has already produced a reproductive health manual. The manual includes information on FGM for semi - and newly-literate groups, and is used by community-based trainers. Negotiations are now underway for the Ministry of Health and Population (MOH & P) to adapt the manual for wider dissemination. The Taskforce is also considering the development of materials for doctors, legislators, decision-makers, media, and other groups.

- Run the FGM Resource Center. The development of the FGM Resource Center became a priority for the Taskforce for several reasons: a) there is a need to monitor how FGM is covered in the media, in part to assess changes in public opinion; b) FGM activists need information and resources on this issue; and c) the researchers working on FGM need access to information and other international and national FGM studies. The Resource Center has books, papers, newsletters, and audiovisual materials on FGM, produced by both the Taskforce and other organizations. To date, the Center has been quite successful in facilitating the process of data collection and dissemination among a wide range of non-governmental organizations throughout Egypt's 26 governorates. The Resource Center is managed by Dr Seham Abdel Salam.

- Work with the media. The Taskforce Media Subcommittee is developing a network of media personnel that can enter into alliances with non-governmental organizations and offer them support in their work. By involving the media at the onset of campaigns and/or interventions and providing media personnel with the necessary information and background on

FGM, media groups will be more informed and sympathetic towards the issue, and willing to include FGM in their media channels. Building such a network will require negotiations with the government and other authorities, since most media channels in Egypt are under government control. As such, this initiative is in its preliminary stages.

The Taskforce is responsive to feedback provided during the FGM Taskforce monthly meetings and direct discussions with non-governmental organizations and others, and plans to modify and expand its activities to respond to members' needs.

THE ROLE OF DONORS

Aside from providing funding and some technical assistance for FGM activities, most of the donors in Egypt participate as advisors at important meetings and workshops held on the subject of FGM. This includes the monthly meetings held by the Taskforce.

Ford Foundation: In addition to providing core funding for the Taskforce, the Ford Foundation also supports other activities related to FGM in Egypt. These include funding individual social science researchers, covering translation costs of documents related to FGM, and funding the participation of Egyptian researchers and activists at international conferences and meetings. On occasion, the Ford Foundation also supports the consultants who assist non-governmental organizations and other groups in identifying technical assistance needs.

Population Council: To date, the Population Council has provided technical assistance and support to two operations research initiatives on FGM:

- A collaborative study with the Egyptian Fertility Care Society (EFCS) to validate the prevalence statistics from the EDHS (details below).

- A pilot study to determine the status and needs of excised Sudanese women in Egypt. At the time of the country assessment visit, this study was just beginning.

NGO PROJECTS AND ACTIVITIES

Egyptian Fertility Care Society (EFCS): EFCS is Egypt's leading Obstetric and Gynaecology Medical Association. Its mandate includes providing technical and medical guidance to medical associations and faculties in Egypt and conducting research on reproductive health issues.

In collaboration with the Population Council, EFCS conducted a study to validate the 1995 EDHS findings on the prevalence of FGM. The research revealed that the EDHS prevalence rate was quite accurate - 93 percent of the women who were examined had undergone FGM. In addition, the research revealed that 60 percent of women had undergone Type II FGM, information not included in the EDHS. The EFCS, with assistance and input from the Taskforce, included a session on FGM in their 1998 Annual Conference on Obstetrics and Gynaecology.

Plans are currently underway to conduct another study to investigate the direct relationship between FGM and maternal morbidity and mortality. This study will be jointly funded by the Ford Foundation and Population Council.

Partnership Projects for Girls and Young Women. This five-year umbrella project, approved and funded by the United States for International Development (USAID), provides Egyptian non-governmental organizations with the funding to carry out advocacy, training and other services for girls and young women living in under-served areas in Egypt. CEDPA plays a leadership and advisory role to Egyptian partners, who are responsible for implementing the various components of the project.

The goal of the Partnership Project is to improve the health and educational status and life options of girls and young women living in Egypt. The project aims to strengthen and expand services at the community level, while simultaneously mobilizing national and governorate leaders to advocate for gender equity and promote a policy environment favorable to the needs of girls and young women. Designed to build on CEDPA's previous work with adolescent girls in Asia, Latin America and Sub-Saharan Africa, the initial activity under the Partnership Project was to adapt the "Choose a Future Programme" - a non-formal educational programme designed to increase girls' self-esteem and confidence and help them acquire basic life skills - to the Egyptian context. This resulted in the creation of the "New Horizons Project" for adolescent girls (see box).

The New Horizons Project:

The New Horizons Project is a non-formal education programme designed to demystify and communicate essential information about basic life skills and reproductive health to Egyptian girls ages 9 to 20. Its practical aim is to empower women to make informed life choices. The programme was developed after a 1995 needs assessment and a series of six participatory workshops to develop a training programme that would meet the needs of rural girls as well as strengthen the capacity of non-governmental organization staff to deliver such programmes. The programme is being implemented in three Upper Egyptian governorates, Beni Suef, Fayoum and Minya, which were chosen for the pilot phase because of their low levels of female education and literacy.

The New Horizons programme is comprised of 100 structured sessions. Each session, which is one hour long, covers one subject area. Materials include a kit of colorfully illustrated posters, cassette tapes with songs, poetry and drama and two instructors' manuals:

- **Basic Life Skills** for all ages starting at 9 years old. This includes sessions on girl's identity, rights and responsibilities, health and nutrition, environment and skills training.
- **Reproductive Health** education for older adolescents starting at the age of 12.

Information about FGM and its harmful aspects is included in the Reproductive Health Manual under the "Violence Against Women" unit. The sessions in this unit include: kinds of violence against women; FGM; harmful physical and psychological effects of FGM; history of FGM and misconceptions; religious views on FGM; and official and international views of FGM.

To date, over 89 New Horizons Girls' Learning Centers have been set up and more than 4000 adolescent girls have completed the programme. Initial results of the overall programme have been encouraging. Field visits by consultants and project staff have shown that girls are not only learning content and acquiring new problem solving skills, but they have also been able to describe how this new knowledge would change their own behaviour. In the four communities in the Minya governorate, 131 girls did not undergo FGM and 17 families agreed not to impose the practice of bridal deflowering on their daughters. A very important lesson is that reproductive health education can be successfully introduced to rural communities in Egypt. Given the encouraging results of the pilot phase of the programme, a wider implementation strategy, started in January 1998, is underway. CEDPA aims to increase the number of girls and young women receiving New Horizons services by creating a nation-wide network of non-governmental organizations and government entities implementing the New Horizons programme.

*Cairo Institute for Human Rights Studies (CIHRS)**:*** CIHRS is a human rights non-governmental organization. It stands apart from other human rights groups because of its unique focus on gender issues, such as empowerment and women's rights. CIHRS works on FGM from a human rights perspective, believing that it is a violation of women's basic human rights and bodily integrity. CIHRS is one of the most active non-governmental organizations in the areas of advocacy and research. It began its anti-FGM campaign in 1994, and FGM has since become a primary component of the Institute's Women's Programme, which promotes awareness of gender-related issues. CIHRS staff are members of the FGM Taskforce and work in close collaboration with the Taskforce to achieve the goal of eliminating FGM.

CIHRS targets human rights activists, intellectuals, and researchers who might be sympathetic to the cause. It also carries out lobbying efforts with politicians, the media, and academics and spreads awareness about the issue of FGM through seminars, workshops, training sessions, and collaborative publications. Despite these efforts, CIHRS has not

developed a structured work plan. All anti-FGM activities thus far have been conducted as a result of individual initiatives.

One of the Institute's collaborative efforts with the FGM Taskforce has been the organization, preparation and implementation of several workshops. A report entitled, "Workshops on FGM: A Report," was published based on these workshops; it is now being utilized as reference material by others. The report includes details on the FGM Taskforce's activities, a review of the workshops conducted, and diverse legal, medical, and social perspectives related to FGM. It also includes information about the Taskforce's three subcommittees and articles that have been written by advocates of the cause. Two thousand copies of the report have been printed and distributed.

CIHRS has also produced a second publication in collaboration with the Taskforce entitled, "FGM: Fallacies and Facts." This scholarly publication, which includes information on the social, medical and religious facts related to the practice, is a resource among the educated population and non-governmental organizations. CIHRS operates a resource center for researchers, journalists, and intellectuals, which includes a large selection of FGM articles. These materials have been shared with the FGM Taskforce's Resource Center. Information on FGM is also published in the Institute's journal "Sawasiah", which means equality.

CIHRS has also conducted several research studies to increase the knowledge and understanding of aspects of FGM. The need for research has, for the most part, been generated in the field - several local communities expressing an interest in knowing more about the statistics and scientific facts about FGM. Research studies that have been undertaken to date include:

- An unpublished study entitled, "Attitudes of Medical Doctors Towards FGM." This is a pilot study to assess the attitudes and knowledge of 500 doctors towards FGM. One of the objectives of the study was to link the medical perspectives to the educational system of doctors and emphasize the importance of including this topic in faculty of medicine curricula.

- A study (currently underway) to assess the successful work carried out by the Coptic Evangelical Organization for Social Services (CEOSS) in eliminating the practice in the governorate of Minya. The study, called "The Experience of an Egyptian Village in Combating FGM", outlines this success story of a community in its efforts to eliminate the practice (See below).

- A study on the human rights perspective on FGM called, "FGM: A Violation of Human Rights," has been translated into Arabic and will be published in a new journal created by the Institute and entitled "Women's Initiative".

For the first time in Egypt, the perspective of FGM as a violation of women's rights has been included in a human rights course originally offered annually to university students by the Institute. The objective of the course is to expose students to the national and international treaties for human rights, specific human rights and problems related to regional human rights.

CIHRS' mandate to increase awareness and improve the effectiveness of the human rights movement plays a very significant complementary role to community-based awareness activities. It provides credible support materials to non-governmental organizations and other groups working at the grassroots level, especially in answering difficult questions posed by human rights-related target groups.

Coptic Evangelical Organization for Social Services (CEOSS): See Section VIII for detailed write-up of this project.

FINDINGS AND RECOMMENDATIONS

The work of the FGM Taskforce has not yet been evaluated. However, it has participated in and supported the evaluation of several of its member non-governmental organizations. The following findings and recommendations are based on a systematic study commissioned by the FGM Taskforce to critically assess anti-FGM efforts, through in-depth analysis of the activities undertaken by non-governmental organizations at the community and national levels in Egypt. Initial criteria for being included in the assessment included a minimum of five years' experience working on anti-FGM activities. Only two of the 110 non-governmental organizations contacted met the five-year requirement. Ultimately, it was determined that five other organizations had sufficient experience to effectively participate in the study, so a total of seven non-governmental organizations was assessed.

Findings from the study revealed the following:

- Despite the efforts of the Taskforce to build a network for non-governmental organizations and provide a forum for information sharing, there is still insufficient coordination among non-governmental organizations working in the area of FGM, which limits the efficacy of the movement. Several activities could enhance coordination: more exchange visits among non-governmental organizations to share each other's experiences; wider participation in the monthly meetings of the Task Force; and an assessment of the comparative strengths of various non-governmental organizations to help them identify ways to complement each other's work.

- Non-governmental organizations do not adequately document their programmes and activities. To increase documentation, the study recommends that the Taskforce create awareness of the importance of documentation for long-term programme effectiveness; provide in-service training to non-governmental organizations in documentation and evaluation methodologies; and maximize the use of local leaders in documenting and following up on programme progress.

- Placing FGM elimination efforts within a comprehensive development strategy and the larger context of reproductive health and gender education is the most effective approach to eliciting behavioural change. Recommendations for doing so include integrating FGM awareness into existing literacy classes for both men and women; and exposing target audiences to FGM messages over a longer period of time, since a single meeting or training has limited effectiveness.
- Efforts to eliminate FGM are more successful when non-governmental organizations are able to gain the support of local leaders and collaboratively create a supportive social atmosphere for these activities. To foster this, non-governmental organizations working at the community level should include local leadership as part of their overall FGM elimination strategy; identify members of the community who are influential, respected and committed and can be trained as advocates against FGM; provide adequate training and resources for community leaders to effectively advocate; encourage families that have stopped the practice to serve as role models within their communities; and train local leaders to use positive peer pressure to support and convince families to discontinue FGM.
- FGM elimination efforts have primarily been focused on women and young girls. Yet it is clear that non-governmental organizations need to address both male and female members of the family in the fight against FGM. It is important to develop materials appropriate to the specific target groups, including religious leaders and doctors, since the public appears to regard these groups as authority figures. It is also important, during the design phase of any anti-FGM intervention, to assess the potential of a proposed target group for successful advocacy. For example, nurses were found to be ineffective in counselling women since the clinic setting offers neither adequate time nor space, and counselling is not considered part of the nurses' job description.
- IEC messages have predominantly focused on highlighting the negative medical side effects of FGM. This has not proven to be the best approach since most women, who do not experience these problems, are not convinced to stop the practice. In addition, the "medicalization" message has given greater weight to the false belief that FGM is a legitimate medical procedure. To change this, a different set of messages need to be developed. IEC materials need to include the social, cultural and psychological aspects of FGM, in addition to concise, factual, medical information. In addition, materials need to be developed to address the following specific concerns: the religious stance - especially in Islam; the effect that abandoning the practice has on girls' future marriageability; the preservation of social values such as virginity, chastity and "proper" behaviour; and the perceived sudden interest in FGM, which has been interpreted by many as an imposition from the West. FGM also needs to be placed within the context of the family to make men more aware of how the practice both directly and indirectly affects their families. FGM elimination activities need to be seen as a complement to Egypt's national goal of improving the quality of women's and girls' health and lives, a core component of overall socio-economic development.

- The availability and dissemination of relevant IEC material is limited**.** Recommendations include updating current materials to meet the needs of the various target groups; creating a national clearinghouse for information and resource material (the Taskforce has already established the Resource Center for this purpose); coordinating the development of materials among non-governmental organizations to maximize scarce financial resources, avoiding duplication of efforts and ensuring a consistent message (the Taskforce could serve as the focal point for such an activity); developing simple, clear materials that are eye-catching and attractive; using various mediums to best respond to the different target groups; using either through video, print stories or audio tapes testimonies of those who have rejected FGM; developing audiocassettes in question-and-answer format so that groups or individuals can listen to them privately; and producing a booklet on FGM for men by men.
- Local staff need more specialized training. Training programmes for local staff that emphasize interpersonal and communication skills need to be developed. Local staff need to be trained to work effectively with different audiences using a wide range of interactive communication tools, such as role-play, theater and audio-visuals.

CONCLUSION

Behavioural change, especially change of a deeply rooted custom like FGM, is a long, slow process. For example, successful results in one village (CEOSS project) only emerged after seven years of hard work. Yet, there is hope for the future. The number of non-governmental organizations interested or actually working in FGM elimination has increased dramatically over the past few years, due in part to the work of the Taskforce. A vibrant and progressive movement of active non-governmental organizations, committed to ending the practice of FGM in Egypt, has developed. The non-governmental organizations are focusing on FGM within the context of a larger concern for women's health, human rights, and the role of women in national development. Hopefully, this report will provide the non-governmental organizations with new insights and a better understanding of how best to eliminate this traditional harmful practice.

ETHIOPIA

INTRODUCTION

In 1985, the Ministry of Health, with support from United Nations Children Emergency Fund (UNICEF), conducted a national study to determine the prevalence and knowledge, attitudes and practice (KAP) of FGM in Ethiopia. The findings of the study indicated that 85 percent of respondents had undergone one of the three types of FGM - clitoridectomy, excision, or infibulation. The main reason given for support of the practice is to preserve the "true blood line" of a family - hence prominence is placed on girls'/womens' virginity and fidelity. Other reasons cited for the continuation of the practice included: economic gain; the control of women by men; the protection of the traditional male-only land holding patterns; easier childbirth; and aesthetics (Hosken, 1993).

FGM elimination activities in Ethiopia are carried out primarily by the National Committee on Traditional Practices of Ethiopia (NCTPE), a non-governmental, non-political, non-profit organization registered under the Ministry of Internal Affairs of the Transitional Government of Ethiopia in 1993.[7] Like other national chapters of the IAC, the NCTPE operates under the auspices of the government but conducts its activities autonomously. It is comprised of 20 representatives from Government Ministries, non-governmental organizations, and United Nations agencies. Initially operating under the auspices of the Ministry of Health (MOH), the NCTPE is now fully incorporated as a non-governmental organization, with full-time employees at the national level.

In 1995, NCTPE established 10 regional sub-committees, each of which was given the responsibility for planning and implementing information campaigns in their respective regions, districts and communities. Representatives of the regional committees are also members of the NCTPE general assembly. NCTPE has one full-time programme coordinator in each region but otherwise relies on volunteer sub-committee members, usually heads of government offices in the region, for office space and transportation. Committee members work with the NTCPE coordinator to implement all planned programme activities and are given a per diem for participating in Training-of-Trainers (TOT) sessions and Training Information Campaign (TIC) programmes at the *wareda* level,[8] and sensitization sessions for students. Committee members are also encouraged to incorporate work on harmful traditional practices into their own agencies' work. Committee members often provide office space for meetings and vehicles for project activities. In Bahar Dar, for example, meetings take place in the Women's Affairs Bureau. Zonal leaders[9] may also loan equipment, e.g., a TV or VCR, for project activities.

Several government ministries, for example, the MOH, Ministry of Labor and Social Affairs (MLSA), and Ministry of Education (MOE), have established women's affairs departments that are responsible for FGM elimination activities and coordination with the NCTPE. In addition, most United Nations and donor agencies are members of the NCTPE and support its activities.

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[7] The NCTPE was founded in 1979 and re-incorporated after a change of government.
[8] *Waredas* are equivalent to districts or a group of towns.
[9] Zonal leaders administer a group of provinces.

The NCTPE programme operates on a national level and has two main objectives:

- To eliminate all forms of harmful traditional practices with special emphasis on FGM.
- To promote beneficial practices such as postpartum breast-feeding and care of women.

PROGRAMME STRATEGIES

To carry out its objectives the NCTPE has four main programme strategies:

Training: The NCTPE carries out four types of training.

Training-of-Trainers (TOT): NCTPE provides a 10-to-15 day training programme for professional committee members drawn from various governmental and non-governmental agencies who will serve as future trainers and resource people for its regional and zonal level training, information, and campaign (TIC) programmes. To date, the NCTPE has carried out nine TOT workshops and has trained a total of 198 participants.

Training Information and Campaigns (TICs): Supported by Headquarters staff, trainers who have attended a TOT workshop conduct two-day TIC training sessions for influential community members at the zonal level. TIC training can include up to 90 participants from 10 waredas. Between 15,000 and 20,000 people have attended TIC training.

Orientation Sessions: The NCTPE also organizes one-day seminars and workshops for community leaders, policymakers, journalists, artists, teachers, and students at nursing and teaching schools and high schools.

Refresher Programmes: In response to a 1994 evaluation, NCTPE initiated refresher training for both TOT and TIC trainees. Refresher training sessions may include supervision skills.

IEC: IEC activities implemented by the NTCPE can be categorized into three main areas: materials production, mass media, and information campaigns.

Materials Production: The NTCPE has produced a substantial quantity of the IEC materials, including posters, calendars, leaflets, brochures, T-shirts, songs, dramas, and videos. All the materials developed are first produced in English or Amharic (the official language of Ethiopia), and then translated into other local languages of different regions of the country, such as Harari, Afar, Oromia, Tigrinya, or Somali. To date, EIC materials have been translated into nine local languages.

Mass Media: Over the years, NCTPE has collaborated with the Educational Mass Media Association (EMA), the Ethiopian Radio Agency, and Ethiopian Television, to disseminate information on the harmful effects of FGM and other practices. NCTPE's most successful mass media work was a joint programme with the EMA to produce entertaining

radio and television programmes and audio-visual materials for students and distance learners on a variety of subjects including health, civic duties, agriculture, rural development, and teaching methods. The programme produced a total of twenty-eight one-minute radio spots that were broadcast between 1995 and 1997. Each spot covered a theme, such as the consequences of FGM or early marriage, and was broadcast in schools, twice a week throughout the school year.

EMA and the NCTPE also produced 10-minute radio programmes that targeted the general public. These programmes included expert interviews and case studies on excisors and women who suffered from FGM complications. Although there are more than 80 languages spoken in Ethiopia, the programme was only produced in 16 languages.

EMA evaluated its media programme every year by soliciting feedback from teachers, students and the general public. Respondents mentioned that the programme is interesting and entertaining, supports the information booklets and curricula used in primary and secondary schools, and assists teachers in discussing harmful traditional practices in the community. EMA also received requests to repeat the radio programmes.

Although successful, the programme recently terminated for a variety of reasons, including lack of funding to cover staff, air-time, and transportation costs, and a lack of technical equipment. This happened despite the continuing demand for the programme, especially in more languages, since radio stations in different regions and states were requesting the programme.

Information Campaigns: Information campaigns usually follow training activities at the wareda level, where large numbers of influential community members are sensitized about the harmful effects of FGM and asked to take action within their communities.

Alternative income: NCTPE initiated two small projects aimed at providing alternative employment for survivors of early marriage in Gojjam (Bahar Dar) and excisors who had denounced excision.

Alternative Income for Early Marriage Survivors (Gojjam): After *Kebele* leaders[10] were informed about NCTPE's intention to support "victims of early marriage," 15 young women registered to join the alternative employment project. The community donated a piece of land with a one-room building that is currently being used as a work space to produce arts and crafts for sale to tourists, hotels, and other interested parties. The project buys the raw materials, and young women collaborate and share the profits. During the assessment visit, nine young women, with the average age of 22, were present at the work site. All them said that they had been excised at infancy and were married at an average age of 12 years (youngest age at marriage was seven and the oldest age was 15). Most of them had childbirth difficulties, and several had delivered through cesarean sections. At least three had lost their babies. The young women provided the following reasons for leaving their husbands: a) feeling weak or experiencing back or pelvic pain that prevented them from carrying out the hard work expected by husbands in rural communities; b) inability to tolerate their husbands' demands for additional children (after two cesarean sections) or sex, and/or

[10] A *Kebele* is equivalent to a small village.

their husband's beatings; c) wanting to go back to school; and d) being abandoned by their husbands after becoming paralyzed (probably due to eclampsia) and losing a baby. The young women's aspirations included completing education and becoming self sufficient so as to support themselves and their children.

Regarding their experience with the alternative employment project, the women felt that the project empowered them to a certain extent; some of them volunteered for the Family Guidance Association of Ethiopia as well as educators against harmful traditional practices. However, they felt that they should be allowed to modify the programme so that individual hard work would be rewarded. They also wanted to use funds for petty trading in the market. NCTPE and the young women are currently reassessing the alternative employment programme and planning to modify the programme based on these suggestions and sustainable business principles.

Alternative Employment for Excisors: Together with the IAC, the NCTPE implemented an alternative employment opportunity project for excisors. The project involved 25 to 30 excisors who promised to "lay down the blade" if they were able to participate in the alternative employment programme. The group started producing shoes, arts, and crafts, but later moved on to making bread, local snacks, and clothes. Although they had several successful shipments of arts and crafts to Japan, for example, they prefer to produce locally consumable goods. In an IAC evaluation of the programme, many of the women said they never excised girls. This raised questions about whether or not they were excisors, just wanted to take advantage of the project, or were denying their earlier "excisor status" after realizing the complications and unpopularity of the practice.

Mainstreaming FGM into Other Agencies' Work: One of NCTPE's strategies is to integrate elimination of harmful traditional practices into the work of its member organizations, including local and international non-governmental organizations, churches, and government institutions. For example, NCTPE succeeded in integrating information campaigns into the activities of rural development agents of the Ministry of Agriculture. NCTPE also encouraged the MOE to include FGM in school curricula.

COLLABORATION AND FUNDRAISING

The National Committee has been successful in collaborating with and receiving funding from a variety of donors, each of which supports one or several regions of the country without overlap. Current donors include UNICEF, Rada Barnen, Redd Barna, CIDA Canada, Netherlands Embassy, AIDOS, and the IAC regional office. WHO supported specific activities such as the launching of the regional strategy for accelerating the elimination of FGM in the African Region in March 1997.

PROGRAMME ACHIEVEMENTS AND IMPACT

It is difficult to assess the impact of NCTPE's activities since a baseline survey was not conducted at the start of the programme, and studies conducted since then are incomparable. However, according to the Executive Director of NCTPE, Ms Abebech Alemneh, reports from the field and recent research studies indicate that some progress has been made. A 1990 KAP study revealed that the prevalence of FGM had declined to

approximately 90 percent. A second similar study carried out later in 1997 indicated that the prevalence of FGM was now around 73 percent (in certain regions). Lastly, a 1997 impact assessment in two regions indicated that people had good information about harmful traditional practices (HTPs) and suggested that early marriage and abduction of girls should be abolished. However, only 30 percent supported elimination of FGM (information on these studies was based on conversations with NTCPE staff - reports of the studies were not accessible or available during the country assessment visit).

Efforts and impact of NTCPE:

- **Raised awareness**: FGM and other HTPs are seen as major health problems by a large number of people in the country.

- **FGM is included in national and regional development agendas**: Elimination of all HTPs including FGM is now on the agenda for discussion by regional state council bodies.

- **FGM is included in major national policies and prohibition statements**: Government policies on population, health, women, education, and culture include statements calling for the elimination of HTPs.

- **The NTCPE enjoys widespread support**: NCTPE's work is supported by government officials from the federal, state and zonal levels since many of them are members of its committees, or participate in their training events and information campaigns. The programme has fostered excellent donor coordination and funding: NCTPE was able to retain and increase its donor pool over the years.

- **Women leaders are advocating for policy and legal reform**: At a recent five-day meeting organized for 300 women by the Women's Affairs Standing Committee (WASC), in collaboration with the Parliament and Women's Affairs Sector of the Prime Minister's Office, the elimination of HTPs - including FGM and early marriage - and the formation of a women's association to tackle these issues, were placed high on the plan of actions. The Ethiopian Women Lawyers Association is spearheading some of the advocacy surrounding these issues.

- **The programme is very systematic and decentralized**: NTCPE reaches communities at the grassroots level through their regional committees, TIC programmes and guidelines and IEC materials.

- **The programme strives to be equitable to all communities**: Since there are different ethnic and religious groups, NCTPE has decentralized the programme and produced materials in each of the major languages of communities that practise FGM.

- **The programme managed to register major HTPs that are prevalent in each region**.

PROGRAMME GAPS AND WEAKNESSES

Although the national programme in Ethiopia is quite extensive in its reach, there are many weaknesses in its infrastructure, especially at the regional and grassroots levels. These include:

- **Lack of offices and infrastructure at the regional level**. NCTPE relies on one staff person working without an office or vehicle, and the good will of committee members for regional level project activities. This creates many obstacles, examples of which include:

  a) committee members need permission to participate in project activities;
  b) availability of office space, vehicles, and equipment at committee members' own agency is not always available;
  c) work depends on their motivation (active versus inactive members); and
  d) committee members need per diem to be able to implement project activities.

- **The programme still relies on elimination of HTPs as the rationale and main message for eliminating FGM.** The same messages that FGM elimination programmes started with in 1978 are being used, and the Ethiopian programme seems not to have evolved beyond that point. Other countries have added new messages about human and legal rights, sexual health, and ethical issues.

- **All the IEC materials use old messages**. Materials, including posters, pamphlets, videos, and booklets, show messages about the consequences of young girls being excised and bleeding, their teeth being extracted, etc., to convince people to stop excising. These messages use scare tactics or shock effects and are based on the simplistic notion that once people know a practice is harmful, they will stop it.

- **The programme is focused only on awareness-raising on a large scale.** Changing behaviour is seen as an explicit objective. Thus, the Training-of-Trainers (TOT) and Training Information Campaign (TIC) participants are taking action to inform people about the harmful effects of FGM and other HTPs but do not seem to have specific skills in behavioural change interventions. The NCTPE training programme is very systematic and gives guidelines on how to conduct TIC programmes, but the contents are again limited to identifying HTPs, providing historical information about FGM, dispelling myths, informing of the consequences of HTPs and developing action plans to disseminate information.

- **The programme design, even down to the grassroots level, is based on the IAC model and does not use community-based approaches.** It does not vary from community to community except when dealing with HTPs that are prevalent in that region. Although NCTPE carried out various research activities, and headquarters may be using the research for its overall planning, these findings are not reflected in programme activities, materials and messages.

- **The alternative employment opportunity pilot projects do not seem to achieve any programmatic goal and may be diverting resources from other project activities**. For example, while improving women's employment opportunities is a worthy cause in itself, retraining 30 excisors for alternative employment may not reduce the number of girls who are subjected to the various HTP operations. Based on the principles of supply and demand, if families want to excise their daughters, other excisors will provide the service. Similarly, the alternative employment for young women does not lead to self-sufficiency or educate the community about early marriage.

- **Even though all the government agencies are members of NCTPE and their policies include prohibition on HTPs, there is a lack of a coordinated and integrated national strategy towards mainstreaming FGM into existing relevant government activities.** For example, there are no activities related to HTP elimination at MOH's Family Health and Women's Affairs Departments. The same is the case at the Ministry of Labor and Social Affairs. The findings from a 1996 Safe Motherhood Assessment carried out by the MOH illustrate the lack of integration and the limited mainstreaming of FGM elimination into government agencies' programmes. In this study, 96 health workers surveyed confirmed that they encountered adverse effects and complications arising from many harmful traditional practices, with most adverse effects being encountered most often following uvulectomy, milk tooth extraction, and female excision (Family Health Department, 1996). However when trained and untrained TBAs were asked about educational messages and advice they could give to their clients after delivery, neither group mentioned providing information on HTPs such as FGM, despite the fact that most girls are excised during infancy. During the assessment visit, 444 third-trimester clients were asked about the messages they received from clinics. None mentioned receiving information on either HTPs in general, or FGM.

- **Although a wide variety of IEC materials have been produced, they are not widely available**. Ninety-six health facilities were visited and the types of information, education, and communication materials available on the day of the visit were assessed: 14 facilities had no materials available, and 86 had only posters. Types of posters mentioned or observed did not include any on HTPs, including FGM.

RECOMMENDATIONS

NCTPE's programme implementation plan needs to expand to ensure equal participation by Ethiopia's different ethnic groups and nationalities as well as increase the number of people reached. Recommendations to improve and continue the progress made to date include:

- **Reactivate the Educational Media Programme and make it more interactive with youth, teachers and community members.** Perhaps the programme format can be changed to dramas addressing different health and HTP themes.

- **Expand and enrich programme messages based on findings from the various research studies conducted to date**. If necessary, conduct research on family decision-making as it relates to excision and other HTPs. Involve project beneficiaries in each community in the message development, materials design, pre-testing, production, distribution and use.

- **Investigate the impact of the programme on the attitudes and behaviours of the TOT, and other programme volunteers, such as policymakers, health care providers, and teachers, especially as it relates to excision of their own children.**

- **Design more demonstration projects to test various programme approaches, peer education, FLE in the schools, community outreach etc., and incorporate lessons learned into the national programme**.

- **Take advantage of NCTPE programme's acceptance in the various government agencies and step up mainstreaming FGM elimination into each agency's programme and not only its policy**. Strengthen collaboration with the Ethiopian Women Lawyers Association and train key women leaders in advocacy strategies and skills for developing systematic plan for policy and legal statutes, including a criminal code against HTPs such as FGM.

MALI

INTRODUCTION

According to the latest DHS, in Mali where Islam is deeply entrenched, 94 percent of women aged 15 to 49 have undergone excision (EDSM, 1996). However, the prevalence rate is lower among two ethnic groups in northern parts of the country - the Tamachek and the Sonrai (EDSM, 1996).

Clitoridectomy is the leading type of FGM (52 percent), followed by excision of the clitoris and the labia minora (47 percent); however, at least one percent of women have been subjected to the severest form of FGM - infibulation, or Type III FGM (EDSM, 1996). Most girls in Mali are excised before the age of 10 with 44 percent being excised before their first birthday. There is a trend towards medicalization of the practice, as parents try to minimize the risk of FGM complications. For example, according to the 1995-96 EDSM, 2 percent of women were excised in hospitals or other health care facilities, and five percent had their eldest daughters excised in health facilities. There is wide support for the practice among Malian women; 75 percent of them favor its continuation. Only one percent of women in the desert cities of Timbouktou and Gao support continuation of the practice.

Malians, like other Africans, practise FGM for various reasons. In Mali, FGM is seen as an important custom, or good tradition and/or a religious requirement. Some people practise FGM because it promotes better hygiene and marriage prospects for girls; it is perceived to give more sexual pleasure to the man; and it preserves the virginity and morality of girls (EDSM, 1996).

FGM ELIMINATION EFFORTS

Mali does not have a cohesive, national-level FGM elimination programme. Recently, however, the Government of Mali has taken on a more significant role. In September 1997, the Ministry of Women, Children and the Family (MWCF) was established and entrusted with improving the social status of women and families through the protection of children's and women's rights and involvement in economic development. The MWCF was also responsible for writing and defining the family code, which includes issues of marriage, parenting, inheritance and guardianship. The Government also formed a committee, comprised of two members of the National Assembly, members from 15 government ministries, and participants from 14 associations, non-governmental organizations and civil society groups, to fight all harmful practices affecting the health of women and children. FGM is one of 16 harmful practices that have been identified for elimination in Mali, including depigmentation among young people, use of aphrodisiac materials, infanticide after a maternal death, uvula cutting, forced feeding, widow inheritance, slimming girls for marriage, and bloodletting.

Currently, there is an NGO Network coordinated by the Centre Djoliba Hommes et Development and the Committee established by the Government. It is not clear, however, whether the Government will allow the NGO Network to function independently as an advocacy body, while at the same time working with the government. A national plan of action aimed at reducing the prevalence of FGM by the year 2002, and eliminating all its

forms from Mali by the year 2007, was recently developed under the auspices of the MWCF and with the involvement of the NGO Network and all donor agencies. WHO's 15-year strategy to accelerate elimination of FGM was used as a blue print for drafting the strategy. The Plan calls for four main areas of work including educating parents, converting excisors, treating FGM complications, and punishment of all involved after a period of national level awareness-raising about the harmful effects of the practice. The Plan also calls for the establishment of a research and documentation center where accurate information about the practice will be collected, used for programming, and disseminated to the general public. The General Assembly is responsible for implementing the Plan through its Executive Secretary (MWCF) and various commissions (programme, social, legal, and media). The Executive Secretary can assign/delegate work to any non-governmental organization, based on its expertise and the availability of funds. The National Committee from Burkina Faso was invited recently to assist the MWCF and NGO Network in designing an effective working relationship.

Since Mali does not yet have a comprehensive national-level programme, there are also no systematic and ongoing regional programmes, infrastructure or staff. Most non-governmental organizations are covering only small areas, and programmes start and stop according to funding availability. For example, although the Centre Djoliba Hommes et Development's programme is national, it does not have any regional infrastructure or comprehensive community-based approach. Centre Djoliba Hommes et Development offers training and technical assistance to individuals and groups regardless of their region or village and support is usually based on individual or group identified needs.

There are at least 15 non-governmental organizations, mostly woman-headed, currently working on FGM elimination in Mali. One of the largest non-governmental organizations – Association Malienne pour Le Suivi et L' Orientation de Pratiques Traditionelles (AMSOPT), an IAC national chapter, works in about 60 villages in four regions and in Bamako. The Association de Soutien au Development de Activities de Population (ASDAP), a health and women-in-development group, is one of the few non-governmental organizations which has stable funding. ASDAP works in six districts in three regions of Mali and two communes in the Bamako District.

PROGRAMME STRATEGIES

Training: Almost all the non-governmental organizations involved in FGM elimination carry out some form of training. The Centre Djoliba Hommes et Development was one of the first non-governmental organizations to initiate training on FGM issues, sexuality, and adolescent reproductive health. The Centre uses a training method called the GRAAB method, which they adapted from Burkina Faso. The training emphasizes allowing the trainees, and later the community, to identify their own problems, whether health-related or otherwise, and create solutions. Centre Djoliba Hommes et Development also uses visual images and a flannelogram to stimulate discussion and facilitate decision-making. The trainees and community members learn about the female body and discuss the effect FGM has on women's sexuality. The training programme is very popular among local associations, youth-serving organizations, and government employees in the social sectors. During 1997, Centre Djoliba Hommes et Development's 17 employees and 20 resource people trained at

least 16,885 people on various topics, including FGM. The training is conducted on a demand basis, and training fees are charged on a sliding scale.

AMSOPT also uses the GRAAB method to build consensus on FGM elimination issues among community members. However, the organization lacks training materials such as the flannelogram, posters, etc. ASDAP trains health care providers, youth, and women leaders on adolescent reproductive health and FGM issues. ASDAP, AMSOPT and Association pour la Defense de Droits de Femmes Maliennes (APDF), a human's rights group, also train excisors on the harmful effects of FGM. Plan International, an international non-governmental organization, works with the Faculty of Medicine, Pharmacology, and Orthodontology and the Society of Medicine to provide continuing education courses, including FGM elimination to medical students, health care providers and non-governmental organization representatives.

Development of IEC Materials: With its mannequin, picture stickers, videos, audio-cassettes and posters, the Centre Djoliba Hommes et Development seems to have the most FGM-related IEC materials. Centre Djoliba Hommes et Development shares its IEC and training materials with its trainees, students and colleague non-governmental organizations. More emphasis is being given to producing IEC materials for all non-governmental organizations to use in their programmes. For example, UNICEF recently funded the collaborative development of a poster for use among all non-governmental organizations. In addition, it also supported the development of a small booklet on FGM to use in its literacy programmes. ASDAP is producing a flip chart on FGM and its complications for health care providers, with support from the Population Council. APDF recently developed materials on women and children's rights.

Most of the IEC materials emphasize the harmful effects of FGM on women's health and sexuality, and that the practice is a human rights violation.

Excisor Conversion Strategy: This strategy usually consists of three phases:

- Identifying excisors and training them on female genitalia and its functions; the harmful effects of FGM; the reasons why FGM is practised; and how excisors perpetuate this practice.

- Training excisors as change agents and motivating them to inform and educate the community and families about the harmful effects of FGM.

- Orienting/training excisors to have an alternative source of income and giving them the resources or equipment they need to allow them to earn a living.

Many non-governmental organizations have adopted the excisor conversion strategy. However, not all of them are proceeding according to the above three phases (Population Council, 1998b). Some are implementing all three phases, for example, APDF, while others are either implementing only the awareness raising phase (AMSOPT, ASDAP) or training excisors to become change agents. The Cooperative de Femmes pour L'Education, la Sante Familiale, et l'Assainissement (COFESA) indirectly raised the awareness of excisors through their IEC programme about adolescent sexual and reproductive health.

Fostering Community Decision to Stop Excising: This strategy is used in Mali by AMSOPT, which is working in at least 60 villages in four regions. AMSOPT utilized the unfortunate death of two girls to ask one community - Solefera - to reflect on FGM and its consequences. Using the GRAAB method, AMSOPT organized separate reflection meetings for community leaders (men), women, and youth, followed by a joint community convention. The meetings focused on the following topics:

- The origins of FGM.
- The reasons why FGM is practised, whether they are valid reasons, and whether the reasons were devised to force women to accept the practice.
- The consequences of FGM, including discussions on what happened to the two girls and why health centers could not save them.
- Other hidden problems that women in the community may be suffering from, including cysts, fistula and difficult childbirth.
- The effect of FGM on the woman's sexuality and the couple's relationship.

This process helped the community realize that their women were suffering because of an unnecessary practice. They were also able to elaborate their own strategies to prohibit or decrease FGM in their community. Under this programme, at least three villages - Solefara, Bala and Makono, in the district of Sanankoroba - declared that they would stop excising their daughters (Coulibaly, 1997). These three villages have marriage connections with 20 other surrounding villages. In order to ensure that their strategies would work, the villages agreed to sensitize these other villages as well.

The strategy worked because AMSOPT transferred ownership of issue to the community and allowed the villagers to devise a solution. A field trip to these three communities indicated that:

- Community leaders are receptive to change, and involving them in an active dialogue on the issue can have positive effects and establish a new norm for the community.
- More enlightened community members, especially those who travelled abroad, can, by sharing their experiences, demystify certain myths and facilitate decision-making.
- The community gives excisors their role; therefore, if the community decides to ban FGM, excisors can no longer perform excisions.
- While engaged in an auto-diagnosis exercise to identify health issues related to FGM, the community is likely to discover other pressing health issues that need to be addressed.

- It is important to understand and work with the most powerful leaders and decision-makers in these communities. For example, a blind man was the most prestigious leader in one of the villages, and everybody who needed to resolve a problem in the community had to pay a courtesy visit to him.

MAINSTREAMING FGM INTO EXISTING PROGRAMMES

Although FGM has been addressed through the various ministries of the Government (including the MOH, the Ministry of Education (MOE) and the Ministry of Information (MOI)), it has not been integrated into any of these institutions' programmes. For example, FGM is not included in the standard pre-service training programmes for health staff or the teaching curricula of the main medical schools of Mali, L'Ecole Nationale de Medecine et de Pharmacie (ENMP) and L'Ecole Secondaire de la Sante (ESS). FGM is not considered a health-threatening practice (Population Council, 1998a).

Staff at health care facilities have also not yet been fully involved in the many anti-FGM efforts in Mali. Very few clinics (only 18 out of 82 community health centers and district level rural health centers in Mali) have included information about FGM in their routine IEC sessions (Population Council, 1997). Periodic discussions on FGM take place based on individual initiatives in a few places, such as Oulikoro, Mopti, Segou, and Kayes. (Population Council, 1998a)

Although service standards, policies, and guidelines for service providers have been revised to include one page on harmful traditional practices, insufficient information is provided on FGM and its medical, psychological, social, cultural, sexual, and ethical dimensions. Therefore, health care providers do not have sufficient information to make an informed decision about the practice both for their own daughters and the community. It has been observed, for example, that the children of health care providers are equally as likely to be excised as children of other people in Mali.

In addition, health care providers have not received formal training to identify and diagnose problems that may have been induced by FGM, or to provide specific services and care for girls and women who suffer from the health complications of the practice. Obstetrics and gynaecology departments focus on the fact that FGM is a contributor to maternal and child morbidity and mortality. They do not place FGM on their priority list.

Some of the non-governmental organizations, including AMSOPT, are planning to work with the Ministry of Health and the Ministry of Education to include FGM in their ongoing training programmes and Family Life Education programmes.

ADVOCACY

Many Malian women's organizations, including those involved in human rights and health, and women-in-development, were involved in the Cairo and Beijing Conferences and have gained significant experience in advocacy and lobbying. Most of the human rights organizations are advocating for an anti-FGM law to be passed. However, the health and women-in-development agencies are cautious about enacting a law and believe that the community is not ready for such a step. They fear it could drive the practice underground.

These agencies are advocating for increased awareness-raising and community education instead. Other anti-FGM organizations, such as the Centre Djoliba Hommes et Development, are in favor of a law but would like to study the effect of the law in Burkina Faso and other countries before actively pursuing that route.

In order to achieve a unified vision for the elimination of FGM, Centre Djoliba Hommes et Development organized a national seminar on FGM in June 1997. Forty participants from associations, non-governmental organizations, government, and international organizations attended. The objectives of the seminar were to restart the dialogue on FGM; promote a participatory approach; determine the impact of 10 years of activities in the country; determine the weaknesses and strengths of different approaches; define appropriate strategies; and strengthen the communication and collaboration between agencies working on FGM.

Participants reflected on some of the harsh realities that Malian women face because of FGM, including dysfunctional relationships (the consequences of FGM can have devastating psychological effects on women and their spouses); and serious health complications. The tendency to medicalize the practice in order to save the younger generations from the risk of infection and haemorrhage was also highlighted.

The workshop also identified some of the persistent constraints that anti-FGM organizations face in their programmes. These include lack of legislation denouncing FGM; lack of well-defined intervention strategies; lack of information and Training-of-Trainers; lack of community support; lack of research on the psychological impact that FGM has on women; and lack of coordination between intervening organizations.

Based on these constraints identified, the participants recommended the following:

- Develop training curricula for elimination of FGM.
- Carry out an inventory of the available IEC materials and standardize IEC materials and Training-of-Trainers.
- Disseminate findings from research that has been already conducted.
- Train health care providers in the prevention of health risks and in treating FGM victims.
- Promote more research on FGM and coordinate research and development activities.
- Develop clinical and psychological counselling support for women suffering from complications.
- Support agencies implementing anti-FGM programmes to develop pertinent strategies and programmes.

- Adopt legislative, judiciary, and regulatory measures to combat FGM.
- Support those who have stopped excising their daughters.
- Support the current network to coordinate anti-FGM activities.

The workshop promoted a common understanding of the needs for a more global, analytical, and participatory approach towards FGM programming. Emphasis was placed on the need to be consistent with messages and approaches.

The NGO Network's advocacy capacity was tested in December 1997, when the second national conference of the National Union of Muslim Women of Mali (UNAFEM) recommended medicalization of clitoridectomy (sunna), a practice they believed to be supported by Prophet Mohammed (Maiga, Le Soudanais, 1997). This declaration resulted in numerous newspaper articles and required a prompt response from network members, who clarified that FGM had no connection with Islam. The Chief Cabinet member of the MWCF also responded by inviting UNAFEM members to have a dialogue (Maiga, Le Scorpionnage, 1997). The network continues to monitor initiatives that tie FGM to Islam, cultural values and sentiments, and/or religious rivalries.

RESEARCH AND DOCUMENTATION

Research studies on FGM conducted in Mali can be categorized into three main types: ethnographic studies; medical studies conducted by health professionals interested in documenting the alterations of the female external genitalia, as well as the health consequences of such; and programmatic studies conducted by non-governmental organizations and women's groups who consider FGM to be a health problem and an infringement on women and girl's rights. During the past several years, organizations have encouraged researchers and students to carry out more medical and programmatic studies. Some of the more interesting studies recently conducted include the following:

- FGM in Mali: Realities and Perspectives of the Struggle. Centre Djoliba Hommes et Development, May 1997.
- Perceptions, Attitudes and Practices of Population of Sanankoroba District. AMSOPT and Plan International, October 1996.
- Evaluation of Excisors' Conversion Strategy for the Elimination of FGM in Mali. The Population Council (not yet completed).
- Testing the effectiveness of Training Health Facility Staff in Client Education About FGM and in Clinical Treatment of FGM Complications in Mali. The Population Council (not yet completed).

The Centre Djoliba Hommes et Development seems to have the best documentation centre on FGM issues in Mali, and provides information on FGM and many other issues. The Centre provides access to a large number of people including students, researchers,

government officials and colleagues from other agencies. They also provide access to the Internet.

COLLABORATION AND FUNDRAISING

In Mali, coordination of FGM elimination activities and facilitation of information and resource sharing among non-governmental organizations occurs via the NGO Network, which is coordinated by Centre Djoliba Hommes et Development and the MWCF. Several seminars, held during 1997 and 1998, facilitated this initiative and led to consensus-building on appropriate strategies and development of a National Action Plan.

Local non-governmental organizations were able to access funding from private donors, especially European donors, United Nations agencies, and private international development agencies, such as the Population Council and Plan International. Although one of the main constraints for local non-governmental organizations and the Government is inadequate resources, there is tremendous donor support for FGM elimination activities as a part of the post-Cairo reproductive health programming. United Nations agencies, mainly UNICEF and UNFPA, and USAID, meet on a regular basis to coordinate donor resources and activities in the country. These agencies include FGM as a priority area for funding if appropriately requested.

POLICY/LAW

Although there is no specific law on the prohibition of FGM, the Malian Government expressed its commitment to the total elimination of FGM in June 1997. Two articles in the Malian penal code (Article 166 and Article 171 - see Appendix 4 for more details) could be used to prosecute people who carry out FGM, including excisors, health care providers and parents. Magistrate Daouda Cisse of the MWCF believes that it is not necessary to pass a law specific to FGM, since excisors and their accomplices can be prosecuted under the current law. He recommends that people be educated about the relevant articles and that the available law be enforced. The Honorable Cisse believes that the country is not ready for legal prosecution at this stage.

> "We need to disseminate information about the harmful effects of the practice prior to enforcing the law. " The Honorable Cisse.

PROGRAMME ACHIEVEMENT

Overall, significant progress has been made in Mali on FGM elimination. Achievements include:

- The development of a network.
- An increased number of research and evaluation reports on FGM.
- Implementation of innovative programmes approaches (GRAAB method, community consensus, excisor conversion, training of health care providers etc.) in different communities by several non-governmental organizations.

- The establishment of the National Committee Contre La Pratique de Excision.
- The development of a national action plan on FGM is currently being developed in collaboration with MWCF.

PROGRAMME IMPACT

It is difficult to determine statistically whether the non-governmental organizations in Mali have yet had any reasonable impact with their programmes, particularly since many of these programmes do not operate on a large scale. Most of the non-governmental organizations' programmes cover small areas, and their work is sometimes interrupted due to lack of resources.

A review of several reports collected in-country, however, does reveal some impact. A seminar report produced by the Center Djoliba indicated that participants had noted that after 10 years of anti-FGM activities, the percentage of excised girls decreased from 99 percent to 93 percent (Centre Djoliba Hommes et Development, 1997a). Evaluation reports compiled by AMSOPT and the Centre Djoliba Hommes et Development highlight the increased knowledge of the harmful effects of FGM among population groups reached by their activities (AMSOPT, 1996, and Centre Djoliba Hommes et Development, 1997b). There is also evidence of increased debate and media coverage of FGM; more political commitment from the Government, increased MOH and MWCF support for the work on FGM elimination; and more donors who are receptive and interested in supporting Mali's plan of action for FGM elimination.

PROGRAMME GAPS AND WEAKNESSES

In general, the organizations lack effective training curricula that address FGM in a comprehensive manner for all levels of trainees. In addition, there is a dearth of research-based IEC materials. Only a few posters, a flipchart that is currently being developed for health care providers, and a few videos developed by Centre Djoliba Hommes et Development, are available.

Some of the weaknesses of particular approaches include:

Fostering Community Decisions to Stop Excising: While this approach uses appropriate participatory methodology, it is important to be cautious of interpreting the consensus reached by the community. On the positive side, such a general decision can spur a new norm that values the non-excised status of girls. However, convincing the community leaders does not necessarily translate into convincing family decision-makers, such as fathers, mothers and grandmothers, who have more direct impact on decisions regarding FGM. Some parents will still excise their daughters clandestinely. According to a member of the anti-FGM Network, the same week that the entire country was celebrating a community's decision to stop practicing FGM, five girls were excised in that very same community. In addition, community members may be saying what programmers want to hear. During a field trip conducted for this review, one of the community chiefs was asked whether there were any unexcised girls in his community. He said that his five-year-old daughter and his granddaughter had not been excised. However, the community nurse later revealed that the two girls had, in fact, been excised that year.

While engaged in an auto-diagnosis, the community may identify other pressing health needs. When this happens, it is often difficult to convince members of the community that the priority, in this instance, is for action to be taken against FGM, rather then to focus on their other health needs. In the three communities visited for this review, safe delivery was considered a priority and discussed by every community member.

Finally, if excisions did not take place in the community, it could mean that there are no eligible girls, rather than that the community has stopped the practice.

RECOMMENDATIONS

The FGM elimination programme in Mali suffered some setbacks when the IAC affiliate was disbanded. The new IAC chapter (AMSOPT) and other non-governmental organizations filled the gap with some innovative but scattered and small-scale programmes. These programmes have had limited reach and impact in the country. A National Plan of Action and a National Committee have been developed under the auspices of the Ministry of Women, Children and the Family. The programme can be characterized as being in its infancy but much can be built on the limited progress that has been made thus far. Specific actions that can be taken include:

- Since the Malian national programme is being designed now, it can benefit from the lessons learned by the international community to develop a truly multi-sectoral programme and institutionalize it through the programmes of the relevant ministries (Ministries of Health, Education, Information, Women, Children and the Family etc).

- To counteract the current medicalization trend in the country, the programme should prioritize incorporating FGM elimination issues into all pre-service and in-service training programmes for health professionals, including medical and nursing schools.

- The programme needs to develop comprehensive training curricula for all types of change agents, including health professionals, community educators, and youth. The content needs to be expanded to address not only the consequences of FGM but also its cultural, mythical, social, sexual, psychological, legal, and ethical considerations.

- It is important to train and mobilize health care providers to avoid excising girls, educate families and the community, treat complications, and counsel women and girls who are suffering from complications.

- The programme can work to enact a law prohibiting the practice of FGM by incorporating language into two existing articles. Information about the law and human rights issues and conventions that Mali ratified needs to be disseminated to both to the general public and to law enforcement agencies.

- The national programme needs to monitor the effect of the law on FGM elimination programmes in Mali and monitor lessons learned in other countries that passed FGM laws, such as Burkina Faso and Ivory Coast.

- Efforts are needed to build the capacity of anti-FGM programme implementers, specially in the area of behaviour change communications (community assessment, development of research-based IEC materials, community mobilization, cultural competency, programme planning, implementation, monitoring and evaluation) and advocacy and coalition-building skills.

- Support the current anti-FGM network, build its advocacy and coalition-building skills, and support each organization's unique contributions. Monitor, evaluate and reward their innovative efforts in the community.

- The NGO Network and the national programme need to ensure parallel implementation of national-level activities and community-based initiatives focused on behavioural change.

- Religious organizations, especially the Islamic associations, should be involved in the fight against FGM and encouraged to build their technical skills in anti-FGM programme implementation. There is also a need for the position of Islam vis-à-vis FGM and women's sexuality to be clarified.

- The national programme must promote research and evaluation of programmes, disseminate information, and encourage the use of such information for programme planning, development of training and IEC materials, and advocacy.

VII. SUCCESSFUL PROJECTS

EGYPT: A Project Report

Community Consensus and Monitoring of At Risk Girls in Egypt: The Coptic Evangelical Organization for Social Services in Egypt

Since its founding in 1950, CEOSS has become renowned for its extensive work in community development. The empowerment of rural women has been a pivotal aspect of its programmes. In 1976, CEOSS established the Family Life Education Unit in which FGM, considered one of several harmful practices that negatively affect women (among traditions such as early marriage and bridal deflowering), is a central component.

In 1995, CEOSS included reproductive health and FGM elimination in its programmes in 22 communities in Minya governorate. CEOSS is actively involved in these communities through seminars, meetings, and awareness campaigns. All members of the family are targeted with education, with special attention given to girls at risk of excision (i.e. those aged between 7 and 13[11] years) and their mothers.

CEOSS's programme activities include education, income generation, agriculture and infrastructure development, and health. CEOSS staff initiate programmes, following a written request from members of the local community. The first step towards programme development is establishment of a local leaders committee comprised of, for example, an *omda* (mayor), a *Sheikh*, and a priest. Leaders are required to practise what they preach and could be disqualified if they excise their daughters. For example, one community leader whose daughter was excised secretly by her grandmother could no longer be an exemplary model and was relieved of her duties. CEOSS also identifies and works with a local non-governmental organization in the community so as to ensure the sustainability of its activities once it withdraws from that community.

Programme implementers, usually a live-in, male/female team, are appointed to work directly with local leaders. This helps break down the barriers between the community and CEOSS. Programme administrators begin their work on FGM by registering the number of girls between the ages of 7 and 13 who are at risk of being excised, as well as gradually introducing issues pertaining to health and literacy, followed by the sensitive topic of FGM. Timing is essential and the group continuously monitors the readiness of the participants before proceeding to introduce new topics or moving to the next stage of the programme. Because CEOSS is working with a predominantly Christian community and because the Christian religions perspectives on FGM are quite clear, it did not meet significant opposition in its programme.

The core of CEOSS's anti-FGM programme is to segment the community according to the number of leaders available, with each taking responsibility for a defined geographic area. An annual plan is developed and each community leader is required to monitor approximately ten girls per year using specially designed monitoring charts. Success or lack thereof, in an area, reflects directly on that particular leader. Information about each girl

[11] This is the preferred age of excision in Minya.

includes whether she has been excised or not. According to the specially designed monitoring chart, if a girl reaches the age of 13 and remains unexcised, she is considered to be out of risk of excision and a successful case.

This system of monitoring is complemented by seminars, meetings with religious leaders and training courses for the villagers. In these settings, any topics that require reinforcement are discussed, particularly religion. Refresher training courses are held year round for local leaders who may request to have the programme changed so as to include other issues of interest.

Six key aspects of CEOSS's approach in grassroots mobilization contribute to their success:

- CEOSS sets realistic targets to be achieved by the end of each work plan.
- The focus of the programme is on young girls who are most at risk of FGM.
- The information conveyed through the CEOSS approach in the area of FGM is clear and positive.
- CEOSS's reliance on local community leaders contributes to sustainability.
- Trained female community leaders have become active participants in community life; the title they receive, and responsibilities accorded to them, give these women a sense of empowerment.
- CEOSS provides regular community follow-up, training, seminars, meetings, and workshops, conducted by specialists from outside the community. This system keeps the topic visible.

CEOSS has been more successful in homogeneous communities, in which people are easily influenced by one another and there is some pressure to conform. Thus, CEOSS's grassroots approach has functioned well in villages with a Christian majority. It has started to work in villages with Muslim majorities, but has not yet been able to duplicate the success stories of the Christian villages of Al Tayeba and Deir El Bersha, which have both stopped the practice.

To date, CEOSS had little interaction with other non-governmental organizations. The successes of groups like CEOSS can serve as examples for others. Thus, CEOSS should consider sharing information with other non-governmental organizations regarding its approach.

KENYA: A Project Report

Alternative Coming of Age Programme in Kenya: A Strategy Among Many

The Alternative Coming of Age Programme is one of several programme strategies used by the Mandeleo Ya Wanawake organization (MYWO) to eliminate FGM from seven districts in Kenya. While the Alternatives Programme is the most successful element, it is successful because it is part of a larger strategy. Trained peer educators play a critical role in recruiting mothers and girls for the programme and educating them about the harmful effects of FGM. Earlier community outreach and mobilization activities raised community awareness about FGM - allowing the alternative rites of passage initiative to focus on fostering decision-making against the practice.

The specific objectives of the Alternative Coming of Age Programme are to:

- Explore alternative rituals to current FGM practices in Kenya with families of girls at risk of undergoing the practice;
- Reach consensus on the type of alternative ritual that is acceptable to all the stakeholders (girls, mothers, fathers, community members) and implement it in the community; and
- Monitor and document the alternative ritual process, support or lack thereof from community members, and whether it is a sustainable solution.

The planning and implementation process was very tedious, but ultimately rewarding. It included:

- **Developing of a conceptual framework** for planning and implementing such a programme, outlining the steps that need to be taken - giving project staff and volunteers a clear vision of the rationale and procedures involved in planning and implementing the strategy. Initial discussions on an alternative rites of passage solution triggered community fears that the project intended to install a foreign strategy. The conceptual framework helped deter these fears since it showed the relevance of what was being proposed and how it related to what is traditionally done.
- **Exploring the feasibility of this programme** with various stakeholders including mothers, girls, community leaders and lastly fathers, with each suggesting whether and how to implement this programme, what information is needed, what type of celebration is necessary, what kind of gifts should be given and who should participate.
- **Designing a programme** excluding mutilation of the genitalia but otherwise mimicking the traditional coming-of-age seclusion, information giving and final celebration based on the consensus reached.
- **Implementation and documentation** of the programme.

The initial candidates for the first alternative rites of passage ceremony were daughters of mothers who had either stopped excising their daughters after being sensitized about the harmful aspects of FGM, and who wanted to declare their position publicly, or mothers who were knowledgeable about the issue but hesitant to stop. Each mother (peer educator) reached out to other mothers, and their husbands, convincing them that their daughters should participate in the modified coming-of-age programme.

The first alternative rites of passage programme "Ntanira Na Mugambo - *Excision by Words*" was conducted in Meru[12] in August, 1996. It involved:

A Week of Seclusion for "Initiates"

This is traditionally known as the healing period during which a newly excised girl is "kept in the house", fed, and instructed on various issues of family life. (The instruction of girls has disappeared in most excisions seclusion periods today.) The mothers in Tharaka Nithi decided to have their daughters go through one week of intensive instruction, guidance, and counselling on modern "family life skills" and "traditional wisdom." This type of education is not ordinarily provided by most parents, yet it is quite important to a girl who is approaching or has reached puberty. Thirty girls participated in this first seclusion.

During the week of seclusion, the girls were trained on a number of subjects, including: self esteem; decision making; personal hygiene; relationships (with parents, peers, elders, opposite sex, etc.); dating and courtship; marriage; peer pressure; male and female reproductive anatomy; menstruation; conception and pregnancy prevention; consequences of teen pregnancy; STDs, including HIV/AIDS, and ways to prevent them; harmful traditional practices including FGM and son preference; male excision; and myths and misconceptions about FGM. In addition to the formal discussion of these topics, the girls and their sponsors - godmothers or aunts - also have an opportunity to informally discuss other issues after dinner. The discussion focuses on positive aspects of their culture "*community wisdom*" which are not covered in the classroom discussions, such as: respect for elders, behaviour, and various religious teachings. The girls and their sponsors also wrote and rehearsed anti-FGM songs and dramas in preparation for the coming-of-age ceremony.

Coming of Age Ceremony

Celebration included feasting, gift giving and presentation of graduation certificates. The ceremony was attended by at least 500 people and was held in the District Chief's compound. Mothers and fathers danced as did the graduates and their younger supportive sisters. Some community members first came out of curiosity and later joined in the jubilation - in essence, sanctioning the occasion. It was a victory for the group of peer educator mothers who started the whole process and for MYWO, PATH-Kenya and the project supporters. The ceremonies were extensively covered by the media in Kenya.

When the project began in 1996, only 12 families in Gatunga (a village in Tharaka Nithi District) participated in the programme. However after only one year the number had grown to 200 families spread over three divisions in the district. The programme continues to gain strength and popularity as more families become involved.

[12] In Meru, excision ceremonies take place during the months of April, August, and December.

Pressure from women who have been sensitized and have become strong advocates against FGM encouraged many men to join and support the programme. This was important since one of the ground rules for those participating in the programme is for both parents (where applicable) to agree to participate. Thus, the women who want to have their daughters initiated into womanhood through the modified rite of passage have to convince their husbands to participate and the men in turn have to make a commitment to support the activities of the programme. They also have to publicly declare that they have stopped excising their daughters. The men, women, girls, and community leaders, therefore, form a core group of anti-FGM support groups and activists.

Between 1996 and 1997, five alternative rites of passage ceremonies took place in Tharaka Nithi District, saving 199 girls from FGM. During the first ceremony (described above) 30 girls graduated after a week of training on family life skills. In December of the same year (1996) the number increased to 49, and then to 70 in August 1997. In December 1997, 50 more girls were initiated to womanhood through the alternative initiation programme in two separate ceremonies. Since August and December are the months when excision takes place in Tharaka Nithi, the members decided to organize their festivals and ceremonies during the same periods so as to counter the intents of people wanting to excise their daughters and encourage them to adopt the alternative rite of passage.

In spite of the initial skepticism towards the programme (many people thought it would "die out" soon after the first ceremony), it has increasingly gained popularity both within and outside the community in which it was initiated. In fact, after the first ceremony, the group of mothers who started the programme and MYWO began receiving inquiries from enthusiastic individuals and/or groups willing to participate in a similar programme. This interest was not only expressed within the district but in other districts as well. Kisii district for example, which had its own pilot programme for alternative rites of passage, borrowed a lot from the Tharaka Nithi model after learning about the success of the programme, and used this information to improve their own coming-of-age ceremonies.

OPPOSITION TO THE PROGRAMME

In both Tharaka Nithi and Kisii districts, groups opposed to Family Life Education issues and those supporting continuation of FGM started spreading malicious rumors about the programme that could have had serious negative repercussions. These rumors reported that alternative rites of passage ceremonies:

- Promote contraceptive use among adolescent girls;
- Force girls to drink blood under oath;
- Inject contraceptives into the girls' clitorises;
- Go against cultural and traditional practices and pollute the community with foreign ideas; and
- Include foreigners who do not care about the interests of the community.

PATH-Kenya and MYWO officials met with community leaders and project officials and discussed strategies towards counteracting these rumors. The leaders and project officials then launched a vigorous campaign to dispel the rumors by basically explaining to the community what actually happened while the girls were going through the alternative initiation process. Graduates of the programme gave testimonies to the community about what they went through and what they learned. Additionally, a series of awareness campaigns and discussions were organized to inform everyone. Realizing that native Kenyans and not foreigners were behind the programme made it easier for people to be convinced and finally support the programme.

PROJECT IMPACT AND ACHIEVEMENTS

While a comprehensive evaluation has not yet been conducted (it is planned for early 1999), information collected through project monitoring visits show that the programme is making an impact in the community. This is reflected in the number of families abandoning the practice and opting for the alternative practice, as well as the number of girls indicating that they have no intention of being excised. Since they participated in the project conceptualization, development and implementation, community members have a strong sense of ownership of the project and are ready to defend it at all costs. Male involvement and participation has been particularly helpful as women and girls are assured of the support of their male counterparts. The boys in the two districts (Tharaka Nithi and Kisii) have expressed their total support for the programme and promised to protect girls threatened with excision. In a recent seminar for boys in Tharaka Nithi, all the participants declared that they will no longer make female excision a prerequisite when choosing a marriage partner.

Since August 1998, about 500 girls have been initiated through the programme in the two districts - several times more than the number of girls who have been actually excised. In Kisii, the initiates have formed a support group of their own, whose role is to protect, defend and support all girls from the community whether or not they are threatened with excision. One of the greatest successes of this project is the fact that none of the graduates of the programme has reversed her stance and chosen to be excised. They have all maintained the group philosophy of "excision by word" (Ntanira Na Mugambo), not by knife. The training the girls received has helped to raise their self esteem and to build their confidence to resist community pressure.

The alternative rite of passage programme has raised interest in other communities. A few districts where FGM is still prevalent want to adapt the concept. This process has not been easy for them as there are many cultural dynamics that they have to consider before introducing the alternative practice. In Kisii the adaptation has taken place in stages. The first stage involved the peer educators organizing small parties for their adolescent daughters and presenting them with gifts. In the second stage, they tried to involve the community members who have abandoned the practice. Currently, they are launching a full blown campaign to involve the entire community in the alternative initiation programme. In another district (Narok), girls have formed a support group which meets for a week each school vacation, during which time they are educated by project staff and peer educators on family life issues. The number of participating girls is growing and the number of actual excision celebrations are becoming less and less in the villages where the programme is active - indicating that more families are either opting for this strategy or most of girls have been excised already.

To ensure sustainability of this project in Tharaka Nithi, MYWO and PATH-Kenya trained 10 people - mostly mothers who participated in the first initiation ceremony - as Family Life Education (FLE) trainers during the week of seclusion. The group registered themselves as non-governmental organization, and with assistance from MYWO and PATH-Kenya, received funding from two donors for the continuation of the alternative ceremonies, income generation, and educational activities.

In Kisii, MYWO conducted 15 Training-of-Trainers (TOT) sessions to continue conducting the Family Life Education training during the week of seclusion.

LESSONS LEARNED

The implementation of this strategy proved that:

- Alternative rights of passage is an effective strategy in communities where girls are initiated during the adolescent years (12-19);
- The format can be adapted for other communities where girls are excised earlier, as in Kisii, where girls are excised before 12 years of age;
- Establishment of the community-based non-governmental organization Ntanira Na Mugambo (the local Family Life Education trainers) to lead those who are committed to continuing this strategy can strengthen its sustainability;
- It is acceptable to the community since it mimicks traditional practice;
- It can be an entry point for Family Life Education in rural communities; and
- It can promote family dialogue on sexuality issues (father, mother, and daughters).

SENEGAL: A Project Report

Elimination of FGM Through Communication Education: The TOSTAN Experience in Senegal[13]

INTRODUCTION

According to research carried out by Marie Helene Mottin-Sylla[14], excision in Senegal is a "village rite" that is performed on girls anywhere between the ages of two and eleven, depending on the ethnic group. In a few areas, Type III FGM is also practised, among the more traditional groups. Mottin-Sylla's research concluded that approximately twenty percent of Senegalese women are excised; however, the Hosken Report states a higher prevalence rate of fifty percent (Hosken, 1993).

Excision is practised mostly among the ethnic groups in the rural areas and not in the Dakar region, where most of the population is concentrated. Many associate the practice with initiation and tradition, purification, chastity and/or religion (the Marabouts). Although ninety-four percent of the population is Muslim, it is clear that the practice is performed more for ethnic rather than religious reasons, as many religious leaders do not require, or outwardly discourage, the practice of FGM (Hosken, 1993).

THE TOSTAN PROJECT

TOSTAN (Breakthrough), a Senegalese non-governmental organization, implements a community-based, basic education programme in rural areas (TOSTAN, ND). The organization's overall goal is to improve the physical and mental well-being of rural women and children. The organization has three specific objectives:

- To offer a basic education programme, focused on all aspects of women's and children's health: physical, legal, socio-cultural, nutritional, etc.
- To provide education in appropriate ways to give women the skills necessary to take charge of their own health and that of their families.
- To inform women and their husbands, through awareness-raising and social mobilization campaigns, about difficulties that confront women with regard to their reproductive health and the survival of their children.

BACKGROUND

TOSTAN was founded about ten years ago by an American - Molly Melching. It is designed as an intensive literacy and skills-training programme for women, built around group discussions. TOSTAN provides a year-long modularized education programme that

[13] This write-up is based on a report from TOSTAN, recent newspaper reports, and other articles describing the project. A site visit was not made.

[14] Marie Helen Mottin-Sylla conducted the first systematic survey and report on FGM in Senegal which was published by Environment and Development in the Third World (ENDA) in 1990/91

covers such topics as sanitation and disease transmission, child health, women's health, human rights, project planning and implementation, and book-keeping techniques. The project organizers see the core of their programme as being able to teach women problem-solving skills, self-awareness and assertiveness (Walt, 1998).

One profound result of TOSTAN's activities is that an increasing number of village women who participated in the training, especially the Women's Health and Human Rights Modules, have decided to take up the issue of FGM; many have mobilized the people in their villages to declare that they will all stop practicing FGM. This decision process occurred gradually. TOSTAN staff did not confront the issue of FGM directly, but rather took several months to introduce health topics. FGM was discussed in a health and human rights context, not as an issue concerned with women's sexuality (Walt, 1998).

The project is implemented by TOSTAN staff and the villagers who participate, with funding from UNICEF. The Ministry of Health also provides technical assistance to address the problems identified by villagers (TOSTAN, ND).

PROJECT ACTIVITIES

The anti-FGM activities took place in the context of a set of activities to develop and incorporate two health-related modules in the community based, basic education programme. Four steps were involved:

- Two training modules and supporting materials on health issues specific to rural women and their children were produced.
- TOT courses were conducted for trainers and facilitators to introduce these modules into the basic education programme for interested communities.
- The modules were included in the basic community-level literacy and education programme.
- Parallel meetings and awareness-raising campaigns with community members and policymakers concerned with women's and children's health were carried out.

As of 1996, TOSTAN had trained 47 facilitators to use the two modules and worked in 232 villages in four of Senegal's ten administrative regions, reaching 13,720 women. While the project did not necessarily include anti-FGM activities as a specific goal, health-related information on FGM was included in the modules. Village women, when learning about the negative health consequences, decided independently to act to end FGM in their villages (TOSTAN, ND). Although the first few women to openly reject FGM were opposed by men and other community members, the women persevered and after continued discussions with village leaders and men, several inter-related villages declared FGM banned from their communities. The process started in September 1996, when the village of Malicounda Bambara pledged to refrain from FGM, an event know as the "Malicounda Commitment." A year later, after the traditional season for performing FGM had passed, no procedures had been performed in the village. The Malicounda women discussed their decision with other TOSTAN participants in the neighboring villages of Ngerin Bambara and

Ker Simbara and the people of Ngerin Bambara decided on their own to make a similar pledge in November 1997. The people of Ker Simbara decided they could not stop FGM without consulting the rest of their extended family living in ten villages, so two of the men, one a religious leader, went from village to village discussing the issues. After weeks of bitter argument, the villagers agreed, in February 1998, to give up the practice. TOSTAN reports that the declarations made by the Malicounda women have started a movement: 13 villages have agreed to give up FGM in the "Diabougou Declaration," as have another 18 villages in the region of Kolda in the "Declaration of Medina Cherif" (Mackie, 1998). These activities also have caught the attention of high-level policymakers, nationally and internationally:

- As a result of the grass-roots efforts, President Abdou Diouf made his first declaration against FGM and now is pushing it to criminalize FGM, punishable by six years in jail.

- In April 1998, on their state visit to Senegal, President and Mrs Clinton visited the women of Malicounda and commended their efforts to stop FGM in their communities.

PROJECT EVALUATION

A formal evaluation of the FGM component of TOSTAN's work has not been conducted yet. However, one analyst, Gerry Mackie, has argued that the process TOSTAN has used, and the results that have been achieved with regard to FGM elimination reflect a process of social change that somewhat parallels the elimination of foot binding in China, which took place over a period of approximately a decade one century ago (Mackie, 1998). The TOSTAN process exhibits three essential steps:

- People are made aware of alternatives, i.e. not everyone binds women's feet or performs excision.

- People are made aware of the health advantages of not binding feet or performing FGM.

- People collectively agree to stop the practice, so that one person or family does not stand out or "force" the children to be different from everyone else (and thus unmarriageable).

This assessment presents a hopeful view that a true momentum to eliminate FGM has been established in Senegal and can be adapted by other communities. At the same time, some observers caution that the declarations may not hold in the long run. One newspaper report quotes a Senegalese professional as saying, "These villagers are doing exactly what the international organizations want them to do. Let's see what happens when they leave" (Hecht, 1998). Success will only have been achieved if the incidence of FGM decreases substantially over time.

KEYS TO SUCCESS

- TOSTAN evaluations highlight that the success of the anti-FGM activities cannot be separated from the community-based, educational nature of the project. Addressing illiteracy and providing skills training are key steps to empowering women, which is in turn key to giving women the courage to begin to address their many problems.

- The TOSTAN process created a forum for villagers to come together and openly discuss the practice of FGM.

- TOSTAN approached the issue from a health and human rights perspective; this worked well because achieving good health is a goal everyone could agree on.

- A critical element was getting entire villages to sign on to the plan so that no one carried a stigma.

- Involving village leaders, particularly religious leaders, was crucial. The Islamic leaders were able to alleviate peoples' concerns about Islam's position on FGM.

- Publicity and press coverage have helped the movement spread beyond the initial three villages.

UGANDA: A Project Report

Celebrating Cultural Identity: The Reproductive, Education and Community Health (REACH) Programme in Uganda

INTRODUCTION

In Uganda, FGM is practised in the district of Kapchorwa, in Eastern Uganda, bordering the Republic of Kenya in the East.[15] It rests on the slopes of Mt Elgon, which forms its southern border and covers an area of about 1,738 square kilometers. The District includes three counties, 11 sub-counties, 54 parishes, and 590 villages. In 1991, its population was estimated at 134,000. The district is mainly inhabited by the Sabiny tribe, who are part of the large Kelengin ethnic group of Kenya. Their main source of income is peasant farming, and they live in widely dispersed rural communities. The mountainous terrain in the district makes transport and communication very difficult. Most rural areas are inaccessible, making visits to the district's only hospital or health dispensaries in sub-counties almost impossible. Most mothers resort to the help of traditional birth attendants (TBAs) for their reproductive health needs.

THE PRACTICE OF FEMALE GENITAL MUTILATION

Circumcision of males and excision of females is practised in the Sabiny community to initiate boys and girls into adulthood. It is seen as a cultural identity and a sacred ritual sanctioned by ancestors and protected by cultural beliefs. Excision is performed on girls between the ages of 15 and 22 years. In some cases however, girls undergo the practice before the age of 15 if they feel they are ready to become adults and are "brave enough" to withstand the pain involved. As a strategy to evade the practice, some girls delay undergoing the procedure for as long as possible, although eventually they end up going through with it because of social pressure and intimidation by relatives and neighbours. Excision is performed yearly; however, the majority of Sabiny prefer to perform the ceremonies in December of every even-numbered year to coincide with the timing of male excision rites. Type II FGM is practised.

As in most communities, FGM in Kapchorwa is associated with several physical and psycho-social effects. Besides dropping out of school and entering early marriage, girls and young women who undergo FGM are predisposed to a number of health risks ranging from haemorrhage, pain, HIV infection, infection, urine retention, lameness, painful intercourse, low sexual pleasure, obstructed labor, and, occasionally, death. Anecdotal information from the community indicates that up to four people have died due to haemorrhage and shock resulting from the practice (Chekweko, 1998). This number is probably an underestimation, as relatives of victims are likely to conceal deaths due to fear of government action.

Despite the harmful consequences and side effects, many members of the Sabiny community still cherish and support the practice. A knowledge, attitudes, and practice (KAP) study carried out among Sabiny students, by Jackson Chekweko (Chekweko, 1994), revealed that the majority of youths support the practice due to peer and parental influence, cultural

[15] Traces of the practice have also been reported in Karamoja, Tororo, and Masindi districts, though only on a small scale. It is assumed that those who practise in these areas are also Sabiny.

motivation and pressure, cultural identity and due to ignorance of its dangers. Many young girls also support the practice because of fear of being marginalized,[16] mocked and harassed by their peers and the community, and because their boyfriends support the practice.

FGM ELIMINATION EFFORTS

Efforts to eliminate excision in Kapchorwa date back as far as the 1930s and 1940s, when missionaries attempted to stop the practice. However, they were not successful, especially since the then British Government of Uganda did not give them any support, claiming that it was a local issue. By 1960, however, through education, some Sabiny girls and women refused to be excised. As a result, some of these women remained unmarried or married non-Sabiny men. In 1980, the Kapchorwa District Council passed a resolution that allowed girls' excision to be optional in the district. This resolution was later transformed into a by-law in 1995. As harmful implications of excision become more known, a cross section of the Sabiny community, including politicians, religious leaders, teachers, and students, joined the national and international community and began to share their concerns about the practice. Several approaches were used to address the problem; however, they brought little success. In 1989, the Ugandan Government, the Inter-African Committee (IAC Uganda) and women activists, using strong health and human rights messages, attempted to ban the practice in Kapchorwa. However, their campaign approach did not work. The Sabiny community felt offended that "outsiders" were passing judgment and finding fault with their culture and traditions, implying that they were backward and barbaric. They opposed the campaign, and the number of girls and women who underwent FGM the following season increased dramatically.

THE REACH PROJECT

The alarming increase in the practice resulting from the earlier efforts drew the concern of the United Nations Population Fund (UNFPA). In close collaboration with the Sabiny community, Dr Francois Farah, the UNFPA Country Representative, developed an innovative, culturally-sensitive approach to address the problem. The project was designed with the involvement of the local community and all its social partners, including district and local leaders, politicians, religious leaders, heads of institutions, women and youth representatives, and UNFPA staff, in a two-day community workshop held in Kapchorwa in 1996. Participants discussed how to approach the issue of FGM and as a result, the Reproductive, Education and Community Health (REACH) Project was created and launched.

Programme Goal and Objectives. The goal of the REACH Project is to enhance the reproductive health conditions of women and female adolescents in Kapchorwa through:

- Discarding the harmful practice of excision, while promoting good cultural values among the community; and

[16] In a number of villages in Kapchorwa, unexcised women/girls are not allowed to milk cows, address gatherings, pick up food from the granary, collect cow dung from the kraal, or grind millet in front of excised women (Kiirya, 1997)

- Providing accessible and affordable quality reproductive health services to the community.

The project specifically sets out to:

- Sensitize at least 30 percent of the target groups within the district population about the harmful aspects of excision;

- Sensitize at least 50 percent of TBAs on the same issue and enhance their basic delivery skills and performance;

- Improve the quality of reproductive health care and family planning services in the maternity wing of Kapchorwa's District Hospital and four sub-county health units; and

- Establish a district population coordination structure in Kapchorwa.

Programme Approach: The programme approach used to achieve the above goals and objectives emphasizes maintaining and enhancing the good cultural values of the practice by discarding the excision of girls and women and replacing this with a symbolic alternative. This symbolic alternative involves continuing to support and celebrate girls' rites of passage ceremonies in the community (i.e. feasting and the giving of clothes and jewelry) while at the same time eliminating the harmful act of mutilation. In addition to the symbolic alternative, the Kapchorwa community also created and instituted a "cultural day" in the community that affirms community identity and positive aspects of culture.

The approach's framework allows the Sabiny community to determine the process of change themselves, at their own pace, and through their own dynamics. The approach also encourages the community to operate within rules and codes that are acceptable to, and taught in their own value-producing institutions (home, schools, and religious institutions). The framework involves separating the practice from the values it is supposed to serve; questioning its relevance to the values; the gains and losses to individuals, subgroups and the community as a whole; and advocating against the practice by reaching out to custodians of ethics and legitimacy within the culture while proposing acceptable alternatives that sustain the values the practice was thought to protect.

Programme Activities: The main thrust of the REACH Programme is to inform the community about the harmful health implications of FGM with the help of qualified local medical personnel and community leaders. To create awareness and gain support from the custodians of culture, REACH staff conduct community seminars and workshops for various groups within the community, including elders.[17] In addition, adolescents have been selected and trained to provide peer education among fellow students while at school and among area mates when at home during the holidays. TBAs and health workers were also trained in basic maternal and child health and family planning (MCH/FP) and delivery skills, and on how to educate their clients about the harmful effects of FGM. Lastly, a district cultural day was started by the project and has now been institutionalized as an annual event that promotes

[17] The Sabiny Elders Association, the main elders group in the community, has been instrumental to the success of the REACH Programme.

good cultural values and openly dispels those taboos and harmful practices that may have outlived their usefulness.

Programme Achievements: Although it has not been operating for very long, the REACH project has had an impact in the Kapchorwa community. Since its inception in January 1996, the programme reports the following achievements:

- Increased community support and commitment to discard the harmful practice of FGM.
- A marked decrease in the practice; according to statistics compiled by REACH staff, the percentage of girls and women undergoing the practice decreased by 36 percent in 1996 compared to 1994 (544 girls/women were excised in 1996 as opposed to 854 girls/women in 1994).
- In some sub-counties where FGM programme activities were intensified - Kaserem, Kabei and Sipi - the reduction in FGM was even greater: 90 percent, 60 percent and 43 percent respectively (based on statistics compiled by REACH staff).
- A conducive environment has been created in which the community is able to discuss issues related to FGM and reproductive health openly. Even politicians can talk about, and associate themselves with, the campaigns against the practice. Debates about the practice are common in Kapchorwa.
- The number of adolescents involved in creating awareness of the harmful practice of FGM has increased. More adolescents applied for training as peer educators and community-based agents in 1997 compared to 1996.
- There is increased demand by the general community, including elders for information regarding FGM and its associated effects. More sensitization seminars at the grassroots level have been requested.
- Although the number of cases of FGM are lower during odd years, NO cases of excision of girls and/or women were reported during 1997.

Collaboration with Other Organizations: One reason the REACH Project has had some success in lowering the incidence of FGM in Kapchorwa is because great effort was placed on collaborating with as many social partners as possible. Collaboration with social partners at the community, national and international levels has lead to increased demand for project activities, swift change in community perceptions about the practice, and a legitimate social change in the district. For example, REACH collaborates closely with the Family Planning Association of Uganda (FPAU) to promote FGM elimination activities. With funding from International Planned Parenthood Federation (IPPF) and the Norwegian Agency for Development (NORAD), FPAU established the "Integrated Community Health Project to Address FGM in Kapchorwa" in 1997. The FPAU uses the same approach and messages in their programme and actually conducts seminars in conjunction with the REACH project where feasible. In addition, the FPAU utilizes trained community-based agents - peer

counsellors (uncircumcised and circumcised boys and unexcised and excised girls) and gender enhancers (women and men) - to provide family planning and FGM counselling through home and school visits, at local health units, and at public rallies. With the assistance of trained physicians from the District Hospital, they also manage FGM complications at the FPAU clinic. The clinic also operates a youth center, where adolescent services and information, including information about FGM, are provided.

The FPAU project covers only 5 of the 11 sub-counties in Kapchorwa, while the REACH project covers the entire district.

KEYS TO SUCCESS OF THE KAPCHORWA PROJECT

- Building partnerships with the community and involving everyone in the design and implementation of the project.
- Supporting and celebrating the social meaning of FGM as a rite of passage while at the same time condemning and eliminating the harmful act of mutilation. This includes facilitating the community's ability to analyze the cost and the benefits of the practice in today's society and identify viable solutions.
- Initiating and instituting a community culture day that affirms community identity and positive aspects of culture.
- Involving community leaders in the decision-making process and in the design and implementation of the project. Educating community leaders about the harmful effects of the practice and supporting their achievements with an international award.[18]
- Addressing the basic reproductive health needs of the community while at the same time aiming to eliminate FGM.
- Continued funding support from a major United Nations agency.
- Using a culturally sensitive "persuasive" approach to FGM, as opposed to the previous judgmental and incriminating "stop the practice" approach, and the philosophy of working with the community members and cultivating a sense of voluntary participation and ownership.

[18] The Sabiny Elders Association recently received the 1998 UNFPA World award in recognition of their efforts to eradicate female excision in Kapchorwa.

PROGRAMME GAPS AND NEEDS

Based on conversations with the REACH staff and on a formal evaluation that was conducted by an external consultant in February 1997 (Kiirya, 1997), the following gaps and needs exist in the programme:

- Despite the decline in the number of girls/women undergoing FGM in the district, many members of the community continue to support and cherish the practice. The main reasons for the continuation of the practice include:

  a) social pressure placed on unexcised girls and women by in-laws and those members in the community who are excised and who wish the cultural practice to continue unquestioned - namely the elders.

  b) awareness about the harmful aspects of FGM has not yet reached the remote areas of the district - the parishes and villages and/or the uneducated.

- Reproductive health problems are still prevalent in many remote areas due to both poor communication and infrastructure, and because of the mountainous terrain of the district.

- There is still a lack of trained health workers and TBAs in the District. Having at least one trained TBA per village will help improve both the basic delivery services and sensitize the community about the harmful effects of FGM in the remote areas of the district.

- There are no IEC materials available to supplement the sensitization seminars.

- Many adolescent girls still are not being reached because they are not able to continue their education past primary school and are therefore not exposed to the information/support provided by peer educators in secondary level schools.

- Peer educators need additional training to answer difficult questions and dispel myths related to FGM.

REPLICATION

Given that FGM is only practised in the Kapchorwa district and by the Sabiny community in Uganda, the project can only be sustained and expanded to the remote areas of the district until the practice is finally eliminated throughout the community. However, lessons learned through this "sensitive persuasive" approach can be used when addressing other culturally bound and harmful practices, and should be shared with other FGM practising countries in Africa, such as Kenya, where similar ethnic groups live.

SUSTAINABILITY

UNFPA has provided core funding to support the REACH project during the past three years. However, due to limited resources, UNFPA has not been able to fund all the activities needed for the project to have a larger and faster impact on the community. The project also needs to be sustained until a normative change has taken place in the community and the majority of the Sabiny people see the practice as something of the past that needs to be eliminated. At the moment, the community's ownership of the project, the advocacy groups and the commitment of the project beneficiaries, specifically the young girls, are the elements of sustainability that the project has in place.

RECOMMENDATIONS

Based on the gaps and weaknesses identified, the following recommendations can be made:

- Given the reaction of the Sabiny people to the first large-scale attempt to eliminate the practice of FGM in Kapchorwa, it is clear that communities need to play a central role in any initiative in this area and that they should be involved in all stages , including the planning, implementation and evaluation.

- Peer educators at schools have had the most impact on creating awareness about the harmful effects of FGM among adolescents. Therefore, increasing their numbers at schools and expanding their work to out-of-school youth will further increase awareness.

- Encouraging girls' education and incorporating education on the harmful aspects of FGM into school curriculum (of upper primary and secondary schools) will help sustain elimination efforts in the future. There is a need to include decision-making and self-esteem building components into the in-school curriculum so that girls will learn ways to resist negative peer pressure from excised girls and the rest of the community.

- In Kapchorwa, the most effective tool to creating community awareness on the harmful aspects of FGM still remains sensitization seminars and workshops. Expanding these activities to the parish and villages levels will increase awareness of the harmful aspects of the practice and lead to further decline of the practice.

- To avoid disharmony among community members, any approach used to address the practice of FGM should be comprehensive and integrated, involving all members of the community. Project staff and volunteers need to be trained on conflict resolution and how to develop support groups for unexcised girls.

- More community-based health workers and agents (TBAs, elders, religious leaders etc.) require training to improve their capacity and skills, to provide friendly and effective services, and to educate distant and difficult to reach communities.

- The project needs to expand the content of its training materials to include information about legal and human rights, including the work of CEDAW and CRC; ethical issues; interpersonal communication and counselling; conflict resolution; stages of behaviour change adoption and participatory social change; and community assessment techniques.

- The project also needs to develop research-based IEC materials, including peer educators guides that allow peers to answer difficult questions and dispel myths about FGM.

- An impact assessment, using both quantitative and qualitative research, needs to be conducted to determine: a) the actual decline in the prevalence of FGM and b) whether the lack of reported cases of FGM are due to families actually stopping the practice or just reporting that they have done so. It is important that the critical factors that lead a particular family to abandon the practice be identified.

- REACH staff and other social partners need to incorporate information and/or sessions on girls' and womens' rights, reproductive health counselling and communication skills into their sensitization and training seminars so as to enhance their capacity to denounce practices that infringe on these human rights; to assert their right to education and to make decisions without gender-related pressure.

CONCLUSION

The Kapchorwa project demonstrated that changing a deeply rooted practice such as FGM is possible as long as the community is involved in the conceptualization, design and implementation of the project; their cultural values and heritage are celebrated and validated; their reproductive health needs are supported holistically; its achievements are rewarded; and funding is provided. This project also highlights that judgmental and incriminating approaches that order communities to "stop the practice" do not work and are counterproductive to change. With additional work to improve implementation and to reach out to smaller communities, the practice of FGM will continue to decrease over time, and may be eliminated completely.

VIII: CONCLUSION

This assessment details the extent of anti-FGM programming in countries in WHO African and Eastern Mediterranean Regions. The pace of efforts to eliminate the practice of FGM has been growing steadily over the last two decades. Available data show that there is now a groundswell of agencies and organizations working in this area and that governments are beginning to include FGM in their policies and plans of action. Available data also shows an attempt to coordinate work among non-governmental organizations and governmental agencies, and an initial effort to integrate anti-FGM messages and activities into existing programmes. Many donors agencies are moving away from seeing FGM as a cultural practice too sensitive for intervention and are now providing financial support to programmes aimed at elimination of the practice.

It is also very encouraging that there are effective programmes working at the community level to protect girls and women from the practice of FGM. These programmes are participatory in nature and generally guide communities to define the problems and solutions for themselves. Four successful efforts, highlighted in Section VII, include the MYWO alternative rights project in Kenya, the community monitoring efforts of CEOSS in Egypt, the basic community education and mobilization work of TOSTAN in Senegal, and the community support project of REACH in eastern Uganda.

At the same time, the assessment shows key areas of programmatic weakness. Most of the organizations that are implementing anti-FGM activities are small and rely heavily on volunteers. Their activities do not yet reach out to most of the communities that still practise FGM. Governments have not, for the most part, moved beyond policy support to fully incorporate anti-FGM activities into their work - for example, medical school curricula have not been revised to include protocols on the management of the physical and psychological complications of FGM. Governments have not yet become committed to scaling up anti-FGM activities.

More importantly, most of the anti-FGM programming does not fully address the complex "mental map" that underlies the practice nor all the key steps needed to bring about behaviour change. For example, most the IEC messages focus only on the harmful health effects of FGM and other traditional practices, without addressing the community values that support the practice. Because FGM takes place in the realm of so many core societal values - particularly control over women's sexuality - programming must evolve to address the full set of issues that support the practice. This is true for information campaigns, including advocacy work, IEC materials, and mass media activities, training activities for staff, and projects carried out at the community level.

This review shows that the foundation for the elimination of FGM has been laid in countries. There are now examples of successful programming at the community level, and committed groups are working in a coordinated and dedicated fashion. The data also point to the areas that programmes need to develop further to assist communities eliminate female genital mutilation. The momentum for change is accelerating. Governments with timely laws and policies, effective plans to scale up elements of success, and financial and technical support, can keep up with the pace of change and protect women' and girls' rights to be free from female genital mutilation and other practices that affect the health of women and girls.

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ANNEX 1

ORGANIZATIONAL PROFILES

Organizational Profiles

Country	Organization	Address	Type of Organization	Programme Description	Target Population
BENIN					
	Comite Inter-African du Benin (IAC Chapter)	BP 538 Porto-Novo, Benin Tel: 229-22-3204 Fax: 229-21-2525	National NGO	Research; Training; Advocacy; Individual counselling; Peer education; Alternative rites of passage; Alternative income strategies for excisors; Income generation strategies for women; ***IEC supported activities***: Campaigns; Community education; Seminars/workshops for key opinion leaders; Working with the media; Materials development.	[19]Targets all population groups
	IWALEWA	BP 88 Dassa-Zoume, Benin Tel: 229-53-0048 Fax: 229-53-0137	National NGO	Individual counselling; Peer education; Income generation strategies for women; Treatment of FGM complications; ***IEC supported activities***: Community education.	Girls, parents, excisors, community leaders, and the general public
BURKINA-FASO					
	APJAD	09 BP 324 Ouagadougou 09, Burkina Faso Tel: 30-02-13 Fax: 36-16-25 and 36-21-38	Youth association	Advocacy; Peer education; ***IEC supported activities***: Campaigns.	Youth in school
	Comite National de Lutte Contre la Pratique de L'Excision (IAC Chapter)	s/c Ministre de Action Sociale et Famille, Burkina Faso Tel: 226-30-7915 and 31-1571	National NGO	Research; Training; Advocacy; Peer education; Treatment of FGM complications; ***IEC supported activities***: Campaigns; Community education; Seminars/workshops for key opinion leaders; Working with the media.	Targets all population groups
CAMEROON					
	Inter-African Committee (IAC Chapter)	BP 3215 Messa Yaounde, Cameroon Tel: 237-21-3589	International NGO	Research; ***IEC supported activities:*** Campaigns; Community education; Working with the media.	Community leaders, general public, and the media
CHAD					
	Comite National de lutte contre les Pratiques n'efastes (IAC Chapter)	s/c OMS-Tchad Tel: 523803	National NGO	Research; Training; Advocacy; Individual counselling; Peer education; Alternative rite of passage; Alternative income strategies for excisors; Income generation strategies for women; ***IEC supported activities:*** FLE in schools campaigns; Community education and discussions; Seminars/workshops for key opinion leaders; Working with the media.	Targets all population groups
EGYPT					
	Association for the Protection of the Environment	Tel: 5102723	National NGO	Individual counselling; Peer education; Income generation strategies for women; ***IEC supported activities:*** Community education.	Youth out of school, and mothers

[19] All target population groups include the following: mothers, fathers, grandmothers, excisors, religious leaders, tribal/community leaders, youth in school, youth out of school, health personnel, teachers, media, policymakers, and general public

Organizational Profiles

Country	Organization	Address	Type of Organization	Programme Description	Target Population
EGYPT (cont'd)					
	Coptic Evangelical Organization for Social Services (CEOSS)	PO Box 162-11811 El Panorama Cairo, Egypt Tel:202-297-5901 Email: ga@ceoss.org.eg	National NGO	Research ; Training; Advocacy; Individual counselling; ***IEC supported activities***: FLE in schools; Community education through literacy, home economics and nutrition classes.	Youth out of school, parents, grandmothers, and excisors
	*Egyptian Society for the Prevention of Harmful Traditional Practices to Woman and Children (ESPHTP) (IAC Chapter)		National NGO	Training; ***IEC supported activities:*** Awareness campaigns***;*** Seminars; Working with media; Materials development.	Urban/rural leaders, social service trainees, community leaders, doctors, dayss (midwives), and nurses
	FGM Taskforce	Tel: 202-354-3305 Fax: 202-378-2643	National NGO	Research; Training; Advocacy; ***IEC supported activities***: FLE in schools; Campaigns; Community education; Seminars/ workshops for key opinion leaders; Working with the media; Materials development.	Policymakers, youth, health personnel, parents, grandmothers, community leaders, general public, and the media
ENGLAND					
	FORWARD (Foundation for Women's Health, Research and Development)	40 Eastbourne Terrace WZ3QR London, UK Tel: 017-17-252-606 Fax: 017-17-252-796	International NGO	Research; Training; Advocacy; Integrated women's health projects; Income generation strategies and women. ***IEC supported activities:*** Campaigns in rural areas; Community education; Seminars/workshops for key community leaders; Wellwoman Clinics,Working with health care workers, local authorities, the media, primary school teachers. Materials development. Male involvement.	Targets all population groups
ETHIOPIA					
	*Inter-Africa Committee on Traditional Practices Affecting the Health of Women and Children (IAC) Headquarters: 147 rue de Lausanne 1202 Genève, Switzerland	c/o Economic Commission for Africa/ATRCW PO Box 3001 Addis Ababa, Ethiopia Tel: 41-22-731-2420 and 732-0821 Fax: 41-22-738-1823 Email: IAC@PADIS.GN.APC.ORG	International NGO	Research; Surveys; Training; Advocacy; Liaison with other IAC Chapters. ***IEC supported activities:*** Information and sensitization campaigns; Seminars; Multi-media training modules; Materials development. Collaborates with UN specialized agencies.	Policymakers, health personnel, excisors, UN Agencies and Treaty Bodies, civil society, and the media.
	Bureau of Labor and Social Affairs	PO Box 934 Bahir Dar, Ethiopia Tel: 08-201135	Government	Advocacy; Peer education; Income generation strategies for women. ***IEC supported activities:*** Seminars/workshops for key opinion leaders; Materials development.	Mothers and general public
	*Ministry of Health Family Health Department	Addis Ababa	Government		
	National Committee on Traditional Practices in Ethiopia (NCTPE) (IAC Chapter)	PO Box 12629 Addis Ababa, Ethiopia Tel: 251-1-18-1163 Fax: (c/o UNFPA) 251-1-51-5311	National NGO	Research; Training; Advocacy; Peer education; Alternative income strategies for excisors; ***IEC supported activities***: Campaigns; Community education; Seminars/workshops for key opinion leaders; Working with the media; Materials development.	Targets all population groups except out of school youth

Organizational Profiles

Country	Organization	Address	Type of Organization	Programme Description	Target Population
ERITREA					
	National Union of Eritrean Youth and Students	PO Box 1042 Asmara, Eritrea Tel: 115091/120488 Fax: 125981	NGO	Research; Training; Advocacy; Peer education; ***IEC supported activities:*** Campaigns; Community education; Working with the media; Materials development.	Youth in and out of school, religious leaders, community leaders, general public, and the media
FRANCE					
	Commission pour L'abolition des Mutilations Sexuelles (CAMS))	6 Place Saint Germain Des Pres 75006, Paris France Tel: 33-1-4549-0400 Fax: 33-1-4549-1671 Email: 113111,2360@compuserve.	International NGO	***IEC supported activities:*** Campaigns; Community discussions; Working with the media.	Targets all population groups
	GAFS	Isabelle Gillette-Faye 66 rue des Grands Champs 75020 Paris, France Tel: 0033-1-43-48-1087 Fax: 0033-1-43-48-0073	National NGO	Peer education; ***IEC supported activities:*** Campaigns; Community discussions; Working with the media; Materials development.	Youth, policymakers, health personnel, parents, grandmothers, excisors, religious and community leaders, and the media.
GAMBIA					
	*BAFROW Youth Advocacy Group	214 Tafsir Demba Mbye Road Tobacco Road Estate PO Box 2854 (Serrekunda) The Gambia Tel: 220-22-52-70/22-34-71 Fax: 220-22-22-32-66	National NGO	Peer education among youth, rural women, and health care workers, about FGM and other harmful traditional practices. Integrated women's health project - Wellwoman Clinic. Alternative income strategies for excisors. Alternative rites of passage.	Youth, health personnel, urban poor and rural women, religious leaders, and policymakers
	The Gambia Committee on Traditional Practices (IAC Chapter)	PO Box 2990 Serrekinda, The Gambia Tel: 220-49-7416 Fax: 220-49-77-81	National NGO	Research; Training; Advocacy; Individual counselling; Peer education; Alternative income strategies for excisors; ***IEC supported activities:*** FLE in schools; Campaigns; Community education and discussions; Organizing competitions; Seminars/workshops for key opinion leaders; Working with the media; Materials development.	Targets all population groups
GHANA					
	Association of People for Practical Life Education	PO Box 2 Mima Accra, Ghana Tel: 230561	National NGO	Training; Advocacy; Individual counselling,; Peer education; ***IEC supported activities***: FLE in schools; Campaigns; Community education and discussions; Seminars/workshops for key opinion leaders; Materials development.	Policymakers, youth, health personnel, excisors, community leaders, general public, and the media
	Ghana Association for Adolescent Reproductive Health	PO Box 4647 Accra, Ghana Tel: 222-995 and 226-240	National NGO	Training; Advocacy; Individual counselling; Peer education; Alternative income strategies for excisors, Income generation strategies for women; ***IEC supported activities***: FLE in schools; Campaigns; Community education and discussions; Seminars/workshops for key opinion leaders; Working with the media; Materials development.	Youth, policymakers, parents excisors, religious and community leaders, public, grandmothers, and the media

Organizational Profiles

Country	Organization	Address	Type of Organization	Programme Description	Target Population
GHANA (cont'd)					
	Ghanaian Association for Women's Welfare	PO Box 9582 Airport Accra, Ghana Tel/fax: 233-21-77-3151	National NGO	Research; Training; Advocacy; Individual counselling; Alternative rites of Passage; Alternative income strategies for excisors; Income generation strategies for women***; IEC supported activities:*** Campaigns; FLE in schools; Community education and discussions; Seminars/workshops for key opinion leaders; Working with the media; Materials development	Targets all population groups
	Ghana Red Cross Society	PO Box 177 Wa, Ghana Tel/fax: 075-622239	National NGO	Training; Individual counselling; Peer education; Alternative income strategies for excisors; Income generation strategies for women; ***IEC supported activities:*** FLE in schools; Campaigns; Community education and discussions; Seminars/workshops for key opinion leaders; Working with the media.	Girls, parents, grandmothers, excisors, religious and community leaders, general public, and teachers
	Ghana Red Cross Society U.E.R.	PO Box 330 Bolga U.E.K., Ghana	Auxiliary to Government	Peer education; Alternative rites of passage; Alternative income strategies for excisors; Income generation strategies for women***; IEC supported activities:*** FLE in schools; Campaigns; Seminars/workshops for key opinion leaders; Working with the media.	Policymakers, youth in and out of school, parents, and excisors
	Health for Million Club	PO Box 108 Nkoranza, Ghana Tel: 061-7202	National NGO	Individual counselling; Peer education; Alternative rites of passage; Alternative income strategies for excisors, ***IEC supported activities:*** Community education and discussions; Working with the media.	Policymakers, parents, teachers, and religious leaders
	Integrated Health Education for the Youth	PO Box 34 Nkoranza, Ghana Tel: 061-7202	National NGO	Individual counselling; Peer education; ***IEC supported activities:*** Campaigns; Community education and discussions; Health education.	Youth out of school, parents, grandmothers, community leaders, and the general public
	Muslim Family Counselling Services	PO Box 9543 K.I.A. Accra, Ghana Tel: 233-21-231215 Fax: 233-21-225658	National NGO	Advocacy; Individual counselling; Peer education; Income generation strategies for women; ***IEC supported activities:*** Campaigns; Community education and discussions; Seminars/workshops for key opinion leaders; Working with the media; Materials development.	Policymakers, youth in and out of school, and parents
	National Council on Women and Development (NCWD)	PO Box 304 Sekondi, Ghana Tel: 031-46940	Government	Advocacy; Individual counselling; Peer education; ***IEC supported activities:*** Campaigns; Community education; Seminars/workshops for key opinion leaders; Working with the media; Materials development.	Policymakers, girls, health personnel, excisors, community leaders, general public, and teachers.
	National Youth Council	PO Box 13 Nkoranza, Ghana Tel: 061-7091	Government	Advocacy; ***IEC supported activities:*** Campaigns; Community education and discussions; Working with the media.	Policymakers and community leaders
	Planned Parenthood Association of Ghana	PO Box 5756 Accra, Ghana Tel: 021-304567 and 027-554150 Fax: 021-304567	International NGO	Advocacy; Peer education; ***IEC supported activities:*** FLE in schools; Community discussions; Seminars/workshops for key opinion leaders.	Youth, parents, grandmothers, excisors, community leaders, and the general public

Organizational Profiles

Country	Organization	Address	Type of Organization	Programme Description	Target Population
GHANA (cont'd)					
	Volta Region Association of non-governmental organizations	PO Box 440 40 Volta Region, Ghana Tel/fax: 233-21-304782	National NGO	Individual counselling; Peer education; Income generation strategies for women; ***IEC supported activities:*** FLE in schools; Campaigns; Community education and discussions.	Youth in school, parents, general public, and community leaders
	Women are the Key Female Human Rights	PO Box 283 Hohoe, Ghana	National NGO	Treatment of FGM complications; Alternative rites of passage; ***IEC supported activities***: Campaigns; Seminars for key opinion leaders; Materials development.	Youth in school, mothers, and community leaders
	Youth Development Foundation (YDF)	PO Box 4941 Kumasi, Ghana Tel: 233-51-29185 Fax: 233-51-23622	International NGO	Advocacy; Peer education, ***IEC supported activities***: Campaigns; Seminars/workshops for key opinion leaders.	Youth out of school
GUINEA					
	CPTAFE (IAC Chapter)	BP 585 Conakry, Guinea Tel: 224-41-13-78 and 78-90-23 Fax: 224-41-13-78 and 41-34-63	National NGO	Peer education; Alternative income strategies for ciricumcisers; Income generation strategies for women; IEC supported activities: Seminars/workshops for key opinion leaders; Materials development	Targets all population groups
GUINEA-BISSAU					
	Comite Nacional de Luute Conira Pratican Nefastes a Saude da Mulher e Crianca	MASPF BP 560 Guinea -Bissau Tel: 245-20-3060 Fax: 245-20-1161	National NGO	Research; Training; Advocacy; Individual counselling; Treatment of FGM complications; Alternative rites of passage; ***IEC supported activities:*** FLE in schools; Campaigns; Community education; Seminars/workshops for key opinion leaders; Working with the media.	Targets all population groups
KENYA					
	Center for the Study of Adolescence	Dr Wangoi Nj'au 19329 Nairobi, Kenya Tel: 254-02-570254 Email: csa@africaonline.co.ke	National NGO	Research; ***IEC supported activities:*** Seminars/workshops for key opinion leaders; Materials development.	Policymakers
	Health Care Development Foundation	PO Box 72594 NBI OR 49 Khwisero, Kenya Email: danielfokallo@Hedek.org	National NGO	Advocacy; Individual counselling; Peer education; Alternative rites of passage; Income generation strategies for women; ***IEC supported activities:*** FLE in schools; Campaigns; Community education and discussions; Seminars/workshops for key opinion leaders.	Youth, parents, grandmothers, excisors, community leaders, and the general public
	Kenya Female Advisory Organization	PO Box 6025 Nairobi, Kenya Tel: 254-035-44502 Fax: 254-035-44502 and 40797	National NGO	Training; Advocacy; Individual counselling; Peer education; Alternative rites of passage; Alternative income strategies for excisors; ***IEC supported activities:*** FLE in schools; Campaigns; Community education and discussions; Seminars/workshops for key opinion leaders; Materials development.	Targets all population groups

Organizational Profiles

Country	Organization	Address	Type of Organization	Programme Description	Target Population
KENYA (cont'd)					
	Maendaleo ya Wanawake Organization (MYWO)	PO Box 44412 Nairobi, Kenya Tel: 21-3908 Fax: 22-5390	National NGO	Research; Training; Advocacy; Peer education; Community mobilization and outreach; Capacity building; Alternative rites of passage; Alternative income strategies for excisors, Income generating strategies for women; ***IEC supported activities:*** FLE in schools; Community education and discussions; seminars/workshops for key opinion leaders; Working with the media; Materials development.	Targets all population groups
	National Council of Churches of Kenya	PO Box 45009 Nairobi, Kenya Tel: 21-5560 and 21-9594 Fax: 21-5196	Church related	***IEC supported activities*** : FLE in schools; Seminars/workshops for religious leaders.	Youth in school, mothers, religious leaders, and teachers
	Northern Aid	74193 Nairobi, Kenya Tel/fax: 25-2778	National NGO	Advocacy; Alternative rites of passage; ***IEC supported activities:*** Community education; Seminars/workshops for key opinion leaders; Working with the media.	Policymakers, health personnel, religious leaders, teachers, and the media
	PATH Kenya	PO Box 76634 30 Ole Odume Road Nairobi, Kenya Tel: 254-2-569331/569357 Fax: 254-2-566714 Email: path@ken.healthnet.org	International NGO	Research; Training; Advocacy; Peer education; Alternative rites of passage; ***IEC supported activities:*** FLE in schools; Community education and discussions; Seminars/workshops for key opinion leaders; Working with the media; Collaborating with other non-governmental organizations in Africa; Materials development.	Targets all population groups
	Seventh Day Adventist Rural Health Services (SDA-RHS)	PO Box 42276 Nairobi, Kenya Tel/fax: 56-6022	National NGO	Research; Training; Advocacy; Individual counselling; Peer education; ***IEC supported activities:*** Campaigns; Community education and discussions; Seminars/workshops for key opinion leaders; Materials development.	Policymakers, youth in and out of school, health personnel, parents, grandmothers, excisors, religious and community leaders, and the general public
MALI					
	Association Centre DJOLIBA Hommes et Developpement	Centre DJOLIBA,BP 298 Bamako, Mali Tel: 223-22-83-32 Fax: 223-22-46-50 Email: djoliba@malinet.ml	National NGO	Research; Training; Peer education; Income generation strategies for women; ***IEC supported activities:*** Community education and discussions; Seminars/workshops for key opinion leaders; Working with the media; Materials development.	Youth, health personnel, parents, grandmothers, excisors, media, general public, religious and community leaders
	Associacion pour le Progres et la Defence des Droits des Femmes	BP 1740 Bamako, Mali Tel: 223-23-23-62 Fax: 223-23-23-62 and 22-08-68	National NGO	Research; Training; Advocacy; Treatment of FGM Complications; Alternative income strategies for excisors, ***IEC supported activities:*** Community education and discussions; Seminars/workshops for key opinion leaders; Working with the media; Materials development.	Targets all population group

Organizational Profiles

Country	Organization	Address	Type of Organization	Programme Description	Target Population
MALI (cont'd)					
	Association de Soutien aux Activites de Population (ASDAP)	BP 951 Bamako, Mali Tel/fax: 223-22-27-69	National NGO	Research; Training; Peer education Treatment of FGM complications; ***IEC supported activities:*** Campaigns; Community education and discussions; Seminars/workshops for key opinion leaders; Working with the media; Materials development.	Targets all population groups
	Assocication Malienne pour Lesuor et Lorientation des pati (AMSOPT)	BPE. 1543 Mali Tel: 223-23-58-95 Fax: 223-22-01-42	National NGO	Research; Training; Advocacy; Individual counselling; Treatment of FGM complications; Alternate income strategies for excisors ***IEC supported activities:*** Community education and discussions; Seminars/workshops for key opinion leaders; Working with the media; Materials development.	Youth out of school, health personnel, parents, grandmothers, excisors, religious and community leaders, and the media
	Comite d'Action pour les Droits de La Femme el de L'enfant (CADEF)	259 rue Badala Sema r/p 2653 Bamako, Mali Tel: 223-22-56-38 Fax: 223-23-41-02	National NGO	Research; Advocacy; ***IEC supported activities:*** Campaigns, community discussions; Seminars/workshops for key opinion leaders; Working with the media; Materials development.	Youth, parents, teachers, general public, and the media
MAURITANIA					
	Association Mauritarienne sur les Pratiques Traditionnelles ayant effet sur la sante des Femmes et des Enfants (AMPTSFE)	BP 3772 Nouakchott, Mauritania Tel: 2222-54825 Fax: 2222-51917	National NGO	Research; Training; Advocacy; Peer education; ***IEC supported activities:*** Community education and discussions; Seminars/workshops for key opinion leaders.	Youths, parents, grandmothers, religious and community leaders, and the general public
NIGER					
	Comite Nigerien sur les Pratiques Traditionnelles (CONIPRAT) (IAC Chapter)	BP 11631 Niamey, Niger Tel: 00227-75-34-72 and 72-42-07 Fax: 00227-75-35-06 and 72-28-45	National NGO, Affiliate of CI-AF and CONGAFEN	Research; Training; Advocacy; Treatment of FGM complications; ***IEC supported activities:*** Campaigns; Community education and discussions; Seminars/workshops for key opinion leaders; Working with the media; Materials development.	Targets all population groups
NIGERIA					
	Action Health Incorporated	54 Somorin Street Ifako-Gbagada, Nigeria Tel/fax: 234-86-11-66	National NGO	Research; Training; Advocacy; Individual counselling; Peer education; ***IEC supported activities:*** FLE in schools; Community education; Seminars/workshops for key opinion leaders; Working with the media; Materials development.	Youth and media
	Afrihealth Information Projects	PO Box 4127 Oshodi, Lagos State, Nigeria Tel: 234-01-52-24-67	National NGO	Research; Advocacy; Individual counselling; Peer education; ***IEC supported activities:*** FLE in schools; Campaigns; Seminars/workshops for key opinion leaders; Working with the media; Materials development.	Policymakers, youth in school, parents, grandmothers, excisors, community leaders, and the media

Organizational Profiles

Country	Organization	Address	Type of Organization	Programme Description	Target Population
NIGERIA (cont'd)					
	Association for Adolescent Reproductive Health Action	PO Box 2083 Flat S. Bida Court Road North, Nigeria	National NGO	Research; Advocacy; Individual counselling; Peer education; Alternative rites of passage; ***IEC supported activities***: FLE in schools; Community discussions; Seminars/workshops for key opinion leaders.	Targets all population groups
	COFAP (Committee of Friends Against Adolescent Pregnancy)	PO Box 2719 General Post Office Calabar, C.R.S. Nigeria	National NGO	Peer education; ***IEC supported activities:*** FLE in schools; Community education; Seminars/workshops for key opinion leaders; Working with the media; Materials development..	Youth in school, parents, policymakers, teachers, general public, and community leaders
	IMO Youth Network Programme	PO Box 372 Owerri, IMO State, Nigeria Tel: 083-234-467	National NGO	Advocacy; Individual counselling; Peer education; Alternative rites of passage; Income generation strategies for women; ***IEC supported activities:*** FLE in schools; Campaigns; Community education; Working with the media.	Youth, health personnel, mothers, grandmothers, community leaders, and the media
	Ministry of Health	BP 2191 Sokoto, Nigeria Tel: 060-23-60-69	Government	***IEC supported activities:*** Campaigns; Community education.	Youth in school and health personnel
	NANNM (National Association of Nigerian Nurses and Midwives)	16 Shokunbi St. Mushin PO Box 3857 Ikeja-Lagos, Nigeria Tel: 932283 Fax: 96120117	National NGO	Research; Training; Advocacy Individual counselling; Peer education; Alternative rites of passage; Alternative income strategies for excisors***; IEC supported activities:*** FLE in schools; Community education and discussions; Seminars/workshops for key opinion leaders; Working with the media; Materials development.	Targets all population groups
	Planned Parenthood Federation of Nigeria	156, 2nd East Circular Rd., PMB 1175 Benin City, Nigeria Tel: 052-25-97-73	National NGO	Research; Training; Advocacy; Individual counselling; Peer education; Alternative rites of passage; Alternative income strategies for excisors***; IEC supported activities:*** FLE in schools; Campaigns; Community education; Seminars/workshops for key opinion leaders; Working with the media; Materials development.	Policymakers, youth in school, parents, community leaders, and the general public
	Social Support Organization	PMB. 1119 Birnin Kebbi, Kebbi State, Nigeria	Youth Serving Organization	Individual counselling; Peer education; ***IEC supported activities:*** FLE in schools; Community education; Materials development.	Youth in school
	Stepwise Organization	PO Box 5565, Ilorin, Nigeria Tel: 234-31-22-4090 Fax: 234-31-22-5805 Email: fhsilorin@anpa.net.ng	National NGO	Research; Training; Advocacy; Income generation strategies for women; ***IEC supported activities:*** FLE in schools; Community discussions; Seminars/workshops for key opinion leaders.	Policymakers, youth in school, and parents
SENEGAL					
	Conseil sous-regional de Lutte contre les Pratiques Traditionnelles Nefastes	s/c enda-ACAS BP 224 Zinguinchor, Senegal Tel: 221-991-14-07 Fax: 221-991-24-94	National NGO	Research; Advocacy; ***IEC supported activities:*** FLE in schools; Campaigns; Community education and discussions; Seminars/workshops for key opinion leaders; Working with the media; Materials development.	Targets all population groups

Organizational Profiles

Country	Organization	Address	Type of Organization	Programme Description	Target Population
SENEGAL (cont'd)					
	COSEPRAT	BP 3001 Dakar, Senegal Tel: 821-50-25 Fax: 221-23-58-96	National NGO	Advocacy; Peer education; ***IEC supported activities:*** Campaigns; community education, Seminars/workshops for key opinion leaders; Working with the media; Materials development.	Targets all population groups
	ENDA-SYNFEV	BP 3370 Dakar, Senegal Tel: 221-821-60-27 Fax: 221-822-26-95	International NGO	Research; Peer education; Income generation strategies for women; ***IEC supported activities:*** FLE in schools; Community education and discussions; Seminars/workshops for key opinion leaders; Working with the media; Materials development.	Policymakers, youth out of school, health personnel, parents, grandmothers, excisors, religious and community leaders, and the general public
SUDAN					
	Babiker Badri Scientific Association for Women's Studies	Ahfad University for Women PO Box 167 Omudurman, Sudan Tel: 249-11-553363 Fax: 249-11-775846	National NGO	Research; Training; Advocacy; Alternative income strategies for excisors; Income generation activities for women; ***IEC supported activities:*** Campaigns; Community discussions; seminars/.workshops for key opinion leaders; Working with the media; Materials development.	Policymakers, youth in school, parents, health personnel, excisors, media, teachers, and community leaders and religious leaders
	SNCTP (Sudan National Committee on Harmful Traditional Practices)	PO Box 10418 Khartoum, Sudan Tel: 249-11-460546 Fax: 249-11-774602	National NGO	Research; Training; Advocacy; Peer education; Alternative rite of passage; Alternative income strategies for excisors; Income generation activities for women; ***IEC supported activities:*** FLE in schools; Campaigns; Community education and discussions; Seminars/workshops for key opinion leaders; Working with the media; Materials development.	Targets all population groups
TANZANIA					
	Family Planning Association of Tanzania	PO Box 1372 Dar es Salaam, Tanzania Tel: 255-51-111639 Fax: 255-51-25491	National NGO	Advocacy; ***IEC supported activities:*** Seminars/workshops for key opinion leaders.	General public
	IAC Dodoma	PO Box 759 Dodoma, Tanzania Tel: 255-61-21125 Fax: 255-61-32-43-52	National NGO	Research; Training; Advocacy; Individual Counselling; Peer education; Alternative rite of passage; Alternative income strategies for excisors; Income generation strategies for women; Treatment of FGM complications; ***IEC supported activities:*** FLE in schools; Campaigns; Community education and discussions; Seminars/workshops for key opinion leaders; Working with the media.	Targets all population groups
	NCTP (National Committee on Traditional Practices) (IAC Chapter)	PO Box 12542 Tanzania Tel: 255-51-118616 Fax: 255-51-38282 Email: nacp@raha.com and adic@ud.co.tz	National NGO	Training; Advocacy; Individual counselling; Peer education; Alternative rite of passage; Alternative income strategies for excisors; Income generation strategies for women; ***IEC supported activities:*** FLE in schools; Campaigns; Community discussions; Seminars/workshops for key opinion leaders; Working with the media; Materials development.	Targets all population groups

Organizational Profiles

Country	Organization	Address	Type of Organization	Programme Description	Target Population
TANZANIA (cont'd)					
	POFLEP (Population/Family Life Education Programme)	PO Box 6009 Arusha, Tanzania Tel: 255-57-3701 Fax: 255-57-3703	Government	Research; Training; Advocacy; Individual counselling; Peer education; ***IEC supported activities:*** Campaigns; Community discussions; Seminars/workshops for key opinion leaders; Working with the media; Materials development.	Policymakers, youth out of school, health personnel, parents, media, and community and religious leaders
	Tanzania Midwives Association	PO Box 65004 Dar-Es-Salaam, Tanzania Tel: 255-15-0540 Fax: 255-25-5051	National NGO	Data is collected in labor wards.	Health personnel and mothers
TOGO					
	CACIEJ (Comite d'Action pour la Cooperation Internationale et I' Epanouissement de la Jeunesse)	BP 10118 Hedjranawoe Lome, Togo Tel: 288-26-88-11 Fax: 288-21-65-61 and 22-02-60	International NGO	Research; Training; Advocacy; Peer education; ***IEC supported activities:*** FLE in schools***;*** Campaigns; Community education and discussions; Seminars/workshops for key opinion leaders; Working with the media; Materials development.	Targets all population groups
	CAPH-TOGO (Comite D'Action Pour le Potentiel Humain)	BP 8497 Lome, Togo Tel: 228-22-12-31 Fax: 228-21-58-35	National NGO	Peer education; Alternative income strategies for women; ***IEC supported activities:*** Campaigns; Community education.	Girls in and out of school, parents, and excisors
	Centre Africain De Fecondite Chez Les Adolescentes	BP 780 Lome, Togo Tel: 228-22-59-12 Fax: 228-22-20-38	Youth Organization	Research; Alternative rites of passage; Peer education, ***IEC supported activities: C***ampaigns; Community discussions.	Youth, mothers, excisors, and the media
	Centre de Recherche Pharmacoloquie Appli Ques lur les Plantes Therapent…….Africans (CERPHAPLATA)	BP 8122 Lome, Togo Tel/fax: 228-21-17-70	International NGO	Research; Individual Counselling; Alternative rites of passage; Treatment of FGM complication; ***IEC supported activities:*** Community education and discussions; Seminars/workshops for key opinion leaders; Materials development.	Religious and community leaders
	Division Sante Familiale	BP 7625 Lome, Togo Tel: 228-21-20-14	Government	***IEC supported activities***: FLE in schools; Campaigns; Community education and discussions; Working with the media.	Policymakers, health personnel, parents, religious leaders, and the media
	South PanAfrican International	PO Box 1832 Lome, Togo Tel: 228-22-05-59 Fax: 228-21-57-06 and 22-20-38	International NGO	Research; Training; Advocacy; Peer education; Individual Counselling; Alternative income strategies for excisors and women; Treatment of FGM complications; ***IEC supported activities***: Campaigns; Community education and discussions; Seminars/workshops for religious leaders; Working with the media; Materials development.	Policymakers, youth, parents, excisors, religious and community leaders, and the media

Organizational Profiles

Country	Organization	Address	Type of Organization	Programme Description	Target Population
TOGO (cont'd)					
	Vivre Mieux	BP 274 Kpalime, Togo Tel/fax: 228-41-04-97	National NGO	Advocacy; Individual Counselling; Peer education; Treatment o FGM complications; ***IEC supported activities;*** FLE in schools; Community discussions.	Youth in and out of school and the general public
UGANDA					
	Africa Rise Learning Center Project	Liaison Office, PO Box 10058 Kampala, Uganda Tel: 256-41-25-17-40 Fax: 256-41-34-55-97	NGO	Research; Training; Advocacy Individual Counselling; Peer education; Alternative rites of passage; Alternative income generation strategies for circumsiers; Income generation strategies for women; ***IEC supported activities:*** FLE in schools; Community education and discussions; Seminars/workshops for key opinion leaders; Working with the media; Materials development.	Policymakers, youth, parents, grandmothers, religious and leaders, teachers, and the media
	Elgon Free Generation of Girls	PO Box 596 Mbale, Uganda	National NGO	Research; Training; Advocacy; Individual Counselling; Peer education; Alternative rites of passage; Alternative income generation strategies for circumsiers; Income generation strategies for women; Treatment of FGM complications; ***IEC supported activities***: FLE in schools; Campaigns; Community discussions; Seminars/workshops for key opinion leaders; Working with the media; Materials development.	Youth in and out of school
	PAMO Volunteers	PO Box 9936 Kampala, Uganda	National NGO	Training; Advocacy; Peer education; Income generation strategies for women; ***IEC supported activities***: FLE in schools; Campaigns; Community education and discussions; Seminars for key opinion leaders; Working with the media; Materials development.	Youth in and out of school, parents, grandmothers, and community leaders
	RYDA (Rubaga Youth Development Association)	PO Box 21167 Kampala, Uganda Tel: 256-41-27-05-98 Fax: 256-41-25-06-68- and 34-55-80	National NGO	Training; Advocacy; Peer education; ***IEC supported activities:*** Campaigns; Community education and discussions; Seminars/workshops for key opinion leaders; Working with the media.	Youth out of school, excisors, community leaders, and the general public
USA					
	Equality Now	250 W. 57th St. Suite 826 NY, NY 10019 Tel: 212-586-0906 Fax: 212-586-1611 Email: equalitynow@igc.apc.org	International NGO	Research; Advocacy; ***IEC supported activities***: Campaigns; Community education and discussions; Materials development.	Policymakers, general public, and the media
	Macro International Inc.	11785 Beltsville Drive, Suite 300 Calverton Md. 20705 Tel: 301-572-0200 Fax: 301-572-0999 Email: reports@macroint.com	Private for- Profit	Research ; ***IEC supported activities:*** Materials development.	Policymakers, health personnel, religious leaders, general public, and the media

Organizational Profiles

Country	Organization	Address	Type of Organization	Programme Description	Target Population
USA (cont'd)					
	NOCIRC (National Organization of Excision Information Resource Centers)	PO Box 2512 San Anselmo, CA. 94979-2512 Tel: 415-488-9883 Fax: 415-488-9660 Email: nacirc@nbn.com	International NGO	Advocacy, ***IEC supported activities:*** Working with the media.	Policymakers, youth, health personnel, excisors, public, teachers, and the media
	Patients in Arms	7480 Gravois Dittmer, Missouri 63023 Tel/fax: 314-274-2767 Email: Carmilarms@aol.com	National NGO	Research; Advocacy; Individual counselling; ***IEC supported activities:*** Campaigns; Community education; Seminars/workshops for key opinion leaders; Working with the media; Correspondence with physicians' licensing boards and hospital staff offices; Materials development.	Policymakers, parents, excisors, community leaders, general public, media, and the federal government
	PATH (Program for Appropriate Technology in Health)	1990 M. St. N.W., Suite 700 Washington, DC 20036 Tel: 202-822-0033 Fax: 202-457-1466 Email: info@path-dc.org WWW: http://www.path.org	International NGO	Providing technical assistance to agencies implementing FGM-eradication programs; Research; Training; Advocacy; Peer education; Alternative rites of passage; Income generation strategies for women; ***IEC supported activities***: Campaigns; Community education and discussions; Seminars/workshops for key opinion leaders; Working with the media; Materials development.	Targets all population groups
	Planned Parenthood Federation of America	810 Seventh Avenue NY, NY 10019 Tel: 212-261-4764 Fax: 212-247-6274	National NGO	Peer education.	Youth, health personnel, and parents
	RAINBO♀(Research, Action &Information Network for Bodily Integrity of Women)	915 Broadway, Suite 1109 NY, NY 10010 Tel: 212-477-3318 Fax: 212-477-4154 Email: nt61@Columbia.edu and RAINBO@aol.com	International NGO,	Support research; Training; Advocacy; Individual Counselling; Peer education; Income generation strategies for women; ***IEC supported activities:*** Campaigns; Community education and discussions; Seminars/workshops for key opinion leaders; Working with the media., Material development	Policymakers, girls, health personnel, parents , community leaders, public, teachers, and the media
	*Wallace Global Fund	1990 M Street Suite 250 Washington, DC 20036 Tel: 202-452-1530 Fax: 202-452-0922 Email: www.wgf.org	International NGO	Funding of FGM programmes; Advocacy	

ANNEX 2

SURVEY METHODOLOGY

DESCRIPTION OF THE SURVEY METHODOLOGY

SURVEY OF PROGRAMMES

The survey was designed to obtain an overview of the kinds and capabilities of organizations involved in FGM elimination; their programmatic approaches and strategies; what audiences they were trying to reach; if their programs had been evaluated; and what lessons about successful programming had been learned.

SURVEY METHODOLOGY

To carry out the survey, a roster of 365 FGM-implementing agencies was developed, with input from WHO's headquarters and regional programmes, and suggestions from colleague organizations. The list of organizations was expanded beyond the groups traditionally known to implement anti-FGM programmes (e.g. the National Committees of the Inter-Africa Committee on Harmful Traditional Practices), to include agencies active in the areas of reproductive health/family planning, adolescent health, human rights, and women's issues. The list included organizations in Africa, Europe, Canada, and the United States.

To design the survey instrument, staff reviewed various programmatic documents including project descriptions, activity reports, evaluation reports, and IEC and training materials. The final questionnaire consists of two sections, one with a set of structured questions, the other more open-ended:

1. The structured section of the questionnaire had five sub-sections:

a) Contact information that will be used to update the roster of organizations working on FGM.
b) Organizational profile including type, personnel, sources of funding, annual budget, budget allocated to FGM activities, duration of FGM programme, etc.
c) Programmatic approaches and strategies, reasons for programme development, target audiences, and messages used.
d) Training and IEC materials developed and distribution channels.
e) Programme outcomes, evaluation measures and indicators used (if any).

2. The open-ended section consisted of questions seeking further information on lessons learned, recommendations for successful programming, and pitfalls to avoid when designing and implementing FGM programmes.

FIELD-TESTING

The questionnaire was first reviewed internally and externally by five technical experts working in agencies that implement or fund FGM programmes. It was later field-tested by two Kenyan organizations - Mandeleo Ya Wanawake Organization and Seventh-Day Adventist-Rural Health Services. Relevant comments were incorporated, and the final version was translated into French.

DATA COLLECTION

The questionnaire was mailed to 365 organizations. In order to maximize the response rate, organizations were given a realistic deadline, followed up with reminder postcards and contacted again either by phone or letter. One hundred and two organizations completed the questionnaire, a response rate of 28 percent. Of the 102 respondents, 88 had programmes aimed at the elimination of FGM, while 14 were either in the process of/or intended to initiate programmes in the near future. Only information received from the 88 organizations with an anti- FGM programme was analyzed for this report.

The responding organizations are concentrated in six countries: Ghana, Nigeria, Togo, Kenya, Tanzania, and Mali. Indeed, 16 percent of the organizations are based in Ghana, 11 percent in Nigeria, 10 percent in Togo, and 8 percent each in Mali and Tanzania. Seven organizations are based in the USA, but their work is mainly to provide technical assistance to local or national organizations (see table below). The fact that responding organizations are concentrated in 6 countries may reflect a greater interest on this issue by the non-governmental organizations based in those countries. Although only Ghana has specific legislation against FGM, the other five countries are either in the process of drafting an anti-FGM law or have a presidential decree banning FGM. Either way, the countries where most FGM programmes are being carried out demonstrate support from their governments.

Geographic Distribution of Survey Respondents

Country	Frequency	Percentage
Ghana	14	16%
Nigeria	10	11%
Togo	9	10%
Kenya	7	8%
USA	7	8%
Mali	5	6%
Tanzania	5	6%
Uganda	4	5%
Egypt	3	3%
Senegal	3	3%
Sudan	3	3%
Benin	2	2%
Burkina Faso	2	2%
Ethiopia	2	2%
France	2	2%
Cameroon	1	1%
Cote d'Ivoire	1	1%
Eritrea	1	1%
Gambia	1	1%
Guinea-Bissau	1	1%
Guinea	1	1%
Mauritania	1	1%
Niger	1	1%
Chad	1	1%
United Kingdom	1	1%

LIMITATIONS OF THE SURVEY

The survey has several limitations that could affect the generalizability of the results. First, the response rate may have been affected by the lengthy and time consuming nature of the questionnaire, and problems with the mail system in many parts of the African and Middle Eastern regions, especially in countries where civil wars are raging, such as Somalia and Sierra Leone. Second, the questionnaires were completed voluntarily by FGM-programme implementers who may be inclined to presenting their programmes as successful. Limitations with the questionnaire design could have also influenced how certain questions were answered.

However, considering the overall response rate of 28 percent and the enthusiasm with which the respondents shared their information, it is safe to assume that the results accurately reflect the kinds of efforts being used in the elimination of FGM in Africa. From the African and Middle Eastern region, 78 programmes from 22 countries responded. The other 10 programmes are based in the US, France, and the United Kingdom. The eagerness of the respondents also manifested itself in the numerous proposals for funding that has been received from the responding agencies right after the questionnaires were received.

ANNEX 3

PLANS OF ACTION, ACTIVITIES BY MULTILATERAL AGENCIES IN THEIR EFFORTS TO ELIMINATE FGM

PLAN OF ACTIONS, ACTIVITIES BY MULTILATERAL AGENCIES IN THEIR EFFORTS TO ERADICATE FGM

WHO

- Research for intervention development, monitoring and evaluation.
- Promoting technically sound policies and approaches.
- Incorporating FGM in the broader concerns of women's health.
- Development of training including guidelines for health care workers.
- Develop educational materials to help facilitate training for professionals in countries.
- Clinical management of health complications of FGM.
- Strengthen partnerships with governments, NGO, scientists, reproductive health programme managers and policymakers, human rights advocates and the UN agencies.

UNICEF

- Provide support to community-based organizations (CBOs) engaged in IEC and training activities on FGM.
- Support of FGM activities through integrated programmes in the area of health, education, communication, and improving women's status.
- Particular emphasis is placed on working with youth organizations and women's groups.

UNESCO

- Provide assistance to the States in preparing teaching materials.
- Include the issue of traditional practices in its functional literacy programmes.

UNFPA

- Advocate for the elimination of FGM in all areas of the world in which it occurs.
- Support the review and revision of national policies, laws and regulations, including traditional practices, pertaining to reproductive health which serve to perpetuate the practice.
- Support IEC efforts of national organizations, governmental, non-governmental organizations and private groups against FGM.
- Support socio-cultural research identifying factors underlying the persistence of FGM.
- Support the collection of data concerning the incidence and prevalence of FGM.

USAID-FGM WORKING GROUP

- Conducting of operations research (OR) to develop and test community-based interventions in a number of African countries.
- Taking a multi-sectoral, gender-based approach to FGM, addressing such areas as human rights and reproductive health within a cultural context.
- Developing IEC and national awareness campaigns in coordination with policymakers, task force, non-governmental organizations and academics.
- Training and support of health professionals
- Training for auxiliary health workers
- Mobilizing women's organizations.

AMNESTY INTERNATIONAL

- Urge governments to ratify and implement international human rights treaties and to uphold other international human rights standards that might be of relevance in eliminating the practice of FGM.
- Make particular efforts, where appropriate, to include information on the relationship between the practice of FGM and the enjoyment of HRs in its HRs awareness work
- Cooperate, where appropriate, in performing these tasks with other non-governmental organizations working on the issue.

ANNEX 4

LEGAL STATUS OF FEMALE GENITAL MUTILATION

LEGAL STATUS OF FEMALE GENITAL MUTILATION *

Country	Prevalence	Type of FGM	Law
BENIN	30% - 50%	Excision	No law against FGM. Draft law being presented to National Assembly in near future. However, Government permits distribution of educational information in government-run clinics and undertakes sensitivity activities in the rural areas.
BURKINA FASO	60% - 70%	Excision	Law outlawing FGM passed in October 1996. Penal code articles enacted include: **Article 380:** Whoever attempts or harms the physical integrity of the genital organ of a female, either by total ablation, excision, anesthetization or by other means, will be imprisoned for a period of three to six years, and fined 150,000 to 900,000 francs or be subject to one of these penalties. If death ensues, the penalty will be imprisonment for a period of five to ten years. **Article 381:** Penalties will be applied to the fullest extent of the law if the culprit belongs to the medical or paramedical field. The jurisdiction of judgment may forbid him to practice for a period of no longer than five years. **Article 382:** A person having knowledge of the acts aforementioned in article 380, and failing to advise the proper authorities, will be fined 50,000 to 100,000 franc.
CAMEROON	5% - 20%	Clitorectomy & excision	No law against FGM. Women's group lobbying for legislation against FGM. Government is supportive of, and active in, FGM elimination efforts. State-run television stations and newspapers have programmes and articles about FGM. Ministry of Women and Social Affairs and non-governmental organizations work closely to make concrete and strong efforts to combat the practice.
CENTRAL AFRICAN REPUBLIC	20% - 50%	Clitorectomy & excision	Law against FGM enacted since 1966. Government is active in anti-FGM campaigns to educate the public against FGM, and has taken measures against the practice. Government adopted policy in 1989 to improve position of women and established a programme called " Women- Nutrition-Development for Children," both of which address FGM.

LEGAL STATUS OF FEMALE GENITAL MUTILATION

Country	Prevalence	Type of FGM	Law
CHAD	60%	Excision most common in all parts of the country. Infibulation confined to eastern part of country in area bordering Sudan.	No law against FGM. In 1995 a government-published policy opposing FGM was enacted into law. Policy includes provisions to increase awareness about FGM, protect women against the practice, and initiate punitive measures against those who continue the practice.
COTE D'IVOIRE	60%	Excision	No specific law against FGM. Would probably be illegal under general laws against the person. New law being drafted prohibiting FGM. Some government support but no funds yet. Ministry of the Family and Women's Affairs joined campaign against FGM in 1996.
DEMOCRATIC REPUBLIC OF CONGO (FORMERLY ZAIRE)	5%	Excision	No law prohibits FGM. Anti-FGM efforts unknown.
DJIBOUTI	90% - 98%	Excision & infibulation	Penal Code outlawing FGM enacted in 1994. Law includes prison term and fine. **(need details if possible)**

LEGAL STATUS OF FEMALE GENITAL MUTILATION

Country	Prevalence	Type of FGM	Law
EGYPT	97%	Excision throughout country. Infibulation concentrated in a few tribes in southern part of country.	No specific penal law that prohibits the practice of FGM. However, approval and/or performance of FGM is a violation of Act 240 of an existing Egyptian penal law, which states that "any person who injures another person or beats him/her in a way that leads to cutting or severing, or impairing the function of any body part, or leads to blindness, shall be punished by 3-5 years imprisonment. In cases of previous deliberate intentions, punishment would be hard labor for 3-10 years" Ministerial decree in 1959 prohibited FGM, making it punishable by fine and imprisonment. Changes have been made over the years. A series of later ministerial decrees allowed certain forms of FGM but prohibited others. At some point doctors were also prohibited from performing FGM in government health facilities, and non-medical practitioners were forbidden from practicing FGM completely. In 1994, the then Ministry of Health (MOH) decreed that FGM should be performed one day a week in governmental facilities only by trained medical personnel, and only if they failed to persuade the parents against the practice. However, this decree was later rescinded (1995) after international outcry and protests deploring medicalization of the practice. In 1996, the Ministry of Health and Population issued a decree finally forbidding the practice except for medical indications, and only with the concurrence of a senior obstetrician. The decree (No. 261) states: "It is forbidden to perform excision on females either in hospitals or public or private clinics. The procedure can only be performed in cases of disease and when approved by the head of the obstetrics and gynaecology department at the hospital, and upon the suggestion of the treating physician. Performance of this operation will be considered a violation of the laws governing the medical profession. Nor is this operation to be performed by non-physicians." The passing of the decree prevented medical practitioners from performing FGM in any governmental facilities or private clinics (since they could face administrative punishment). However, it still did not legally prevent the performance of FGM in a home by a non-governmental medical practitioner. This decree was challenged in court by Islamic fundamentalists and medical practitioners who support the practice. As a result, on June 24, 1997 an administrative court overturned the decree, declaring it unconstitutional. This ruling was later appealed and sent to a higher administrative court, and was overturned on December 28, 1997.

LEGAL STATUS OF FEMALE GENITAL MUTILATION

Country	Prevalence	Type of FGM	Law
ETHIOPIA	90%	Clitorectomy & excision. Infibulation in areas bordering Sudan and Somalia. Mariam Girz practised to lesser extent.	No law prohibits FGM. Constitution however, prohibits harmful traditional practices. A 1960 penal code prohibits torture and cutting off any body parts.
ERITREA	95%	Clitorectomy, excision, & infibulation	No law prohibits FGM. In 1996, government policy enunciated to eliminate FGM; to create and enforce legislation prohibiting practices such as FGM; to include in women's health care; prevention of practices such as FGM; and to provide treatment, counselling and rehabilitation for women suffering from complications of FGM. Government includes information on FGM in its health and general education programmes. Ministry of Health carries out government policy on FGM and provides training on topic to primary health care coordinators throughout country.
GAMBIA	60 - 90%. Almost 100% of Fulas & Srahulis practises FGM.	Excision. Infibulation in very small percentage of women and girls. Also special "sealing" performed.	No law prohibits FGM. Government recognizes harmful effects of FGM and supports NGO activities. However concern exists for anti-FGM efforts to be addressed with caution.
GHANA	15% - 30%	Excision	Law prohibiting FGM enacted in 1994. Section 69A of Criminal Code makes it a second degree felony with fine and imprisonment. Article 39 of Constitution abolishes injurious and traditional practices. History of enforcement of this criminal law. Two practitioners convicted of second degree felony. Government supports FGM publicly at all levels.
GUINEA	70% - 90%	Clitorectomy, excision & infibulation	Article 265 of Penal Code prohibits FGM. Article 6 of Constitution prohibits cruel and inhumane treatment. Supreme court preparing clause for Constitution prohibiting FGM. Government initiated a 20 year (1996-2015) collaboration with WHO to work towards elimination of the practice. Government works with non-governmental organizations to eradicate FGM through films, TV, seminars etc.

LEGAL STATUS OF FEMALE GENITAL MUTILATION

Country	Prevalence	Type of FGM	Law
GUINEA-BISSAU	50% average; 70% - 80% in Fula & Mandinka areas; 20% - 30% in urban Bissau.	Clitorectomy & excision	No law prohibits FGM. In 1995 a law proposed to outlaw FGM was defeated. Assembly did, however, approve proposal to hold practitioners criminally responsible if woman dies as a result of FGM. Government, with assistance of donors and Ministries of Health and Social Affairs and Women, implemented a nationwide educational programme in January 1997. Government also works closely with non-governmental organizations on outreach programmes.
KENYA	50% average. Prevalence varies from almost zero in heavily populated western areas to 90% of women in Somali ethnic group in Northeast.	Clitorectomy & excision. Some infibulation in far eastern areas bordering Somalia.	No law prohibits FGM. In 1982 and 1989 presidential decrees issued banning FGM but never formally enforced. Parliament vote defeated a motion to outlaw FGM on basis that each tribe "has a right to choose what to do with its girls." Government does, however, forbid government hospitals and medical clinics from practicing FGM.
LIBERIA	50% of females over 18 pre-civil war 1989 estimate during civil war (1990 - 1996).	Excision	No law prohibits FGM. Liberian National Committee conducted research, trained volunteers and provided health training about harmful effects FGM. Also collaborated with Government to create and build awareness about FGM in MCH and primary health care programmes.
MALI	94% - 96% average. In south over 95%. For example: Bamako: 95.3%; Koulikero: 99.3%. Very low percentage in north. For example: Tombouctou and Gao: 9.3%	Clitorectomy, excision, & infibulation. (southern part of country)	No specific law prohibiting FGM, but Penal Code outlaws assault and grievous bodily harm. Article 166 prohibits voluntarily cutting or injuring a person as well as committing any violence on a person. Article 171 states that any person who administers willingly any procedure or substance to an individual (without his consent) and causes an illness or disability is punishable by six months to 3 years. Law being drafted to outlaw FGM. Government established National Action Committee in 1996 to promote elimination of harmful traditional practices, including FGM. Government regional offices support NGO activities.

LEGAL STATUS OF FEMALE GENITAL MUTILATION

Country	Prevalence	Type of FGM	Law
MAURITANIA	25% average. Among minority Soninkes and Halpulaar: 95.5%	Clitorectomy (common among the Soninkes) and excision (common among Toucouleurs). Also symbolic excision using gum arabic plant - based product mixture to shrink the clitoris.	No law prohibits FGM. Practice not allowed in government hospitals. Secretary of State of Women's Affairs formed committee to eradicate FGM in June 1997.
SIERRA LEONE	80% - 90%	Excision	No law prohibits FGM. No government support to eradicate practice.
SOMALIA	98%	Infibulation	No law against FGM. Former Barre Government appointed committee to eradicate FGM. Extensive work carried by former government's Ministry of Education. Institute for Women's Education, (IWE) established in 1984, engaged in activities to eradicate FGM in general health programme. All activities etc. destroyed with overthrow of government.
TANZANIA	10%	Excision & infibulation	No law prohibits FGM. Government involved in efforts to eradicate practice.
TOGO	12% average. Ethnic groups vary. Cotocoli, Tchamba, Mossi, Yanga and Peul: 85 - 98%; Moba: 22%; Gurma: 12%	Excision	No law prohibits FGM. Togosese League for Women's rights is drafting law to prohibit FGM. Recent anti-FGM documentary shown on national television, which is government controlled.
UGANDA	5% average. Number of girls undergoing FGM in recent years are: 1990: 971; 1992: 903; 1994: 854; 1996: 544.	Clitorectomy & excision	No law yet that prohibits FGM. The new Constitution in Uganda gives freedom to good cultures to be practiced. However, the Government publicly condemns FGM and says it would protect any women bringing a claim to its attention. In 1980, Kapchorwa District Council passed a resolution which allowed girls' excisions to be optional in the District. In 1995, the District Council transformed this resolution into a by-law.

*** Source: Office of Asylum Affairs, Bureau of Democracy, Human Rights and Labor, U.S. Department of State, 1997, and reports collected during country assessments.**

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