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PROGRAM GUIDELINES FOR INTEGRATING ACTIVITIES TO ERADICATE FEMALE GENITAL MUTILATION INTO USAID PROGRAMS

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A revised version of a document prepared by:

Research, Action, and Information Network
for Bodily Integrity of Women (RAINB♀)
915 Broadway, Suite 1109
New York, NY 10010
Phone: 212-477-3318
Fax: 212-477-4154

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The observations, conclusions, and recommendations set forth in this document are those of the authors alone and do not represent the views or opinions of POPTECH, BHM International, The Futures Group International, or the staffs of these organizations.

PREFACE

The United States Agency for International Development (USAID) has been placing increased emphasis on issues of reproductive health and individual human rights, and within that context is moving to increase its efforts in support of the eradication of female genital mutilation (FGM). To this end, USAID is proceeding to develop a strategy for addressing FGM and for integrating its activities in this area into existing USAID programs to the extent possible. USAID contracted with the Population Technical Assistance Project (POPTECH) to develop such a strategy. In turn, POPTECH subcontracted with Dr. Nahid Toubia, an expert in the field, and the Research, Action and Information Network for Bodily Integrity of Women (RAINB♀), a specialized technical agency, to prepare this report, which reviews past USAID activities addressing FGM and presents recommendations for future efforts.

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EXECUTIVE SUMMARY

Introduction

Female genital mutilation (FGM),[1] also known as female circumcision, refers to a range of practices that involve cutting and removing the female genitals. The rationale behind the practice varies across communities, and includes control of women's sexuality, initiation into adulthood and community membership, and health and hygienic beliefs. Globally, an estimated 130 million girls and women have been affected by FGM.

In recent years, increased attention has been focused on the practice because of both its serious health consequences and its clear violation of women's human rights. The United States Agency for International Development (USAID) has shown an interest in supporting activities to prevent and eradicate FGM since the 1970s. Until recently, however, USAID's response to the practice has been primarily reactive. The agency has often been caught between domestic concerns expressed by individual citizens—either directly to USAID or through pressure on the Congress to support FGM eradication—and the views expressed by some African governments and individuals that foreign aid agencies should not involve themselves with this issue, which they saw as a matter of local culture. In general, then, the 1970s and 1980s were marked by a localized approach to FGM eradication, and thus by the lack of an integrated effort to address the issue.

In the 1990s, however, international policies toward women's health and rights have broadened. FGM has moved into the realm of widely accepted women's health and gender equity concerns, and many African governments, nongovernmental organizations (NGOs), and professionals have begun welcoming partnerships to address the issue. At the same time, USAID has broadened its mandate to include reproductive health and individual human rights and moved toward increasing its capacity to deal with FGM.

Within this context, USAID has recognized the need for strategic thinking in the design of policies and programs to address FGM. To help meet this need, USAID funded the preparation of this report, whose purpose is to conduct a systematic review of USAID activities addressing FGM, and to develop a policy direction and program guidelines for future USAID efforts to deal with the issue.

A two-part approach was used to gather the information on which this report is based. The first part focused on collecting information through meetings with USAID/W staff and a review of relevant USAID documents (1970s to the present). The second part of the study approach focused on collecting information from the field and elsewhere beyond USAID/W

[1]In this document, the term "FGM" is used throughout for consistency, since it is the official term used by the United Nations and adopted by USAID. This use does not reflect the position of RAINB♀ regarding the debate on terminology, which is clearly stated in the organization's published literature.

through a USAID Mission questionnaire, an NGO questionnaire, review of documents, and attendance at conferences and meetings. Finally, findings from the above efforts were synthesized and analyzed.

The recommendations for future action presented in this report are based on the results of this analysis, consultation with USAID/W staff, and the authors' knowledge and expertise in the field of FGM. The report offers recommendations in three areas: development of a USAID policy on FGM, specific future activities to address FGM, and the integration of FGM into existing USAID projects.

Development of a USAID Policy on FGM

Because of the size of USAID and the number of individuals who could potentially be involved in one way or another with FGM policy and programs, it is vitally important that the agency's approach toward FGM be unified and published as a policy statement. Such a statement should include two essential components. First, it should explain reasons why USAID opposes the practice of FGM. These would include a commitment to women's reproductive health and the improved physical and psychological health and well-being of children, both of which are jeopardized by FGM. Second, it should emphasize USAID's commitment to promoting gender equity and advancing the cause of democracies, in which women are important partners; FGM is a clear hindrance to these goals.

In addition, the policy statement should include the reasons why USAID is committed to supporting actions against the practice. The agency's mandate on FGM comes first and foremost from the expressed need of national governments, women's NGOs, and other African institutions that request the support of international donors in their efforts to deal with the issue. Another driving force is the unequivocal consensus reached in recent world conferences on the unacceptability of violence against women in general and FGM in particular, and the need for international action against this violence. This consensus included all the governments of countries where FGM is practiced, as well as the U.S. Government.

The policy statement could also include references to three important documents that state goals and objectives of USAID: *USAID's Approach to Female Genital Mutilation*, *USAID's Strategies for Sustainable Development*, and the *Strategic Plan for Population, Health and Nutrition*.

Recommended USAID Activities to Address FGM

The implementation of any recommended FGM activities will depend on the continued availability of funds for FGM eradication activities and the level of that funding. Given these unknown variables in a constantly changing political environment, it is not possible to develop a plan of action with specific activities and a fixed budget. Instead, we considered it

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more useful to develop generic guidelines and activities that could be adapted to different funding levels and mechanisms. To facilitate cross-referencing, both the guidelines and the recommended activities are numbered sequentially, the former with the prefix 'G' and the latter with the prefix 'R.'

The following guidelines for future USAID activities to address FGM were developed to meet expressed needs and overcome past shortcomings identified in conducting this study:

- **G1. Linkages between USAID efforts and those of other donor and technical agencies** on FGM eradication are important to avoid repetition, unproductive competitiveness, and waste of scarce resources.

- **G2.** There is a need to develop a cohesive **USAID program plan for anti-FGM action** and avoid sporadic support of projects.

- **G3.** For an effective program plan, **improved mechanisms for communication and coordination** among divisions and bureaus within USAID/Washington (USAID/W) and between the agency's headquarters and the Missions and Regional Offices are essential.

- **G4. Continuity and long-term sustainability** are major concerns for those responsible for fiscal allocation of the expanding mandate and shrinking budget of USAID.

- **G5. Evaluation of the cost-effectiveness** of a project and the proportion of the funding it demands from the total funds available for FGM must be a criterion for project selection.

- **G6. Using the agency's existing strength and expertise** is another way to ensure sound investment, rather than becoming involved in new and inadequately tested program areas.

- **G7. To advance specialized knowledge on FGM**, it is important that USAID support a few well-selected projects focused solely on FGM, with the explicit intention of developing research and intervention techniques custom designed for specific USAID programs.

- **G8.** It is important that USAID maintain **a consistent and complementary approach combining health and human rights** in its support for efforts to eradicate FGM.

Based on the above guidelines, the following specific USAID FGM activities are recommended:

Intra-agency Capacity Building

- **R1. FGM liaison office.** The establishment of a staff position and a liaison office for FGM eradication activities in Washington is a priority recommendation.

- **R2. In-house advocacy.** Staff at different levels in Washington, the Regional Offices, and the Missions should be made aware of the agency's policies and plans regarding FGM support.

- **R3. Staff training.** Once staff have become familiar with the agency's overall policy, it will be important to provide them with adequate information to strengthen their capacity to deal with the issue.

- **R4. Documentation.** There is a need for thorough project documentation, including project reports and evaluation, as well as copies of research tools and information, education, and communication (IEC) and training materials; a centralized repository for these materials is also needed.

- **R5. Information sharing.** Both the Missions and NGOs involved with efforts to eradicate FGM need more information. Information exchange and dissemination would be the most important task of an FGM liaison office (see R1).

In-Country Support

- **R6. Influencing policy.** The most constructive way to influence policy may be through positive encouragement and the addition of extra funds earmarked for FGM activities to negotiated health or population assistance budgets.

- **R7. Financial support.** Such support could be provided through several mechanisms, such as centrally allocated funds targeted to FGM activities in USAID's annual budget; incremental funding within existing programs and bilateral assistance agreements to add FGM components; and use of existing flexible and discretionary funds in Washington, the Regional Offices, and the Missions to support FGM projects.

- **R8. Technical assistance.** This support can be provided by culturally sensitive and capable professionals from within the country or from neighboring countries, or by international consultants.

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Program Development

- **R9. Research.** There is a particular need for both operations research and evaluation research to examine the effectiveness of various FGM eradication efforts.

- **R10. Interventions.** FGM interventions appropriate to USAID's size, existing funding mechanisms, and programs fall into three broad areas: population and health programs; democracy, gender equity, and human rights; and coordination of health and human rights project support.

Monitoring and Evaluation

- **R11. Long-term monitoring.** Each individual FGM project may not directly result in reduced incidence of FGM, but the cumulative effects of information, counseling, legal reform, and women's increased awareness of their rights will ultimately reach a critical point where behavioral change will occur. It would be realistic to use 10-year intervals as long-term monitoring points for detecting a decline in incidence rates.

- **R12. Periodic program assessment.** For USAID, a five-year program plan is a reasonable time frame for defining a set of activities to be developed and supported. At the four-year mark, a review and evaluation of the FGM program would examine the project-specific outcomes and evaluate the cost-effectiveness of different funding mechanisms in light of those outcomes.

- **R13. Project evaluation.** There is a need to develop project-specific evaluation components, including evaluation of deliverables by quality of content as well as quantity, and to develop meaningful outcome indicators.

Integration of FGM into Existing USAID Programs

The following are examples of USAID projects and mechanisms into which an FGM component could be integrated:

- The PRIME Project (Primary Providers' Education and Training in Reproductive Health)
- The Policy Project
- The FOCUS Program
- The MotherCare Project
- Population Communications Services (PCS)
- PROWID
- Basic Support for Institutionalizing Child Survival (BASICS) and Program for Appropriate Technology in Health (PATH)

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- Other Cooperating Agencies and subcontractors
- Regional Bureaus, offices, and initiatives
- Health and Human Resource Analysis for Africa (HHRAA) Project and the Support for Analysis and Research in Africa (SARA) Project (managed under HHRAA)
- West Africa Family Health and AIDS Project
- Greater Horn of Africa Initiative

Conclusion

The challenges USAID faces in strategically and effectively addressing FGM are not unique. As a Western government donor agency, USAID faces the double obstacles of bureaucratic mechanisms and strong links to U.S. foreign policy. However, the agency also brings to the challenge its many excellent resources, multisectoral technical skills, and a commitment to improving the health and status of women and their communities. The present study is a testimony to USAID's serious commitment to supporting FGM eradication activities by learning from the past and planning effectively for the future.

This report documents the past while also pointing to ways of improving FGM support in the future. It does not attempt to devise a new plan of action, but concentrates on improving on what is already being done with existing mechanisms, through incremental additions. A thoughtful, well-articulated policy, a program plan, better documentation, better information dissemination, and better evaluation can all lead to a strengthening of existing USAID mechanisms and a more effective approach in the effort to eradicate the practice of FGM. In particular, the establishment of an FGM liaison office is a central recommendation without which it may not be possible to improve FGM eradication support in the future.

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ABBREVIATIONS

CA	Cooperating Agency
DHS	Demographic and Health Surveys
FGM	female genital mutilation
FY	fiscal year
ICPD	International Conference for Population and Development
IEC	information, education, and communication
NGO	nongovernmental organization
OR	operations research
REDSO	USAID Regional Office
SARA	Support for Analysis and Research in Africa Project
SDA	Seventh Day Adventist
TA	technical assistance
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
USAID/W	United States Agency for International Development/Washington
WHO	World Health Organization

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1. INTRODUCTION

1.1 Background and Purpose

Female genital mutilation (FGM),[2] also known as female circumcision, refers to a range of practices that involve cutting and removing the female genitals. These practices include clitoridectomy, in which part or all of the clitoris is removed; excision, in which both the clitoris and the labia minora are amputated; and infibulation, in which the clitoris and some or all of the labia minora are removed, and the labia majora are then incised and secured with thorns or stitches until they heal, covering the urethra and most of the vagina.[3] The rationale behind the practice varies across communities, and includes control of women's sexuality, initiation into adulthood and community membership, and health and hygienic beliefs. Globally, an estimated 130 million girls and women have been affected by FGM. The practice has been identified in 28 African countries, with prevalence ranging from 5 to 96 percent. It has also been identified among some minorities in Asia and among African immigrant communities in Europe, North America, and Australia.

In addition to its serious health consequences, FGM clearly violates women's human rights. Women's rights and health are protected under major human rights treaties, such as the International Bill of Human Rights and the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment. In 1990, the Committee on the Elimination of All Forms of Discrimination Against Women adopted a General Recommendation against Female Circumcision.

Harmful traditional practices are also recognized in the African Charter on the Rights and Welfare of the Child, as well as the Convention on the Rights of the Child. The Forty-Sixth World Health Assembly adopted a resolution—sponsored by a group of African countries—that highlighted the importance of eliminating such practices, including FGM. Other international conferences, such as the International Conference on Population and Development in Cairo (1994) and the Fourth World Conference on Women in Beijing (1995), have also condemned FGM.

Since the 1970s, the United States Agency for International Development (USAID) has shown an interest in supporting activities to prevent and eradicate FGM. This interest has been demonstrated over the last three decades through policy statements, official correspondence, programmatic support, and internal capacity-building efforts. The activities

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[2]In this document, the term "FGM" is used throughout for consistency, since it is the official term used by the United Nations and adopted by USAID. This use does not reflect the position of RAINB♀ regarding the debate on terminology, which is clearly stated in the organization's published literature.

[3]World Health Organization report. Appendix A includes the full text of the World Health Organization *Definition and Classification of Female Genital Mutilation*.

supported by the agency have varied in their scope, nature, and continuity, depending largely on the domestic and international environment with regard to women's health at the time and on specific events occurring within and outside the agency. Often, the agency has reacted to external pressure to address (or not address) FGM, rather than taking a policy stance toward the practice. In general, the agency has until recently given little attention to broader women's health issues beyond family planning and made little investment in major women's health concerns, such as maternal mortality. In the 1990s, the cumulative efforts of individual staff members across the agency to promote women's health issues and gender perspectives, coupled with a broadening of the agency's mandate to include reproductive health and women's empowerment, resulted in a renewed interest in addressing FGM within USAID-supported programs. However, the imposition of budget reductions around the same time as this expanded mandate has constrained the possibilities for developing new program areas. This is particularly true with regard to FGM, a subject that is considered difficult to handle and politically sensitive, and is perhaps viewed as marginal to the agency's primary objectives.

Within this context, USAID has recognized the need for strategic thinking in the design of policies and programs to address FGM. To help meet this need, USAID funded the preparation of this report, whose purpose is to conduct a systematic review of USAID activities addressing FGM, and to develop a policy direction and program guidelines for future USAID efforts in this area.

1.2 Scope

This report documents the history of USAID's activities on FGM, highlights lessons learned, and makes recommendations for future approaches that fit within existing agency structures. This report is not meant to evaluate USAID's policies, programs, or mechanisms in general. Moreover, given the overwhelming prevalence of FGM in Africa as compared with other regions, it was decided to limit the scope of the report to African countries.

1.3 Approach

A two-part approach was used to gather the information on which this report is based. The first part focused on collecting information from USAID/Washington (USAID/W) and reviewing relevant USAID documents:

- **Meetings with USAID/W staff.** Meetings were held with staff from the Office of Population and the Office of Health and Nutrition (both part of the Center for Population, Health and Nutrition); the Office of Women in Development; and the Bureau for Africa. Interviews were not possible with staff from the Bureau of Asia and the Near East or from the Center for Democracy and Governance because of time limitations, but the programs of these divisions were considered in the overall

strategic review. Interviews included questions about where FGM may fit into existing programs; the relative advantages (resources, mechanisms, expertise, and networks) of each office for effectively addressing FGM; general USAID mechanisms and operations; and ideas for how to address the issue in the future. Reviewers also attended meetings of the Intra-agency Working Group on FGM, which is facilitated by the Office of Women in Development and comprises representatives from the offices mentioned above. Appendix E provides a listing of the meetings held.

- **Review of USAID documents (1970s to the present).** Documents reviewed include program reports and summaries; internal memoranda; official cables; and correspondence on FGM between USAID/W and cooperating agencies, private citizens, and Mission and congressional staff. Appendix F provides a listing of the specific documents reviewed.

The second part of the study approach focused on collecting information from the field and elsewhere beyond USAID/W:

- **USAID Mission questionnaire.** A questionnaire was submitted to 16 Missions and Regional Offices (REDSOs) covering all African countries where FGM is reported, though not all Missions or REDSOs responded to this questionnaire. It included questions on national prevalence of FGM, governmental and nongovernmental policies, opportunities and obstacles to action, extent of Mission involvement in FGM activities, USAID-specific mechanisms and obstacles to action, and strengths and needs of USAID/W and the Missions with regard to FGM. Questionnaires were self-administered. Follow-up interviews to clarify information were conducted by telephone, fax, and e-mail. Appendix C includes a copy of this questionnaire.

- **NGO questionnaire.** A second questionnaire was sent to 31 local nongovernmental organizations (NGOs) and/or individuals in the same African countries in which the Mission questionnaire was administered. Individuals were chosen based on their expertise in FGM and their experience with donors such as USAID. Questions addressed the national situation regarding FGM prevalence; governmental and nongovernmental policies; opportunities and obstacles to action; the role of donors, in particular USAID; and the role and recommendations of local NGOs. Questionnaires (in English and French) were self-administered. Follow-up interviews to clarify information were conducted by telephone, fax, and e-mail. Appendix C includes a copy of this questionnaire.

- **Review of documents and attendance at conferences and meetings.** These efforts were undertaken to assess the involvement of other international donors in FGM activities.

Finally, findings from the above efforts were synthesized and analyzed. The recommendations for future action presented in this report are based on the results of this

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analysis, consultation with USAID/W staff, and the authors' knowledge and expertise in the field of FGM. It should be noted that USAID activities on FGM were not always part of a clearly articulated action plan and were not implemented by just one division or program. As a result, it was often difficult to find adequate documentation of events, policies, and projects. To fill in the gaps, this report also incorporates staff recollections and views of events. However, because of high turnover in USAID staff, few long-serving representatives could be found who remembered early events. In addition, it was necessary at times to rely on the input of those staff members who were available and able to support our efforts within the time constraints of the project, while in some cases, relevant individuals may have been missed.

1.4 Organization of This Report

Section 2 summarizes past USAID activities to address FGM. Sections 3 through 5 present recommendations for USAID's strategic direction and future activities to support the eradication of FGM: Section 3 addresses the development of a USAID policy on FGM, Section 4 describes specific recommended activities, and Section 5 examines how FGM can be integrated into existing USAID projects. Section 6 presents a brief conclusion. In addition, six appendices are provided: Appendix A is a chronology of events worldwide related to FGM; Appendix B is a detailed review of USAID activities addressing FGM; Appendix C presents the views and activities on FGM of the USAID Missions and local African NGOs, as gathered using the questionnaires described in Section 1.3; Appendix D summarizes international donor support for FGM eradication activities; and Appendices E and F list the meetings held and the documents reviewed, respectively, in gathering the information on which this report is based.

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2. SUMMARY OF PAST USAID ACTIVITIES TO ADDRESS FGM

Over the years, developments in the domestic arena and, later, the international attention to FGM have strongly influenced USAID's response to the practice, which until recently has been primarily reactive. USAID has often been caught between domestic concerns expressed by individual citizens—either directly to USAID or through pressure on the Congress to support FGM eradication—and the views expressed by some African governments and individuals that foreign aid agencies should not involve themselves with this issue, which they saw as a matter of local culture. These two opposing forces have caused USAID's interest in supporting FGM eradication activities to fluctuate.

In the early 1970s, in response to domestic pressure, USAID acknowledged the need to address FGM. During the rest of the 1970s and early 1980s, USAID continued to receive large numbers of inquiries regarding FGM from U.S. citizens and members of Congress. These ranged from questions about the extent of USAID's work on FGM to accusations that, by virtue of its inaction, USAID was actually supporting the practice. On the other hand, political sensitivity around the role of Western donor agencies toward cultural practices mitigated against any concrete action addressing FGM. In responding to direct inquiries, however, USAID clarified that it neither condoned nor supported the practice, and that in fact divisions within USAID had begun to support some eradication efforts. By the late 1970s, USAID was taking specific actions regarding women's issues and had moved further on FGM by explicitly stating, in its health policy documents, that the practice has a negative impact on the health status of young children and women of reproductive age.

Throughout the 1980s, USAID consistently maintained that the agency's support of FGM eradication was conducted only at the invitation of individual countries, and that its influence in the matter therefore had to be limited and in line with host country policies. Steps taken to address the issue were based on two principles: (1) local action against FGM could be strengthened and increased by educating USAID staff and government officials in developing countries on the harmful effects of the practice, and (2) USAID should ally itself with other international donors, technical agencies, and local organizations to minimize sensitivity around the issue of FGM, to strengthen the overall impact of donors, and to ensure that efforts would not be seen solely as a U.S. initiative. Three suggestions were made for concrete activities: (1) inform USAID staff and others about FGM, (2) attempt to limit the practice by developing special programs as part of USAID's approach to primary health care, and (3) design training programs to engage professionals in developing countries in efforts to eliminate FGM.

In general, then, the 1970s and 1980s were marked by a localized approach to FGM eradication, and thus by the lack of an integrated effort to address the issue. Opportunities to integrate FGM activities into USAID-supported programs were generally missed. USAID capacity-building activities in FGM were ad hoc, poorly documented, and overlapping. Examples are a series of outreach cables to Missions by USAID to encourage them to address FGM and suggest funding of research on its prevalence and impact (see Appendix B),

development of training materials for health providers, establishment of links with other bilateral donors, and creation of an agency-wide task force. There is little documentation of the results of the supported projects and no evaluation of their outcome. There is a clear absence of cumulative experience that could move USAID forward on this issue.

In the 1990s, international policies toward women's health and rights have broadened. A series of world conferences has focused attention on issues of reproductive health, human rights, and gender equity, and the potential role of international donors in addressing these issues has become clearer. FGM has moved into the realm of widely accepted women's health and gender equity concerns, and many African governments, NGOs, and professionals have begun welcoming partnerships to address the issue. At the same time, USAID has broadened its mandate to include reproductive health and individual human rights and moved toward increasing its capacity to deal with FGM.

The momentum to support more programs and build capacity to deal with FGM within the agency has continued to grow throughout the 1990s, partly in response to U.S. media pressure (e.g., ABC's *Day One* program of September 1993), and the leadership of USAID has become more explicitly committed to action on FGM. In 1993, Richard McCall, USAID Chief of Staff, in testimony to the House Committee on Foreign Affairs, Subcommittee on International Security, International Organizations and Human Rights, stated that FGM was a serious violation of human rights that could not be further neglected. He instructed technical staff in various USAID offices to increase FGM activities within their own programs. In December 1993, the Intra-agency Working Group on FGM was established and became the leading force driving interest in FGM within the agency. More recently, in March 1996, USAID administrator J. Brian Atwood affirmed the agency's commitment to addressing gender issues by launching the Gender Action Plan, a strategic document ensuring that gender is integrated into all agency policies and programs.

Parallel to events directly related to FGM were other developments within USAID that strengthened the concern for women's health and gender issues. In 1992, the (then) Bureau for Research and Development, which included the Office of Population as one of its units, created a Gender Working Group "to institutionalize gender considerations within all its programs." Some of the staff members involved in this group were also members of the Intra-agency Working Group on FGM and thus able to introduce the issue into the Gender Working Group's program plans and objectives. Another reinforcing development was the creation in 1993 of the Intra-agency Reproductive Health Task Force, which serves as a forum for reproductive health information exchange and offers technical guidance to the Center for Population, Health and Nutrition and its partners. FGM was introduced in the task force's reproductive health policy documents and program plans as relevant for USAID-supported interventions, including family planning services and operations research.

In fiscal year (FY) 1995, as a result of lobbying by Congresswoman Patricia Schroeder and others, USAID was asked by Congress to use $1 million to "develop and integrate, where appropriate, educational programs to eradicate FGM into its population, health, education,

and women in development activities." This guidance strengthened the extent to which the agency could respond to FGM, and mobilized various offices within USAID/W to develop ideas and strategies to this end. In May of 1995, the agency's divisions collaborated on an FGM statement, which included the health consequences of FGM, USAID's approach to FGM, strategic objectives regarding FGM, and USAID actions to date. In 1995, the Program and Policy Coordination Bureau issued "Guidelines for Strategic Plans"; Technical Annex A on population, health, and nutrition makes specific mention of FGM.

In general, projects supported in the 1990s have been better documented than earlier efforts, seem more detailed in their design, and involve more technical assistance. Experiments to integrate FGM into existing USAID programs, such as the Demographic and Health Surveys (DHS) and the MotherCare and Africa Operations Research/Technical Assistance (OR/TA) projects, have already started. It will be important to document carefully the outcome of those integration efforts. Finally, while funding for FGM activities—sporadic and incremental in the 1980s—has increased substantially in the 1990s, there has been no overall program plan and little or no coordination to ensure that supported activities would complement and strengthen each other. Moreover, there is no mechanism to guarantee funding for such activities in the future.

Appendix B provides a detailed review of past USAID activities addressing FGM.

3. DEVELOPMENT OF A USAID POLICY ON FGM

As discussed in Section 2, USAID's activities to address FGM have been constrained by the need for sensitivity to the perception of interference in local cultural beliefs and practices. Although such sensitivity continues to be necessary, there is now less reason to be hesitant about openly committing to support for FGM eradication programs, given the international consensus reached in the World Conference on Human Rights (Vienna, 1993), the International Conference for Population and Development (Cairo, 1994), and the World Conference on Women (Beijing, 1995). In the declarations of these conferences, governments and NGOs from countries where FGM is practiced agreed with the rest of the world that FGM is a violation of girls' rights and that all efforts should be made to stop the practice. Still, activities by governments that go beyond the signing of international declarations and accords are needed.

Because of the size of USAID and the number of individuals who could potentially be involved in one way or another with FGM policy and programs, it is vitally important that the agency's approach toward FGM be unified and published as a policy statement. Such a statement would explain the basis on which USAID supports FGM eradication and the reasons behind that support. This statement would be useful for agency staff, serving as an important reference to guide them in dealing with the issue at both international and local levels. And for national governments, NGOs, and individuals, it would articulate an unambiguous mandate and the agency's well-reasoned position on the practice.

Such a statement should include two essential components. First, it should explain the reasons why USAID opposes the practice of FGM. These would include a commitment to women's reproductive health and the improved physical and psychological health and well-being of children, both of which are jeopardized by FGM. Second, it should emphasize USAID's commitment to promoting gender equity and advancing the cause of democracies, in which women are important partners. FGM is a clear hindrance to these goals. The application of international human rights standards and the viewing of FGM as a violation of those rights might also be cited, but this line of reasoning runs the risk of being challenged since the U.S. Government has not as yet ratified the Convention on Eradication of All Forms of Discrimination Against Women and the Convention on the Rights of the Child.

In addition, the policy statement should include the reasons why USAID is committed to supporting actions against the practice. The agency's mandate on FGM comes first and foremost from the expressed need of national governments, women's NGOs, and other African institutions that request the support of international donors in their efforts to deal with the issue. Another driving force is the unequivocal consensus reached in the recent world conferences on the unacceptability of violence against women in general and FGM in particular, and the need for international action against this violence. This consensus included all the governments of countries where FGM is practiced, as well as the U.S. Government.

The policy statement could also include references to three important documents that state goals and objectives of USAID. The first is USAID's FGM statement, *USAID's Approach to Female Genital Mutilation* (May 1995). This document could form the primary basis for a formal policy statement. The second is *USAID's Strategies for Sustainable Development* (January 1994). Under "Operational Approaches," the second objective is "improving individual health, with special attention to the reproductive health needs of women and adolescents and the general health needs of infants and children" (p. 2). This objective could be interpreted to include FGM. The third document is the *Strategic Plan for Population, Health and Nutrition* (December 1995). Two strategic objectives in this document may apply to FGM. The first is SO 2, which includes "approaches and technologies to enhance key reproductive health interventions identified, developed, evaluated and disseminated." The other, SO 3, includes "improved policies and increased global, national and local resources for appropriate child health interventions" and "enhanced knowledge of key child health/nutrition behavior/practices in selected countries." It is also important to mention in the FGM policy statement the rising concern and demand for action by the American public and members of Congress. Public opinion demonstrates growing domestic support in the United States for financial investment in the issue, using American tax dollars.

Finally, in addition to a specific FGM policy statement, it would be useful to mention eradication of FGM in future updates of USAID strategic plans.

4. RECOMMENDED USAID ACTIVITIES TO ADDRESS FGM

This section presents recommendations for future USAID activities to address FGM, based on analysis of the agency's programs and mechanisms, as well as a general study and understanding of the field of FGM. The implementation of these recommendations will depend on the continued availability of funds for FGM eradication activities and the level of that funding. Given these unknown variables in a constantly changing political environment, it is not possible to develop a plan of action with specific activities and a fixed budget. Instead, we considered it more useful to develop generic program priorities and guidelines that could be adapted to different funding levels and mechanisms. This section first presents a set of guidelines on which the recommendations are based, and then describes the recommended activities. To facilitate cross-referencing, both the guidelines and the recommended activities are numbered sequentially, the former with the prefix 'G' and the latter with the prefix 'R.'

4.1 Guidelines for Future Activities

The following guidelines for future USAID activities to address FGM were developed to meet expressed needs and overcome past shortcomings identified in conducting this study.

G1. Linkages between USAID efforts and those of other donor and technical agencies on FGM eradication are important to avoid repetition, unproductive competitiveness, and waste of scarce resources. The establishment of a centralized information and coordination mechanism would facilitate such linkages (see recommendation R1). Exchange of publications and project reports and mutual attendance at agency forums should result in sufficient knowledge of the latest developments in the field (see recommendation R5).

G2. There is a need to develop a cohesive **USAID program plan for anti-FGM action** and avoid sporadic support of projects. Review of past USAID activities related to FGM revealed an ad hoc and sporadic pattern of financial support for FGM projects in the 1980s (see Section 2). This is understandable given the silence surrounding the issue at the time and the availability of only a few national groups or institutions capable of developing projects to address it. The pattern was that of an "opportunistic funding" or "take what you can get" approach, without the possibility for advanced planning or selection.

In the 1990s, opportunities for thoughtful planning became possible as more NGOs and research institutions became interested in developing FGM projects. Given recent developments, this trend is expected to increase at a more rapid pace in the future. It is now possible for USAID to fund projects within a well-developed program plan that would cover strategic areas of activity within the overall FGM research effort, as well as intervention activities supported by other donors and international agencies. Such a program plan (see Figure 1) would identify priority areas and specify criteria for selecting appropriate projects for funding. A time frame for implementing the program plan, with expected results at each

Figure 1.

Example of an FGM Program Plan

Duration:	Five years
Activities:	<u>Intra-agency capacity building—USAID/W</u>
	Establish liaison office in USAID/W.
	Develop a policy statement and program plan.
	Undertake staff training.
	Establish electronic information source.
	<u>Research</u>
	Establish FGM prevalence and epidemiology in as many countries as possible using the DHS.
	Support secondary analysis of DHS results, in particular data on girl mortality and maternal morbidity.
	Research means of integrating FGM into reproductive health, family planning, and child survival services.
	Support research to influence public policy, human rights awareness, and legal reform.
	<u>Interventions</u>
	Develop and test specialized FGM interventions for use by existing health and population programs.
	Develop and test human rights education approaches, and coordinate them with health programs where possible.
	<u>Integration</u>
	Identify 2-3 major USAID programs for integrating FGM activities.
	<u>Monitoring & Evaluation</u>
	Identify project-specific outcome indicators.
	Monitor overall impact of program after 4 years, and plan for the following 5 years.
Funding Sources:	$2 million per year funds targeted for FGM.
	Incremental allocation from funds of existing programs.
	Mission funds.
	Bilateral country agreement funds.
Implementing Agencies:	National NGOs, academic institutions and governmental ministries.
	CAs and subcontractors.
	Specialized FGM regional and international organizations.
	U.N. agencies.

level of investment, would direct the agency's FGM support in different countries toward a common set of goals.

Such a planned approach toward FGM support need not conflict with cultural sensitivity and the development of appropriate interventions that are locally defined. In fact, at this stage a more technical approach would add validity and respectability to an issue too frequently associated with the excesses of political and emotional reactions.

G3. For an effective program plan, **improved mechanisms for communication and coordination** among divisions within USAID/W and between the agency's headquarters and the Missions and Regional Offices are essential. In the past, such communication and coordination have been the result of individual efforts or personal relations. Coordinated group efforts such as the Intra-agency Working Group on FGM and the Reproductive Health Task Force were important early activities for which interested staff volunteered. However, the number of participants in such groups has decreased as some individuals have been drawn away by the demands of their primary areas of responsibility. Although the groups have scaled down, the effort has continued. Still, the nature of such group efforts does not lend itself to central documentation, nor do they involve enough outreach to all relevant individuals and entities within the agency. A more structured and clearly budgeted mechanism to oversee central documentation, information exchange, and coordination would be necessary to ensure continuity and increased effectiveness (see recommendation R1).

G4. Continuity and long-term sustainability are major concerns for those responsible for fiscal allocation of the expanding mandate and shrinking budget of USAID. This concern is shared by those acting on FGM at the local level, who are fully aware that a practice with such a long history and deep cultural roots requires sustainable long-term commitment to bring about change. USAID's FGM program plan and the activities it contains must be geared toward realistically achievable outcomes within a feasible time frame. Careful selection and design of the FGM projects to be supported by USAID, as well as integration into existing projects (see Section 5), will assist in the long-term sustainability of these efforts.

G5. Evaluation of the cost-effectiveness of a project and the proportion of the funding it demands from the total funds available for FGM must be a criterion for project selection. For example, if the total available funding is $1 million, and a single survey to determine the prevalence of FGM in a country would cost half of that amount, it is important to ask whether the information generated would be worth the cost. One might also ask what use the information generated would be if there were few funds left to support interventions. As a general principle, it is advisable to avoid one-shot, short-term, large-scale projects. A sound approach is to seek opportunities for incremental investments with a high yield by integrating FGM into other programs, as discussed in Section 5.

G6. Using the agency's existing strength and expertise is another way to ensure sound investment, rather than becoming involved in new and inadequately tested program areas.

For example, USAID staff and the Cooperating Agencies (CAs) have more experience in research than do most other bilateral donors. When investing in FGM interventions, it would be most cost-effective to link them to the areas of service and information, education, and communication (IEC) strategies in which the agency has invested for decades: family planning and reproductive health. Moreover, quantitative operational research tools and methodologies may be easier to apply to FGM than behavioral research and assessment techniques.

G7. To advance specialized knowledge on FGM, it is important that USAID support a few well-selected projects focused solely on FGM, with the explicit intention of developing research and intervention techniques custom designed for specific USAID programs. Despite our strong recommendation for integrating FGM activities into major existing USAID programs, such integration could be premature if approaches to FGM were not well developed or were developed by professionals with no experience in the field. For example, including questions on complications of FGM in a survey questionnaire could result in no complications being reported, giving the false impression that FGM has no complications. Those familiar with the practice know that it often occurs at a very early age, when a child may not understand complications, or that at the time of questioning, the complications may have faded from a woman's memory. Reporting on complications also requires a certain degree of medical knowledge, for example, the ability to classify bleeding as hemorrhage or identify the type and severity of an infection.

G8. It is important that USAID maintain **a consistent and complementary approach combining health and human rights** in its support for efforts to eradicate FGM. A health approach concerned with reducing complications could result in projects that would promote safer ways to continue the practice, even if in a modified form. However, the cutting of a normal and functioning part of the body of a child, for reasons other than saving life, is unacceptable on the basis of sound health ethics and human rights. On the other hand, a purely human rights approach with no concern for the health consequences of FGM, both physical and psychological, would ignore women's holistic approach to their well-being and run the risk of being perceived as interventionist and foreign. The best combined approach is to support and empower women to value their health and believe in their right to preserve their bodily integrity, and to assist the community in modifying its perception of a conflict between gender equality and the well-being of society.

4.2 Recommended Activities

This section presents recommended future activities in four key areas: (1) intra-agency capacity building, (2) in-country support, (3) program development, and (4) monitoring and evaluation. As noted above, funding levels for FGM activities remain a major unknown that constrains in the most essential way those activities which can be implemented. With this in mind, Figure 2 shows suggested priority activities at three funding levels: low, medium, and high.

Figure 2.

Priority Activities at Three Funding Levels

Level 1: Low Funding

- Establish an FGM liaison office, and develop a policy statement.
- Establish an electronic information source.
- Establish FGM prevalence and epidemiology in as many countries as possible using the DHS (avoiding costly independent national surveys), and support validation studies and secondary analysis of DHS data to identify the prevalence of certain complications that would be important for policy decisions, such as infertility, mortality, and morbidity.
- Develop and test a few FGM interventions for use by existing health and population programs through operations research.
- Give financial support to national NGOs, and provide technical assistance on program development, documentation, and evaluation.
- Undertake Washington and Mission staff training.

Level 2: Medium Funding

Add to Level 1:

- Develop a more extensive program plan.
- Expand operations research to include testing of FGM models for integration into reproductive health, children's services, and training programs.
- Allocate special funds for integrating FGM into specific USAID programs.
- Develop and test a few human rights and legal approaches.

Level 3: High Funding

Add to Levels 1 and 2:

- Advance human rights training approaches.
- Earmark funds for CAs not currently involved with FGM to develop FGM modules within their programs.
- Support U.N. agency programs.
- Support technical workshops and regional and subregional conferences to review the status of activities and evaluate progress.

4.2.1 Intra-agency Capacity Building

Past USAID efforts to increase the agency's capacity to deal with FGM were commendable, but lacked the focus and professional investment routinely applied to other project areas. With minimum financial investment and clearer mechanisms, goals, and objectives, much could be done to increase the outcomes and efficiency of FGM projects.

R1. FGM liaison office. The establishment of a staff position and a liaison office for FGM eradication activities in Washington is a priority recommendation. This office would be the centralized mechanism for information sharing and program coordination. Without the establishment of such a mechanism, FGM activities will continue to be unstructured, sporadic, and difficult to advance. A modest office with one staff member and an administrative assistant, supported by an advisory committee from the relevant divisions (i.e., the existing Intra-agency Task Force) may be sufficient. The tasks of this office would include the following:

- Oversee the development of a policy statement and program plan.
- Facilitate the distribution of essential information.
- Develop a staff training model, and organize training of staff in Washington and the field.
- Ensure coordination of activities undertaken by the different divisions of USAID/W and the Missions.
- Collect and preserve program and project documents from projects supported by USAID and other agencies.
- Disseminate information on the latest developments in the field to appropriate agency staff on a regular basis.
- Maintain country files that include baseline data, where available, and past and present eradication activities.

The creation of a dedicated FGM office and staff member may be the most cost-effective investment USAID could make to enhance the quality and efficacy of its FGM projects. The office should be limited to a liaison function; the oversight of projects and the monitoring of their progress would be the responsibility of the advisory committee and the staff in the divisions and the Missions. To maximize the effectiveness of the liaison office, it should be placed in the division where the highest level of FGM activity is taking place, and where there is direct and frequent communication with staff at the Mission level who support and oversee FGM projects. The decision on where to place the liaison office would also depend

on budgetary allocations for FGM activities by the different divisions and on which divisions would be able to cover its operating expenses.

R2. In-house advocacy. Staff at different levels in Washington, the Regional Offices, and the Missions should be made aware of the agency's policies and plans regarding FGM support. A well-articulated policy and unequivocal commitment to the issue in a published document can help achieve this goal (see Section 3).

Communication of information within USAID on findings from different projects and new understanding of the links between FGM and different aspects of reproductive health and women's development would help make the case for continued FGM efforts over time. Briefing papers prepared specifically for members of Congress and key government officials to highlight recent advances in policies, legislation, and programs would also keep FGM on the policy makers' agendas.

R3. Staff training. Once staff have become familiar with the agency's overall policy, it will be important to provide them with adequate information to strengthen their capacity to deal with the issue. Information on the latest in prevalence rates, classification of types by the World Health Organization (WHO) (see Appendix A), and the most current state of national laws and international human rights documents is essential. A program plan and technical guidelines for project selection would also be valuable tools (see Section 4.1, guideline G2). Distribution of information through reports and publications is necessary, but may not be enough, since staff often lack the time to read lengthy reports. A more structured plan of training through workshops and seminars on FGM for the purpose of staff education may be more useful in both Washington and the regions. A module for staff training could be developed and applied by specialized USAID staff or through contracting for outside services.

R4. Documentation. As discussed in Section 2, one of the major shortcomings of USAID-supported projects in the past has been a lack of adequate documentation, including project reports and evaluations, as well as copies of research tools and IEC and training materials. The absence of a centralized repository for these materials has resulted in a loss of institutional memory regarding past activities, and an absence of cumulative knowledge that builds on both successes and failures. Once such documentation has been developed, it should be made easily accessible to agency staff, CAs, other funders and technical agencies, and the public where appropriate (see Section 4.1, guideline G1). By taking this step, USAID would not only improve its own knowledge and experience, but also contribute to the intellectual and professional growth of the field of FGM eradication in general.

R5. Information sharing. In the responses to the Mission and NGO questionnaires (see Appendix C), respondents unanimously expressed a need for more information. A sense of isolation and a lack of professional experience in designing appropriate projects are frequently expressed by those engaged in activities to eradicate FGM. Information exchange

and dissemination would be the most important task of an FGM liaison office (see recommendation R1).

One problem expressed by USAID staff and other professionals is the limited time available in which to remain well informed about rapidly changing developments in their fields of interest. Creative ways to make information dissemination efficient and user-friendly could be designed to meet the needs of the staff and catch their attention. One suggestion is to consider the creation of an FGM Internet or e-mail newsletter summarizing new information, listing upcoming events, and reviewing new reports and publications. The newsletter might be accessible to USAID staff or made available for general Internet access. The responsibility for the design and update of the newsletter would be with the liaison office recommended above or with a contracted service.

In addition, both to foster linkages between USAID and other organizations and agencies involved in FGM eradication activities and to promote information sharing, USAID representatives should attend appropriate forums addressing the issue (see Section 4.1, guideline G1).

4.2.2 In-Country Support

While intra-agency capacity building is an important emphasis for future activities, it is recommended that the majority of budgetary allocations to FGM eradication go toward in-country support, which is likely to have the greatest impact on the problem. USAID's support for national activities to eradicate FGM may take many forms, including those recommended below.

R6. Influencing policy. Much debate has centered on the appropriateness of exerting pressure to influence government policies with regard to FGM and on the nature of such pressure. USAID is a major population and health donor in Africa, and the pressure it exerts will undoubtedly be felt, whether positively or negatively. Some journalists and members of Congress have advocated requesting legislation against FGM as a condition for U.S. financial assistance to countries in Africa. However, if such suggestions were implemented, they could backfire and cause a reaction against USAID and other foreign assistance to FGM eradication, indeed giving credence to national conservative voices who label such assistance as foreign intervention. If the reason to stop FGM is to improve the health of women and children and bring social and economic development to African nations, such goals can and must be achieved through the voluntary participation of the individuals and societies concerned.

Moreover, government legislation as such may not be the most effective way to stop the practice. A government could agree to the conditions, pass a law, and create false mechanisms to give the impression that it is acting on FGM while in fact it is resenting the intervention and blocking any real progress. A more constructive way to influence policy

may be through positive encouragement and the addition of extra funds earmarked for FGM activities to negotiated health or population assistance budgets. With such extra funds there must also be a clear expectation of deliverables resulting from those funds; for example, governments could be requested to facilitate the work of NGOs by using USAID funds to support them and by opening the media and the school curricula to NGOs acting on FGM.

It is also important to inform the U.S. public of the different projects supported by USAID and their outcomes. Knowledge of the agency's positive support could help temper some of the demands for sanctions against FGM-practicing countries. Communicating USAID efforts to the media through the above-recommended liaison office or senior spokespersons is another mechanism that would keep the public informed.

R7. Financial support. Increased financial support for FGM eradication activities was a need strongly expressed by both Mission staff and national NGOs. Such support could be provided through several mechanisms, such as the following:

- Centrally allocated funds targeted to FGM activities in USAID's annual budget
- Incremental funding within existing programs and bilateral assistance agreements to add FGM components
- Use of existing flexible and discretionary funds in Washington, the Regional Offices, and the Missions to support FGM projects

These funds could be used in several ways[4]:

- Intra-agency capacity building, communication, and coordination
- Support for national government programs
- Funding to CAs for project development and technical assistance
- Direct funding to local NGOs and research institutions
- Funding of FGM programs within international organizations and U.N. agencies

It is important to document the overall yearly amount of funds spent by USAID on FGM activities. It is also important to consider the proportion of that funding directed to each of the above funding mechanisms, and evaluate each mechanism against the outcomes produced (see Section 4.1, guideline G5).

R8. Technical assistance. In the 1980s, cautious and sensitive support of locally defined FGM activities with minimal outside interference was important, but there was a general neglect of the need for technical assistance (TA) and the intellectual investment of professionals in the field. The result was inadequately designed projects with unidentified

[4]For an expanded discussion of the various agency funding mechanisms, see Appendix B.

outcomes, poor documentation, and an absence of evaluation (see Section 2). In the 1990s, more support is being channeled through CAs and specialized technical agencies with built-in TA components.

NGOs and local institutions should continue to define the activities and select the priorities. At the same time, they have expressed the need for TA in designing and implementing their projects. This support can be provided by culturally sensitive and capable professionals from within the country or from neighboring countries, or by international consultants. Sensitivity is essential in these efforts and must be applied by all involved in transcultural development assistance. On the other hand, maintaining a hands-off approach to TA would result in the continued isolation of FGM from the mainstream professional discourse and ultimately to a lack of intellectual investment in approaches to the issue.

Given the current state of knowledge, TA might be provided through one of the following mechanisms:

- **Internal TA**—National professionals with experience in FGM research and/or interventions or with experience in related reproductive health and human rights activities could be recruited to assist local NGOs.

- **South-to-south TA**—Professionals from other countries within the region having FGM or closely related experience could be recruited.

- **Specialized FGM-TA agencies**—These agencies have more specialized staff with a wide range of FGM knowledge and experience.

- **CAs with FGM-TA capacity**—Some CAs have existing FGM capacity, and others are in the process of developing it. Although not all would be able to develop broad FGM technical capacity, many could invest in applying their existing strengths to develop more FGM activities for their areas of expertise, such as research, development of training materials, and counseling.

- **Technical divisions of U.N. agencies involved in FGM**—WHO, UNICEF, and the United Nations Population Fund (UNFPA) are in the process of developing program guidelines and priority areas of activity on FGM. WHO is developing a research agenda and is raising funds to support behavioral research. UNICEF has already developed a program plan to support national NGOs in developing health and educational FGM modules for integration into programs on child health and women's literacy programs. UNFPA is looking into ways of integrating FGM into the reproductive health and family planning services the agency supports. USAID may want to follow the development of these programs within these agencies and identify areas where it might want to invest support.

4.2.3 Program Development

R9. Research. Review of bilateral donor and U.N. agency funding in the area of FGM reveals the paucity of funds dedicated to research. USAID has historically invested in both survey and operations research (OR), as well as in evaluation research. These efforts need to be extended to FGM, particularly to evaluation of the appropriateness and effectiveness of various interventions, as well as methodologies for measuring outcomes.

(1) Survey Research

The 1990 Sudan DHS module on FGM was later modified to include eight basic questions on prevalence and attitudes. While inclusion of this module in subsequent surveys in other countries represents an important step forward in documenting the prevalence of FGM, adaptation of the module by individual countries has varied considerably. Yemen, for example, included only two questions (regarding approval of the practice) in its DHS (1991/92), yielding no data on prevalence. Cote d'Ivoire included only three questions in its survey (1994), and Central African Republic included only five (1994/95). Egypt, on the other hand, expanded the module greatly to include 28 questions. The results, due to be published in December 1996, are expected to yield rich information. As of this writing, versions of the module have also been used in Eritrea, Mali, and Tanzania, but results are not yet available. In the future, it will be important for the DHS to work closely with countries to ensure effective adaptations of the module to maximize the information gleaned on FGM.

Given that the DHS is supported primarily by USAID, incremental funding to the appropriate research institutions for secondary analysis of generated but unused DHS data could yield results beyond what is available in the basic country reports. This is a good example of incremental funding that would yield valuable information at low cost. Questions on FGM were added to the Situation Analysis study in Burkina Faso, which could also yield useful information at low cost.

If the recommended USAID FGM liaison office concentrated on ensuring that more countries include the FGM module in their DHS surveys and discouraged investment in isolated FGM surveys, considerable funds could be saved for other FGM activities. In countries where a DHS is not pending, there may be opportunities to include FGM questions in existing maternal and child health or other surveys. If no such survey is imminent, it may be necessary to undertake limited pre-intervention data collection as a baseline for the primary purpose of evaluating an intervention.

In summary, existing knowledge of FGM prevalence should be sufficient to inform policies and programs. More accurate prevalence data should not be a priority for major USAID financial investment unless it is limited and essential to the guidance or evaluation of interventions. Use of the DHS and other major surveys will yield the necessary prevalence information in due course.

(2) Operations Research

This is another major area of USAID advantage. The central question for OR should be: What are the most effective means for incorporating FGM prevention into existing reproductive health, family planning, and child survival programs? This operational question could be applied by the specialized Africa OR/TA project, as well as by CAs that are undertaking the provision of services, counseling, education, and training under USAID-supported projects. For example, could FGM be included in family planning, antenatal, or child health counseling? What would be the incremental cost of adding such counseling? Would health providers feel comfortable talking about FGM? What training would providers need to enable them to address FGM? Would such clinic-based counseling be more or less preferable to community-based counseling?

Many more operational questions around the treatment of FGM complications, IEC messages, and community outreach efforts could be designed for incorporation into OR studies.

(3) Evaluation Research

This is another area in which USAID and its collaborators have existing expertise. The need to invest in the development of methods for evaluating the quality and impact of FGM projects cannot be overemphasized, and the potential benefit and contribution to the field would reach far beyond the agency's own programs. Although evaluation research may be part of OR, evaluation techniques must be built into all FGM projects, regardless of whether they are labeled as such.

R10. Interventions. The range of possible interventions for the eradication of FGM is considerable. Smaller donors and technical agencies with more flexible funding mechanisms than those of larger agencies have the capacity to invest in less conventional areas, such as the use of media and art to effect behavioral change. USAID could concentrate on developing FGM activities within program areas more suited to the agency's size, existing funding mechanisms, and programs.

(1) Population and Health Programs

In Africa, USAID is a major donor to population and health programs. In some communities, family planning clinics are the only health-related services with which women and their families come in contact. Some USAID-supported CAs are producers and implementers of training materials for all levels of the health sector. Others have developed advanced and effective counseling protocols specific to African cultures. Many USAID-supported programs provide primary health, maternal and child health, and youth services. All these projects can be used to assist in the

prevention and eradication of FGM with incremental investments and technical support on how to develop and incorporate an FGM component.

Vertical or isolated FGM programs should not be developed unless they are specifically designed to develop modules to be linked to existing USAID or other major national programs. Apart from the high cost of vertical programs, evidence suggests that they are less acceptable to the community, and therefore less effective.

(2) Democracy, Gender Equity, and Human Rights

Another set of USAID-supported activities could be developed in these areas. Promotion of democracy and human rights in the area of cultural practices should be programmatic and not follow the "expose, pressure, and embarrass" techniques of some human rights organizations. In these areas, USAID could support projects undertaking gender equity and human rights education. Research projects to generate objective information would foster a rational public policy debate, avoiding misinformation and superstition. Support to national legal institutions and women's NGOs for undertaking legal and policy research and making the case for legal reform would produce long-lasting results by strengthening these democratic institutions. Such a programmatic approach would be sensitive and constructive and unlikely to meet with political objections. It is also important to take an OR approach to policy research and human rights projects so that project ideas can be modeled, then evaluated for efficacy and applicability before they are replicated or advanced further.

(3) Coordination of Health and Human Rights Project Support

Combining support for health and human rights projects within the same country could be an effective way of maximizing the impact on FGM. For example, the programmatic expertise of the Center for Population, Health and Nutrition and the facilitative capacity of the Office of Women in Development, combined with the commitment of both to address gender issues and FGM, make these two groups a potentially powerful team. Collaborative efforts have already been undertaken in Washington and could be expanded further to influence country programs.

For example, a project supported by the Center for Population, Health and Nutrition could provide training for health providers in treatment of FGM complications and counseling to women from the medical point of view. This project could be combined with support by the Office of Women in Development to a local women's or human rights group to train the same providers in the health ethics and human rights violations inherent in FGM. A combined counseling approach would educate women on the health consequences of FGM, as well as inform them of their rights and empower them to make better decisions to preserve their bodily integrity. Such an approach would promote the integral connection between the health and human rights concerns related to FGM.

4.2.4 Monitoring and Evaluation

R11. Long-term monitoring. The ultimate desired outcome of FGM projects is to eradicate the practice, to preserve women's bodies, and to empower them to make better choices regarding their sexuality and reproduction. The time frame for achieving this outcome must be realistic. Each individual project may not directly result in reduced incidence of FGM, but the cumulative effects of information, counseling, legal reform, and women's increased awareness of their rights will ultimately reach a critical point where behavioral change will occur.

It would be realistic to use 10-year intervals as long-term monitoring points for detecting a decline in incidence rates. The DHS could continue to be the ultimate monitoring tool for detecting that decline, since the surveys are applied roughly every 3-5 years. Any expectation of significant decline in a shorter time frame is unrealistic and could lead to the failure to meet expectations.

R12. Periodic program assessment. For USAID, a five-year program plan is a reasonable time frame for defining a set of activities to be developed and supported. At the four-year mark, a review and evaluation of the FGM program would examine the project-specific outcomes and evaluate the cost-effectiveness of different funding mechanisms in light of those outcomes (see Section 4.1, guideline G5). The process would also evaluate USAID efforts within the context of all other international and national efforts at the time. A further five-year program plan would be designed based on the experience gained and lessons learned. The FGM liaison office could coordinate the review and evaluation process, which would be undertaken by staff from the divisions that supported the projects.

R13. Project evaluation and process indicators. There is a need to develop project-specific evaluation components, including evaluation of deliverables by quality of content as well as quantity, and to develop meaningful outcome indicators. It would be unrealistic to use lowered incidence of FGM as the outcome indicator for a short-term project. However, intermediate outcome indicators could and should be developed. The nature of the intermediate outcome indicator will depend on the nature of the project. A project to develop educational or counseling materials could be evaluated by the quality and accuracy of the material produced, the number of people trained, and the impact of the material on their knowledge and attitudes. Attempts to measure impacts on behavior could lead to false results because of reporting bias. A youth services reproductive health program with an FGM component could measure the number of requests for information and counseling presented to the service by both girls and boys. A human rights education program could be evaluated with regard to the impact of the education on women's self-perception and any actions they have taken based on their new awareness of their rights.

The above are only a few of many examples of measurable project outcomes that could be documented and reported to improve the technical and scientific approaches to FGM. With

more specific project reporting and evaluating requirements, improvement in the quality of project outcomes could be expected.

5. INTEGRATION OF FGM INTO EXISTING USAID PROGRAMS

There is a broad range of opportunities to integrate FGM into existing service delivery, training, and research programs and mechanisms. Given these opportunities, as well as the constraints of reduced budgets, such an integrated approach to FGM would be most effective for USAID. Specific examples already mentioned in Section 4 are the DHS and Operations Research. To illustrate the scope of possibilities, examples of other USAID projects and mechanisms into which an FGM component could be integrated are discussed below. This is followed by a brief summary of the relative advantages of the relevant USAID offices with regard to support for FGM eradication activities.

5.1 Existing Programs and Mechanisms

The PRIME Project (Primary Providers' Education and Training in Reproductive Health) is managed by the Communications, Management and Training Division of the Center for Population, Health and Nutrition. PRIME is a human resource development project that provides support in family planning and reproductive health training to health care providers ranging from nurses to traditional birth attendants. Through national strategic and human resource development plans, as well as policy and research activities to strengthen those plans, the project focuses on strengthening the link between training and service delivery and on improving service quality and access. There is a potential opportunity to develop and test FGM training modules through this project. The Program for International Training in Health (INTRAH), a CA responsible for implementing the project, has already received training from RAINB♀ on FGM for its North Carolina and regional staff. They have expressed interest in developing modules on FGM for inclusion in the various manuals they produce for training of various levels of health professionals. No such modules have been developed to date.

The POLICY Project is the centerpiece of the Policy and Evaluation Division, and was developed to create a supportive environment for family planning and reproductive health programs through the promotion of a participatory process for population policies that respond to clients' needs. The project is implemented by the Futures Group International in collaboration with Research Triangle Institute and the Center for Population and Development Activities (CEDPA), and is committed to furthering the goals and recommendations of the International Conference for Population and Development (ICPD) (see Appendix A). It works to build a supportive policy environment on reproductive health issues, build skills, and create participatory policy development and implementation. It does this through a range of activities, including technical assistance on participatory policy development methods, technology transfer, training, small grants, and research awards. The POLICY Project also includes support for south-to-south exchange of information and observational travel for policy makers to learn about the evolution and implementation of population policy in other countries. Given the need for a strong and favorable policy environment for efforts to eradicate FGM, USAID-supported FGM efforts could be

strengthened by these activities. Furthermore, the POLICY Project is currently planning work in Egypt, Ethiopia, Ghana, Kenya, Mali, and Tanzania, countries where FGM is practiced. Given the project's commitment to the ICPD goals, its own capacity could be increased by addressing FGM.

The International Planned Parenthood Federation (IPPF) Grant is managed by the Family Planning Services Division of the Center for Population, Health and Nutrition, and contributes to core and technical support provided by IPPF, London, to its affiliated family planning associations at the national level. This support strengthens the ability of the family planning associations to implement and expand programs that address the goals of IPPF's strategic plan, VISION 2000. A small grants component of this project devised to build regional capacity is an example of a possible source of flexible support for integrated FGM projects. This is particularly true given the VISION 2000 agenda, which includes a comprehensive reproductive and sexual health and rights mandate and the goal of increasing the access of young people to appropriate information, education, and services in addressing their reproductive and sexual health needs.

The FOCUS Program was developed by USAID in collaboration with Pathfinder International, the Futures Group, and Tulane University School of Public Health to improve the health and well-being of young adults through the promotion of responsible behavior that delays exposure to sexual activity; sexually transmitted diseases, including HIV/AIDS; and high-risk pregnancies. The effort also promotes positive health behaviors, including breastfeeding and child spacing, to improve both maternal health and child survival. The project works with organizations serving youth to develop a strategic approach to addressing young adult health issues; it accomplishes this through technical working groups on these issues and workshops on program planning, policy analysis, and cost analysis skills. Education/training modules addressing the health implications of FGM for mothers and young adults could be incorporated into these sessions, thereby expanding the project's effective initiatives and assisting others to implement new initiatives that would foster positive health outcomes for young adults.

The MotherCare Project is implemented by John Snow, Inc., and is managed by the Nutrition and Maternal Health Division of USAID. MotherCare is a two-phase, 10-year project that was developed in 1988. It is designed to improve pregnancy outcomes by strengthening and improving service delivery, influencing behaviors that affect the health and nutritional status of women and infants, and enhancing policy formulation on maternal and neonatal health care at the regional and national levels. Short- and long-term technical assistance, training, workshops, and applied research support are available in eight focus areas: (1) assessment of maternal-newborn health services; (2) behavior change for self-care, complication recognition, and referral; (3) strengthening of the health referral network; (4) policy and standards formulation; (5) prevention, diagnosis, and treatment of sexually transmitted diseases (STDs); (6) prevention and treatment of micronutrient deficiencies and undernutrition; (7) life-saving skills training for medical professionals and traditional birth attendants; and (8) service delivery improvement for prevention and treatment of causes of

maternal morbidity and mortality. Effective FGM activities have been developed and integrated into these focus areas, as was done in USAID-sponsored MotherCare projects in Guinea and Eritrea in 1995.

Population Communications Services (PCS), a project of The Johns Hopkins University, has compiled a listing of over 350 abstracts and FGM-related records on POPLINE CD-ROM. This listing also has information on the location of sites throughout Africa and the Near East, is regularly updated, and has been disseminated to numerous organizations addressing the practice of FGM, including the International Federation of Women Lawyers in Kenya and the Egyptian Task Force on FGM. Members of the PCS Task Force on FGM, which includes staff from the Africa, Near East and Research Division, meet to exchange information and discuss recent developments and potential activities; the Task Force also sponsors visiting speakers to PCS. The PCS Task Force on FGM meets regularly with the PCS Reproductive Health Task Force, as well as with the Inter-Agency Working Group on FGM. PCS is also actively expanding, updating, and disseminating its list of resources relating to FGM in the Media/Materials Clearinghouse.

PROWID is a cooperative agreement between the Office of Women in Development, the International Center for Research on Women, and the Centre for Development and Population Activities. PROWID is funding the Foundation for Research on Women's Health, Productivity and Environment to combat the practice of female genital mutilation in The Gambia. The Foundation will expand its project of Passage Rites, which redirects the puberty and passage rights for girls away from FGM. Grassroots communities and children will be incorporated in the new ceremonies, as will professional circumcisors, traditional birth attendants, and religious and community leaders.

Basic Support for Institutionalizing Child Survival (BASICS) and Program for Appropriate Technology in Health (PATH) are funded by USAID's Office of Women in Development through the Office of Health and Nutrition to address reproductive health aspects of FGM in two sites in Kenya. In collaboration with the Seventh Day Adventist Church, focus group discussions have revealed qualitative information regarding the nature and incidence of the practice. PATH has provided technical assistance to indigenous health workers for developing a pilot FGM prevention strategy.

Other CAs and subcontractors through which USAID contracts are arranged provide administrative and technical support to local projects. CAs have considerable technical expertise in project implementation and in evaluation, research, and policy analysis, as well as strong infrastructure. Some CAs have regional headquarters and country offices, while others are based in the United States and work through field staff.

The process by which contracts and subcontracts are awarded determines the amount of financial support and the quality of technical assistance local projects ultimately receive. Many of the staff interviewed agreed that considerations of appropriate funding mechanisms for USAID can sometimes override concern for technical expertise in a small area, such as

FGM, within a larger contract. While many CAs have related technical expertise in reproductive health and family planning, some do not have expertise specific to FGM and may not be connected with local FGM networks or initiatives. There have been cases in which CAs were selected to oversee FGM projects with little justification beyond budgetary deadlines and the ease of application of funds, with no consideration of resident or subcontractual expertise on FGM. Subcontracts to an increasing number of international, regional, and local NGOs with expertise in FGM have already been used by some CAs and could be used increasingly by others.

Given the importance of specialized knowledge about FGM and the cultural and political sensitivity around the issue, a careful assessment of the CAs' capacities on this issue is necessary. Requirements for tangible products and well-evaluated project outcomes would also ensure better project implementation.

Using CAs or CA mechanisms could be extremely beneficial to FGM projects in that it could facilitate an integrated approach. FGM activities could be increasingly integrated into existing program areas, such as family planning service delivery or counseling. However, support for free-standing FGM projects may still be necessary to develop specialized expertise. Additionally, there is a need to increase capacity on FGM within CAs. However, this process needs to be planned, funded, and coordinated so that the limited funds available to local projects can not be diverted away. Conversely, there are many cases in which FGM fits logically into the mandate of a particular CA that is not paying attention to the issue and not investing in enhancing its capacity to support FGM activities. USAID/W is well placed to identify some of these CAs and provide guidance and encouragement on how they can incorporate FGM into their work.

Regional Bureaus, offices, and initiatives could provide support to FGM activities. Two of the four regional bureaus—the **Bureaus for Africa and Asia/Near East**—are relevant to FGM activities. Regional Bureaus work in collaboration with the Bureau for Global Programs and Missions to fund projects through global bureau or bilateral agreements and to provide technical assistance. Additionally, Regional Bureaus consult with Regional Offices (REDSOS) to get feedback on project ideas and the feasibility of implementation. However, there seems to be no formal mechanism for collaboration, and many efforts depend on already established relations with the Bureau for Global Programs and direct contacts with Missions. Like the Center for Population, Health and Nutrition, the Bureau for Africa has identified priority countries.

The Office of Sustainable Development of the Bureau for Africa created the **Health and Human Resource Analysis for Africa (HHRAA) Project** to increase the use of research, analysis, and information for improving health, nutrition, education, and family planning policies and programs in Africa. The **Support for Analysis and Research in Africa (SARA) Project**, which is managed under HHRAA, identifies issues, provides technical guidance, undertakes research management, disseminates results, and establishes links with African experts and institutions. The SARA Project is currently developing generic training materials

on advocacy skills for local networks and organizations. These materials include information on basic elements of advocacy, such as identifying policy issues and solutions, developing and delivering advocacy messages, and making effective presentations. These materials may be relevant and transferable for advocacy against FGM, particularly in countries such as Kenya, where both community-based norms and national policy are being targeted by advocates. Additionally, the Africa Bureau has resident technical advisors who oversee projects and provide technical assistance to Missions.

FGM is included in the HHRAA strategic framework under the area of Safe Motherhood and Reproductive Health. Through the SARA Project, staff at the Bureau for Africa have initiated a review of FGM as an increased risk factor for HIV/AIDS. Staff from the Bureau for Africa have participated actively in the Intra-agency Working Group on FGM.

In addition to the Bureau for Africa, there are regional offices in West Africa (REDSO/W) and East and Southern Africa (REDSO/ESA). These have their own administrative and programmatic presence in the region, with offices in Abidjan (REDSO/W) and Nairobi (REDSO/ESA).

Other regional mechanisms include region-specific projects. The **West Africa Family Health and AIDS Project** addresses service delivery, communications, and logistics. This project and REDSO/W offer important opportunities to reach West African countries with high FGM prevalence that are not priority countries for the Bureau for Africa and the Center for Population, Health and Nutrition.

Another regional project that could incorporate an FGM component is the **Greater Horn of Africa Initiative (GHAI)**. A cross-agency initiative directed by the Africa Bureau and Missions, the GHAI covers 10 countries and currently has two main areas of focus: democracy and governance, and food security. Members of the Intra-agency Working Group on FGM are currently lobbying the GHAI to develop a health initiative with a focus on FGM. There is a need to articulate the connection between FGM and the objectives of the GHAI in order to make a case for using their funds to support this effort.

Some of the countries where FGM is prevalent, in particular Egypt and Yemen, fall under the Bureau for Asia/Near East. While the Mission in Egypt is active in its support for anti-FGM activities, it seems that the regional office in Washington has not been involved in the FGM Task Force, other than the occasional attendance of one staff member at meetings. The involvement of the Bureau in Washington is important for coordination between the work in this region and the Africa region.

5.2 Relative Advantages of USAID Operating Units in Addressing FGM

In the past the Missions, by virtue of their location and perspective, have played a key role in undertaking support for FGM activities. The Center for Population, Health and Nutrition

and the Office of Women in Development are the two divisions that have taken the lead in developing FGM-related activities at USAID/W. Other agency divisions that have played a role or demonstrated interest are the Africa Bureau, the Asia/Near East Bureau, and the Center for Democracy and Governance.

5.2.1 The Missions

As part of USAID's recent restructuring, the Missions are increasingly driving the agency's agenda. Some Missions, such as Somalia and Sudan in the 1980s and Egypt, Ghana, and Kenya in the 1990s, have already demonstrated initiative and leadership in supporting FGM eradication activities. Other Missions are just beginning such efforts and would benefit from coordinated agency-wide support to strengthen their capacity to address FGM. The role of USAID/W in generating extra resources and providing policy, programmatic, and informational assistance would be catalytic to the Missions' efforts to address FGM. The results of the Mission questionnaire presented in Appendix C identify some needs and provide some suggestions on how to meet these needs.

5.2.2 Center for Population, Health and Nutrition

For the past three decades, USAID has supported population, health, and nutrition programs. In the last 10 years, the agency has become the largest international donor in this sector, particularly in Africa. USAID's strategy for the Population, Health and Nutrition Program reflects the contradiction between a broadening program mandate to include reproductive health and human rights and the reality of diminishing resources. The agency's major goal in the population, health, and nutrition sector is to stabilize world population and protect human health. Its strategic objectives include reducing unintended pregnancies, maternal mortality, infant and child mortality, and sexually transmitted disease (STD) transmission, with a focus on HIV/AIDS. The center contributes to these objectives by providing global leadership, research and evaluation, and field support (both technical and financial), and focusing on improved availability, quality, and use of key interventions in the population, health, and nutrition sector. The center's current mandate also includes principles adopted from the ICPD Program of Action, and USAID policies on gender and women's empowerment. The center's most recent strategic plan (1995) is the most comprehensive agenda on reproductive health and rights developed by USAID.

At the same time, recent cuts in funding and limited resources have forced USAID to identify priority areas that optimize both efficiency and impact in terms of the number of countries and the nature of the activities supported. The center and the Missions are therefore developing and implementing a Joint Programming and Planning Country strategy, which prioritizes countries and establishes mechanisms for maximizing resources devoted to those priority countries on the basis of potential impact at the local, national, regional, and global levels. Thus, at a time when the agency's agenda is expanding to include FGM more

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explicitly, its resources to address the issue may be reduced. This reality confirms the need for strategic planning and cost-effective spending. In Africa, the Joint Programming and Planning Country strategy will have considerable impact. Priority or "Joint Programming" countries include countries where FGM is highly prevalent, such as Ethiopia, Kenya, and Egypt, or has low prevalence, such as Tanzania and Uganda. With the exception of Ghana and Nigeria, most West African countries with high FGM prevalence are not priority countries. Some, such as Guinea, Mali, and Niger, may still be categorized as "Joint Planning" countries, while others with lower priority in terms of global impact can still receive some bilateral support for population, health, and nutrition activities.

In this context, the center has faced—and continues to face—both considerable opportunities and limitations in addressing FGM. Its 30 years of support has resulted in considerable technical experience in the development, implementation, and evaluation of population, health, and nutrition programs, ranging from operations research and service delivery to policy development. A very limited amount of this technical experience has been applied to the development of FGM programs to date. Additionally, recent efforts within the center in the areas of gender issues and reproductive health have illustrated the possible impact of combining the center's strong technical and program experience with the more contextual approaches to gender and women's empowerment that are necessary in the development of effective FGM programs.

5.2.3 Office of Women in Development

USAID began to formulate both policies and mechanisms to address the status of women in developing countries as early as 1974. In 1977, a restated amendment of the Foreign Assistance Act of 1961 (the Percy amendment) recognized women's roles in economic production, family support, and development. To implement its mandate in this area, USAID created the Office of Women in Development, and in 1982 became one of the first donors to articulate a policy on women in development. This policy recognized the need to understand and address the differences between the roles played by women and men in societies, and the unequal access to resources that determines and reinforces these roles. The policy further mandates that relevant data be disaggregated by gender, that country strategies involve women, and that USAID consultants address gender issues in their work.

Almost 15 years later, the Office of Women in Development continues to examine the roles women play and the resources they can access in the areas of education, population, health and nutrition, economic growth, democracy and governance, and the environment. The office does not have priority countries, but through a planning and consultative process has made strategic choices about priority areas for action during 1995-2000. These include improving the economic status of women in Latin America and the Caribbean, Asia and the Near East, and Africa; improving educational opportunities for girls in South Asia and Africa; improving women's legal rights and participation in governance and civil society in all regions; and integrating gender issues throughout USAID's regional and country programs.

Within these objectives, there are opportunities to address FGM. These include playing a key role in keeping FGM on USAID's agenda and mobilizing resources for the support of related programs. Support for education programs on women's human rights including FGM is both a major challenge and a major opportunity. As USAID's institutional "house" for gender issues, the Office of Women in Development draws attention to the less traditional aspects of development assistance, such as power dynamics between men and women, and social and cultural practices and behaviors. The office's multisectoral approach and existing relationships with other offices could provide opportunities to sustain interest in FGM across the agency.

As an advocacy office, the Office of Women in Development has substantially fewer resources than other arms of the agency that address FGM. However, the office has already coordinated some USAID activities on FGM by facilitating the Intra-agency Working Group on FGM, and by communicating on the issue with Missions and other international donors and agencies.

6. CONCLUSION

The challenges USAID faces in strategically and effectively addressing FGM are not unique. As a Western government donor agency, USAID faces the double obstacles of bureaucratic mechanisms and strong links to U.S. foreign policy. However, the agency also brings to the challenge its many excellent resources, multisectoral technical skills, and a commitment to improving the health and status of women and their communities. The present study is a testimony to USAID's serious commitment to supporting FGM eradication activities by learning from the past and planning effectively for the future.

In the 1970s and 1980s, many Missions took the lead in providing financial support to both national government efforts and NGO initiatives to eradicate FGM. At the time, FGM was still marginalized as a "harmful traditional practice" and not considered integral to reproductive and child health and women's empowerment. Some Missions had already started to support FGM eradication activities through Democracy and Governance funds and mechanisms even before the international community recognized FGM as a human rights issue.

USAID/W has successfully initiated several intra-agency efforts to address FGM, including two interdivisional working groups. These efforts have undoubtedly resulted in the improved capacity of the agency to deal with the issue, as well as the increased funds available for direct program support.

This report documents the past while also pointing to ways of improving FGM support in the future. It does not attempt to devise a new plan of action, but concentrates on improving on what is already being done with existing mechanisms, through incremental additions. A thoughtful, well-articulated policy, a program plan, better documentation, better information dissemination, and better evaluation can all lead to a strengthening of existing USAID mechanisms and a more effective approach in the effort to eradicate the practice of FGM. In particular, the establishment of an FGM liaison office is a central recommendation without which it may not be possible to improve FGM eradication support in the future.

APPENDICES

APPENDIX A

CHRONOLOGY OF EVENTS RELATED TO FGM

Pre-1970 Individual efforts to bring attention to FGM in Africa date back to the turn of this century. In the 1940s, the British colonial administration and some missionaries attempted to stop the practice by passing legislation and church rules, but only succeeded in provoking anger against foreign intervention. Local and international efforts to combat the practice did not develop further until the late 1960s and the early 1970s.

1970-1990 **Perspectives and Attitudes.** During this time most responses to FGM in the United States and Europe were expressed either as shock and horror or concern about the health complications arising from the practice. In addition, FGM was viewed primarily as an aberrant "traditional practice," rooted in little-understood cultural norms. This perspective generated a great deal of emotional reaction, and documents from that time reflect this attitude toward the issue. In the late 1980s, as the U.S. Government opened programs to settle thousands of refugees from Ethiopia, Eritrea, and Somalia in the United States, the practice was brought closer to home. Lack of objective information and thoughtful suggestions for action made it difficult, however, for those "outraged and concerned" to move beyond emotional expression. The strongly expressed emotions were perceived as a cultural attack by many African individuals and governments, and any suggestions for action at the international level were perceived as unwelcome interference by the West.

The United Nations Mid-Decade Conference on Women and the Non-Governmental Forum, Copenhagen, 1980. This conference became a forum for heated debate on who had the right to condemn and therefore act to stop FGM. The debate on terminology had started and came to represent two opposing points of view. The term "female genital mutilation" was seen by some Africans as a sensationalist and harsh term that discounted the cultural context and intent underlying the practice. The term "female circumcision" was dismissed as euphemistic by some Western feminists who protested equating the practice with male circumcision as widely practiced in the United States. Many African women expressed concern and resentment at "Western feminist campaigns" against FGM, some of which included the production of evocative photographs and videos of circumcised genitals. Others asserted that, given the cultural nature of the practice, it was inappropriate for Western organizations and individuals to address it. In fact, controversy at the conference centered not on whether FGM was right or wrong (the majority of attendees disapproved of it), but on who had the legitimacy to lead the campaign against it and what form such a campaign should take. The

Association of African Women for Research and Development (AWARD), one of the first African women's regional networks, had adopted a strong position against FGM and urged women in affected countries to address the problem locally, as many of its local chapters were already doing. In Copenhagen, AWARD strongly objected to the approaches and attitudes of some Western individuals.

Key research and publications on FGM. Around this time, several reports and research papers were published that attempted to document the practice in a more structured and scientific way. Examples of important publications are the report of the World Health Organization (WHO) meeting in Khartoum in 1979, "FGM in Egypt" by Marie Assaad (*in Studies in Family Planning*, 1980), and the *Hosken Report* by Fran Hosken (1979). The International Planned Parenthood Federation (IPPF) and the Population Information Program of The Johns Hopkins University included articles on the practice in their respective publications, *People* magazine (Vol. 6, No.1, 1979) and *Population Reports*. The availability of information and data in the international literature widened the scope of interest in the issue and gave it credibility beyond the conflicts it provoked within the women's movement.

Formation of the Inter-African Committee. In 1984, AWARD organized a meeting of African NGOs in Dakar, Senegal, which resulted in the formation of the Inter-African Committee on Harmful Traditional Practices Affecting the Health of Women and Children (IAC). The IAC's long-term objective is to eradicate all harmful traditional practices, including FGM, early marriage, and nutritional taboos, and promote beneficial traditional practices, such as breastfeeding. Much of their work is focused on FGM. Over the next 10 years, IAC affiliates or national committees were founded in over 22 African countries, with a head office in Addis Ababa and a liaison office in Geneva. The IAC affiliates created an important regional network that drew the attention of national governments and public opinion to the harmful nature of the practice. National committees worked with varying degrees of success to develop activities and programs to stop FGM. In general, the IAC's approach to FGM is more focused on health concerns, with little analysis of the underlying gender issues inherent in the practice.

1990-1996 **Three World Conferences, 1993-1995 (Vienna, Cairo, and Beijing).** Prior to 1993, several articles already existed on international human rights law, including articles in the Universal Declaration of Human Rights, the Convention on the Elimination of all forms of Discrimination against Women, the African Charter on Human and People's Rights, and the Child's Convention, which referred to cruel and inhumane treatment and the individual's right to bodily integrity. However, it was not until 1993 at the

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World Conference on Human Rights that violence against women was accepted as a violation of human rights within the context that women's rights are human rights. In Vienna (1993), FGM was presented by African women as a practice violating their right to bodily integrity and their right to freedom from violence. While the Vienna Declaration did not explicitly mention FGM, it did condemn cultural practices that violate women's rights. In 1994, this recognition was taken a step further at the International Conference for Population and Development (ICPD) in Cairo to include women's reproductive and sexual rights. The ICPD produced the first international document to mention FGM specifically. This document not only condemned the practice, but also urged governments to prohibit it and institute measures to eliminate it. The fields of health and human rights were subsequently broadened and overlapped primarily because of the efforts of the international women's health movement. Explicit connections were made between specific women's rights issues and appropriate program and policy responses. For example, violence was recognized as a public health issue; women's health, rights, and empowerment were placed at the center of international population policy; human rights organizations began to address gender-based violations; and AIDS was recognized as a development issue. Similarly, FGM began to move from the marginal designation of traditional practice to a more central place on the women's rights, reproductive health, and development agendas.

In March 1995, the World Summit for Social Development in Copenhagen called for intensified and coordinated international support for efforts against FGM. Most recently, the Fourth World Conference on Women in Beijing, September 1995, confirmed and expanded the international consensus on FGM and added a call for the enactment and enforcement of legislation against those who practiced it. The U.S. Government played a significant role in supporting women's voices in these conferences and in the delicate negotiations that led to the inclusion of these clauses in the documents.

U.S. public opinion. In the 1990s, the deployment of U.S. troops in Somalia brought many American journalists in direct contact with FGM for the first time, and a plethora of articles on FGM appeared in the print media. The publication of two books and a film on the issue by the African American writer Alice Walker drew popular attention to the issue, which began to be featured on popular talk shows, TV documentaries, and news programs. The Congressional Women's Caucus, led by Congresswoman Patricia Schroeder of Colorado, drafted a bill to explicitly criminalize FGM in the United States and to protect children in immigrant communities.

Starting in 1994, the Immigration and Naturalization Service (INS) began to receive asylum claims by women and their children trying to escape FGM. The domestic debate on immigration, as well as concern about FGM, resulted

in high-profile coverage of these cases. By June 1996, fear of FGM had been accepted as a reason for asylum by the INS, and as of September, performing FGM on minors living in the United States had been criminalized, effective March 1997.

Following criminalization of FGM, the U.S. Department of Health and Human Services is mandated by Congress to (1) determine the prevalence of FGM in the United States, (2) educate immigrant communities on the health dangers of FGM, and (3) develop a curriculum on FGM for U.S. medical and nursing schools. All aliens from endemic areas are to receive information on the harmful effects of FGM and on the legal status of FGM in the United States. Monetary assistance from U.S.-supported international financial institutions to countries where FGM is practiced is to be curtailed if educational programs to prevent FGM are not implemented.

WHO Definition and Classification of FGM

Definition and Classification of Female Genital Mutilation

Preamble

Female genital mutilation is a deeply rooted, traditional practice. However, it is a form of violence against girls and women that has serious physical and psychosocial consequences which adversely affect health. Furthermore, it is a reflection of discrimination against women and girls.

WHO is committed to the abolition of all forms of female genital mutilation. It affirms the need for the effective protection and promotion of the human rights of girls and women, including their rights to bodily integrity and to the highest attainable standard of physical, mental and social well-being.

WHO strongly condemns the medicalization of female genital mutilation, that is, the involvement of health professionals in any form of female genital mutilation in any setting, including hospitals or other health establishments.

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 of 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 falls under the definition of female genital mutilation given above

APPENDIX B

PAST USAID ACTIVITIES ADDRESSING FGM

This appendix provides a detailed review of USAID activities addressing FGM during the period 1980-1996. It covers three broad areas: intra-agency capacity building, collaboration and consultation, and financial support to projects and programs.

1980s

Intra-agency Capacity Building

1980 In June 1980, USAID/W (Office of Population and Africa Bureau) sent a cable to 24 Missions in affected countries encouraging them to support local action against FGM.[5] Suggested interventions included research on the prevalence and the physical and psychological effects of the practice, and the design of appropriate medical and educational interventions for health and family planning projects. Mission staff, CAs, and local organizations were also provided with updated information packets (no copies were found on file). In addition, they were offered support for addressing FGM, but the nature of that support was not made clear.[6]

In response to this cable, Missions in Zaire, Liberia, Upper Volta (now Burkina Faso), Tanzania, and Kenya reported on the prevalence of the practice. Three Missions (Egypt, Togo, and Somalia) responded to the cable with concrete requests for funding and/or technical assistance. USAID/Egypt reported working with the Egyptian Ministry of Health on the issue. They were then provided with a list of informed and experienced Egyptian women in the NGO sector with whom they could work. USAID/Togo requested funding to support the Togolese Association for Family Well Being (ATBEF) in designing appropriate medical and educational interventions, and to develop training materials and information on the harmful effects of FGM for incorporation into Togo Family Health Center projects. USAID/W expressed the desire to assist the Mission and ATBEF by identifying a funding source. USAID/Somalia requested USAID/W support to fund National Committee efforts, including data collection, mass education campaigns, and research on the physiological effects of FGM. While these requests may have been followed up by the Office of Population or the Africa Bureau directly or through CAs, it was not possible

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[5]The full text of this cable is provided at the end of this appendix.

[6]Some Missions were already giving financial support to FGM projects prior to receiving this cable. For example, the Mission in Somalia was already supporting IEC projects at the village level, as well as research. No reports on the outcomes of these projects were available in the files. The Mission in Sudan also reported giving support for activities, the details of which were not found.

to find documented evidence that such technical and financial support was made available.

Also in 1980, USAID commissioned a review of all existing medical and scientific literature on FGM. The study, conducted by the Division of Program and Policy Analysis of the Office of International Health at the U.S. Department of Health and Human Services, describes the geographical distribution of the practice in Africa and Asia, age at circumcision by tribe and region, and sociological reasons for and health impacts of the practice. The study includes an annotated bibliography in French and English of available literature.

1981 In 1981, the Office of Health was charged with the coordination of an Inter-Bureau Task Force on FGM to respond to external inquiries and increase agency capacity and overall coordination. This task force worked with Regional Bureaus and Missions to design appropriate country activities toward eliminating FGM, and to respond to external inquiries about the agency's efforts in this area. No documentation was found on what this task force achieved and how it was eventually dissolved.

Collaboration and Consultation

1981 In 1981, in line with its principle of working in coordination with other donors and agencies, USAID issued a joint statement with the World Health Organization (WHO) and the United Nations Children's Fund (UNICEF) expressing readiness to support governments in their efforts against FGM. However, there is no evidence that this statement led to collaborative activities or that any of the U.N. agencies received USAID funding to undertake FGM work.

Financial Support to Projects and Programs

Documents on USAID's activities on FGM in the 1970s and 1980s indicate early interest in integrating the issue into a variety of agency-supported programs, such as family planning services and democracy and governance initiatives. A range of partners was identified that included international CAs and local advocacy organizations. There is no evidence that such integration actually took place during the period.

During the 1980s, USAID-supported FGM projects focused primarily on survey research to determine the prevalence of the practice in specific countries or communities. Some clinical studies to document complications were supported as well. There was also support for what is termed "action-oriented research," which included the study of beliefs and attitudes, geared toward the development of informational material and services. Other activities included training for health care providers and community leaders, as well as information dissemination. It is important to note here that although some information is available on the

projects USAID funded in the 1980s, little information was found on the nature and outcome of these projects, and no evaluation of their quality or impact. No project reports or published results were found, with the exception of an FGM training module developed by the Institute for Development Training (see below).

1981 In 1981, USAID/Egypt offered assistance to the Ministry of Health in addressing FGM. This assistance included support for additional midwives in the Ministry's training and education program.

In response to the 1981 USAID/W cable discussed above, the Mission in Sudan considered including FGM eradication when designing a major health-sector project in the country. No further information is available as to whether that proposed activity took place.

1982 In 1982, USAID/Somalia funded and established a three-year Family Health Initiative Project, aimed at improving and expanding maternal and child health services to include family planning as an integral part of primary health care. The project was designed to provide family planning services through existing health facilities; provide training to medical staff, traditional birth attendants, and community health workers; and support IEC activities using radio, newspapers, community-orientation centers, and family life education centers, as well as women's organizations and grassroots networks. One major outcome of the project was the 1983 Somali Fertility and Family Planning Survey in Urban Somalia (covering five major cities). This survey included a module with 17 questions on female circumcision. The program also funded the participation of Somalis in the Inter-African Committee meeting in Senegal.

1983 In 1983, USAID contracted with the Institute for Development Training, University of North Carolina, to develop a handbook on FGM. The resulting volume, *Health Effects of Female Circumcision*, covers prevention, diagnosis, and treatment of complications. This handbook, published in Arabic and English, was part of a series of training materials on women's health to be incorporated into family planning training programs in Africa and the Near East. No report was found on the extent to which that module was used or on an assessment of its impact in the documents reviewed for this study.

1984-1990 In 1984, USAID funded the Somali Family Health Services Project, aimed at improving the health and well-being of Somali families. A coalition of governmental and nongovernmental agencies, including the Somali Health Care Association, the Ministry of Health, the Somali Women's Democratic Organization, the Institute of Women's Education, and the Ministry of Planning, implemented the project. Major activities included seminars for policy makers and religious leaders, government and youth institutions, and health professionals; training; information campaigns; operations research activities; media training; and production of IEC support materials. FGM elimination messages were an integral part of the project activities,

and were included in all curricula, training programs, seminars, community-based campaigns, and outreach to religious leaders. An operations research component supported all project activities. Unfortunately, all data, reports, and documentation of impact were lost in the evacuation of the USAID Mission and Civil War in 1990-1991.

During this period, USAID/Ghana supported the DANFA Rural Health Project on maternal and child mortality, which included gathering information on FGM and designing appropriate medical and educational interventions.

In Egypt, the Pathfinder Fund (now Pathfinder International) used USAID funds to support the Alexandria Family Planning Association in training community leaders to provide family planning education, and to identify and counsel new mothers against circumcising their daughters. The project was budgeted at $25,000.

1990s

Intra-agency Capacity Building

1993 On July 24, 1993, the Office of Women in Development and the Office of Health sent a joint cable to USAID Missions in Africa, Asia, and the Near East requesting information on FGM practices and opportunities for action in host countries.[7] The Office of Health summarized the 15 Mission responses received. These indicated a significant prevalence of FGM in USAID host countries in Africa. They also highlighted opportunities, as well as interest and willingness, for providing support to governments and NGOs addressing FGM in the areas of family planning programs, democracy and governance activities, and educational campaigns. However, at the time, support by USAID Missions for FGM activity was reported only from Senegal and Ghana.

In December 1993, the Office of Women in Development, coordinator of the Intra-agency Working Group on FGM (see below) sent another cable to 30 Missions containing a summary of the latest information on FGM as published by Nahid Toubia, M.D., in 1993. A copy of Toubia's publication *Female Genital Mutilation: A Call for Global Action* was sent by pouch to all relevant Missions. The cable encouraged the Missions to support local organizations already working to prevent the practice, such as the Inter-African Committee national affiliates, and to consider incorporating FGM activities into ongoing programs in areas such as health, human rights, and education. Among the 10 responses to that cable, Missions in Cameroon,

[7]The full text of this cable, as well as that discussed in the next paragraph, is provided at the end of this appendix.

Ghana, Kenya, Mali, and Senegal reported that they were already supporting FGM-related activities (see the section below on "Financial Support to Projects and Programs").

Additionally, the Bureau for Africa initiated research through the Support for Analysis and Research in Africa (SARA) Project on the possible linkage between FGM and increased risk of HIV. A report from the project concluded that there was little evidence to support the link and that further research was needed to verify the hypothesis. The report was made available to staff, CAs, and the public.

1993-1994 In December 1993-January 1994, a USAID/W-based Intra-agency Working Group on FGM was established to share and disseminate information about FGM, to coordinate FGM activities within the agency, and to advise the agency on appropriate actions. Starting out as an agency-wide, high-profile initiative, the working group quickly became a smaller body committed to practical activities toward increasing awareness of and investment in FGM. Although all relevant divisions continue to be members of the working group, attendance depends on the ability of staff to free themselves from their primary commitments. The group takes a multisectoral and gender-based approach to FGM, and seeks to incorporate attention to FGM into ongoing activities related to human rights and reproductive health. Reflecting the 1980s principle of working with other donors and agencies, the working group is committed to gathering information and lessons learned from other donors, U.S. private voluntary organizations, and NGOs in various African countries. More concretely, after the congressional mandate to use $1 million in fiscal year 1995 for FGM activities, the working group, with input from the Africa, Asia, and Near East Bureaus, identified priority areas and activities for the prevention of FGM, and made recommendations about the allocation of funds and responsibilities, including the development of this strategy. The working group continues to be active as of this writing.

Collaboration and Consultation

1993 By the mid-1990s, USAID was increasingly participating in regional and interagency activities to share information and strategies with other donors. In October 1993, the Office of Women in Development invited a group of African women from seven countries to share their views on FGM informally and candidly and discuss ideas for appropriate approaches to address the practice. In further consultations with African and American NGOs and health and human rights experts, and after a literature review, the office concluded that there was a need for concrete and appropriate steps by USAID to address FGM. However, no document was found that articulates in technical detail what these appropriate steps might be.

1994 In February 1994, the Office of Population organized a special session on FGM at the annual meeting of USAID's CAs in Washington. The latest information available was reviewed, and recommendations for action by Missions, CAs, and USAID/W were proposed. A summary of information presented at the session was included in the report of the CA meeting, which was distributed throughout the agency.

In April 1994, USAID provided support to the Inter-African Committee to host a strategizing conference in Addis Ababa, Ethiopia. Representatives from the Office of Women in Development, USAID/Ethiopia, and REDSO/East and Southern Africa attended the meeting. A trip report by Sylvie Morel-Seytoux was distributed, and included the following recommendations for USAID action against FGM:

- As local mechanisms such as the Inter-African Committee are in place, USAID can and should continue its approach of supporting local initiatives.

- Given the range of FGM practices and different contexts on the continent of Africa, care must be taken to design projects to reflect local realities if interventions are to be effective and sustainable.

- FGM education campaigns are essential in all countries, even those with legislation banning the practice.

- Where appropriate, information on the harmful consequences of FGM should be included as an integral part of USAID's ongoing family planning, HIV/AIDS, reproductive health, and maternal and child health projects; literacy programs; and school curriculum development programs.

- The resolution of the Inter-African Committee to include FGM on the agenda of the 1995 Women's Conference in Beijing demonstrates that international involvement and support on FGM in Africa are welcome, as long as they are carried out in support of local initiatives.

1994-1995 In 1994 and 1995, USAID staff participated in the annual meetings of the Inter-agency Working Group on FGM, initiated and facilitated by RAINB♀, with the objective of helping international donor and technical agencies share information and coordinate activities on FGM. Representatives from African NGOs attended the meetings and briefed international agencies on in-country activities and ideas for donor involvement. Trip reports were prepared by staff attending those meetings and were distributed to other staff members. It was not possible to ascertain how widely documents and reports generated from these meetings were disseminated within Washington or to the Missions.

1995 In June 1995, USAID representatives participated in a Funders' Briefing on FGM, cosponsored by the Moriah Fund, the Special Projects Fund of Population Action

International, and the Public Welfare Foundation. This meeting enabled USAID staff to learn about other donors' approaches and investments in FGM prevention and eradication, and funding opportunities and strategies. The Office of Women in Development took further steps to communicate with other donors, including the World Bank, WHO, and UNICEF, on the issue of FGM. No written documents were made available to clarify the nature of these communications.

Also in June 1995, USAID sent a representative to the WHO Technical Working Group on FGM, where FGM classification was established (see Appendix A).

Financial Support to Projects and Programs

Financial and technical support from USAID for projects addressing FGM increased considerably in the mid-1990s. Project support through Washington included funds for research, development of training and IEC materials, and advocacy and legal reform projects. Most of these projects are still ongoing, and no information is as yet available on their outcomes and evaluation.

1993 In 1993, USAID/Senegal supported the Ministry of Public Health and Social Action's communication outreach program emphasizing the impact of FGM on women's and children's health, HIV/AIDS prevention, and other related issues that influence the practice of FGM.

Also in 1993, in response to the July and December cables from USAID/W requesting information on FGM (see above), several Missions reported supporting FGM activities in the area of advocacy and legal reform. USAID/Mali, through democracy and governance human rights funds, supported the Mali Committee for the Protection of Women's and Children's Rights in launching a civic and health education program aimed at eradicating FGM. They also encouraged further proposals from local activists and researchers. USAID/Ghana, Cameroon, Kenya, and Mali provided travel support for local activists to attend regional and international advocacy meetings on FGM. USAID/Kenya reported establishing a small working group on FGM to assist in reviewing and updating their strategic thinking on the matter. Other Missions reported that they were assessing how best to integrate FGM into their activities and requested assistance for developing sustainable responses. Activities supported included travel to international and regional conferences on FGM and research on the magnitude of the problem. Possible mechanisms for action were suggested, including family planning programs, maternal and child health programs, HIV/AIDS projects, and democracy and governance programs.

In general, the responses demonstrated a high level of concern by the Missions, and varying levels of FGM support. For example, the response from the Mission of the Central African Republic indicated that they had used human rights funds to support

the development of a comic book on FGM in French and Sangho. The Mission seriously questioned the 50 percent prevalence rate quoted by Toubia in her publications, and asked to review the evidence and methodology that led to these figures. This request was never forwarded to the author, indicating lack of follow-up and inability to provide informational support on an ongoing basis. The Mission of the Central African Republic also passed on the information that the United Nations Population Fund (UNFPA) was supporting a survey designed to update the country's family code and that the second phase would include questions on the prevalence of FGM. There is no evidence that the results of that survey were forwarded for dissemination within the USAID system.

1994 In fiscal year 1994, USAID/W for the first time allocated funds earmarked for support of FGM activities. Internal USAID documents quote a figure of US$500,000 for fiscal year 1994, allocated to projects in Kenya and Egypt.

In 1994, the Offices of Population and Women in Development provided financial support to RAINB♀, through Pathfinder International, to work in collaboration with members of the Egyptian Task Force on FGM to develop training material on FGM. This material will include issues of concern for women's reproductive and sexual health, as well as topics on gender relations. The material is directed at trainers who come in contact with illiterate or semiliterate women and men through adult education, health services, family planning, or agricultural rural extension projects. The beliefs and attitudes of the target population were studied through focus group discussions, and training modules are being designed to deal with myths and misinformation about the basic physiology and anatomy of the body, causes of disease, and issues of sexuality and fertility. The section dealing directly with FGM addresses both the health and human rights problems that result from the practice. The material is in Arabic and contains several illustrations in the training book and accompanying posters for the classroom. The project will conclude by the end of 1996.

The Office of Women in Development and the Office of Health and Nutrition also supported a project in 1994 to develop pilot IEC materials for FGM prevention in Kenya through the BASICS project. The Seventh Day Adventist (SDA) Rural Health Services in Kenya will work, with technical assistance from the Program for Appropriate Technology in Health, toward promoting the gradual reduction of FGM in project sites through appropriate IEC interventions, prevention of early marriage and teen pregnancy, and promotion of education and other opportunities for girls. Project objectives are to increase community awareness of the harmful effects of FGM, educate and mobilize health professionals and members of the SDA Church to join efforts to eradicate FGM, and include these efforts in the development agenda of the district where the communities are situated. Under the direction of SDA, qualitative research will be conducted on the knowledge, attitudes, and practices of health care workers (seen as potential agents of change) toward FGM in their

communities, as well as the factors that perpetuate the practice. Informed by the research findings, the project intends to hold local and national dissemination workshops to share research findings with policy makers, community members, and appropriate health care workers. The project will also design and implement appropriate interventions that focus on health workers and the community, conduct media and materials development training for project staff and volunteers, and conduct outreach activities.

1994-1995 In fiscal years 1994 and 1995, FGM survey research was included as part of the work plans and budgets of ongoing survey research projects in the Office of Population. In 1994, the Demographic and Health Surveys (DHS) Program, supported primarily by USAID, conducted surveys in collaboration with the governments of the Central African Republic and Cote d'Ivoire. Survey results provided the first reliable data on the prevalence of FGM in these countries.

1995 In fiscal year 1995, USAID was mandated by Congress to use $1 million to "develop and integrate, where appropriate, educational programs to eradicate FGM into its population, health, education, and women in development activities." This funding allowed several existing agency-supported CAs to address FGM through mechanisms such as operations research and technical assistance to local groups. In addition, the Women in Development Office supported PROWID, a small grants program that supports innovative pilot interventions, operations research, and advocacy conducted by community-based institutions and NGOs to demonstrate ways in which women can be better involved in and benefit from development interventions across a wide range of sectors. These sectors include women's participation in economic development, legal rights, women's health and nutrition, reproductive rights, education and training, and the environment. PROWID is administered through a cooperative agreement with the International Center for Research on Women and the Center for Development and Population Activities to strengthen the efforts of women's groups and community organizations to educate communities, the media, and policy makers about human rights and to implement preventive programs, including legal reform. The program includes specific funding to support activities addressing the legal and human rights aspects of FGM.

Also in fiscal year 1995, the Office of Population supported the inclusion of FGM components in the Operations Research/Technical Assistance (OR/TA) Africa Project II of the Population Council. The OR/TA Project is a five-year research program to improve the quality and expand the delivery of family planning and reproductive health services in sub-Saharan Africa. The project's research priorities include incorporating gender concerns in family planning programs. With regard to FGM, a project is being supported in Mali to develop and test community-focused intervention models. Interventions include training of community health workers in methods to prevent FGM and IEC campaigns to educate communities about the harmful nature of

the practice. Additionally, alternative skills and income sources for circumcisors, as well as alternative initiative rites for young girls, will be explored.

Also in 1995, the Office of Health and Nutrition responded to a request by the Guinean Inter-African Committee national affiliate, CEPTAFE, for support for FGM research and IEC activities. A needs assessment and three-part community-based project were supported through a MotherCare contract, with technical assistance from PATH. Components of this CEPTAFE/MotherCare/PATH project include research, institutional capacity building, and a social communications intervention that can serve as the basis for refocusing as well as expanding the existing national FGM eradication program. Qualitative and quantitative research will be conducted in urban and rural communities in two regions of Guinea to measure prevalence and the knowledge, attitudes, and practices of men, women, and youth; to identify myths related to the practice; and to identify decision makers and possible entry points for community education. Case studies will be developed with both practicing and nonpracticing excisors to learn how excision practices are carried out and change over time, and what is needed to eradicate FGM in urban and rural communities. In response to a recent Eritrean request for FGM-specific support, PATH will also work with a local agency and community representatives there to develop and implement a project, with support from the Office of Health and Nutrition through the MotherCare Project.

CABLE 1

The following is the text of the cable sent to the following Missions on June 27, 1980, by A.I.D.

Missions: Khartoum, Mogadishu, Nairobi, Cairo, Kampala, Dar es Salaam, Bangui, Lagos, Ouagadougou, Abidjan, Bamako, Conakry, Freetown, Dakar, Nouakchott, Monrovia, Lome, Cotonou, Yaounde, Brazzaville, Kinshasa, Niamey, Sana, N'Djamena

"1. The practice of female genital mutilation (also termed female circumcisio particularly in Africa) poses a serious health problem for women and young gir in Africa and parts of the Near East. It is estimated that between 30 and 75 million women and female children have been subjected to the procedure.

2. The WHO Seminar in Khartoum on "Traditional Practice Affecting the Health of Women and Children" and the Africa Regional Preparatory Meeting for the UN Mid-Decade Conference on Women in Lusaka included specific discussion of female genital mutilation. As a result the issue has been raised within the U.N. system and will certainly be adressed at the U.N. Conference in Copenhage in July.

3. Recent Congressional testimony and magazine articles in the U.S. have brought increased attention to this problem. I met with the Assistant Secretary of State for Human Rights on May 20, 1980, to discuss A.I.D. initiatives in this area and have endorsed Agency efforts to deal with this issue.

4. A.I.D./W has established an Inter-Bureau Task Force the responsibilities of which are to work with Regional Bureaus to assist Missions to design appropriate country activities toward elimination of the practice and to respond to outside inquiries made about A.I.D.'s efforts in this area.

5. Because of the cultural and political sensitivities associated with the practice, USAIDS may wish to maintain a low profile while exploring the problem. Some of the activities which A.I.D. Missions should consider initiating include the following:

a. Collection of data on the prevalence of the practice, preferably by funding local researchers.

b. Support of research by Host Country personnel on the physiological and psychological effects of the practice on women.

c. Design of appropriate medical and educational interventions to be included in health/family planning projects.

d. Information dissemination to discourage the practice."

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Continuation of Text:

"6. In addition to materials previously sent, a separate packet of background information is being pouched to all missions in regions where female genital mutilation practices prevail. Mission personnel are asked to read these materials. Africa Bureau will be sending further materials; Africa Missions are requested to take this material into consideration in their thinking about 5 above. Missions in other regions may also find the Africa material useful; it is available on request.

7. Individual Mission' efforts to investigate aspects of the practice of female genital mutilation in their countries are greatly appreciated. Missions are also requested to send comments and further questions back to AID/W Bureaus along with specific information on the following, to the extent that it is available: (Missions which have already provided this information need not repeat it.)

a. The type and extent of female genital mutilation practices known to exist in their countries.

b. Initiatives being taken or planned by donors or Host Governments to discourage or eliminate the practice.

c. Any information regarding the use of AID-funded health equipment and/or procedures to perform female genital mutilation procedures. (Ms. Fran Hosken, Editor, Women's International Network News has made allegations to the Senate Appropriations Committee that this has occurred.) "

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TELEGRAM

CABLE 2

AGENCY FOR INT'L DEV.
TELECOMMUNICATIONS CENTER

PAGE 01 STATE 226168 241338Z 3388 062958 AID4164
ORIGIN AID-00

ORIGIN OFFICE VID-01
INFO AFEA-04 AFSA-03 AFSW-06 AFCW-04 ASAA-01 AFFE-02 AFAR-05
ASDR-01 POSP-01 POID-01 RDAA-01 NEAL-04 ADA-03 SCOP-01
NEME-03 SERP-01 SECS-02 AHAD-01 NENA-03 ASSA-03 NEDP-03
FARP-02 ASCA-02 NEAA-03 AFFW-02 POCE-01 MLC-01 REG-01
/066 A8 24/1238Z

INFO LOG-00 AF-00 NEA-00 OIG-04 SA-00 /000R

DRAFTED BY: AID/RD/VID:MJNEWITT:LL:DPS
APPROVED BY: AID/AA/RD:AVANDUSEN
AID/RD/N:REMREY (DRAFT) AID/RD/N:NSTARK (DRAFT)
AID/AFR/ARTS:RSUKIN (DRAFT) AID/AFR/ARTS:MPICARD (PHONE)
AID/DAA/ASIA:PFORBES (DRAFT) AID/DR/TR:GBLOOM (DRAFT)
AID/ASIA/DR:KAJONES (PHONE) AID/ASIA/SA:SCHERNENKOFF (DRAFT)
AID/ASIA/EA:LAROSS (DRAFT)
AID/NE/DR:NEL-SAMABARY (DRAFT)
AID/NE/DR:BJANSEN (DRAFT)
AID/NE/DR:MWINTER (DRAFT)
AID/NE/DP:VHOLLOREN (DRAFT)
AID/NE/DP:LLEDUC (DRAFT)

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P 241328Z JUL 93
FM SECSTATE WASHDC
TO USAID MISSIONS IN AFRICA PRIORITY
USAID MISSIONS IN ASIA
USAID MISSIONS IN NEAR EAST

UNCLAS STATE 226168

AIDAC

E.O. 12356: N/A
TAGS:
SUBJECT: OPPORTUNITIES TO HELP REDUCE THE PREVALENCE OF

FEMALE EXCISION AND INFIBULATION

ABIDJAN FOR REDSO/WCA
BANGKOK FOR USAID
ISLAMABAD FOR USAID
NAIROBI FOR REDSO/ESA
NAIROBI FOR USAID

1. MEMBERS OF AN INFORMAL WORKING GROUP FROM THE RD/VID AND HEALTH OFFICES MET ON JUNE 24, 1993 WITH THE ACTING AA/RD, ANN VAN DUSEN, TO DISCUSS WHAT INITIATIVES ARE CURRENTLY BEING UNDERTAKEN TO ELIMINATE FEMALE EXCISION AND INFIBULATION (KNOWN ALSO AS FEMALE CIRCUMCISION OR FEMALE GENITAL MUTILATION) AND HOW SUCH EFFORTS COULD BE EXTENDED THROUGH EXISTING PROJECTS AND FUNDING MECHANISMS. THERE WAS GENERAL AGREEMENT OF THE NEED TO FIND WAYS TO PROVIDE MORE SUPPORT TO LOCAL NGO INITIATIVES AND WOMEN'S GROUPS WHO ARE CONCERNED WITH THIS ISSUE. HOWEVER, PRIOR TO RECOMMENDING ADDITIONS TO EXISTING ACTIVITIES, THE WORKING GROUP AGREED THAT WE SHOULD FIRST HEAR WHAT IS HAPPENING ON THE GROUND AND FROM THE FIELD PERSPECTIVE.

2. SPECIFICALLY, WE WOULD APPRECIATE YOUR RESPONSES TO THE FOLLOWING QUESTIONS:

(A) WHAT IS THE SITUATION REGARDING THESE PRACTICES IN THE COUNTRY IN WHICH YOU WORK (I.E., PREVALENCE, TRADITIONS, REGULATIONS AND LAWS PREVENTING THESE PRACTICES, EDUCATION AND INFORMATION CAMPAIGNS, RELEVANT NGOS AND WOMEN'S GROUPS, ETC.)?

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(B) WHAT SOURCES OF DATA ARE AVAILABLE ABOUT SUCH PRACTICES AND HOW RELIABLE ARE THESE SOURCES?

(C) WHAT IS THE POSITION OF GOVERNMENT CONCERNING THESE PRACTICES?

(D) WHAT ACTIVITIES TO DATE TO YOUR KNOWLEDGE HAS USAID UNDERTAKEN TO PREVENT AND/OR ELIMINATE FEMALE EXCISION AND INFIBULATION?

(E) WHICH ACTIVITIES HAVE BEEN MOST SUCCESSFUL?

(F) WHAT IS KNOWN ABOUT THE CONSEQUENCES OF FEMALE EXCISION AND INFIBULATION IN YOUR COUNTRY (E.G., HEALTH IMPACTS, ETC.)?

(G) WHAT OPPORTUNITIES DO YOU SEE FOR FURTHER A.I.D. INVOLVEMENT AND SUPPORT FOR ELIMINATING THESE PRACTICES?

3. AS YOU ARE UNDOUBTEDLY AWARE, THE UNITED STATES GOVERNMENT VIEWS FEMALE EXCISION AND INFIBULATION AS VIOLATIONS OF HUMAN RIGHTS. A.I.D. DOES NOT CONDONE THESE PRACTICES AND HAS JOINED WITH THE WORLD HEALTH ORGANIZATION AND UNICEF IN OFFERING TO SUPPORT GOVERNMENT INITIATIVES TO ELIMINATE THEM. WHILE THERE IS REPORTED PROGRESS IN ERADICATING FEMALE EXCISION AND INFIBULATION IN SEVERAL AFRICAN COUNTRIES, IT IS BELIEVED BY SOME THAT

84 MILLION AFRICAN WOMEN ALIVE TODAY HAVE BEEN AFFECTED BY THESE PRACTICES AND THESE PRACTICES CONTINUE. THUS, CONTINUING TO SUPPORT INDIGENOUS ERADICATION EFFORTS SHOULD REMAIN AN IMPORTANT CONCERN.

4. THANK YOU FOR RESPONDING TO THE ABOVE QUESTIONS AND WE LOOK FORWARD TO SHARING THE RESULTS OF THIS EFFORT WITH YOU. IF YOU HAVE ANY QUESTIONS, PLEASE CONTACT LYNELLYN LONG (RD/VID), NANCY STARK (RD/N) OR BOB EMREY (RD/N).

WARTON

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UNCLASSIFIED

CABLE 3

AGENCY FOR INT'L DEV.
TELECOMMUNICATIONS CENTER

OUTGOING
TELEGRAM

M. F. Anderson

PAGE 01 OF 03 STATE 387143 298808Z 5129 843578 AID1336
ORIGIN AID-00

ORIGIN OFFICE VID-01
INFO AFEA-04 AFSV-06 AFCV-04 AFDP-06 AFFE-02 ASTR-03 AFAR-05
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AAXA-01 NENA-03 ASSA-03 NEDP-03 NEDR-09 ASEA-02 AFON-06
NEAA-03 AGGE-01 /038 A6 LV 29/1658Z

INFO LOG-00 AF-00 NEA-00 /003R

DRAFTED BY: AID/G/RD/VID:KBLAKESLEE:JPM
APPROVED BY: AID/G/RD/VID:KBLAKESLEE
AID/A:MMARLETT AID/POL/PAR/GWILL
AID/A:RMCCALL AID/RD/A/AA/G:AVANOUSEN
AID/A/DAA/G:DGILLESPIE AID/AFR/DAA:DCOBB
AID/AFR/DP:JGOVAN AID/AFR/SA:KBROWN
AID/AFR/SVA:JGILMORE
AID/AFR/ARTS:JVOLGIN
AID/DAA/ANE:LMORSE
AID/ASIA/TR:KAJONES
AID/ANE/ASIA/SA:SCHERNENKOFF
AID/ASIA/EA:LAROSS
AID/NE/DR:SSXAN
AID/G/RD/N:RWRIN
AID/G/RD/POP:EMAQUIRE
AID/G/RD/POP:MNEUSE
STATE/AF/E:TANDREWS (PHONE)
AID/G/RD/N:BEMREY (INFO)
AID/G/RD/N:NSTARK (INFO)
AID/AFR/ARTS:NSUKIN (INFO)
AID/AFR/ONI:MPICARD (INFO)
AID/AFR/ONI:VDREYER (INFO)
AID/ASIA/TR:GBLOOM (INFO)
AID/NE/DP:LLEDUC (INFO)
AID/NE/DR:NELSANABARY (INFO)
AID/LPA/LEG/CL:DRAYBURN (INFO)

AID/LPA/XA/PL:KANDERSON (INFO)
AID/G/RD/VID:DSCHUMANN (INFO)
AID/G/RD/VID:SMOREL-SEYTOUX (INFO)
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FM SECSTATE WASHDC
TO AMEMBASSY COTONOU
AMEMBASSY OUAGADOUGOU
AMEMBASSY YAOUNDE
AMEMBASSY NDJAMENA
AMEMBASSY ABIDJAN
AMEMBASSY CAIRO
AMEMBASSY ADDIS ABABA
AMEMBASSY BANJUL
AMEMBASSY ACCRA
AMEMBASSY CONAKRY
AMEMBASSY BISSAU
AMEMBASSY TEL AVIV
AMEMBASSY AMMAN
INFO AMEMBASSY BANGUI
AMEMBASSY DJIBOUTI
AMEMBASSY FREETOWN
AMEMBASSY KHARTOUM
AMEMBASSY ABU DHABI
AMEMBASSY NAIROBI
AMEMBASSY BAMAKO
AMEMBASSY NIAMEY
AMEMBASSY LAGOS
AMEMBASSY MUSCAT
AMEMBASSY DAKAR

AMEMBASSY DAR ES SALAAM
AMEMBASSY LOME

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AMEMBASSY TUNIS
AMEMBASSY KAMPALA
AMEMBASSY SANAA
AMEMBASSY KINSHASA

UNCLAS STATE 387143

AIDAC FOR MISSION DIRECTORS

E.O. 12356: N/A
TAGS:
SUBJECT: SUPPORTING PREVENTION OF FEMALE GENITAL MUTILATION

NAIROBI PLEASE POUCH TO MOGADISHU

FEMALE GENITAL MUTILATION AND USAID PROGRAMS:

1. SUMMARY: A SERIES OF RECENT EVENTS BOTH WITHIN AND OUTSIDE THE AGENCY HAS BROUGHT CONSIDERABLE ATTENTION TO THE ISSUE OF FEMALE GENITAL MUTILATION (FGM). FGM WAS ADDRESSED AS A HUMAN RIGHTS ISSUE AT THE HUMAN RIGHTS CONFERENCE IN VIENNA IN JUNE, 1993. PUBLIC ATTENTION ON THE ISSUE INCREASED AFTER THE ABC TELEVISION PROGRAM, "DAY ONE," FEATURED THE TOPIC OF FGM IN SEPTEMBER, 1993. LETTERS TO USAID FROM THE PUBLIC EXPRESSING CONCERN HAVE FOLLOWED. IN SEPTEMBER 1993, RICHARD MCCALL, USAID CHIEF OF STAFF, TESTIFIED BEFORE THE SUBCOMMITTEE ON INTERNATIONAL SECURITY, INTERNATIONAL ORGANIZATIONS AND HUMAN RIGHTS OF THE HOUSE COMMITTEE ON FOREIGN AFFAIRS, AFFIRMING FGM AS A SERIOUS VIOLATION OF HUMAN RIGHTS. PUBLIC ATTENTION TO THE ISSUE HAS CONTINUED AS A RESULT OF THE AMERICAN AUTHOR, ALICE WALKERIS, RECENTLY PRODUCED DOCUMENTARY, "WARRIOR MARKS," ON THE TOPIC OF FGM IN AFRICA. AN ARTICLE IN THE DECEMBER 20, 1993 ISSUE OF NEWSWEEK DISCUSSES THE DEBATE EVOLVING FROM WALKERIS BOOK.

2. ON JULY 24, 1993, THE OFFICE OF WOMEN IN DEVELOPMENT AND THE OFFICE OF HEALTH SENT A CABLE (STATE 226168) TO USAID MISSIONS IN AFRICA, ASIA AND THE NEAR EAST, REQUESTING INFORMATION ON FGM PRACTICES IN THE HOST COUNTRIES. ON OCTOBER 23, 1993 THE WID OFFICE INVITED A GROUP OF AFRICAN WOMEN, REPRESENTING SEVEN AFRICAN COUNTRIES WHERE FGM IS PRACTICED, TO INFORMALLY AND CANDIDLY SHARE THEIR VIEWS ON FGM, AS WELL AS THEIR OPINIONS ON APPROPRIATE APPROACHES TOWARD ENDING THE PRACTICE IN AFRICA.

3. MANY AFRICAN HEALTH AND WOMENIS ORGANIZATIONS ARE MONITORING THE PRACTICE OF FGM, AND A NUMBER ARE ACTIVELY AND SUCCESSFULLY WORKING WITH LOCAL COMMUNITIES TO REDUCE THE PRACTICE. PROGRAMS RANGE FROM GRASS ROOTS HEALTH EDUCATION OUTREACH, TO NATIONAL MEDIA CAMPAIGNS. SUPPORT TO LOCAL NGOIS, INCLUDING LOCAL WOMEN'S ORGANIZATIONS, IS ONE OF THE BEST WAYS FOR USAID TO HELP IN THE PREVENTION OF THIS PRACTICE.

4. THE SUGGESTIONS AND INFORMATION OFFERED IN THIS CABLE ARE BASED ON INTERVIEWS WITH AFRICAN WOMEN, DISCUSSIONS WITH AFRICAN AND AMERICAN NGO LEADERS WORKING ON FGM SOLUTIONS, A REVIEW OF AVAILABLE LITERATURE ON FGM, DISCUSSIONS WITH HEALTH AND HUMAN RIGHTS EXPERTS, AND

INFORMATION PROVIDED BY USAID MISSIONS. MUCH OF THE STATISTICAL AND BACKGROUND INFORMATION ON FGM CAME FROM NAHID TOUBIA'S REPORT, "FEMALE GENITAL MUTILATION: A CALL FOR GLOBAL ACTION," PRODUCED BY WOMEN, INK., NEW YORK, NY, 1993. A COPY OF THIS PUBLICATION WILL BE POUCHED TO USAID MISSIONS IN AFFECTED COUNTRIES IN AFRICA, ASIA AND THE NEAR EAST. END SUMMARY

BACKGROUND ON FEMALE GENITAL MUTILATION:

5. FEMALE GENITAL MUTILATION, ALSO REFERRED TO AS FEMALE CIRCUMCISION, REFERS TO VARIOUS PRACTICES WHICH ALTER OR CUT THE FEMALE GENITALS, RANGING FROM INFIBULATION (THE MOST SEVERE PRACTICE WITH THE GREATEST HEALTH CONSEQUENCES), TO EXCISION. ALTHOUGH THE WESTERN MEDIA REFERS TO THE PROCEDURE AS FGM, MANY AFRICANS PREFER THE TERM FEMALE CIRCUMCISION. THE AGE AT WHICH FGM IS PRACTICED VARIES WIDELY, RANGING FROM AS EARLY AS INFANCY TO 16 YEARS OLD. MOST COMMONLY, GIRLS UNDERGO FGM BETWEEN THE AGE OF FOUR AND EIGHT YEARS.

PHYSICAL AND PSYCHOLOGICAL CONSEQUENCES OF FEMALE GENITAL MUTILATION:

6. FGM, ESPECIALLY IN ITS MOST SEVERE FORMS, CAN HAVE SERIOUS PHYSICAL COMPLICATIONS, INCLUDING: 1) HEMORRHAGING RESULTING IN ANEMIA WHICH CAN AFFECT A CHILDIS GROWTH, 2) INFECTIONS RANGING FROM ULCERATING WOUNDS TO GENERAL TOXIC INFECTION (SEPTICEMIA) THAT CAN LEAD TO DEATH, 3) SEVERE PAIN DURING THE OPERATION AS WELL AS IN THE LONG-TERM, 4) URINE RETENTION WITH ACCOMPANYING PAIN AND COMPLICATIONS, 5) A VARIETY OF SERIOUS OBSTETRICAL COMPLICATIONS, 6) SHOCK DURING THE PROCEDURE THAT CAN RESULT IN DEATH, AND 7) PERMANENT DAMAGE TO THE URETHRA OR ANUM, AMONG OTHERS.

7. FGM CAN ALSO HAVE SERIOUS NEGATIVE PSYCHOLOGICAL AND SOCIAL COMPLICATIONS. THE LITTLE RESEARCH THAT EXISTS IN THIS AREA SUGGESTS THAT FGM CAN HAVE A PROFOUND PSYCHOLOGICAL IMPACT ON WOMEN AND GIRLS. ALSO, DUE TO THE LONG PERIOD OF TIME IT TAKES TO HEAL AFTER THE PROCEDURE, THERE CAN BE A PROLONGED ABSENCE OF THE GIRL FROM FORMAL EDUCATION. HOWEVER, IT MUST BE ACKNOWLEDGED THAT MANY WOMEN ENDORSE THE PRACTICE BECAUSE IT IS PERCEIVED TO BE IMPORTANT FOR A NUMBER OF REASONS RELATED TO MORALITY, SOCIAL ACCEPTANCE, AND MARRIAGEABILITY.

PREVALENCE OF FEMALE GENITAL MUTILATION:

8. TOUBIA ESTIMATES THAT GLOBALLY, TWO MILLION GIRLS A YEAR, OR APPROXIMATELY 6,000 PER DAY, ARE AT RISK OF GENITAL MUTILATION. THE PRACTICING POPULATION IS OVER 5 PERCENT IN AFRICA, AND LESS THAN 1 PERCENT IN ASIA, EUROPE, CANADA, AND THE UNITED STATES (TOUBIA, 1993). ESTIMATES OF THE TOTAL NUMBER OF WOMEN WHO HAVE UNDERGONE FGM IN THE WORLD RANGE BETWEEN 85 AND 114 MILLION.

9. ACCORDING TO TOUBIA'S REPORT (1993), IN AFRICA THE PRACTICE OF FGM IN THE FOLLOWING COUNTRIES (WHERE USAID HAS MISSIONS) IS ESTIMATED TO BE: BENIN (50 PERCENT), BURKINA FASO (70 PERCENT), CAMEROON (DATA N/A), CENTRAL AFRICAN REPUBLIC (50 PERCENT), CHAD (60 PERCENT), COTE D'IVOIRE (60 PERCENT), DJIBOUTI (90 PERCENT), ETHIOPIA AND ERITREA (90 PERCENT), GAMBIA (60 PERCENT), GHANA (30 PERCENT), GUINEA (50 PERCENT), GUINEA BISSEAU (50

PERCENT), KENYA (50 PERCENT), MALI (75 PERCENT), NIGER (20 PERCENT), NIGERIA (50 PERCENT), SENEGAL (20 PERCENT), SIERRA LEONE (90 PERCENT), SOMALIA (98 PERCENT), SUDAN (89 PERCENT), TANZANIA (18 PERCENT), TOGO (50 PERCENT), UGANDA (5 PERCENT), AND ZAIRE (5 PERCENT).

10. THE LIMITED RESEARCH AVAILABLE INDICATES THAT THE PREVALENCE OF FGM VARIES ACCORDING TO EDUCATION, SOCIAL CLASS, AND RURAL OR URBAN HABITATION. THE PRACTICE TENDS TO BE THE HIGHEST IN POOR, RURAL COMMUNITIES WHERE EDUCATIONAL OPPORTUNITIES ARE LIMITED.

FEMALE GENITAL MUTILATION AND CHILDRENIS RIGHTS:

11. FGM IS PRIMARILY PERFORMED ON GIRLS BETWEEN THE AGES OF FOUR AND EIGHT. IT IS ESTIMATED THAT 99 PERCENT OF THOSE WHO UNDERGO FGM HAVE THE OPERATION WITHOUT PRIOR KNOWLEDGE OF WHAT IT INVOLVES.

SUGGESTIONS FOR ACTION BY USAID MISSIONS TO HELP REDUCE THE PREVALENCE OF FGM:

12. THE SERIOUSNESS OF FGM MERITS USAIDIS ATTENTION. MISSIONS ARE ENCOURAGED TO SUPPORT LOCAL ORGANIZATIONS WHICH ARE WORKING TO PREVENT THE PRACTICE, AND TO CONSIDER INCORPORATING FGM PREVENTION ACTIVITIES INTO ONGOING, RELEVANT PROGRAMS. THE ISSUE OF FGM SHOULD NOT BE SINGLED OUT IN A SENSATIONAL OR PATRONIZING MANNER, WHICH COULD RESULT IN AN ANTI-WESTERN CULTURAL BACK-LASH AT THE COMMUNITY OR COUNTRY LEVEL.

13. DUE TO THE MULTI-SECTORAL NATURE OF THIS PRACTICE, AND ITS BASIS IN GENDER ROLES, THE OFFICE OF WOMEN IN DEVELOPMENT WILL COORDINATE USAIDIS EFFORTS IN THIS AREA, WITH ACTIVE COLLABORATION FROM OTHER PROGRAMS, PARTICULARLY POPULATION, HEALTH, AND BUREAUS FOR REGIONS WHERE FGM IS AN ISSUE.

14. FGM IS A GENDER BASED SOCIO-CULTURAL, HEALTH, AND HUMAN RIGHTS ISSUE. THE NEGATIVE EFFECTS OF FGM ARE ON THE PHYSICAL AND PSYCHOLOGICAL HEALTH OF FEMALES, BUT THE PRACTICE IS ROOTED IN SOCIAL, ECONOMIC AND CULTURAL TRADITIONS ABOUT FEMALE IDENTITY AND MARRIAGE. FGM IS A VERY SENSITIVE AND CULTURALLY SPECIFIC PROBLEM, WHICH INVOLVES MANY PEOPLE IN THE COMMUNITY, INCLUDING MEN, WOMEN, GIRLS, BOYS, GRANDPARENTS, MID-WIVES, TRADITIONAL BIRTH ATTENDANTS, DOCTORS, NURSES, AND RELIGIOUS AND COMMUNITY LEADERS. PREVENTION EFFORTS MUST BE DESIGNED TO APPROPRIATELY REACH EACH TARGET GROUP AND TO BE CULTURALLY SENSITIVE. FOR EXAMPLE, PROGRAMS WHICH AIM TO CHANGE THE ATTITUDES OF MOTHERS AND DAUGHTERS MAY NEED TO INCLUDE MALES TO BE EFFECTIVE.

15. FGM PREVENTION PROGRAMS MAY NEED TO INCLUDE ALTERNATIVE INCOME GENERATING ACTIVITIES. THE VESTED INTEREST OF THOSE WHO PERFORM FGM IS LINKED TO THE CONTINUATION AND SPREAD OF THE PRACTICE. TRADITIONAL HEALTH WORKERS OR TRAINED HEALTH PERSONNEL WHO COME FROM POOR FAMILIES WITH LOW SOCIAL STATUS MAY EARN FROM PERFORMING FGM MANY TIMES WHAT ONE COULD EARN AS A NURSE

BEST AVAILABLE COPY

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APPENDIX C

VIEWS AND ACTIVITIES OF USAID MISSIONS AND LOCAL AFRICAN NGOs

As discussed in Section 1.3, questionnaires on FGM views and activities were sent to USAID Missions and local NGOs in Africa. Of the 47 questionnaires sent, 29 were completed and returned to RAINB♀—an overall response rate of 61.7 percent. Of the total sent, 16 were sent to Missions, with 11 responding (68.7 percent) and 31 to NGOs, with 18 responding (58 percent). Copies of the questionnaires are included at the end of this appendix.

C.1 National Situation

Six of the 11 responding Missions believe FGM is an issue of concern in their country, mainly because of its high prevalence, the recognition of its health consequences, the existence of an organized local movement in the country, and recognition of the violation of rights involved. The four Missions that believe FGM is not an issue of concern in their country cited a low level of awareness of its harmful effects, coupled with political and cultural sensitivities.

Generally, the Missions see national governments as the key players in any effort to eradicate FGM, and believe the absence of a national policy or laws and the lack of a firm government stand against the practice are the main obstacles to addressing the issue effectively. However, Missions differ widely on the other obstacles they perceive, which include the pressures and weight of tradition; a lack of awareness regarding FGM; a lack of funding, personnel, and technical support for Mission eradication efforts; a reluctance to have donors involved in sensitive issues; the influence of religion, especially Islam; resistance to change on the part of elders; opposition from practitioners of FGM, since it represents an economic activity for them; and various country-specific government problems (e.g., the lack of government in Somalia and the coup d'etat in Niger).

The main opportunity the Missions see for eradication efforts is the development of IEC and national awareness campaigns in coordination with policy makers, task forces (where they exist), NGOs, and academics. The Missions believe such joint efforts would get national governments involved and committed. Other main opportunities mentioned by the Missions include political support, training and support of health professionals, and the mobilization of women's organizations.

C.2 Mission Situation

The Missions that responded generally feel FGM is an appropriate issue for them to address. Two Missions believe the issue is not appropriate, mainly because recent funding limitations have forced them to place higher priority on other programs. Missions have addressed FGM through funding for research; through policy and advocacy collaboration with the Ministry of Health of the host country; and through integration into a number of existing USAID programs, including programs in reproductive health, child survival, maternal and child health, family planning, AIDS, and health and nutrition. One Mission has given funding to the Inter-African Committee. Missions were divided on what would be the most effective USAID approach to FGM. The majority believe bilateral mechanisms would be most effective, either alone or in combination with cooperating organizations or funding from regional offices, or both. Five Missions believe cooperating organizations would be most effective, either alone or in combination with the other mechanisms. When asked how they thought FGM would fit into their strategic objectives, almost half stated that FGM would fit into reproductive health interventions designed to contribute to lowering maternal mortality rates.

Missions were evenly divided on the best mechanism for effectively addressing FGM: three believe activities could be integrated into existing health or democracy and governance activities; three believe their main opportunity would be working with and supporting local NGOs, especially women's groups; and three believe their main opportunity would be funding through either the Ministry of Health, the Office of Women in Development, the Office of Democracy and Governance, or a U.S. private voluntary organization.

The primary Mission needs from USAID/W for effectively addressing FGM are funding, information on existing FGM programs, and training support. Missions overwhelmingly stated a need for information—from international organizations, from other Missions, and from local NGOs.

C.3 NGO Perceptions

There were 37 different donors reported as supporting FGM efforts in the eight countries in which the responding NGOs are located. Of the 18 respondents, 12 have worked with USAID on previous projects, while 8 have worked specifically on FGM projects. Primarily, these NGOs believe USAID could be most supportive, given its resources, by providing funds and start-up grants to NGOs, as well as technical assistance. A number of other possible types of support were mentioned, including coordination of information sharing; training in FGM diagnosis, management, and referral; training in communication for behavior change; research to document the extent of FGM; formulation of a global strategy against FGM and support for countries in their efforts to implement a national strategy; provision of school scholarships to young girls; and training for circumcisors in alternative employment. NGOs are troubled by the lack of financial support from USAID and its

existing bureaucratic procedures, and believe that if the agency worked with local NGOs and providers and showed serious commitment and sensitivity, much could be accomplished that NGOs cannot do on their own. All 18 respondents believe FGM activities should be integrated into existing programs. Like the Missions, NGOs believe FGM could be addressed in the following existing programs: family planning programs, including community-based distribution of contraceptives; AIDS and family health programs; reproductive health programs; maternal and child health programs; child survival programs; and democracy and governance human rights activities. On the other hand, NGOs believe they have been hampered by Mission closings and are concerned that FGM would take a subordinate role if integrated into existing programs, unless there were clear agreement on its priority.

4/8/96

USAID FC/FGM Review: QUESTIONNAIRE TO ALL MISSIONS & REDSOS

BACKGROUND

At the request of the United States Agency for International Development (USAID), the Research, Action, Information Network for Bodily Integrity of Women (RAINB♀O) is systematically reviewing the agency's past and present work on the prevention/eradication of female circumcision/female genital mutilation (FC/FGM) in order to develop a coherent strategy for future work. This assessment includes a review of key USAID documents, interviews with staff in Washington, information gathered from questionnaires to USAID Missions and local non-governmental organizations and individuals. The ultimate objective is for USAID to develop integrated and cost-effective strategies to foster the eradication of FC/FGM. A final report will be prepared by RAINB♀O and distributed by the end of 1996.

The Missions and REDSOs have an important leadership role, as well as a unique perspective on USAID's role, in addressing an issue like FC/FGM. The attached questionnaire was designed to solicit vital ideas, information and perspectives from Missions and REDSOs. It was developed by RAINB♀O, and reviewed and approved by members of the USAID Intra-agency Task Force on FGM, and includes general questions on policies on FC/FGM in country, the extent of Mission involvement, and appropriate (as well as inappropriate) mechanisms for action.

Please note that we refer to the practice as "FC/FGM," to allow for the diversity of views regarding the appropriate terminology.

Please ensure that this questionnaire is reviewed and filled out by the division/individual(s) most involved in FC/FGM or related activities. RAINB♀O will compile and analyze the responses and integrate this information into our analysis of the review and recommendations for future action for USAID's activities on FC/FGM. The information/opinions will be synthesized and analyzed for presentation in the final report to USAID. While information/opinions may be attributed to countries, nothing will be attributed to individuals.

We appreciate the time and effort that Mission staff will take in responding to this questionnaire, and have tried to make the questions straightforward, while allowing for a range of responses. Please feel free to include as much information as you would like. We have left extra space after each section, and urge you to add extra sheets if necessary. Additionally, when possible and appropriate, please attach any relevant documentation and include specific examples. Please feel free to pass a copy on to other colleagues at the Mission who are informed and involved in the issue.

Please send/fax/e-mail the completed questionnaire and any attachments to RAINB♀O, to arrive by Friday, May 3, 1996. If you have any questions, please contact Susan Izett or Eileen Conneely at RAINB♀O, 915 Broadway, Suite 1109, New York, New York 10010, U.S.A.
Phone: (212) 477-3318 Fax: (212) 477-4154 E-mail: nt61@columbia.edu. THANK YOU.

I. NATIONAL SITUATION

1. Please specify country:

2. Is FC/FGM generally recognized as an issue of concern in the country?
Please check appropriate response(s)
____ No ____ Yes
If no, why:
____ Low prevalence of the practice
____ Low awareness of harmful effects
____ Political/cultural sensitivities
____ Other issues seen as more important (please specify which issues below)
____ Lack of resources or infrastructure
____ Other, please specify below:

_____

If yes, why:
____ High prevalence of FC/FGM
____ Health consequences of FC/FGM recognized
____ Violation of rights recognized
____ Organized local movement against FC/FGM
____ International pressure to address FC/FGM
____ Other, please specify below:

_____

3. What has been the national response against the practice, if any?
Please check appropriate response(s)
____ Policy statements by government officials (President, ministers, etc.)
____ Ministry level involvement (please specify which ministries, below)
____ Legislation under discussion
____ Enacted legislation
____ Professional regulations or involvement (public health, medical, legal, educational, etc.)
____ Activities by local non-governmental organizations (research, IEC, national working group, etc.)
____ ctivities by international organizations operating in-country
____ Other, please specify below:

_____

4. Are you aware of other donors supporting efforts against the practice?
____ No ____ Yes

If yes, please specify donor, organization and activities supported:

5. What do you see as the main obstacles to effectively addressing FC/FGM in the country/region? *Please give specific examples, if possible*

6. What do you see as the main opportunities to effectively address FC/FGM in the country/region? *Please give specific examples, if possible*

7. Any other comments on National Situation:

II. MISSION SITUATION

1. Is FC/FGM seen as an appropriate issue for the Mission to address?
Please check appropriate response, and briefly elaborate below

____ No ____ Yes

Why?:

For the remaining questions in this section, please feel free to elaborate when necessary, and/or specify not applicable (N/A)

2. How would you say FC/FGM has been addressed within the Mission?
Please briefly elaborate below

____ As a discreet, vertically funded issue, addressed on a project-by-project basis
____ As an issue integrated into existing programs (such as reproductive health and family planning, WID, human rights, education, etc.)
____ Combination of the two
____ Other, please specify below:

_____

3. What Mission activities have been conducted on FC/FGM to date, if any?

____ Collecting information
If so, please specify what kind of information what it is used for.

____ Financial support to projects
If so, please specify types of projects (research and data collection, IEC, training, etc.), general project and annual budgets and start and end dates of projects. (And see 4. and 5. below)

____ Other activities, please specify below:

4. Which projects/activities supported have been most successful, and why?

5. Which projects/activities supported have been least successful, and why?

6. Which U.S. Government divisions are involved in FC/FGM activities?

____ U.S. Embassy
____ U.S.IS
____ USAID Mission (please specify divisions):
    ____ Population
    ____ Health & Nutrition
    ____ Women in Development
    ____ Democracy & Governance
    ____ Other, please specify below:

_____

7. Please specify, in what capacity the groups are involved? (Funding, coordination, participating/observing local activities, technical assistance, training, etc.)

Division: Capacity:

8. Are there any joint FGM activities between divisions?
____ No ____ Yes

If yes, please describe the project(s), as well as the rationale and breakdown of responsibilities

9. Which staff are involved?
Please specify title, whether they are direct hire or fellow, whether they are international or local hire. Please also specify if any individual(s) serve as point person(s) on FC/FGM at the Mission.

10. Any other comments on Mission Situation:

III. MECHANISMS FOR ACTION

1. What do you see as the opportunities specific to USAID addressing FC/FGM effectively? (e.g. funding, existing Mission relationships with NGOs, etc.)
Please give specific examples, whenever possible

2. What do you see as the obstacles specific to USAID addressing FC/FGM effectively?
Please give specific examples, whenever possible

3. In your experience/opinion, what is the most effective approach for USAID to use to support activities to address FC/FGM?

____ Bi-lateral mechanisms between Mission and local efforts
____ Support through Global Bureau's Cooperating Agencies
____ Funding from Regional Offices or REDSOs

____ A combination of these mechanisms

Please specify why, and indicate whether any mechanism is particularly suited to specific types of activities.

4. How would FC/FGM fit into the Mission's strategic framework if the Mission were to include/increase support for such activities?

5. What kind of support does the Mission need from USAID/W for USAID to effectively address FC/FGM? *Please feel free to briefly elaborate below*

____ Funds
____ Training (FGM information, advocacy skills, outreach and networking, research methods, program development, monitoring and evaluation, etc.)
____ Information on existing programs (USAID and others)
____ More active involvement
____ Less active involvement
____ Other, please specify below:

_____

6. What kind of support can the Mission provide USAID/W for USAID to effectively address FC/FGM?

7. What other kind of support does the Mission need to begin/optimize addressing FC/FGM from sources, such as local NGOs, international NGOs such as RAINB♀O, Cooperating Agencies, etc.? *Please feel free to briefly elaborate below*

____ Information from local organizations (local situation, needs, encouragement to address issue, etc.)
____ Information from international organizations (medical guidelines, research to date, existing networks and resources, sharing strategies, etc.)
____ Information from other Missions (information exchange, strategies that have worked, strategies that have not, etc.)
____ Training (advocacy, policy, information on FC/FGM)
____ Other, please specify below:

8. Any other comments on Mechanisms for Action:

IV. OTHER SOURCES OF INFORMATION

1. Are there key documents on FC/FGM within the Mission and the country that you would recommend that would provide further information on the Mission's approach and involvement in FC/FGM activities (strategic plan, Mission statement, policies, funding guidelines, call for proposals, project reports, etc.)? *Please list, and attach when possible*

2. Could you recommend local experts who have worked with the Mission on the issue of FC/FGM or related issues, whose perspectives on USAID's work on FGM would be helpful.

Please include contact information, when possible

3. Any other comments on Other Sources of Information:

Please feel free to add any additional comments. Thank you.

4/8/96

USAID FC/FGM Review: QUESTIONNAIRE TO NGOS & INDIVIDUALS

BACKGROUND

At the request of the United States Agency for International Development (USAID), the Research, Action, Information Network for Bodily Integrity of Women (RAINB♀O) is systematically reviewing the agency's past and present work on the prevention/eradication of female circumcision/female genital mutilation (FC/FGM). This assessment includes a review of key USAID documents, interviews with USAID staff in Washington and a questionnaire to USAID Missions and regional offices in relevant countries. The ultimate objective is for USAID to develop appropriate, integrated and cost-effective strategies to foster the eradication of FC/FGM.

We are reaching out to local experts like yourself, who work in the area of FC/FGM and related issues, and who have had experience with donors such as USAID. We are interested in your perspective concerning the question of how donors can best support activities addressing issues like FC/FGM. This questionnaire was designed by RAINB♀O, and reviewed and approved by members of the USAID Intra-agency Task Force on FGM. It seeks to gather vital ideas, information and observations of local leaders like yourself, and includes general questions on advocacy related to FC/FGM in country, the role of donors in general, the role of USAID in particular and the role of NGOs in responding to FC/FGM. The information/opinions will be synthesized and analyzed for presentation in a final report to USAID. While information/opinions may be attributed to countries, nothing will be attributed to individuals. These questionnaires are, and will remain, the property of RAINB♀O. We encourage you to be as candid as possible. Frank observations and constructive critical analysis will facilitate the process of providing USAID with a realistic and appropriate foundation upon which to build future strategies against FC/FGM.

Please note that we refer to the practice as "FC/FGM," to allow for the diversity of views regarding the appropriate terminology.

We appreciate the time and effort that you will take in responding to this questionnaire, and have tried to make the questions straightforward, while also allowing for a range of responses. Please feel free to include as much information as you would like. We have left extra space after each section, and urge you to add extra sheets if necessary. Additionally, when possible and appropriate, please attach any relevant documentation and include specific examples.

Please send/fax the completed questionnaire and any attachments to RAINB♀O, to arrive by Friday, May 3, 1996. If you have any questions, please contact Susan Izett or Eileen Conneely at RAINB♀O, 915 Broadway, Suite 1109, New York, New York 10010, U.S.A.
Phone: (212) 477-3318 Fax: (212) 477-4154 E-mail: nt61@columbia.edu.

THANK YOU

Please print or type answers into questionnaire. Please check all that apply, except where indicated.

I. NATIONAL SITUATION

1. Please specify organization and country:

2. Is FC/FGM generally recognized as an issue of concern in the country?
____ No ____ Yes

If no, why:
____ Low prevalence of the practice
____ Low awareness of harmful effects
____ Political/cultural sensitivities
____ Other issues seen as more important (please specify which issues below)
____ Lack of resources or infrastructure
____ Other, please specify below:

_____

If yes, why:
____ High prevalence of FC/FGM
____ Health consequences of FC/FGM recognized
____ Violation of rights recognized
____ Organized local movement against FC/FGM
____ International pressure to address FC/FGM
____ Other, please specify below:

_____

3. What has been the national response against the practice, if any?
____ Policy statements by government officials (President, ministers, etc.)
____ Legislation under discussion
____ Enacted legislation
____ Professional regulations or involvement (public health, medical, legal, educational, etc.)
____ Activities by local non-governmental organizations (research, IEC, national working group, etc.)
____ Activities by international organizations operating in-country
____ Other, please specify below:

_____

4. What do you see as the main obstacles to effectively addressing FC/FGM in the country/region?

5. What do you see as the main opportunities to effectively address FC/FGM in the country/region?

6. Any other comments on National Situation:

II. ROLE OF DONORS

1. Are you aware of donors supporting efforts against the practice of FC/FGM in the country?
Please check appropriate response
____ No ____ Yes

If yes, please specify donors, organizations and activities supported:

2. How would you characterize the current level of interest in FC/FGM of international donors?

____ High
____ Moderate
____ Low
____ None

Do you feel the level of interest is appropriate?

____ No ____ Yes

Why? *Please elaborate below*

3. What would be the most useful ways in which donors could support advocacy against FC/FGM?
Please check appropriate response(s) and briefly elaborate below.

____ Funding
____ Technical assistance (research, IEC, training, sharing information, monitoring and evaluation, institutional capacity-building, etc.)
____ Participating in local activities
____ Influencing/lobbying policy makers and governments
____ Exerting pressure on governments (media exposure, imposing conditionalities on financial assistance, etc.)
____ Other, please specify:

_____

4. In your opinion, what might be the least helpful ways in which donors could be involved in advocacy against FC/FGM?

5. How do you think activities addressing FC/FGM should be addressed by donors?
Please check appropriate response, and briefly elaborate below

____ As a discreet, vertically funded issue, addressed on a project-by-project basis

____ As an issue integrated into existing programs (such as reproductive health and family planning, WID, education, human rights, etc.)

Why?

6. Any other comments on Role of Donors:

III. USAID

1. Have you or your organization worked directly with USAID in general?
Please check appropriate response, and briefly elaborate below.

____ No ____ Yes

On what kind(s) of issues and projects?

2. Have you or your organization worked with the USAID Mission on FC/FGM?
Please check appropriate response, and briefly elaborate below

____ No ____ Yes

If yes, on what kind(s) of activities and projects?

3. In your opinion, in what ways could USAID, given its resources and mechanisms, be most supportive to local efforts addressing FC/FGM? *If possible, please provide specific examples*

4. In your opinion, given its resources and mechanisms, in what ways could USAID programs be detrimental, or at least not have a positive impact, on local efforts? *If possible, please provide specific examples*

5. Are you aware of any existing USAID projects in which FC/FGM could be addressed as a component? If so, please specify:

6. Any other comments on USAID:

IV. LOCAL NGOS & RESOURCES

1. In what ways could local NGOs advise/inform the USAID Mission on effective action against FC/FGM?

2. Are there key documents on FC/FGM within the country that you would recommend (strategic plans, mission statements, policies, funding guidelines, call for proposals, project reports, etc.)? *Please attach when possible*

3. Could you recommend other local experts who have worked with the USAID Mission on the issue of FC/FGM or related issues, whose perspectives on USAID's work on FGM would be helpful. *Please include contact information, when possible*

4. Any other comments on Local NGOs & Resources:

Please feel free to add any additional comments. Thank you.

USAID REVUE DES ACTIVITÉS SUR L EXCISION: QUESTIONNAIRE POUR LES ONGs ET LES INDIVIDU.S.

INTRODUCTION

Á la demande de l Agence pour le developpement international des États -Unis (USAID), le Reseau de rècherche d action et d information sur l integrite corporelle de femmes (RAINB♀) est en train d examiner méthodiquement les activités de l USAID en ce qui concerne l excision/mutilation génitale féminine (MGF). Cette revue inclut une révision des documents principaux de l USAID, les intervues avec les personnels à Washington DC et deux questionnaires: le premier est visé aux Missions de l USAID et les bureaux regionaux dans les pays cibles; le deuxieme est celui, et il est visé aux ONGs qui travaillent sur le sujet. Le but de ce project est le développement des stratégies appropriées, intégrées et rentable pour l eradication de l excision/MGF.

Ce questionnaire était developper par RAINB♀ et réviser par le Intra-agency Task Force sur MGF de l USAID. Il inclut des questions sur le plaidoyer, le rôle des donateurs, le rôle de l USAID, et le rôle des ONGs en la lutte contre l excision. Avec ce questionnaire, nous cherchons des idées, des informations et des conseils des experts locaux, comme vous, qui travaillent à la lutte contre l excision, et qui a l expérience en travaillant avec les donateurs comme l USAID. Aussi, nous voudrions votre point de vue concernant comment les strategies des donateurs peuvent bien aider et renforcer les activités sur l excision. RAINB♀ va analyser les informations et les conseils et va préparer un résumé des résultats dans un rapport pour l USAID. S il vous plait, essayez de réponder aux questions franchement. Les questionnaires appartiens á RAINB♀ et dans notre rapport les avis sera attribués aux pays, pas aux individus. Vos avis honêts nous aideront en faisant des recommandations et des stratégies appropriés à l USAID.

Dans ce questionnaire, nous utilisons le term l excision pour comprendre tous les types de la circoncision feminine et de la mutilation genitale feminine.

Nous sommes reconnaissant de votre temps et votre effort en completant ce questionnaire. Nous esperons que nos questions sont au point et directs. Avec tous les questions vous avez la liberté d élaborer vos réponses et de donner les réponses multiples. S il est possible, utilisez les exemples précisés en répondant et attachez des documents principaux. Aussi, si vous avez besoin de plus d espace pour réponder, vous pouvez attacher d autres fiches.

S il vous plait, envoyez le questionnaire complété et d autres documents à RAINB♀ . Nous voudrions les questionnaires le 3 mai, vendredi. Si vous avez des questions, vous pouvez contacter, Susan Izett ou Eileen Conneely á :
RAINB♀ . 915 Broadway, Suite 1109, New York, NY 10010, U.S.A
Téléphone: (212) 477-3318 Fax: (212) 477-4154 E-mail: nt61@columbia.edu

S il vous plait, écrivez clairement ou bien tapez les réponses á la machine. Pour chaque question, choisisez tous les réponses appropriés, sauf ou indiqué.

I. SITUATION NATIONALE

1. Précisez le nom de votre organization et le pays ou votre organization se trouve.

2. Est-ce que l excision est regardé comme un sujet d importance en votre pays?
___ Non ___ Oui

Si non, pourquoi?
___ une fréquence basse de l excision
___ une sensibilisation basse sur les risques de santé de l excision
___ des difficultés politiques et des sensibilités culturelles (expliquez brievement)
___ d autres sujets sont considerés plus importants (précisez lesquelles au-dessous)
___ pas assez des ressources financières ou de l infrastructure
___ autres, précisez :

Si oui, pourquoi?
___ une fréquence élevée de l excision
___ les risques de santé sont bien connus
___ l excision est regardé comme une violation des droits humains
___ les activités des organizations locales sont très forte
___ la communauté internationale exerce des pressions sur le gouvernement
___ autres, précisez :

3. Quelle et la réponse nationale concernant l excision?
___ les déclarations politiques du gouvernement
___ le commencement de la discussion de la législation
___ l engagement des secteurs professionels (de la santé publique, des professions médicales, des légales, et des enseignments, etc.)
___ les activités des ONGs (la rècherche, l information l éducation et la communication (IEC), les interventions)
___ les activités des organisations internationales, dans le pays
___ autres, précisez lesquelles:

4. Quels sont les obstacles (les pierres d achoppement) principaux qui ménacent la lutte contre l excision dans votre pays?

5. Quels sont les possibilités et les opportunités principaux pour aider la lutte contre l excision?

6. D autres commentaires sur la situation nationale:

II. ROLE DES DONATEURS

1. Connaissez - vous des donateurs qui donnent l assistance (soit financière ou technique) à la lutte contre l excision dans votre pays?
___ Non ___ Oui
Si oui, précisez lesquelles et les activités qu ils aident.

2. À votre point de vue, quel est le niveau de l intérêt des donateurs internationaux sur la lutte contre l excision?
___ élevé
___ modéré
___ bas
___ rien
A votre avis, est-ce que ce niveau est acceptable?
___ Non ___ Oui

Expliquez pourquoi:

3. Quel est le moyen le plus efficace pour les donateurs d aider la lutte contre l excision? (Choisisez tous les réponses appropriés.)

___ les ressources financières
___ l assistance technique (la rècherche,le IEC, la formation, le surveillance, l évaluation)
___ la participation en les activités locals
___ l appui politique sur le gouvernement et l assistance avec la formation des politiques
___ autres, précisez:
Élaborez brievement vos réponses.

4. A votre avis, quel moyen est moins efficace pour les donateurs ? Expliquez brievement.

5. A votre avis, comment est-ce que les donataires doivent aborder le problème de l excision?

___ avec les projets distincts et verticaux

___ comme un aspect integré aux projets déja en place (les projets de santé de la réproduction, les projets de la planification familiale, l éducation, les projets de la developpement pour les femmes, etc.)

Pourquoi?

6. D autres commentaires sur les donataires:

III USAID

1. À ce moment ou dans le passé, est-ce que vous ou votre organization avez travaillé directement avec l USAID? **(n import quel projet)**

___ Non ___ Oui

Si oui, sur quels activités ou quels projets?

2. Est-ce que vous ou votre organization avez travaillé avec l USAID **sur la lutte contre l excision**?

___ Non ___ Oui

Si oui, sur quels activités et quels projets?

3. A votre avis, quel sont les meilleurs moyens pour l USAID d aider et de renforcer les travaux des organisations locales sur l excision? Précisez les exemples, s il vous plaît.

4. A votre avis, quel sont les moyens moins efficaces pour l USAID d aider et de renforcer les travaux des organisations locales sur l excision? Précisez les exemples, s il vous plaît.

5. Connaissez-vous un projet existant de l USAID ou on peut incorporer les activités sur l excision?

6. D autres commentaires/ rémarques:

IV. LES ONGs LOCALS ET LES RESSOURCES FINANCIÈRES

1. Comment les ONGs locaux peuvent informer les bureaux regionales de l USAID sur les actions efficaces contre l excision?

2. Est-ce qu il y a des documents principaux sur l excision que vous pouvez recommender?

3. Nous voudrions contacter tous les experts qui travaillent dans ce sujet. Pouvez vous recommender d autres experts en votre pays qui a travaillé avec un projet de l USAID sur l excision ou d autres sujets et qui peut nous aider. Si oui, donnez le nom, l adresse, le numéro de téléphone et le numéro de fax s il vous plaît.

4. D autres commentaires/ rémarques:

Vous pouvez ajouter d autres informations ou attachez d autres documents.

Merci beaucoup.

APPENDIX D

INTERNATIONAL DONOR SUPPORT FOR FGM ERADICATION ACTIVITIES

The following is a brief review of international assistance efforts to support the prevention and eradication of FGM in Africa. It does not include funding efforts to work on the issue of FGM among immigrant communities in the West. Some agencies have published documents articulating their policies and intended areas of support, but the majority have incorporated FGM into their international assistance without articulating the direction, nature, and scale of that support. It is not possible to identify the budgetary allocations or the levels of funding available to projects if indeed such defined allotments have been made. To avoid giving erroneous or inaccurate information, we have elected not to include numbers or names of organizations that receive funding. This is not a comprehensive list, and many smaller foundations, NGOs, or church charities may have been omitted unintentionally. In the case of smaller foundations, NGOs, church charities, and individulas, it is not always possible to verify whether a past funder is currently giving support.

D.1 Bilateral Agencies

D.1.1 Denmark

In May 1995, the Danish International Development Agency (Danida) organized a seminar on FGM in Copenhagen to draw on the latest information on the subject. In her opening speech, Ellen Magarethe Loj, Under-Secretary Ambassador, Ministry of Foreign Affairs, stated:

> In Denmark, we are in the process of becoming more aware about female genital mutilation. The prevention of this practice in the perspective of sexual and reproductive health and rights, as well as human rights is comprised in our strategy for Women in Development, the Health Sector Policy and the Population Strategy, and we are about to elaborate guidelines in this area (*Report from the Seminar on FGM*, Copenhagen, 29 May 1995, Ministry of Foreign Affairs, Danida, Denmark).

In May 1996, Danida published *Guidelines on the Prevention of Female Genital Mutilation,* articulating the Danish government's policy on the issue. Danida's support for eradication efforts includes funding U.N. agencies and international and regional NGOs specializing in the field. They also promote other areas of women's empowerment, such as access to education, health, and employment and rights to land and inheritance, as a means to prevent and abolish FGM. Apart from influencing programs supported by Danida, the above

guidelines will allow Danish embassies to support FGM projects at the national level through discretionary funds.

D.1.2 Sweden

The Swedish International Development Agency (SIDA) has incorporated FGM into their support for reproductive health and empowerment of women. They are currently supporting technical and advocacy organizations both within and outside the U.N. system, as well as providing direct project funding in Africa. SIDA is a major funder in Africa, and their support covers all areas of activity and is not restricted to research or interventions.

D.1.3 Norway

The Norwegian Agency for International Development (NORAD) has also included FGM in its reproductive health and women's empowerment mandates. They give support to international NGOs and the U.N., and directly support projects in Africa. NORAD support is broadly defined and is not restricted to any specific countries or activities.

D.1.4 Holland

The Dutch Ministry of Foreign Affairs and its representatives in African countries have been supporting FGM activities since the 1980s. They support international and regional NGOs, as well as in-country projects.

D.1.5 United Kingdom

In the past, the British Overseas Development Agency has given support to regional and international NGOs based in the United Kingdom and Europe for work on FGM. More recently, they have initiated some in-country support in English-speaking West Africa, for example in Sierra Leone and The Gambia.

D.1.6 Canada

The Canadian International Development Agency has in the past given direct funding to international NGOs. Currently their support is channeled through the International Development Research Center in Toronto, which also raises funds from other sources and gives technical and financial support to qualitative research.

D.1.7 Australia

The Australian International Assistance Bureau has focused its support for FGM eradication activities on U.N. agencies. It is not clear whether they have mechanisms to support international, regional, or local NGOs.

D.2 Multilaterals

D.2.1 United Nations Children's Fund (UNICEF)

UNICEF issued an Executive Directive on October 31, 1994 (CF/EXD/1994-009), signed by James Grant, stating:

> While UNICEF is firmly committed to respecting cultural differences, in the case of FGM it is vital that a clear position be taken on the unacceptability of this practice. The rationale for a strong position stems from the medical facts, which reveal that FGM has negative impact on girls' and women's morbidity and mortality, and human rights standards, which do not tolerate violence against girls and women. In order to develop strategies and support programs that are culturally sensitive, UNICEF's work should be in close partnership with regional, national and local NGOs, professional associations, religious institutions and governments. In the regions where FGM is practiced, UNICEF Regional Offices should take the lead role in initiating and coordinating programming to end the practice.

A Strategic Framework and Programming Guidelines to Eliminate FGM was then prepared (not yet available for circulation), which gives specifics on how UNICEF intends to develop work in this area. Based on this framework, a five-year action plan was developed to support FGM eradication for eight countries in the three regions of North, West, and East Africa. The FGM program will first be an initiative of the New York office, but centralized support will be phased out over the five years, during which time FGM is expected to be integrated into country and regional plans. UNICEF expects to give support to NGOs for training and material development and capacity building. The agency does not support research, monitoring, and evaluation.

UNICEF's reporting on FGM activities started with a profile on the issue in *Progress of Nations* (1966, p. 7).

D.2.2 World Health Organization (WHO)

The Forty-Sixth World Health Assembly (1993) and the Forty-Seventh World Health Assembly (1994) passed resolutions urging member states to assess the extent of FGM, and establish national policies and programs to abolish the practice, including development of legal instruments. The resolutions also encourage governments and international organizations to work on the issue in collaboration with local NGOs. As a result, FGM has become an area of priority within the Women, Health and Development Program of the WHO Reproductive and Family Health Division, which has received special funds from donors to work on the issue.

A meeting of a Technical Working Group on FGM was organized in July 1995, and the recommendations and report of that meeting are available from WHO. Research and development of technical guidelines is the most likely area of focus for this program, but final plans are still under discussion.

D.2.3 United Nations Population Fund (UNPFA)

As UNPFA undertakes implementation of the International Conference on Population and Development (ICPD) Programme of Action, FGM has been identified as a priority issue for the agency. A Technical Consultation on Female Genital Mutilation was organized in Addis Ababa, Ethiopia, in March 1996, but the outcome and recommendations of that meeting are not yet available.

In the recently published 1995 report of UNFPA, three core program areas are defined: (1) reproductive health, (2) population and development strategy, and (3) advocacy. FGM is mentioned under reproductive health (p. 15). It is included again in the regional review of the Arab States and EErope (p. 27), but is not specifically mentioned in the regional review of Africa (sub-Saharan).

UNFPA is expected to give support to NGOs for integration of FGM into reproductive health programs, for development of informational and educational material, for capacity building, and for advocacy.

D.2.4 The World Bank

In 1995, the World Bank started a three-year special program fund for Female Genital Mutilation and Adolescent Health. The fund supports in-country activities through intermediary or umbrella organizations on a year-by-year basis.

D.3 U.S. Foundations

D.3.1 Ford Foundation

Through its three Africa-based regional offices and their reproductive health programs, the Ford Foundation has emerged as a leading funder for FGM eradication activities within the region in the 1990s. Their funding covers both research and intervention programs.

D.3.2 Wallace Global Fund

The funds available for FGM eradication through the Special Project of Population Action International (previously the Population Crisis Committee) have now been incorporated into the newly developed Wallace Global Fund. This long-standing donor in the field of FGM has moved away from direct project funding in Africa to funding of international NGOs to provide support and technical assistance.

D.3.3 John D. and Catherine T. MacArthur Foundation

As an influential donor in the field of reproductive health, the MacArthur Foundation has started some support in this area through funding of international NGOs.

D.3.4 Other U.S. Foundations

The Public Welfare Foundation and The Shaler Adams Foundation are funding FGM work through international NGOs, as well as direct funding to in-country projects. The Moriah Fund can fund only through U.S.-based organizations, and the Global Fund for Women supports in-country projects only. The L. J. Skaggs and Mary C. Skaggs Foundation has been mentioned as a funder in the 1980s. The Rockefeller Foundation identifies FGM as part of reproductive health and has on occasion given support for research and documentation activities.

D.4 European and North American NGOs

In Europe, some government and much private funding is channeled through national NGOs, and many organizations have been active supporters of FGM eradication. Some examples are Novip (Holland), Radda Barnen (Sweden), Redd Barna (Norway), Oxfam (U.K. and Canada), Save the Children (U.K.), and Womankind (U.K.). There are undoubtedly many more smaller NGOs that occasionally provide funding to international NGOs or to projects in Africa.

D.5 Churches, Charities, Social Clubs, Societies, and Individuals

Many European and North American churches and religious charities have contributed at some point in time to efforts to eradicate FGM. Another source of support has been social networks, such as Zonta Clubs, and other societies, such as the Red Cross and the Society for the Protection of Human Rights, U.K. Private individuals with considerable wealth, such as Lawrence Rockefeller, as well as ordinary concerned citizens, occasionally contribute at all levels of funding.

APPENDIX E

MEETINGS CONDUCTED

February 14, 1996	Rochelle L. Thompson, Program Analyst Office of Field and Program Support
	Marjorie C. Horn, Deputy Chief, Research Division Office of Population
	Claudia S. Morrissey, Reproductive Health Advisor Office of Health and Nutrition
February 21, 1996	F. Cate Johnson, Women's Legal Rights Advisor Office of Women in Development
February 22, 1996	Nahid Toubia Executive Director, RAINB♀
	UUAID FGM Working Group Meeting
February 27, 1996	Phyllis Gestrin, Senior Technical Advisor Bureau for Africa
	Patricia S. Coffey, Michigan Fellow, Technical Advisor, Africa OR/TA Project, Research Division Office of Population
March 6, 1996	Elizabeth S. Ralston, Michigan Fellow, Reproductive Health Assistant Office of Population
	Barbara B. Crane, Policy Advisor, Policy and Evaluation Division Office of Population
March 12, 1996	Staff (Nahid Toubia, Kate Randolph, Susan Izett, Zeinab Eyega) RAINB♀

April 2, 1996	Estelle E. Quain Senior Research Investigator and Co-coordinator, Gender Working Group Communications, Management and Training Division Office of Population
April 4, 1996	Barbara O. de Zalduondo, Behavioral Research Advisor, HIV/AIDS Division Office of Health and Nutrition
April 24, 1996	Abdi Wardere, Program Analyst Office of Population (informed on Greater Horn of Africa Initiative)
April 25, 1996	Carolyn Jefferson (by phone), Consultant, PATH MotherCare Project Office of Health and Nutrition
April 26, 1996	Julia Masterson (by phone) CEDPA

APPENDIX F

LIST OF DOCUMENTS REVIEWED

The following are USAID publications and documents, unless otherwise specified.

F.1 Center for Population, Health and Nutrition

"Engendering Demography: Gender training in USAID's Office of Population," presentation prepared for the Annual Meeting of the Population Association of America, San Francisco, CA, April 1995, by Estelle E. Quain.

"FGM Strategy," draft table, Claudia Morrissey, Office of Health and Nutrition.

Implementing Reproductive Health Programmes: Report of a Donor Workshop, United Kingdom Overseas Development Administration (ODA) and USAID, New York, 12-14 June 1995.

Improving Women's Health Through Post-Abortion Care, technical information packet, May 1995.

Overview of Programs in Reproductive Health, working (not approved by the agency) paper, June 1995 (from Elizabeth Ralston).

The Policy Project: Creating a Supportive Policy Environment for Family Planning and Reproductive Health Programs.

Report on Responses from 15 USAID Missions to USAID/Washington Cable (State 226168;7/24/93), "Query on Female Genital Mutilation," December 20, 1993.

Strategic Plan, Center for Population, Health and Nutrition, Bureau for Global Programs, Field Support and Research, December 1995.

Update on USAID Activities Concerning the Eradication of FGM, as of November 6, 1995, Inter-agency Working Group update from Trish Coffey.

USAID Responds to HIV/AIDS: A Report on the Fiscal Year 1994 HIV/AIDS Prevention Programs of USAID.

USAID's Support for the Prevention of FGM, (draft from Rochelle Thompson, not for circulation), 1995.

User's Guide to the Center for Population, Health and Nutrition, Bureau for Global Programs, Field Support and Research, January 1996.

F.2 Bureau for Africa

Health and Human Resources Analysis for Africa (HHRAA) Progress Report, 1992-1994, Bureau for Africa, Office of Sustainable Development, Division of Human Resources and Democracy.

Possible Linkage Between FGM and Increased Risk of HIV Infection, May Post, Support for Analysis and Research in Africa (SARA) Project, 1995.

Priority Information Needs and Research Issues in Health, Population, Nutrition, and Basic Education in Africa: A Summary of the Strategic Frameworks for Research, Analysis and Information Dissemination for the Health and Human Resources Analysis for Africa (HHRAA) Project, prepared by SARA Project, Bureau for Africa, April 1995.

Workshop on Advocacy, Report from SARA, *1995.*

F.3 Women in Development

"FGM and HIV Transmission: Missing Data, Ignored Relationships," Catherine Johnson, Lisa Messersmith, and Elizabeth Ralston, National Council for International Health abstract, June 1995.

Strategic Plan: Women in Development, Bureau for Global Programs Field Support and Research, FY1995-2000, March 1995.

Summaries of FGM Proposals Received, FY 1996.

Summary of Responses from USAID Missions to December 1993 Cable (State: 387143), "Supporting Prevention of FGM."

Trip Report for the Inter-African Committee on Harmful Practices (IAC) Conference in Addis Ababa, Ethiopia, April 11-15, 1994, Sylvie Morel-Seytoux, Africa Advisor.

USAID's Approach to FGM (from Cate Johnson).

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F.4 Cables and Other Correspondence

Various cables and correspondence within USAID, between Missions and Washington, between Congress and USAID, and between concerned citizens and USAID, 1980-1990.

F.5 Other

Gender Plan of Action, Brian Atwood, March 1996.

Testimony to the House Committee on Foreign Affairs, Subcommittee on International Security, International Organizations and Human Rights, by USAID Chief of Staff, Richard McCall, September 29, 1993.

N. Toubia, *Female Genital Mutilation: A Call for Global Action*, New York: RAINB♀, 1995.

USAID Response to a 1980 Senate Appropriate Committee request for information on female circumcision.