

**FEMALE GENITAL CUTTING**  
the facts and the myths

# FGC Symposium

June 3, 1999

**USAID**

**Final Report**

Intra-Agency Working  
Group on FGC

## Acknowledgments

The U.S. Agency for International Development's Intra-Agency Working Group on Female Genital Cutting would like to extend its heartfelt gratitude to the many people and organizations that made the Symposium on Integrating FGC Into USAID Programs possible.

Special thanks are due to the Population Reference Bureau and the Academy for Educational Development, who, through MEASURE *Communication*, provided invaluable assistance in organizing the Symposium and in producing the materials for it as well as this Symposium report. We would like to acknowledge in particular Ms. Alix Murdoch, Ms. Marcia Rock, Ms. Sara Adkins-Blanch, Dr. John Haaga, and Ms. Pamela Allen, MEASURE *Communication* CTO.

We greatly appreciate the participation of the presenters at the Symposium: Ms. Valerie Dickson-Horton, Deputy Assistant Administrator, Africa Bureau; Ms. Barbara Turner, Senior Deputy Administrator for Global Bureau; Dr. Duff Gillespie, Deputy Assistant Administrator, Center for Population, Health, and Nutrition; Mr. Romany Abadir, Senior Program Officer, CEDPA (Egypt); Dr. Nafissatou Diop, Research Associate, Population Council (Senegal); Dr. John Flynn, Senior Advisor, Office of the Assistant Administrator, Africa Bureau; Ms. Molly Melching, President, Tostan; Dr. Asha Mohamud, Senior Program Officer, PATH; Dr. Muneera Salem-Murdock, Deputy Director, Office of Women in Development; and Dr. Nahid Toubia, President, RAINBO.

We would like to thank those organizations who brought information to display and distribute during the Symposium: Ms. Lois Gochnauer, U.S. State Department, Office of the Senior Coordinator for International Women's Issues; Dr. Saralyn Mark, Senior Medical Advisor, Department of Health and Human Services, Office of Women's Health; the Centre for Development and Education Activities (CEDPA); the Center for International Health Information (CIHI); Equality Now; Johns Hopkins University Center for

Communication Programs (JHU/CCP); the Program for Appropriate Technology in Health (PATH); the Population Council; Research, Action and Information Network for the Bodily Integrity of Women (RAINBO); and the World Health Organization.

Many people were involved in the development and preparation of the Symposium and the materials: Dr. Duff Gillespie; Ms. Elizabeth Maguire, former Director, Office of Population; Dr. Margaret Lycette, Director, Office of Women in Development; Mr. Jeff Spieler, Chief, Research Division, Office of Population; Mr. Gary Cook, former Deputy Director, Office of Population; and Ms. Barbara Crane, Policy Division. They provided valuable insights during the review process. We would also like to thank Pal-Tech staff for providing secretarial support, and Ms. Emily Collings for assisting in finalizing the invitations to the Symposium.

Our gratitude is extended as well to Ambassador Sally Shelton-Colby, Assistant Administrator for Global Programs; Mr. Brian Atwood, former USAID Administrator, for supporting our efforts and sending messages to all Agency staff reminding them of the importance of the issue; and Ms. Vivian Lowery Derryck, Assistant Administrator, Africa Bureau.

And last but not least, thanks to Rosemarie Phillips, who served as the rapporteur of the Symposium and is the writer of this report.

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# **Female Genital Cutting: The Facts and the Myths**

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## Introduction

Female genital cutting (FGC) is practiced in many countries around the world, but is most prevalent in Africa. Recently, FGC has become a matter of international concern, particularly with respect to health, human rights, and gender equity. African governments, nongovernmental agencies (NGOs), and development professionals look to the U.S. Agency for International Development (USAID) and other aid agencies to be partners in the growing global effort to end the practice of FGC. World conferences—including the International Conference on Population and Development (1994) and the Fourth World Conference on Women (1995)—have made strong statements on the need to combat violence against women, including FGC, and have called on governments to adopt policies to prohibit FGC and to support community efforts to eliminate the practice.

In the United States, interest in the issue and demand for action have been increasing as well. The U.S. Congress passed a sense of Congress resolution in 1995 calling on U.S. agencies to include educational programs where appropriate into population, education, and women in development activities. In 1996, the practice of FGC was prohibited in the United States.

As the demand and rationale for USAID involvement in ending FGC has increased, USAID's approach to this issue has evolved from a localized response in particular settings to recognition that FGC is a development issue with global implications. USAID has taken steps to develop a strategic approach in which FGC is integrated into many USAID activities and programs.

In 1993, the Women in Development (WID) office was designated as USAID's coordinator for FGC issues, and in 1994, the Intra-Agency Working Group on FGC was formed to coordinate activities in the various bureaus and offices. In 1997, the Agency issued "Program Guidelines for Integrating Activities to Eradicate FGC into USAID Programs," and subsequently sponsored a Fellow from the Population Fellowship Program at the University of Michigan to work on FGC issues. The FGC Fellow is jointly sponsored by the Office of Population, the Office of Health and Nutrition, the Women in Development Office, and the Africa Bureau.

In June 1999, the Intra-Agency Working Group (IWG) organized a Symposium to explore with USAID staff ways of incorporating activities to eradicate FGC into Agency programs. The purpose of the Symposium was: (1) to discuss FGC from a cultural, human rights, health, and holistic developmental perspective; (2) to examine successful interventions by indigenous NGOs as well as new strategies currently being tested; and (3) to discuss problems and opportunities for including FGC activities in a range of USAID programs. This report summarizes the results of that meeting.

The Symposium discussion, the subject matter of this report, highlighted how much progress has been made in recent years—both in the field and at policy levels. NGOs working in a variety of settings are evolving approaches that first make it acceptable to discuss this very private issue and then empower women to take leadership in addressing the issue in their communities. These approaches are community-specific but they also provide lessons that are applicable in a variety of settings.

USAID's policy is to support efforts at the community level and to integrate FGC into ongoing activities in ways that are culturally sensitive and appropriately designed. USAID's work in FGC prevention, therefore, is best done not through a separate program but as part of many USAID activities. The Symposium explored some of the many ways in which this is already being done and challenged USAID staff to find additional ways to address this cross-cutting issue.

Campaigns against FGC are becoming more widespread and more effective, and it appears increasingly plausible that the practice of FGC can be eradicated. Empowering women is an important first step toward achieving the goal of eradication, but eradication, in turn, also empowers women, who are then better able to turn their energies to other development issues.

Marjorie Horn  
Phyllis Gestrin

*Co-Chairs, Intra-Agency Working Group on FGC*

## Executive Summary

Between 100 million and 180 million women around the world have undergone female genital cutting (FGC), and some 600 girls are at risk every day. FGC has serious health effects, including hemorrhage, shock, pain, and various infections that can significantly damage a girl's lifetime health. It is also a serious human rights violation.

FGC occurs primarily in Africa, but it is a global issue. The impact of compromised health and human rights violations for so many women affects countries' development prospects, economic growth, prosperity, and governance. In addition, migration has spread the practice to Europe and North America; and in some Asian countries, FGC is practiced by minority groups.

Interest in FGC has been increasing in recent years, both internationally and domestically. Campaigns against FGC are becoming more widespread and more effective, and it appears increasingly plausible that the practice can be eradicated. The USAID Symposium examined what has been learned in 20 years of eradication efforts, as well as current and future opportunities for including FGC activities in a range of USAID programs.

### Experience to Date With FGC Eradication Efforts

In reviewing a wide range of FGC programs over the last 20 years, Dr. Nahid Toubia, President of the Research, Action, and Information Network for the Bodily Integrity of Women (RAINBO), noted that a large body of experience in what does and does not work has been accumulated. She cautioned that the goal should not be simply ending FGC but making gender-based violence unacceptable in the context of promoting protection of women's reproductive and sexual health and rights.

Several speakers presented examples of programs implemented by NGOs that are succeeding in a variety of specific local contexts:

- In Senegal, villages where women have participated in basic education and empowerment programs are making written pledges that they will end FGC in their communities.

- In Mali, experience indicates that when health service providers receive training in the health effects of FGC, they are less likely to perform the procedure and more likely to at least be willing to educate their patients. As a result of these initial findings, the Ministry of Health is taking steps to extend such training to all health service providers.
- In Kenya, alternative rituals are being developed that meet many of the same needs as traditional circumcision ceremonies. These alternative ceremonies are gaining community acceptance and are endorsed by community elders and the Kenya Medical Association.
- In Egypt, community members who resist pressure to circumcise their daughters are receiving positive reinforcement for their decision, and local organizations are learning how to find and support such individuals.

### Integrating FGC Into USAID Programs

These and other successful local programs are catching the attention of governments and donors such as USAID, which are looking for new and creative ways to integrate FGC elimination into ongoing programs.

Dr. Duff Gillespie of the Center for Population, Health, and Nutrition cited a number of factors that have traditionally gotten in the way of donor involvement in FGC. Nevertheless, he noted how much progress has been made in the last decade in getting constructive international attention and donor involvement focused on FGC, and he challenged his colleagues to overcome the barriers and not be discouraged by them.

John Flynn of the Africa Bureau recounted his experience as mission director in Guinea, where he worked with local women leaders, as well as religious and other opinion leaders, to engage them in a series of discussions not only on FGC but also on such issues as education for girls, women's reproductive health, and family planning. Because FGC elimination has been integrated into many development efforts, it has a good chance of succeeding, even though it has only been on the development agenda for a few years.

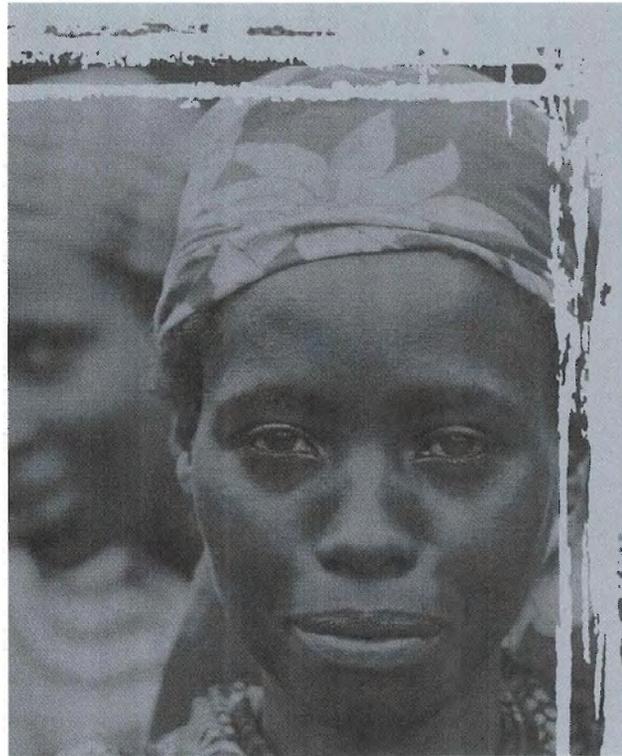
Munera Salem-Murdock of the Office of Women in Development noted that key to successfully addressing

FGC is to rely on locally designed, implemented, and controlled strategies and programs. To have the greatest impact, USAID should focus on integration and training. Other USAID programs (such as child survival, education, reproductive health, and democracy and governance) should integrate FGC into existing projects and activities. Providing training to women can help give them skills to act as advocates and educators in their own societies.

### Implications for the Future

Successful local efforts are helping to build a body of knowledge about how to address FGC most effectively. Although the details of these local experiences are unique to their particular settings, together they offer some important lessons:

- Empowering women to make their own decisions is an essential first step.
- Individual behavior change is not enough; the decision to end FGC



must have support from the surrounding community or network.

- Public declarations are a powerful means of moving the decision to end FGC from the individual to the larger community.
- FGC is not an isolated issue but part of a full range of development concerns.

The implication of these conclusions is that a great deal is possible with even small infusions of additional resources. The accumulating body of experience shows that FGC is most likely to be abandoned when progress is made on a range of development, health, and human rights issues, and when local women and their surrounding communities are empowered to make such decisions themselves. By integrating FGC into existing development programs, USAID can aid in that process with a significant return on a relatively small investment.

BOX 1

### What Are the Complications and Effects?

#### Short-term complications include:

- Pain
- Injury to adjacent tissue of the urethra
- Hemorrhage
- Shock, acute urine retention
- Infection and failure to heal.

#### Long-term effects include:

- Recurrent urinary tract infection
- Pelvic infections
- Infertility
- Keloid scars (cysts)
- Damage to the urethra or anus
- Problems during childbirth.

However, the type and severity of complications and effects depend on the type of FGC.

FIGURE 1

## Female Genital Cutting

**Between 100 million and 180 million women have undergone FGC. At least 600 girls are at risk of undergoing the procedure every day.**

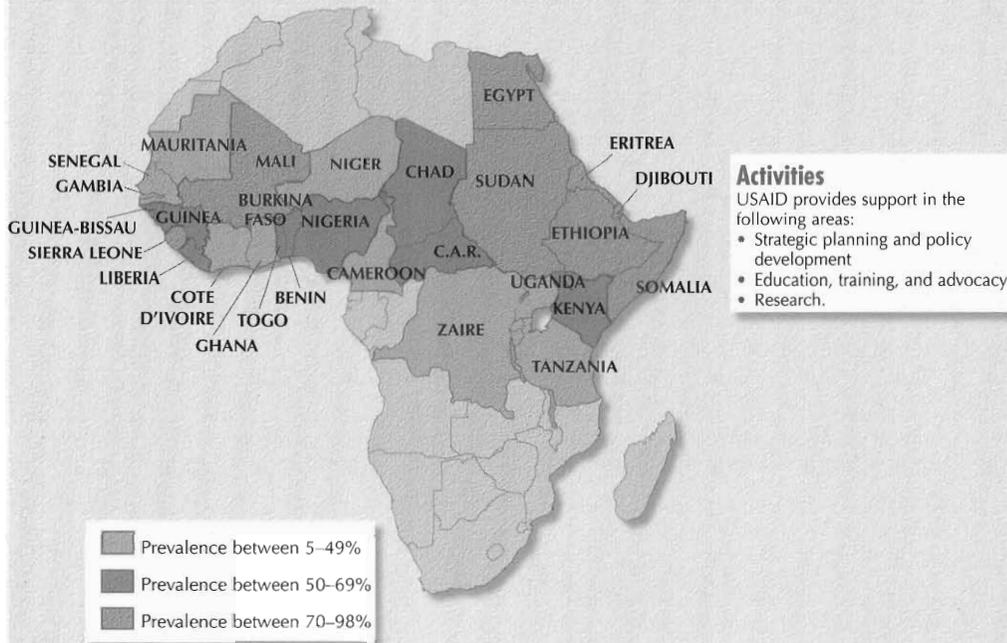
### Why?

Traditions vary—the main justifications are:

- Preserves the girl's virginity
- Gives pleasure to the husband
- Improves fertility and prevents maternal and infant mortality
- Establishes identity and good social standing
- Renders the woman marriageable.

Furthermore, people believe:

- Female genitals are unhygienic and need to be cleaned to maintain good health
- Female genitals are ugly and will grow to become unwieldy if they are not cut back
- FGC is a rite of passage to womanhood when it is performed at puberty or at the time of marriage.



BOX 2

## How is FGC Practiced?

### Types

The World Health Organization (WHO) identified four types of FGC:

1. Excision of the prepuce with or without excision of part or all of the clitoris;
2. Excision of the prepuce and clitoris of the labia minora;
3. Excision of part or all of the external genitalia and stitching/narrowing of the vaginal opening (infibulation);
4. Unclassified, which includes:
  - 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.

# FGC as a Human Rights and Reproductive Health Issue

Between 100 million and 180 million women around the world have undergone FGC—also called female circumcision, female genital mutilation (FGM), and female genital surgeries (FGS)—and some 600 girls are at risk every day. This is a serious health issue, whose short-term consequences include pain, injury to adjacent tissue of the urethra, hemorrhage, shock, acute urine retention, infection, and failure to heal. Long-term health effects can include recurrent urinary tract infections, pelvic infections, infertility, keloid scars (cysts), damage to the urethra or anus, and problems during childbirth. These effects significantly damage a girl's lifetime health, although the type and severity of conse-

quences vary depending on the particular procedure. Because FGC violates a woman's right to good health and bodily integrity, it is a human rights issue as well.

FGC affects a significant proportion of the population that is absolutely critical for healthy development, economic growth, prosperity, and sound development. These development implications and such widespread human rights violations make FGC a matter of global concern. Although it occurs predominantly in Africa (see Box 3), FGC is not confined to that continent. Through migration, it has spread to Europe and North America; it is also practiced by minority groups in some Asian countries such as India and Indonesia.

BOX 3

## FGC Prevalence

Country	Prevalence <sup>1</sup>	KEY: Type I = Clitoridectomy Type II = Excision Type III = Infibulation
Benin	50%	Type II mainly practiced (in Atacora, Borgou and Zou); ages 5–10.
Burkina Faso	70%	Types I and II.
Cameroon	20%	Anecdotal national estimate. In southwest and far north, 100% by Muslims and 63% by Christians (Types I and II).
Central African Republic	43%	Region Sanitaire IV, 91%; Banda (84%) and Mandjia (71%) ethnic groups; women with primary (47%) and secondary (23%) schooling.
Chad	60%	Anecdotal national estimate. Types I and II found in south, east and central regions.
Côte d'Ivoire	43%	Women with no education (55%); primary or secondary education (24%); Muslims (80%) and Christians (16%).
Congo	5%	Anecdotal national estimate.
Djibouti	98%	MOH reports almost universal practice of Type III.
Egypt	97%	Type I common. Type III reported in the south near Sudan.
Eritrea	95% <sup>2</sup>	Anecdotal national estimate.
Ethiopia	85%	Types I and II are common. Type III practiced near Sudan and Somalia.
Gambia	80%	Anecdotal national estimate. Types I and II: Mandinga and Serehule (100%); Fula (93%); Jola (65.7%); and Wolof (1.9%).
Ghana	30%	In Upper East and West regions, prevalence ranges between 75% and 100%.
Guinea	60%	Anecdotal national estimate.
Guinea Bissau	50%	A limited survey reported 100% prevalence among Muslim women.
Kenya	50%	Anecdotal national estimate. In known practicing districts, overall prevalence for Types I, II, and III is 89.6% (6,967,500 women).
Liberia	60%	Anecdotal national estimate. Type II.
Mali	94%	Type I (52%), Type II (47%), and Type III (1%).
Mauritania	25%	MOH estimate.
Niger	20%	Anecdotal national estimate. Practiced in Diffa, Niamey, and Tillabery provinces.
Nigeria	40%	Anecdotal national estimate (considered low). Types I, II, and III reported.
Senegal	20%	Predominantly in the north and southeast. Only a minority of Muslims, who constitute 95% of the population, practice FGC. <sup>3</sup>
Sierra Leone	90%	All ethnic groups practice FGC except for Christian Krios in the western region and in the capital, Freetown. Types I and II.
Somalia	98%	FGC is universal; over 80 percent of the operations are Type III.
Sudan	89%	Type III (85%) and Type I (15%) reported. Twice as many women under age 25 (20%) as over age 40 (10%) had undergone Type I.
Togo	50%	Anecdotal national estimate. Common in Tchaoudjo.
Uganda	5%	Anecdotal national estimate. Only one or two tribes known to practice.
United Republic of Tanzania	10%	Types I and II in the Arusha, Dodoma, Iringa, Kilimínjaro, Mara, Ngorogoro, and Singida regions. Type III practiced among Somali settlers and refugees.

<sup>1</sup> Prevalence for Central African Republic, Côte d'Ivoire, Egypt, Mali, and Sudan from *Demographic and Health Survey* results. Prevalence and Notes: Nahid Toubia and S. Izett, *Female Genital Mutilation: An Overview* (World Health Organization: 1998). <sup>2</sup> *Demographic and Health Survey-Eritrea* (Calverton, MD: Macro International Inc: 1998). <sup>3</sup> Nahid Toubia, *Female Genital Mutilation: A Call for Global Action* (New York: RAINBO, 1993).

## Twenty Years of Experience in Addressing FGC

In developing strategies for integrating FGC into ongoing USAID programming, it is important to learn from both the mistakes and successes of FGC-focused activities in the last two decades. With this in mind, the first presenter, Dr. Nahid Toubia, president of RAINBO, summarized the lessons learned from 20 years of FGC activities by national governments, local organizations, and USAID and other donors. Her presentation sought to answer the following questions:

- Is there less, more, or no change in FGC today than two decades ago?
- Are baseline data and monitoring adequate?
- Have some countries or communities experienced significant change?
- Are the reasons for an increase, decrease, or no change in prevalence socioeconomic or programmatic?
- What are the underlying hypotheses, values, and content of various approaches?
- Which approaches have proven to be effective, neutral, or counterproductive?

Dr. Toubia noted that data on the extent of FGC are accumulating gradually. Demographic and Health Surveys (DHS) data in at least seven countries provide good baseline information as well as a model for how to collect such basic information on prevalence and attitudes for and against FGC.\* The DHS model can be used in all countries in which FGC is widespread.

Even without monitoring data, it is clear that change is occurring in many places and important lessons are being learned about the kinds of approaches that work



and those that do not. Dr. Toubia reviewed the relative merits of various approaches:

**Health Risk Messages.** The approach of having authoritative individuals (doctors, nurses, educators, and other professionals) warn about the health risks associated with various forms of cutting has been tried for 15 years to 20 years. It appears not to work and may even be counterproductive if the procedure becomes “medicalized” as families turn to health professionals to reduce the risk of side effects but do not abandon the practice.

**Training Circumcisers.** Educating traditional circumcisers about the health risks associated with cutting and/or providing alternative means of income has been tried for five years to 10 years in various places. Although there has been no objective evaluation, anecdotal evidence suggests that while such training may get a few individual practitioners to stop performing the procedure, it has no effect on demand. As a result, families seek other providers rather than stop the practice and traditional practitioners return to cutting within a short period of time.

**Alternative Rituals.** Developing alternative rituals to substitute for the traditional cutting ceremonies is a relatively new approach. There has been no formal evaluation, but initial evidence indicates that alternative ceremonies are well received and have a positive impact on reducing the number of cuttings. Still to be assessed are whether this initial effect can be sustained over the longer term and what kinds of alternative rituals work best.

\* Dara Carr, *Female Genital Cutting: Findings from the Demographic and Health Surveys Program* (Calverton, MD: Macro International, Inc., 1997).

FIGURE 2

## Stopping FGC is Part of Promoting Women's Health and Rights



Source: RAINBO

**Comprehensive Social Development.** For the last five years to 10 years, one approach has been to incorporate FGC within a range of social and economic development initiatives that include women's empowerment. In Egypt, at least, whole villages have abandoned the practice as a result of more comprehensive social and economic change in the region. Monitoring is needed to assess the long-term sustainability of this promising approach.

**Integrated Learning.** This approach provides women with broad-based training in literacy, analytical and decisionmaking skills, and health and human rights information—empowering them through participatory techniques. These techniques give women the tools to collectively decide about FGC and to negotiate community support. This approach is well documented in Senegal, where more than 50 villages have ended FGC. Formal evaluation and long-term monitoring are needed to prove that the approach is sustainable over a long period of time.

**Intensified Social Marketing.** Another recent approach is to involve community power holders in evaluating the costs and benefits of continuing FGC. This approach is generally directed at community elders, giving messages about FGC through such methods as public relations campaigns, cultural days, and award ceremonies. This approach appears to be working successfully in Uganda, but formal evaluation and monitoring are needed.

**Passing Criminal Laws.** A small number of countries have passed laws to make FGC illegal, generally imposing penalties on providers.\*

Based on this collective body of experience, Dr. Toubia cautioned that FGC is not an end in itself but an important component of a broader set of issues. The goal should not be simply to end FGC but to make gender-based violence unacceptable in the context of promoting protection of women's reproductive and sexual health and rights (see Figure 2).

\* Countries with laws making FGC illegal include Burkina Faso, Central African Republic, Côte d'Ivoire, Djibouti, Egypt (ministerial decree prohibiting FGC in medical facilities), Ghana, Guinea, Senegal, Tanzania, and Togo; Australia, Belgium, Canada, Germany, the Netherlands, the United Kingdom, and the United States. Source: Office of the Senior Coordinator for International Women's Issues, Bureau for Global Affairs, and the Office of Asylum Affairs, Bureau of Democracy, Human Rights, and Labor, U.S. Department of State, January 15, 1999.

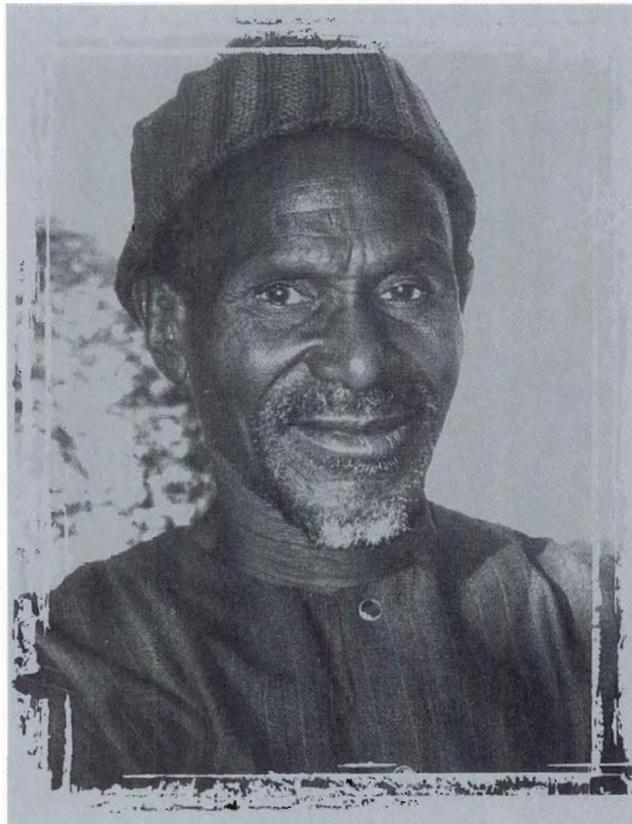
## Successful Field Interventions

In some places, change is evident, and FGC is beginning to be eliminated. Although each local context is different, it is useful to look at what is working in a variety of settings—both to learn from the specific example and to understand that change is possible.

### The Power of Public Declarations

In villages throughout Senegal, women are publicly declaring their commitment to ending FGC. Their experience suggests that, while education about FGC and its effects on health is important, it is not enough to end the practice. But the power and example of women and their communities declaring publicly that they will no longer participate in the ritual is spreading from village to village.

Ms. Molly Melching of Tostan, a Senegalese NGO, described the fast-developing events in that country. In July 1997, women taking Tostan's basic education class in the village of Malicounda Bambara decided—first as a class and then with the support of their husbands and their village leaders—that they would no longer practice FGC on the young girls in their village. One of the village leaders, Demba Diawara (see photo on right), who attended that declaration and had once supported FGC, then walked from village to village, discussing why FGC should be ended. He concluded from that experience—as others have elsewhere—that information and education alone are not enough. What is needed is a family—a community—commitment. The endogenous marriage pattern and close ties among the extended family make FGC a group behavior. As



such, all members of the community (which may extend through numerous villages) must agree to stop the practice.

In February 1998, 13 villages made the first written pledge to end FGC in their communities, with each community deciding its own measures for enforcing the pledge. There have been no reported cases of female circumcision in those villages since then.

Another 18 villages made the same commitment in July 1998 in the presence of the media, government representatives, and development partners.

Public pledges are a powerful tool for ending centuries-old traditions. But to work, they must be rooted in women's confidence and decision-making capacity. The first public declarations in Senegal evolved through a nondirective two-year basic education program integrating cognitive, technical, and psycho-social skills. As women in the program gained a sense of their own rights and those of other women, confidence in their decision-making and advocacy skills, and accurate

health information, they began to question genital cutting and prompted the community to declare itself to be against the practice.

Based on the experiences of the 31 villages that first ended FGC, Tostan has developed a shorter program that is now being implemented on an experimental basis. This six-month empowerment program consists of human rights training, problem-solving skills, basic hygiene, and women's health information. The two education programs have in common that they allow villagers to analyze their own situation, set their own goals,

develop critical thinking skills, find solutions to problems, and rehearse strategies for social change throughout the learning process.

A third avenue leading to public declarations against FGC is social mobilization by participants in an education program and members of the same ethnic group. To succeed, these efforts must come from relatives and village leaders in the community, not from outsiders. At least 20 additional villages have made public declarations through one of these processes.

### **Training Health Providers: Using Operations Research to Stop FGC**

Through the Africa Operations Research/Technical Assistance (ORTA) Project, implemented by the Population Council and supported by the USAID Office of Population, NGOs in Mali conducted research to determine the relative effectiveness of training traditional FGC practitioners and medical personnel in health centers. Dr. Nafissatou Diop of the Population Council's field office in Senegal discussed the research findings.

Nearly two decades of effort to raise awareness among traditional providers about the negative health consequences of FGC and to promote alternative income-generating activities for circumcisers were found to have been ineffective in stopping the practice of FGC. Many who initially gave up the practice took it up again when promises of alternative compensation did not materialize and when they realized that their status in the community suffered when they no longer performed this function.

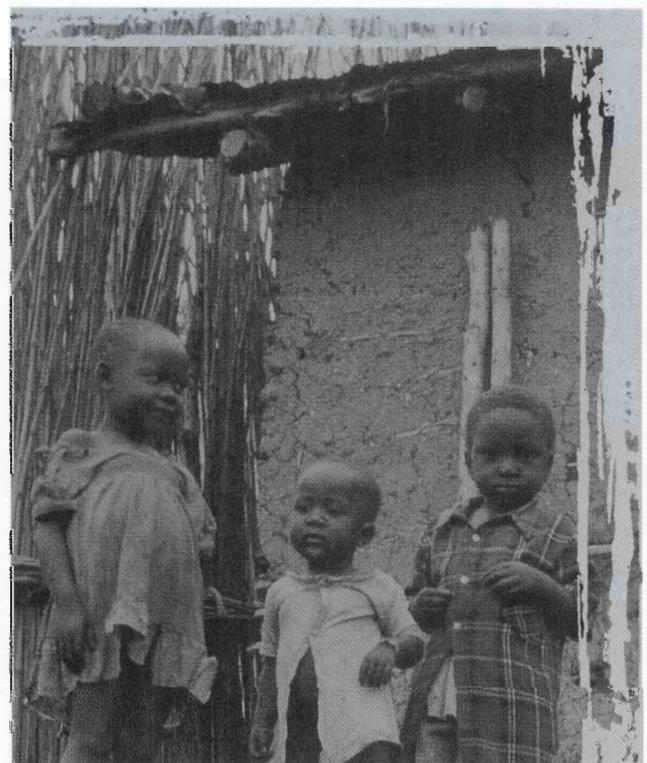
In contrast, more recent efforts to train medical personnel look promising. A recent project sought to increase knowledge about the health complications of FGC among personnel in health clinics, as well as to reduce the number of health personnel willing to perform circumcisions on girls and increase the number willing to conduct information, education, and communication (IEC) activities. The project consisted of a three-day training session on FGC for 61 health service providers in 14 clinics, followed by observation and supervision of trained personnel in the clinic setting. Tests before and after the training show that knowledge of FGC and its complications increased dramatically, and that the vast majority (88 percent) of trained health personnel think education is important in discouraging FGC. Moreover, 93 percent said they would be willing to

personally conduct such education. In fact, however, only three clinics organized health talks and only 3 percent of providers gave counseling to their patients.

Based on the initial findings, the Ministry of Health decided to continue this kind of training by:

- integrating the FGC module into in-service reproductive health training programs, and working with the Ministry of Education to introduce FGC training into health schools;
- emphasizing IEC materials in clinics and distributing the flip chart developed during the project for that purpose;
- issuing a decree forbidding the practice of FGC in public health clinics; and
- undertaking further operations research to improve the quality and effectiveness of IEC in health clinics.

Although most FGC activities to date have been conducted by NGOs, governments that have officially committed themselves to eliminating the practice of FGC are looking for models that work. In this case, Mali acted immediately to utilize the results of this research study. Assistance is needed in designing and financing activities that can help societies meet their goals of eliminating FGC.



## Alternative Rites of Passage

A project conducted jointly by PATH and Maendeleo Ya Wanawake Organization (MYWO), a women's NGO in Kenya, is showing remarkable success in involving girls in alternative rites of passage. By promoting alternative rituals that meet many of the same needs as traditional circumcision ceremonies, the project is enabling a growing number of girls and their families to choose not to undergo genital cutting. Dr. Asha Mohamud of PATH described the alternative rituals and the impact they are having in Kenya.

The project was begun in 1991 and consisted of the following phases: (1) formative research (1991–92); (2) design and fundraising (1993); (3) implementation (1994–98); and (4) evaluation (1999).

The research period developed important information that guided the overall direction and approach of the project. Before developing alternative rituals, it was important to understand the reasons why FGC is practiced. Figure 3 provides a conceptual framework for understanding the role of FGC in society. This “mental map” shows the religious, personal (hygiene and aesthetics), and societal beliefs that contribute to the practice; these beliefs have to do with maintaining virginity, upholding family honor, and controlling

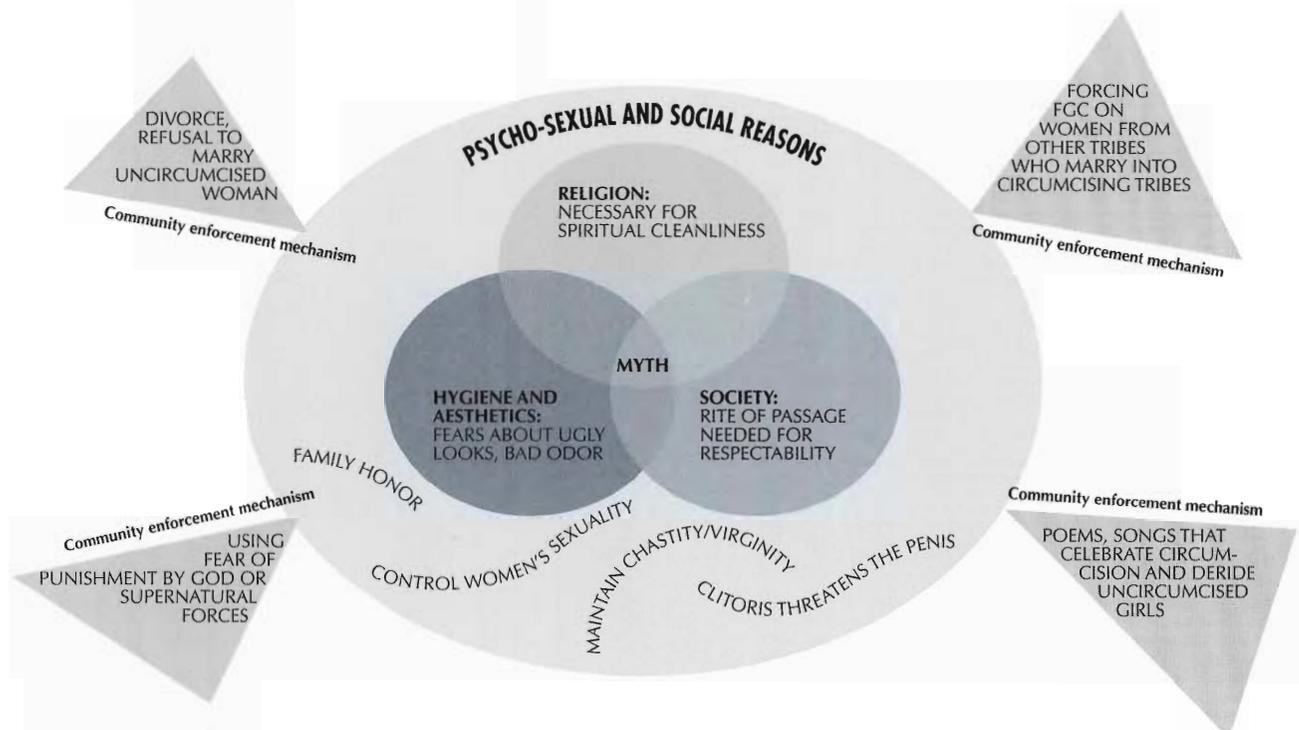
women's sexuality. Moreover, communities have a range of enforcement mechanisms to ensure that the majority comply, including fear of punishment from God, men's unwillingness to marry uncircumcised women, insistence that even women from other tribes get circumcised when they marry in, as well as local poems and songs that reinforce the message.

The research found that the cutting ceremony meets a number of important individual and community needs. Circumcision is a significant rite of passage during which girls are the center of the community's attention and receive important recognition. For fathers, it is an opportunity to display their wealth and status; for mothers, it is one chance to receive gifts and recognition in return for years of giving to others. In addition, it is a social occasion during which family and friends enjoy the feasting and celebration.

Based on this information, the project sought to develop an alternative coming of age ceremony by working with mothers in families hesitant about traditional practices but unable to withstand the social pressure favoring FGC. Through a feasibility study conducted in the area, MYWO identified three people who wanted to participate. These three then recruited others who were already convinced that FGC is harmful. This

FIGURE 3

## Mental Map: Why FGC Continues



Source: Asha Mohamud, PATH

process brought in a large number of people to participate in the alternative ritual.

The alternative coming of age ceremony consisted of collecting the traditional wisdom that was imparted to girls when they were circumcised, developing a program that took account of those messages (see Box 4), conducting a five-day seclusion period to teach the girls those messages, culminating in a one-day celebration including feasting and gift-giving. Once they participated in this alternative rite, the girls and families became a support group for others contemplating this decision; they were also the core group recruiting others to take this step.

The “circumcision with words” ceremony has grown rapidly, from 79 girls in 1996 to 1,136 girls in 1998. Begun in one district, it is now being implemented in four districts, and demand is growing in other districts as well. Alternative rites of passage are gaining community acceptance and are endorsed both by community elders and the Kenya Medical Association. None of the girls who participated in alternative ceremonies was circumcised later, and they are all strongly motivated to recruit others. Significant media coverage helped to promote both awareness and interest. A formal evaluation is in process, but the Ministry of Health is already planning to replicate the effort at the national level pending funding.

In planning replication, it is useful to determine the key factors contributing to the success of this effort:

- It uses a participatory process that empowers the girls and their families.
- It focuses on decisionmaking and specific behavioral goals.
- It requires individuals and groups to publicly declare what they can and will do to eliminate female cutting—in their families, in their communities, and in Kenya.
- It supports positive aspects of coming of age ceremonies by including those elements in the alternative rites.
- It addresses the community’s need for sexuality education for girls.
- It aims to create a critical mass of supporters for alternative rites of passage.

#### BOX 4 **Kenya’s Alternative Right of Passage Course Content**

- Self-esteem: coping with criticism
- Responsibility for own decision
- Dating and courtship
- Coping with peer pressure
- Personal hygiene
- Marriage
- Pregnancy and STD/AIDS prevention
- Contraception
- FGC, early marriage, and gender empowerment, including rights of the girl child
- Respect for community
- Respect for elders.

#### **The Positive Deviance Inquiry: Empowering Communities Through Existing Solutions**

In 1994, the National FGC Task Force was created to strengthen the decades-long effort to eradicate FGC in Egypt. These efforts began in the early 1960s, but were generally on a small scale until the 1994 International Conference on Population and Development (ICPD). In 1996, with funding from the Centre for Development and Population Activities (CEDPA), the Task Force studied the efforts of Egyptian NGOs in this area in order to identify successful strategies for the future. One recommendation from this study was to create positive images of uncircumcised women as a way to advocate for discontinuing the practice.

With support from USAID’s Promoting Women in Development (PROWID) project, CEDPA and its NGO partners have been conducting a “positive deviance inquiry” (PDI) project. The goal of a PDI, according to Romany Abadir of CEDPA, is to discover the few individuals in a community who are different from the norm in a positive way. What are the unique or special practices or characteristics that enable them to overcome or solve a widespread problem in the community? In relation to FGC, “positive deviants” are those who in some way have said “no.” They include:

- **Individuals who have stopped or prevented the cutting of their young girls.** They could be mothers, fathers, grandmothers, husbands, elder sisters, the girl herself, or other relatives.

- **Individuals who have stopped performing the excision.** They could be traditional birth attendants, doctors, or traditional circumcisers.
- **Community leaders who openly oppose the practice.** They may include Imams, priests, teachers, and officials.

A positive deviance inquiry involves finding the solutions that already exist in the community—finding the positive models and learning from them what enables them to make a choice that goes against the norm. What factors enable 3 percent of the population to resist circumcising girls in a context where the prevalence of cutting is 97 percent? This information is obtained through interviewing the positive deviants. In Egypt, the interviews showed that emotional and psychological factors are more important than religious or medical factors in determining resistance to genital cutting.

The PDI Project found that giving the “positive deviants” the opportunity to talk about their choices was in itself an empowering tool. It broke the silence surrounding FGC. Once the fear of speaking out was removed, individuals themselves moved toward advocacy, taking initiatives within their communities. It also encouraged NGO and community development agency staff to become advocates. Because community members have ownership of both the process and the results, it is likely to be sustainable.

The objective of the PDI Project in Egypt was to train local NGOs and community development agencies in how to conduct a PDI; to develop a framework for using PDIs as an advocacy tool for eradicating FGC; and to document the process so it can be replicated by others. To date, it has been conducted in four communities and has shown itself to be a successful tool for convincing others in the community to stop the practice of genital cutting.

The next step is to increase the scale of the project to reach more NGOs and community development agencies, as well as to integrate the approach into a comprehensive program. In addition, a strategy is being developed to reach multiple target groups through a variety of channels, and to network among communities.



*Ten or fifteen years ago, FGC was a culturally sensitive issue that was not easily discussed. Today, things have changed and there is widespread recognition that the issue directly affects the health and well-being of not only women but whole societies. There is also considerable demand on USAID and other donors to address the issue—in the form of international resolutions, U.S. legislation, and public opinion. Thus this is not a new issue for USAID, but part of an ongoing effort to find new and effective ways to integrate FGC into a wide range of USAID activities.*

—Ms. Barbara Turner  
Senior Deputy Administrator,  
Global Bureau

## Integrating FGC Into USAID Programs

In the last decade or so, FGC has moved from being a private issue to one that is recognized as integral to the social and economic development of countries, and both the intellectual and financial commitment to eliminating FGC have increased. This session looked first at some factors that traditionally—and still—impede donor involvement, and then at the many emerging possibilities for action by USAID and other donors. The innovative programs of local NGOs in a wide variety of settings are catching the attention of governments and donors; USAID and others are looking for new and creative ways to integrate FGC elimination into ongoing programs.

### Overcoming Barriers to Donor Involvement

In addition to the many personal, community, and country-level barriers that may block action on this issue, USAID and other donors face difficulties at the international level. Dr. Duff Gillespie of the Center for Population, Health, and Nutrition outlined the factors that traditionally have made donors reluctant to get involved in FGC.

- **Cultural Imperialism.** Western governments are concerned to avoid confronting issues involving local culture.
- **Gender Bias.** Because government bureaucracies are generally male-dominated, issues affecting women have additional hurdles to overcome in getting attention.
- **Victim Ambiguity.** Unlike other health issues, in the case of FGC it is not always clear to the outside agency who the victim is and where the intervention is needed, particularly since young, defenseless girls who are victims often become advocates for the procedure when they grow older.
- **Ignorance.** For a long time, little was known about the health consequences and psychological trauma associated with FGC. While knowledge alone is not enough to change either personal or collective behavior, developing the knowledge base has been an important first step in developing effective interventions.
- **Geographical Confinement to Africa.** Issues that are geographically bounded traditionally get less high-level donor attention than those with wider impact.

- **Long-term Perspective.** Bureaucrats and policymakers tend to prefer addressing issues that can be solved in a relatively short period of time. The goal of fully eradicating FGC is likely to take a long time to achieve.
- **Competition for Scarce Resources.** At both the domestic and the international level, FGC competes with other important issues—malaria, tuberculosis, polio, family planning, nutrition—for scarce resources. Thus, advocates for FGC eradication efforts must continually educate decisionmakers on this issue.
- **Unclear Return on Investment.** In many other development areas, donors have a clear idea of the kind of return—the development impact—they can expect from their investment. In the area of FGC, that documentation does not yet exist and considerable work is still needed by donors, NGOs, and governments to demonstrate what measures are most effective.

Dr. Gillespie noted that many development issues have some of these barriers to donor involvement, but only FGC has them all. Nevertheless, he noted how much progress has been made in getting constructive international attention and donor involvement focused on FGC in the last decade. The challenge is to overcome the barriers and not be discouraged by them.

### Moving From Idea to Program: Incorporating FGC at the Mission Level

Dr. John Flynn, currently Senior Advisor in the Africa Bureau, spoke about his experience in integrating FGC into the program of the USAID Mission in Guinea while he was Mission Director (1995–98). He outlined the process of moving an issue from an abstract idea to a concrete program that commands resources and respect.

An important first step for him was a change in personal perception—from looking at FGC as a narrow, special interest issue with high emotional significance to seeing it as a development issue with programmatic implications. By not letting an emotional approach dominate, he and other mission staff were able to apply the same analytic and strategic thinking used in other development areas.

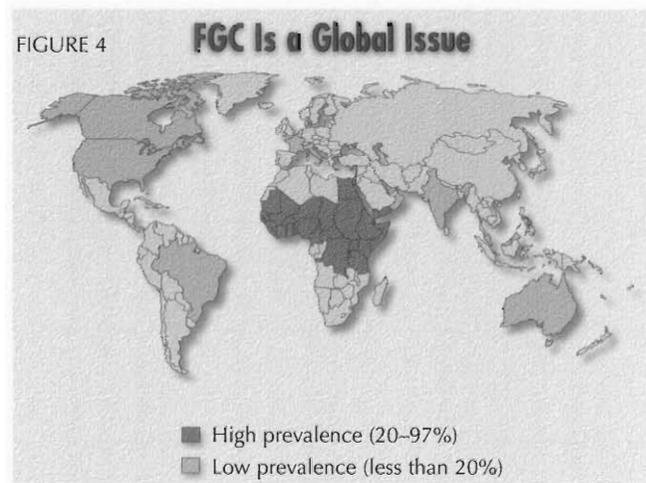
The strategic program was then designed around the concept that in Guinea—as in most African countries—USAID’s principal customers are women and children. In fact, USAID’s investment of many years in developing leadership and technical skills among women is now paying off: Strong dynamic women leaders have emerged in social, economic, and political sectors, helping to create a context in which social change is possible.

As donors, the development task often is to help create an enabling social environment in which a range of changes can take place. The approach was to work with the emerging women leaders, and to engage religious and other opinion leaders in a series of discussions not only on FGC, but also on such issues as education for girls, women’s reproductive health, and family planning. Within a short period of time, they supported action in all of these areas. In addition, the Mission harnessed the tremendous power of IEC, and gave modest support to groups interested in working on FGC. The Mission also undertook a formal knowledge, attitudes, and practice survey that helped guide the approach.

Together, these things contributed substantially toward creating the environment in which FGC could take its place as an important development issue. Although the elimination of FGC has been on the development agenda only a few years in Guinea, it has a good chance of succeeding because it is integrated into many development efforts.

### **Initiative Must Be Local**

USAID has an important role to play in helping to eliminate FGC. It is a broad development issue with human rights, health, education, and advocacy aspects. But in every context, the decision to eradicate FGC must come from the local community. USAID’s role is to support that decision, not to direct it.



In discussing this point, Dr. Muneera Salem-Murdock of the WID Office noted that the particular causes, approaches, and potential solutions to FGC vary by context. There are common patterns and lessons that can be learned, but the examples already given show that the key to success is to rely on locally designed, implemented, and controlled strategies and programs. To do this, women need knowledge and power. They need knowledge about the physical, psychological, and emotional harm that comes from the practice of FGC; and they need the power not only to apply the knowledge in their own households but also to educate, communicate, and defend their position to opinion leaders and decisionmakers.

In trying to support local women on this issue, USAID recognizes that FGC will not be eradicated through separate FGC projects. Instead, USAID can have the highest impact at the lowest cost by focusing on integration and training. USAID programs in other sectors—such as child survival, education, reproductive health, and democracy and governance—should integrate FGC into existing projects and activities. In addition, providing training to women can help give them skills to act as advocates and educators in their own societies.

## Implications for the Future

In recent years, communities and countries have begun to make progress toward the internationally agreed upon goal of eradicating FGC. Local efforts in diverse settings are starting to build a body of knowledge about how to address FGC most effectively. It is useful to review the lessons from those experiences to determine the characteristics that are essential to an effective program.

**Empowering women to make their own decisions is an essential first step.** The “cutting” is a symptom of a larger problem—women’s limited social, economic, political, and decisionmaking roles. When women as a group have access to education and information, including human rights information, they take steps to end FGC.

**Individual behavior change is not enough; the decision to end FGC must have support from the surrounding community or network.** Unless others in the community support the decision to forgo circumcision, girls continue to be at risk.

**Public declarations are a powerful means of moving the decision to end FGC from the individual to the larger community.** Public declarations bring into the open issues, feelings, and ideas that had long been secret and create the community climate within which individual women and families can choose not to circumcise their girls. But the process of coming to a public declaration has additional power in that it en-

gages all members of the community, including husbands and religious leaders, making them advocates of ending FGC as well.

**FGC is not an isolated issue but part of a full range of development concerns.** It is most effectively addressed as part of the larger problem of women’s health, human rights, economic, and social issues.

The implication of these conclusions is that a great deal is possible with even small infusions of additional resources—from democracy funds for empowerment and advocacy activities, from operations research, from evaluations to develop and test new strategies for eradication, and from data collection to improve our knowledge of the prevalence of the practice. The goal should be for a wide range of USAID activities and programs to be looking for ways to integrate FGC into ongoing projects. It is a multidimensional and cross-sectoral development issue that needs attention and support on many fronts.

The accumulating body of experience shows that FGC is most likely to be abandoned when progress is made on a range of development, health, and human rights issues, and when local women and their surrounding communities are empowered to make such decisions themselves. By integrating FGC into existing development programs, USAID can aid in that process with a significant return on a relatively small investment.

## Further Reading on FGC

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# Appendix 1

## Agenda

### Female Genital Cutting Symposium

June 3, 1999

#### *Opening Plenary*

Chair: Ms. Valerie Dickson-Horton  
*Deputy Assistant Administrator, Africa Bureau*

Welcome: Ms. Asma Abdel-Halim  
*FGC Fellow*

#### *FGC as a Human Rights and Reproductive Health Issue*

Chair: Ms. Asma Abdel-Halim

Speakers: Dr. Nahid Toubia  
*President, RAINBO*  
Ms. Molly Melching  
*President, Tostan*

#### *Successful Field Interventions*

Chair: Dr. Marjorie Horn  
*Deputy Chief, Research Division,  
Office of Population*

Speakers: Dr. Nafissatou Diop  
*Research Associate, Population Council (Senegal)*  
Dr. Asha Mohamud  
*Senior Program Officer, PATH*  
Mr. Romany Abadir  
*Program Officer, CEDPA (Egypt)*

#### *Integrating FGC Into USAID Programs*

Chair: Ms. Barbara Turner  
*Senior Deputy Administrator, Global Bureau*

Speakers: Dr. Duff Gillespie  
*Deputy Assistant Administrator, Center for Population, Health, and Nutrition*  
Dr. John Flynn  
*Senior Advisor, Office of the Assistant Administrator, Africa Bureau*  
Dr. Muneera Salem-Murdock  
*Deputy Director, Office of Women in Development*

## Appendix 2

### List of Participating Organizations

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#### **Research, Action, and Information Network for the Bodily Integrity of Women (RAINBO)**

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E-mail: [rainbo@aol.com](mailto:rainbo@aol.com)  
Web site: [www.rainbo.org](http://www.rainbo.org)

#### **Tostan**

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Tostan Thies  
Senegal

#### **U.S. Department of Health and Human Services**

Office of Women's Health  
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#### **U.S. Department of State**

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#### **World Health Organization (WHO)**

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Web site: [www.who.int](http://www.who.int)



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This publication was funded by the  
United States Agency for International Development (USAID)  
through the MEASURE *Communication* Project (HRN-A-00-98-000001-00).