

ABANDONING FEMALE GENITAL CUTTING

Prevalence, Attitudes, and Efforts to End the Practice

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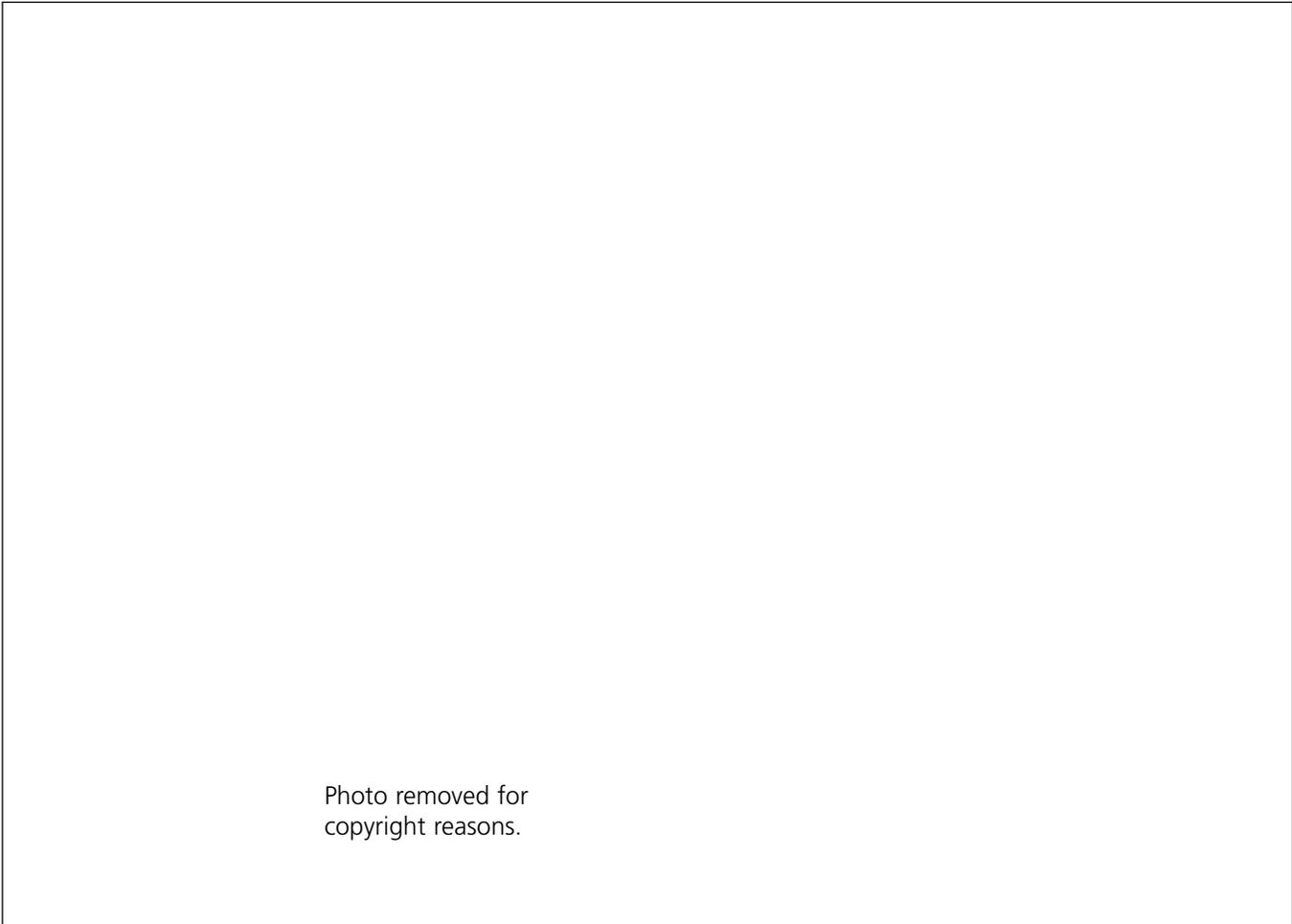


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FGC often serves as a rite of passage to womanhood or defines a girl or woman within the social norms of her ethnic group or tribe. The practice is generally performed on girls between ages 4 and 12, although it is practiced in some cultures as early as a few days after birth or as late as just prior to marriage, during pregnancy, or after the first birth.

SUMMARY

More than 130 million girls and women worldwide have undergone female genital cutting (FGC), and each year nearly 2 million more girls are at risk.¹ FGC is a traditional practice that involves cutting or altering the female genitalia as a rite of passage or for other sociocultural reasons. While some research indicates that many women who undergo FGC do not have health problems as a result of the procedure, for others, the practice can have serious health consequences.² These include hemorrhage, shock, pain, infection, difficulties during childbirth, and psychological and sexual problems that can damage a girl's lifetime health. These potential health effects are aggravated by the type of female genital cutting that girls and women experience. Other factors in determining the extent of health effects of FGC include the practitioner's expertise and tools, hygienic conditions, and access to adequate health care.

Over the past twenty years, FGC has been increasingly recognized as a health and human rights issue among governments, the international community, and professional health

organizations. As a result of this attention, consensus against FGC has gradually emerged and strong efforts are now being made on the international, national, and community levels to end the practice. Non-governmental organizations working locally and internationally implement the majority of FGC abandonment programs; presently, there are at least 100 groups working on the issue. While community-based programs are at the core of efforts to abandon FGC, national and international laws, policies, and resources are also needed to create a supportive environment for these local initiatives.

FGC exists mainly in sub-Saharan and Northeastern Africa, but it has spread to other regions of the world through migration. It is practiced by people from all educational levels and social classes, among urban and rural residents, and among many different religious and ethnic groups. There is, however, great variability from country to country regarding these and many other factors. These include the age at which FGC occurs, prevalence and attitudes regarding FGC, the type of FGC practiced, and the type of practitioner who performs the pro-

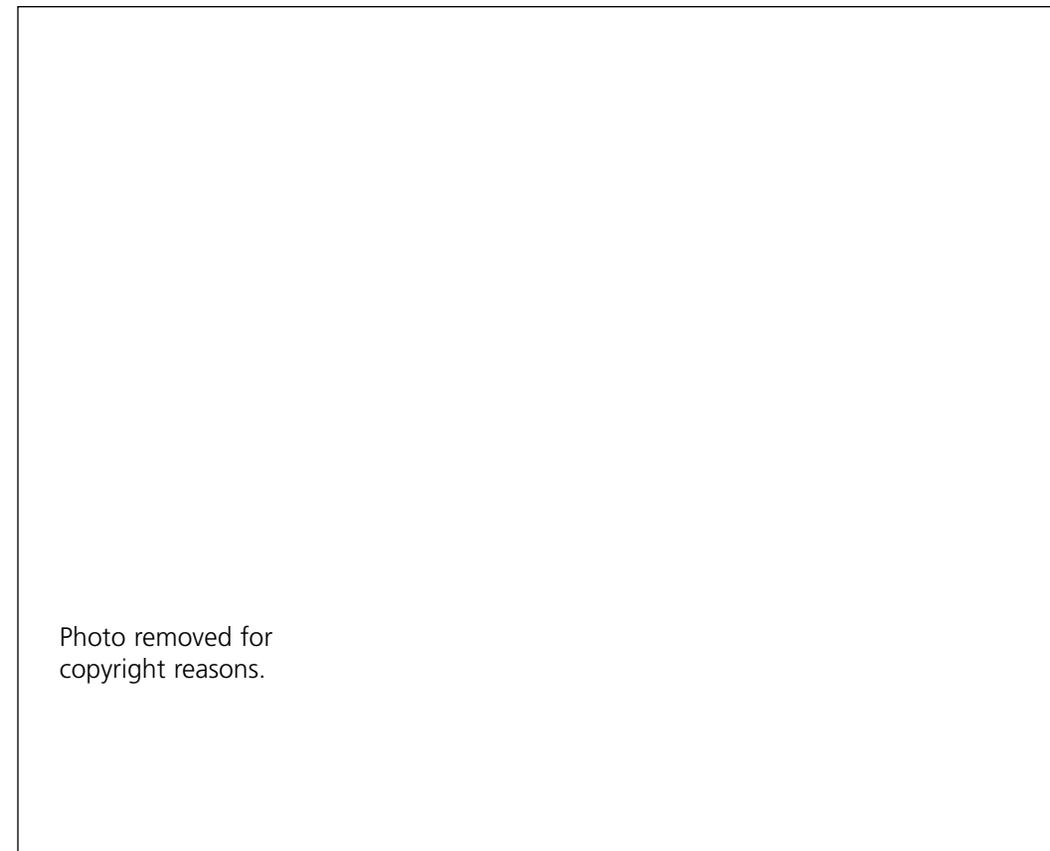


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Women of Malicounda Bambara, the first village in Senegal to publicly declare an end to FGC on July 31, 1997, celebrate their decision.

cedure, the conditions under which FGC is performed, and the rituals and traditions surrounding the practice.

This report sheds light on the practice of FGC, drawing on recent Demographic and Health Survey (DHS) data (and special tabulations of these data) from nine countries: Burkina Faso, the Central African Republic (CAR), Egypt, Eritrea, Kenya, Mali, Sudan, Tanzania, and

Yemen. FGC national prevalence in these countries ranges from nearly universal (90 percent or more) in Egypt, Eritrea, Mali, and Sudan, to 18 percent in Tanzania. In Burkina Faso, CAR, Eritrea, Kenya, and Tanzania, there is some evidence of a decline in the practice among younger women. On the other hand, in Egypt, Mali, and Sudan, there has been virtually no change over time. In some coun-

tries, there is a striking contrast between high prevalence of FGC and low approval for the practice. This gap between practice and attitudes may provide opportunities for intervention, especially in Burkina Faso, CAR, Eritrea, and Kenya. Conversely, the high prevalence and persistent strong approval for FGC in other countries like Egypt, Mali, and Sudan may require different interventions.

Urban women with some education are typically less likely to practice and approve of FGC; however, this is not the case in all countries. FGC is a cultural, rather than a religious or ethnic practice. It occurs among all religious groups in Africa, though no religion mandates it. Ethnic affiliation is also associated with female genital cutting. In some countries, all ethnic groups practice FGC in every region; in others, the practice is more limited to one or more groups living in specific areas.

Traditional practitioners, who are not usually medically trained, perform the majority of FGC procedures. In many cases, the practitioner comes from a family in which generations of women have been traditional practi-

tioners. In some countries, daughters are just as likely to be cut by traditional practitioners as their mothers were. In other countries, medical professionals increasingly perform the procedure, especially on younger girls, although this does not necessarily make the practice safer.

This report presents an overview and recent statistics about the practice of FGC, a summary of FGC abandonment approaches, and a brief discussion of projects in four countries (Egypt, Kenya, Senegal, and Uganda) identified as promising by the World Health Organization (WHO) and the Program for Appropriate Technology in Health (PATH). Finally, the report offers guidance to policymakers and program managers involved in implementing FGC abandonment policies and activities.

Countries Featured in This Report



INTRODUCTION

More than 130 million girls and women worldwide have undergone female genital cutting—also known as female circumcision and female genital mutilation (see Box 1)—and nearly 2 million more girls are at risk each year.³ The practice often serves as a rite of passage to womanhood or defines a girl or woman within the social norms of her ethnic group or tribe. The tradition may have originated 2,000 years ago in southern Egypt or northern Sudan, but in many parts of West Africa, the practice began in the 19th or 20th century.⁴ No definitive evidence exists to document exactly when or why FGC began.⁵ FGC is an ancient practice but has also been recently adopted, for example, among adolescents in Chad.⁶

FGC is generally performed on girls between ages 4 and 12, although it is practiced in some cultures as early as a few days after birth or as late as just prior to marriage, during pregnancy, or after the first birth.⁷ Girls may be circumcised alone or with a group of peers from their community or village. Typically, traditional elders (male barbers and

female circumcisers) carry out the procedure, sometimes for pay. In some cases, it is not remuneration but the prestige and power of the position that compels practitioners to continue. The practitioner may or may not have health training, use anesthesia, or sterilize the circumcision instruments. Instruments used for the procedure include razor blades, glass, kitchen knives, sharp rocks, scissors, and scalpels.⁸ A discouraging trend is the use of medical professionals (physicians, nurses, and midwives) in some countries (e.g., Egypt, Kenya, Mali, and Sudan) to perform the procedure due to growing recognition of the health risks associated with FGC and heightened concern regarding the possible role of FGC in HIV transmission.⁹ WHO has strongly advised that FGC, in any of its forms, should not be practiced by any health professional in any setting—including hospitals and other health centers.¹⁰

FGC has health risks, most notably for women who have undergone more extreme forms of the procedure (see Box 2, page 4). Immediate potential side effects include severe pain, hemorrhage, injury to the adja-

cent tissue and organs, shock, infection, urinary retention and tetanus—some of these side effects can lead to death.¹¹ Long-term effects may

include cysts and abscesses, urinary incontinence, psychological and sexual problems, and difficulty with childbirth. Obstructed labor may

Box 1

Deciphering the Terms: Circumcision, Mutilation, or Cutting?

Female genital cutting (FGC), also known as female circumcision (FC) and female genital mutilation (FGM), involves the cutting or alteration of the female genitalia for social rather than medical reasons. The term FC was widely used for many years to describe the practice; however, it has been largely abandoned as it implies an analogy with male circumcision.¹ Various communities still use the term FC because it is a literal translation from their own languages. Male circumcision, which has also been increasingly criticized, involves cutting the foreskin of the tip of the penis without harming the organ itself. Female circumcision is a far more damaging and invasive procedure. Furthermore, while male circumcision is seen as affirming manhood, female circumcision is often perceived as a way to curtail premarital sex and preserve virginity. FGM is the term most commonly used by women's rights and health advocates who wish to emphasize the damage caused by the procedure. In the mid-1990s, many local practicing communities and activists decided to shift to the use of the more neutral term, female genital cutting, because they considered FGM to be judgmental, pejorative, and not conducive to discussion and collaboration on abandonment. The U.S. Agency for International Development (USAID) followed suit and prefers the term FGC.² There is ongoing debate about the appropriate terminology for the practice.

Notes:

1. Anika Rahman and Nahid Toubia, *Female Genital Mutilation: A Guide to Laws and Policies Worldwide* (London and New York: Zed Books, 2000): 4.

2. U.S. Agency for International Development (USAID), "USAID Policy on Female Genital Cutting," revised September 20, 2000.

occur if a woman has been infibulated. This involves cutting off the external genitalia and sewing together the two sides of the vulva, leaving a small hole for urination and menstruation. If the woman's genitalia is not cut open (defibulated) during delivery, labor may be obstructed and cause life-threatening complications for both the mother and the child, including perineal lacerations, bleeding and infection, possible brain damage to infants, and fistula formation.¹²

All of these possible side effects may damage a girl's lifetime health, although the type and severity of consequences depend on the type of procedure performed (see Box 2). Infibulation or Type 3 is the most invasive and damaging type of FGC. Operations research studies conducted in Burkina Faso and Mali have shown that women who were infibulated were nearly two and a half times more likely to have a gynecological complication than those with a Type 2 or Type 1 cut. Risks during childbirth also increased according to the severity of the procedure. For instance, in Burkina Faso, women with Types 2 or 3 cutting had a higher likelihood of experiencing hemorrhaging or perineal tearing during delivery.¹³

While it is difficult to determine both the number of women who have undergone FGC and how many have undergone each type of circumcision, WHO has estimated that clitoridec-

tomy, which accounts for up to 80 percent of all cases, is the most common procedure. Fifteen percent of all circumcised women have been infibulated—the most severe form of circumcision.¹⁴

FGC is practiced in at least 28 countries in sub-Saharan and north-eastern Africa but not in southern Africa or in the Arabic-speaking nations of North Africa, with the exception of Egypt. It is practiced at all educational levels and in all social classes and occurs among many religious groups (Muslims, Christians, animists, and one Jewish sect), although no religion mandates it.¹⁵ For countries presented here with DHS data, prevalence varies from 18 percent in Tanzania to nearly 90 percent or more in Egypt, Eritrea, Mali, and Sudan. According to WHO estimates, 18 African countries have prevalence rates of 50 percent or more.¹⁶ Through migration, the practice has also spread to Europe, North and South America, Australia, and New Zealand. Although doctors, colonial administrators, and social scientists have documented the adverse effects of FGC for many years, governments and funding donors have become increasingly interested in the practice because of the public health and human rights implications.

Global efforts to end FGC have used legislation to provide legitimacy for project activities, to protect women, and to discourage circum-

Box 2

Types of Female Genital Cutting

Female genital cutting (FGC) refers to a variety of operations involving partial or total removal of female external genitalia. The female external genital organ consists of the vulva, which is comprised of the labia majora, labia minora, and the clitoris covered by its hood in front of the urinary and vaginal openings. In 1995, the World Health Organization classified FGC operations into four broad categories described below:

- **Type 1 or Clitoridectomy:** Excision (removal) of the clitoral hood with or without removal of the clitoris.
- **Type 2 or Excision:** Removal of the clitoris together with part or all of the labia minora.
- **Type 3 or Infibulation:** Removal of part or all of the external genitalia (clitoris, labia minora, and labia majora) and stitching and/or narrowing of the vaginal opening, leaving a small hole for urine and menstrual flow.
- **Type 4 or Unclassified:** All other operations on the female genitalia including
 - pricking, piercing, stretching, or incising of the clitoris and/or labia;
 - cauterization by burning the clitoris and surrounding tissues;
 - incisions to the vaginal wall; scraping or cutting of the vagina and surrounding tissues; and introduction of corrosive substances or herbs into the vagina.

Note:

1. World Health Organization, *Female Genital Mutilation: Report of a Technical Working Group* (Geneva: WHO, 1996): 9.

cisers and families who fear prosecution. In the 1960s, WHO was the first United Nations (UN) specialized agency to take a position against female genital cutting. It began efforts to promote the abandonment of harmful traditional practices like FGC in the 1970s, focusing largely on gathering information about FGC's

epidemiology and health consequences and speaking out about FGC at international, regional, and

national levels. In 1982, WHO issued a formal statement to the UN Commission on Human Rights and recommended several actions:

- Governments should adopt clear national policies to end FGC, and educate and inform the public about its harmful aspects.
- Anti-FGC programs must consider the practice's association with difficult social and economic conditions and respond to women's needs and problems.
- Women's organizations at the local level should be encouraged to take action.¹⁷

In 1988, WHO began to integrate FGC into the development context of primary health care. Over the intervening years, WHO shifted its position on FGC from addressing the practice only in terms of health to acknowledging it as both a health and human rights issue. In the 1990s, FGC gained recognition as a health and human rights issue among African governments, the international community, women's organizations, and professional associations. The 1993 Vienna Human Rights Convention, the 1994 International Conference on Population and Development, and the 1995 Fourth World Conference on Women called for an end to the practice. When performed on girls and nonconsenting women, FGC violates

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When performed on girls and nonconsenting women, FGC violates a number of recognized human rights protected in international conventions and conferences.

a number of recognized human rights protected in international conventions and conferences, such as the Convention on Children's Rights, the Convention on the Elimination of All Forms of Discrimination against Women, and recommendations of the Committee on the Elimination of Discrimination against Women (CEDAW). These conventions explicitly recognize harmful traditional practices such as FGC as violations of human rights, including the right to nondiscrimination, the right to life and physical integrity, the right to health, and the right of the child to special protections.¹⁸

Respect for international human rights law does not require that every

culture use an identical approach to abandoning FGC. One Muslim scholar suggested that respecting different cultures means accepting "the right of all people to choose among alternatives equally respectful of human rights," and that human rights must include life, liberty, and dignity for every person or group of people.¹⁹

In Africa, 10 countries—Burkina Faso, the Central African Republic (CAR), Côte d'Ivoire, Djibouti, Ghana, Guinea, Niger, Senegal, Tanzania, and Togo—have enacted laws that criminalize the practice of FGC. The penalties range from a minimum of six months to a maximum of life in prison. In Nigeria, three of 36 states (as of 2000) had

also enacted legislation regarding FGC. In Burkina Faso, Ghana, and Senegal, these laws are enforced and circumcisers are imprisoned. In these countries, various groups educate the public about the law, use a variety of strategies (e.g., public service announcements and watchdog committees) to denounce FGC, and stop circumcisers by going to the police. Several countries also impose fines. In Egypt, the Ministry of Health issued a decree declaring FGC unlawful and punishable under the Penal Code. There have been several prosecutions under this law, which include jail time and fines. In addition, seven more developed countries that receive immigrants from countries where FGC is practiced—Australia, Canada, New Zealand, Norway, Sweden, the United Kingdom, and the United States—have passed laws outlawing the practice.²⁰ Enforcement of these laws, however, is extremely uneven. France, on the other hand, consistently enforces general penal code provisions against providers of FGC but has not adopted specific legislation regarding FGC.

Why Is FGC Performed?

The traditions surrounding FGC vary from one society to another. In some communities, FGC is a rite of passage to womanhood and is performed at puberty or at the time of marriage. In other communities, it may be performed on girls at a younger age for other reasons such as a celebration of womanhood, preservation of custom or tradition, or as a symbol of ethnic identity. The ritual cutting is often an integral part of ceremonies, which may occur over several weeks, in which girls are feted and showered with presents and their families are honored. It is described as a joyous time with many visitors, feasting, dancing, good food, and an atmosphere of freedom for the girls. The ritual serves as an act of socialization into cultural values and an important connection to family, community, and earlier generations. The ceremonies often involve three interrelated aspects:

- **Educational** A girl learns her place in society and her role as woman, wife, and mother.
- **Physical** A girl must undergo physical pain to prove she is capable of assuming her new role courageously without showing suffering or pain; the pain is experienced both through the actual cutting and through punishment received by girls in complete submission throughout weeks of initiation.
- **Vow of silence** Each girl must make a solemn pledge not to speak about her experience during the ceremony.²¹

The reasons for performing FGC differ, but many practicing communities believe that it preserves the girl's virginity and protects marital fidelity because it diminishes her sexual desire.²² Practicing communities cite reasons such as giving pleasure to the husband, religious mandate, cleanliness, identity, maintaining good health, and achieving good social standing. At the heart of all this is rendering a woman marriageable, which is important in societies where women get their support from male family members, especially husbands. A circumcised woman will also attract a favorable bride price, thus benefiting her family. The practice is perceived as an act of love for daughters. Parents want to provide a stable

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Educating girls and their families is key to encouraging the abandonment of FGC.

life for their daughters and ensure their full participation in the community. Many girls and women receive little formal education and are valued primarily for their role as sources of labor and future producers of children. For many girls and women, being uncircumcised means that they have no access to status or a voice in their community. Because of strong adherence to these traditions, many women who say they disapprove of FGC still submit themselves and their daughters to the practice.

Understanding Why the Practice Continues

FGC is a cultural practice. Efforts to end it require understanding and changing the beliefs and perceptions that have sustained the practice over the centuries. Irrespective of how, where, and when the practice began, those who practice it share similar beliefs—a “mental map”—that present compelling reasons why the clitoris and other external genitalia should be removed.²³ The details of these mental maps vary across countries, and there are distinctive features to each culture that providers, community workers, and others involved with anti-FGC campaigns need to take into consideration.

Figure 1 provides a conceptual framework for understanding the role of FGC in society. This mental map shows the psychological and social reasons, and the religious, societal, and personal (hygienic and aesthetic) beliefs that contribute to the practice. These beliefs involve continuing longstanding custom and tradition; maintaining cleanliness, chastity, and virginity; upholding family honor (and sometimes perceived religious dictates); and controlling women's sexuality in order to protect the entire

community. In the countries surveyed by Demographic and Health Surveys, good custom/tradition is the most frequently cited reason for approving of FGC. Bad custom/tradition is also mentioned as one of the primary reasons for discontinuing the practice.²⁴

To encourage abandonment of FGC, health care providers, community workers, and others involved with anti-FGC programming need to understand the mental map in the communities where they are working. Communities have a range of enforcement mechanisms to ensure that the majority of women comply with FGC. These include fear of punishment from God, men's unwillingness to marry uncircumcised women, insistence that women from other tribes get circumcised when they marry into the group, as well as local poems and songs that reinforce the importance of the ritual. In some cases, women who are not circumcised may face immediate divorce or forced excision. Girls who do undergo FGC sometimes receive rewards, including public recognition and celebrations, gifts, potential for marriage, respect and the opportunity to engage in adult social functions. In other instances, girls and

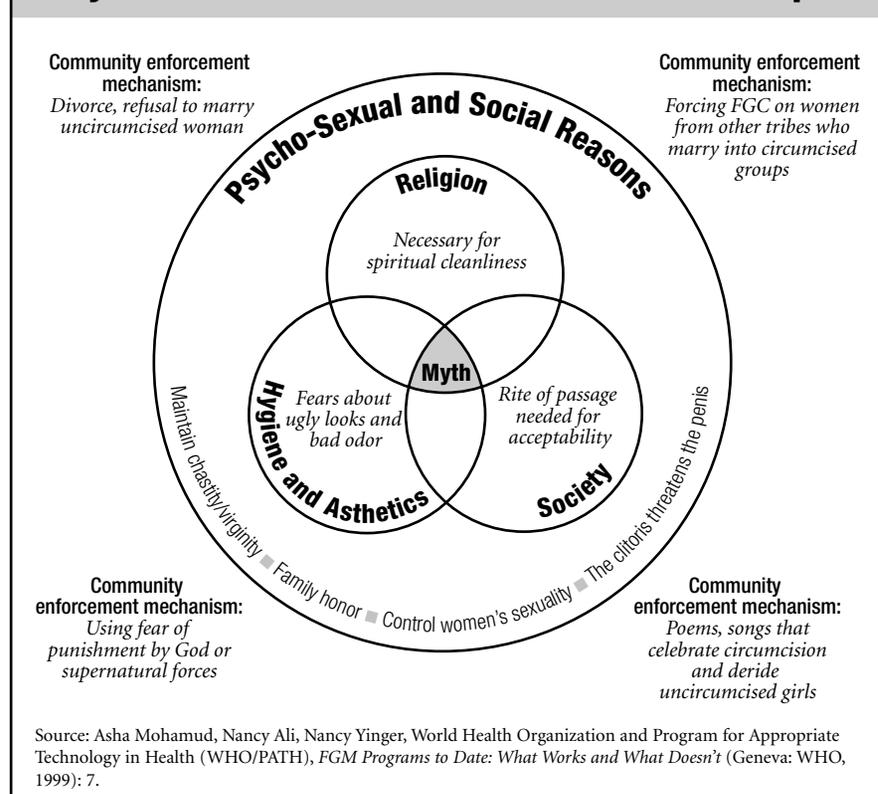
women are cut without an accompanying ceremony; thus, importance is attached to being circumcised rather than to having gone through a ritual.²⁵

The desire to conform to peer norms leads many girls to undergo circumcision voluntarily, yet frequently girls (and sometimes infants) have no choice in whether they are circumcised. A girl's family—typically her mother, father, or elder female relatives—often decides whether she will undergo FGC. Due to the influence of tradition, many girls accept, and even perpetuate, the practice. In Eritrea, men are more likely than women to favor ending the practice.²⁶

FGC could continue indefinitely unless effective interventions convince millions of men and women to abandon the practice. Many African activists, development and health workers, and people following traditional ways of life recognize the need for change but have not yet achieved such an extensive social transformation.

Figure 1

Why the Practice of FGC Continues: A Mental Map



PREVALENCE AND ATTITUDES REGARDING FGC

Key to FGC abandonment efforts is an understanding of the prevalence of FGC nationally and locally, signs of change in the practice of FGC, and attitudes toward the procedure. For many years, a profusion of poor-quality statistics substituted for high-quality data on this topic. One sign of progress is how much more information we now have about FGC.

This section presents recent DHS data from Burkina Faso, CAR, Egypt, Eritrea, Kenya, Mali, Sudan, Tanzania, and Yemen (see Appendix Table on page 29). The analysis considers several aspects of FGC:

- Prevalence and attitudes for women ages 15 to 49 by background characteristics (age, education, ethnicity, religion, region, and residence);
- Signs of change in attitudes and prevalence for women ages 15 to 49 and among women ages 20 to 39 by FGC status of daughter;
- Types of practitioners who performed cutting on women ages 15 to 49 by age group, country, residence;

Prevalence of FGC

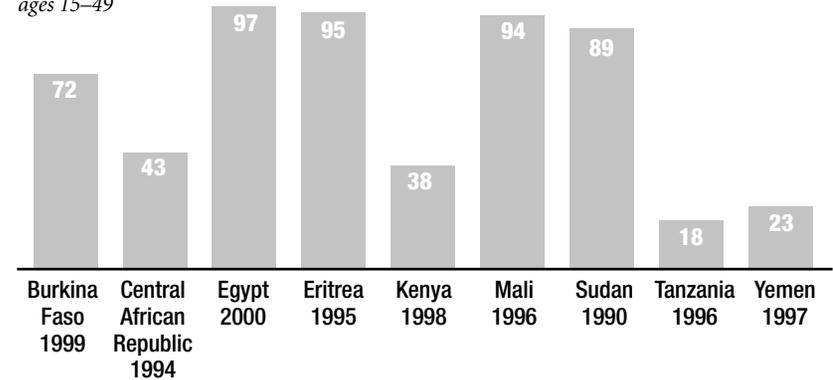
There is great variability in the prevalence of FGC in the countries surveyed. Prevalence data collected from the DHS reveal high national levels of FGC for women ages 15 to 49 in Burkina Faso, Egypt, Eritrea, Mali, and Sudan (see Figure 2). More moderate overall levels exist in CAR, Kenya, Tanzania, and Yemen.

It is important to note that in some countries, national FGC prevalence may not completely reflect the prevalence of FGC among practicing groups. In Sudan, 89 percent of women have been cut and 79 percent support the practice. This percentage only considers women in the northern part of the country who are cut and more likely to know of and approve of these practices. It does not reflect the large number of groups who do not practice FGC such as those in the southern part of the country. In Kenya, at least 12 ethnic groups practice FGC with prevalence ranging from 43 percent to 97 percent.

Figure 2

Prevalence of Female Genital Cutting

Percent of women ages 15–49



Source: Special tabulations of Demographic and Health Survey data by Principia International, Inc. (Chapel Hill, NC) and published data from ORC Macro (Calverton, MD).

In seven of the nine countries, prevalence levels are about the same among younger and older women.

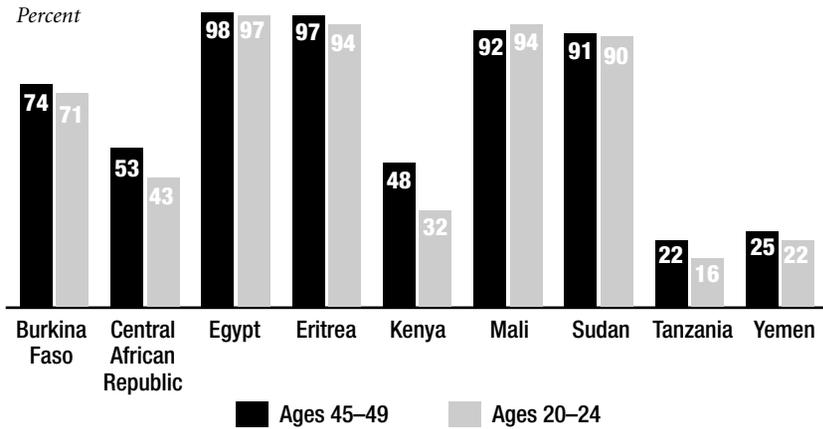
In two countries, prevalence appears to have declined.

In Burkina Faso, Eritrea, Tanzania, and Yemen, women ages 20 to 24 are only slightly less likely than women ages 45 to 49 to have undergone FGC (see Figure 3). There is a three to six percentage point difference between younger and older women in these countries. In Egypt, Mali, and Sudan, younger women are just as likely

to have undergone FGC as their mothers: There is only a one or two percentage point difference between younger and older women. This finding may suggest that in some countries with high FGC prevalence, the practice may be more enduring. In CAR and Kenya, there appear to be larger differences in prevalence between younger women and women of their mothers' generation—a 10 percentage point and a 16 percentage point difference, respectively. It is important to note that in CAR and Kenya there is no information about

Figure 3

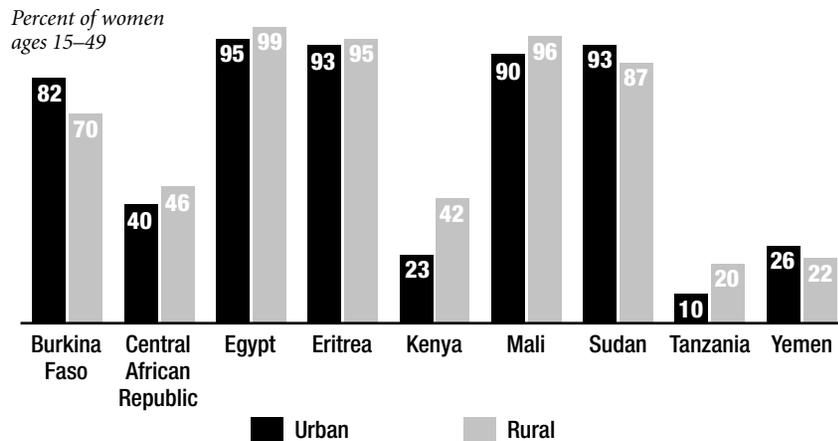
Prevalence of Female Genital Cutting Among Younger and Older Women



Source: Special tabulations of Demographic and Health Survey data for 1989-2000 by Principia International, Inc. (Chapel Hill, NC) and published data from ORC Macro (Calverton, MD).

Figure 4

Prevalence of Female Genital Cutting, by Urban or Rural Residence



Source: Special tabulations of Demographic and Health Survey data for 1989-2000 by Principia International, Inc. (Chapel Hill, NC) and published data from ORC Macro (Calverton, MD).

how many women ages 20 to 24 may still be cut, thus the difference in prevalence among younger women may actually be less.

Women who live in urban areas are generally less likely to practice FGC. In all of the countries surveyed, except Burkina Faso and Sudan, the prevalence of FGC is lower for women living in urban areas (see Figure 4). This may be due to the greater availability of and exposure to information in urban versus rural settings and to ethnic settlement patterns. In Kenya, 23 percent of urban women have experienced the procedure, as compared with 42 percent in rural areas. In Tanzania, 10 percent of urban women have experienced FGC, as compared with 20 percent of women in rural areas. The difference in prevalence in urban and rural settings is less marked in Egypt and Eritrea.

In Burkina Faso and Sudan, however, women in urban areas are more likely to have undergone FGC than their rural counterparts. In fact, urban women in every age group in these countries are more likely than rural women to have undergone FGC. These differences are particularly marked in Burkina Faso where 75 percent of urban and 61 percent of rural women ages 15 to 19 have experienced FGC. At the other end of the age spectrum, 86 percent of urban women ages 45 to 49 are cut,

as compared with 73 percent of their rural counterparts. These results may be due to the fact that ethnic groups in the more rural southern part of the country do not practice cutting; therefore, the prevalence of FGC is lower in rural areas.²⁷ The results may also be due to differences in women's reporting. Urban women may have more information regarding FGC than their rural counterparts and may thus be more able to respond to questions posed about FGC. Sixteen percent of rural women surveyed did not know about FGC; this compares with 3 percent of urban women.

In many countries, women with more education are less likely to practice FGC.

In general, women undergo FGC at too early an age for education to influence their likelihood of being cut. Educational status can, however, indicate or provide evidence of family wealth and women's status within a household. In many of the countries surveyed, higher levels of education are often associated with higher socioeconomic status.

For the most part, the prevalence of FGC is lower among educated women. The amount of education is also key. Those with primary or no education are more likely to have been cut than those who have received secondary level instruction (see Figure 5). In many of the countries surveyed, however, (Egypt and

Kenya are exceptions), the number of women with secondary education is small. For instance, in Mali, the situation is similar—685 out of about 9,700 women have higher education. In Yemen, 135 out of 7,854 women completed secondary school.

The most marked differences exist in CAR (48 percent for noneducated women as opposed to 45 percent for women with primary education and 23 percent for women with secondary education), Kenya (51 percent versus 40 percent and 27 percent), and Tanzania (23 percent versus 17 percent and 7 percent). Differences are less marked in Egypt, Eritrea, and Mali.

In three countries (Burkina Faso, Sudan, and Yemen), women who have primary and secondary education are more likely to have been cut than their uneducated peers. In Burkina Faso, 79 percent of women with primary education and 74 percent with secondary education, have undergone FGC, as compared with 71 percent of women with no education. In Sudan, the case is similar (98 percent of women with primary and secondary education versus 83 percent with no education).

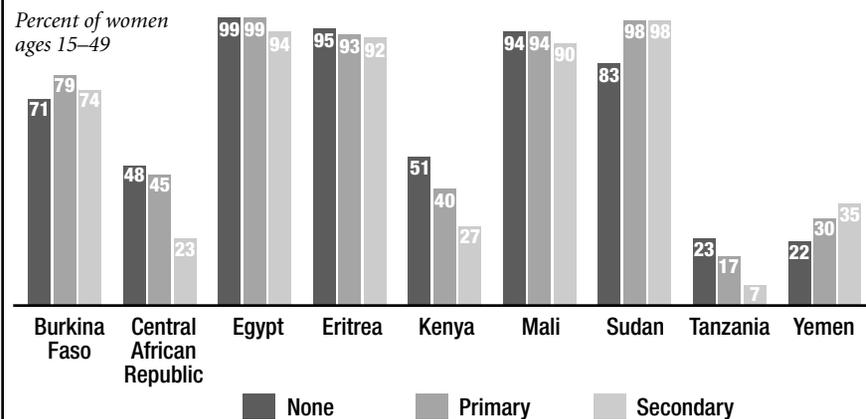
A number of factors may contribute to the findings in Burkina Faso and Sudan. In Burkina Faso, FGC has been illegal since October 1996, and people may be unwilling to admit having been circumcised, given its illegality. Data from 1996 and 1998

surveys conducted by the Population Council support this concern. In the 1998 survey, 33 percent of those who did not know the practice was illegal stated that they would cut their daughter(s) in the future. For those who did know FGC was illegal, however, only 10 percent indicated that they would cut their daughters in the future. Furthermore, from 1996 to 1998, the overall proportion of persons who reported wanting to circumcise their daughters decreased dramatically. These data could be interpreted as reflecting the law's discouragement of the practice. Alternatively, it could also indicate that respondents are unwilling to say that they have or intend to carry out an illegal act.²⁸

Burkina Faso has also had a long-standing and intensive information, education, and communication (IEC) campaign, particularly in urban areas, that may have greatly increased awareness about the issue, especially among educated women (see Box 3). As a result, women who were cut as babies may be more likely (due to exposure to information regarding the topic) to recognize that they have undergone FGC. Another factor may be that ethnic groups in the southern part of the country do not practice cutting.²⁹ Traditionally, these women have had less access to education than their counterparts in other parts of Burkina Faso. In Sudan, a similar situation may exist; ethnic groups in the western

Figure 5

Prevalence of Female Genital Cutting, by Educational Level



Note: In Egypt, primary education refers to primary incomplete.

Source: Special tabulations of Demographic and Health Survey data for 1989–2000 by Principia International, Inc. (Chapel Hill, NC) and published data from ORC Macro (Calverton, MD).

Box 3

An Information, Education, and Communication (IEC) Campaign in Burkina Faso

In Burkina Faso, there has been a long tradition of awareness-raising and FGC abandonment activities. These began with a radio campaign initiated in 1975 and culminated in a presidential decree in 1990 creating the National Committee to Fight Against the Practice of FGC—the Comité National de Lutte Contre la Pratique de l'Excision (CNLPE). The committee's primary activities have been training, and information, education, and communication (IEC) targeted at various audiences (particularly in urban areas), including traditional leaders, religious groups, youth, military and civil police, and the media. Findings from CNLPE's 1996 national study on FGC indicated that these efforts have been instrumental in increasing people's awareness about the harmful nature of the practice and its complications. This has particularly been the case in urban areas; rural communities have not benefited as widely from these IEC efforts.¹

Note:

1. Program for Appropriate Technology in Health/World Health Organization (PATH/WHO), *Female Genital Mutilation, Programmes to Date: What Works and What Doesn't* (Geneva: WHO, 1999): 62–71.

Table 1

Women Ages 15–49 Who Have Undergone Female Genital Cutting, by Religion

Country	Muslim		Christian		Traditional/Other	
	% Surveyed	% Circumcised	% Surveyed	% Circumcised	% Surveyed	% Circumcised
Burkina Faso	56	78	27	66	17	61
Central African Republic	9	50	90	43	2	42
Egypt	95	98	5	88	-	-
Eritrea	38	99	62	92	-	-
Kenya	5	28	92	38	3	31
Mali	91	94	3	85	6	90
Sudan	98	90	2	47	-	-
Tanzania	31	14	57	19	12	22

Source: Special tabulations of Demographic and Health Survey data for 1989–2000 by Principia International, Inc. (Chapel Hill, NC) and published data from ORC Macro (Calverton, MD). Data for Yemen are not available.

part of the country do not carry out FGC and have historically had more limited exposure to education than groups living elsewhere in Sudan.³⁰

Women who practice FGC come from many religious groups (Christians, Muslims, a small sect of Jews, and indigenous groups).

However, the practice is not mandated by any of these groups; FGC has cultural rather than religious underpinnings.

In Burkina Faso, CAR, Egypt, Eritrea, Mali, and Sudan, Muslim women are more likely to have undergone FGC than Christian women and women practicing other

religions (e.g., animism). In Kenya and Tanzania, a higher percentage of Christian than Muslim women engage in FGC. In Tanzania, women who practice traditional religions have the highest prevalence of FGC in the country (22 percent). These results need to be considered in light of the small percentages of women surveyed in some countries (see Table 1). There was no information on religion for Yemen.

Ethnic affiliation and regional residence are also important factors in the extent of FGC practiced.

In Eritrea, FGC is practiced uniformly among all ethnic groups. In

other countries, such as Burkina Faso, CAR, and Kenya, the practice varies among different ethnic groups.³¹

- In Burkina Faso, FGC prevalence is 60 percent or more among 16 ethnic groups. Among six groups (other African, Togolaise, Touareg/Bella, Gourounsi, Gourmatche, and Ivory Coast), the practice is less widespread—23 percent to 60 percent.
- In CAR, there is even greater variability among ethnic groups. Among the Banda and Mandjia, FGC prevalence exceeds 70 percent. Among other groups, such as the Gbaya, Haoussa, and Sara, less than half of the population practices FGC. In three groups, Yakoma-Sango, Mboum, and Zandé-Nzakara, FGC prevalence is less than 5 percent.
- In Kenya, where the national FGC prevalence rate is 38 percent, there is also considerable variability among ethnic groups. Among the Kisii and the Masai, FGC prevalence is 97 percent and 89 percent, respectively. Among other groups, such as the Kamba, Kikuyu, Meru/Embu, Taita/Taveta, Kalenjin, and Somali, the prevalence rate ranges from 33 percent to 63 percent. In a few groups such as the Luo and the Luhya, FGC prevalence is less than 2 percent.

- While ethnic information was not collected for Egypt, Sudan, and Yemen, it was collected in the Tanzania DHS but was not included in the special tabulations of DHS data conducted for this report.

In Egypt and Eritrea, FGC prevalence is 75 percent or more in every region of the country. In other countries (Burkina Faso, CAR, Kenya, Mali, Sudan, Tanzania, and Yemen), there is variability among regions in the extent of the procedure:

- In Burkina Faso, at least 79 percent of women in Ouagadougou, the capital city, and the northern and western parts of the country undergo the procedure; in the east and central/south the practice is less widespread (60 percent or more).
- Regional variability is more pronounced in CAR. Ninety-one percent of women practice FGC in Région Sanitaire (RS) IV (the eastern part of the country), 56 percent and more in RS I and RS V; fewer women practice FGC in the capital city of Bangui (35 percent) and in the western part of the country—RS III (28 percent), and RS II (14 percent).
- In Kenya, communities who live in four regions of the country are more likely to practice FGC; these

include the Rift Valley (56 percent), and Nyanza, central, and eastern regions (43 percent or more). Communities on the coast (20 percent), in the Nairobi area (19 percent), and the western part of the country (2 percent) are less likely to practice FGC.

- In Mali, nearly 90 percent of women or more practice FGC in five regions of the country—Kayes and Koulikoro (99 percent), Sikasso (97 percent), Ségou (94 percent), Mopti (88 percent), and the capital of Bamako (95 percent). In two regions of the country—Timbuktu and Gao—10 percent of women or less undergo the procedure.
- In Sudan, there is extremely high prevalence of FGC in many regions (87 percent or more). In Darfur, the prevalence is somewhat lower (65 percent). Three of the southern regions of the country are believed not to practice FGC.³²
- In Tanzania, the highest levels of FGC exist in Arusha (81 percent), Dodoma (67 percent), and Mara (43 percent). Other regions of the country—Tanga, Singida, Iringa, and Kilimanjaro—have prevalence levels of 25 percent to 36 percent. In a few regions, FGC is barely practiced.

- In Yemen, 69 percent of women living in the coastal region were cut, as compared with 15 percent in the mountains region and 5 percent in the plateau and desert region.

Attitudes Toward FGC

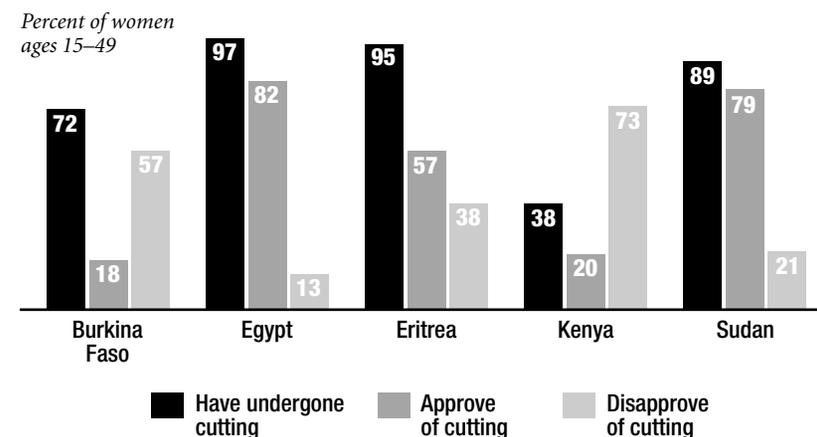
There are striking contrasts in some countries between high prevalence of FGC and low approval for the practice. In Burkina Faso, while 72 percent of women ages 15 to 49 have undergone FGC, only 18 percent approve of the practice. There is a proportion of women who don't know their opinion regarding FGC or who don't know about FGC. In Burkina Faso, 12 percent of women do not know whether FGC should be continued or stopped.

Similarly, in Eritrea, 95 percent of women have been cut, yet only 57 percent approve of the practice (see Figure 6).

In Egypt and Sudan, attitudes regarding FGC are more consistent with the high prevalence of the practice. In Egypt, 97 percent of women have been cut and 82 percent approve of the practice (down to 75 percent in 2000). In Sudan, 89 percent of women have been cut and 79 percent support FGC. It is important to note that this percentage only considers women in the northern part of

Figure 6

Women Who Have Undergone FGC and Women Who Approve or Disapprove of the Practice

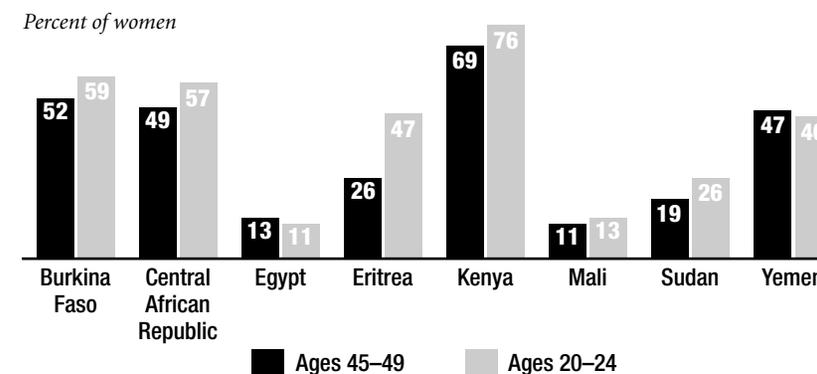


Note: Approval and disapproval are shown for all women ages 15 to 49, whether or not they have been cut. Data for Egypt are from the 1995 DHS.

Source: Special tabulations of Demographic and Health Survey data for 1989–2000 by Principia International, Inc. (Chapel Hill, NC) and ORC Macro (Calverton, MD).

Figure 7

Older and Younger Women Who Oppose Female Genital Cutting



Note: No data on attitudes are available for Tanzania. Data for Egypt are from the 1995 DHS.

Source: Special tabulations of Demographic and Health Survey data for 1989–2000 by Principia International, Inc. (Chapel Hill, NC) and published data from ORC Macro (Calverton, MD).

An Update on Egypt

The newly released 2000 Egypt Demographic and Health Survey (DHS) indicates that 97 percent of women in the country have been circumcised—no change from the 1995 DHS. According to the 2000 Egypt DHS, women who are younger, live in urban areas, and have secondary or higher education are less likely to have or to consider having their daughters circumcised than their older, rural, and less educated counterparts. These findings are consistent with those in the 1995 DHS. According to the 2000 Egypt DHS, the trend toward greater medicalization of the practice has also persisted. In 2000, trained medical personnel performed slightly more than 60 percent of circumcisions, and traditional birth attendants performed the majority of the remaining circumcisions.

Attitudes regarding the practice, however, appear to be changing. In 2000, 81 percent of women with daughters reported that they had a daughter who was already cut or they planned to have a daughter cut. This represents a slight decline from 1995 when 87 percent of women with daughters said that they had or planned to have a daughter cut.

In the 2000 survey, attitudinal differences by residence and education are striking. Urban and more educated women are less likely than other women to believe that circumcision is an important aspect of religious tradition or that men prefer wives to be circumcised. For instance, in the urban Governorates, about four in 10 women agree with the statement that “husbands prefer wives to be circumcised.” This compares with eight in 10 women in rural Upper Egypt who agree with this statement.¹

Note:

1. Fatma El-Zanaty and Ann Way, Egypt 2000 Demographic and Health Survey (Cairo, Egypt: National Population Council, and ORC Macro: Calverton, MD, 2001).

Sudan who are cut and more likely to know of and approve of these practices. It does not reflect the large number of groups who do not practice FGC such as those in the southern part of the country.

Younger women are more likely to oppose the practice.

In most of the countries surveyed, women ages 20 to 24 express greater support for ending FGC (see Figure 7). This situation is particularly marked in Eritrea, where women ages 20 to 24 are nearly twice as likely as

women ages 45 to 49 to oppose FGC. In Burkina Faso, CAR, and Kenya, where moderate to high disapproval for the practice already exists among older women, younger women are also more likely to oppose the practice. In Sudan, where there is less opposition to FGC, younger women also express greater opposition to the practice than their older counterparts. This suggests that younger generations may have greater access to anti-FGC information and are less influenced by tradition.

In Egypt, there may be some signs of change in attitudes. A 1999 nationally representative survey of 1,500 Egyptian adolescents (1,200 girls and 300 boys) indicated that young Egyptian women were at least 10 percentage points less likely to undergo FGC than were their mothers. This survey is part of a larger research program on adolescence called the 1997 Adolescence and Social Change in Egypt Survey. It estimates circumcision rates across the entire population of single adolescent girls as opposed to only ever-married women (the focus of DHS). The survey reported that girls with more highly educated mothers were less likely to be circumcised—34 percent less likely with mothers who had been to vocational school and 64 percent less likely with mothers who had a secondary education or higher.³³ These results are further supported by findings from the Egypt DHS which

shows a 6 percentage point decline in the proportion of women with daughters who report that they had a daughter who was already cut or who planned to have a daughter cut—from 87 percent in 1995 to 81 percent in 2000 (see Box 4).

In Mali, there is little difference among younger and older women in their views toward FGC, according to DHS results.

In all of the countries surveyed, there is lower approval for FGC among women in urban areas.

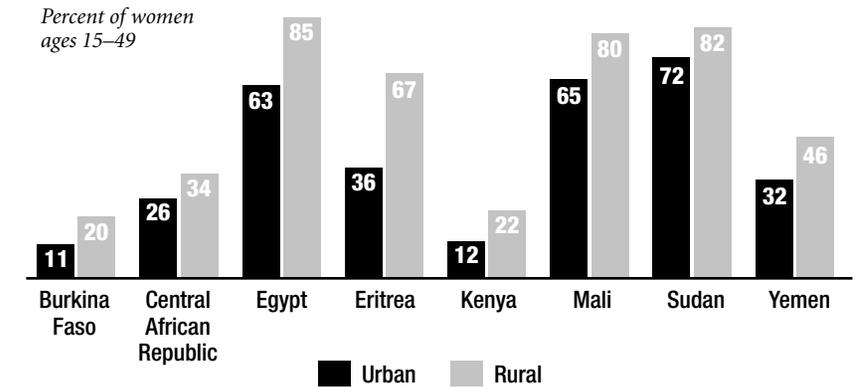
Greater urban access to education and diverse ideas and practices may account for this finding.

While Egypt, Mali, and Sudan have high national approval for FGC, there are disparities in attitudes between urban and rural dwellers. For instance, in Egypt, while 63 percent of urban women approve of the practice, more than 85 percent of rural women support FGC. A similar situation exists in both Mali and Sudan with greater percentages of rural than urban women approving of the practice (see Figure 8).

In Eritrea, there is an even wider gap in attitudes toward FGC between urban and rural women. Of urban women, 36 percent approve of the practice, compared with 67 percent of rural women (see Figure 9).

In Burkina Faso, where FGC prevalence is higher in urban than rural settings, a smaller percentage of urban women support FGC, compared with rural women (11 percent versus 20 percent). In both urban and rural areas, the percentage of women who think that the practice should continue is much less than the percentage who have been circumcised. It appears that social pressure to comply with the practice is high, but attitudes are changing (see Figure 9).

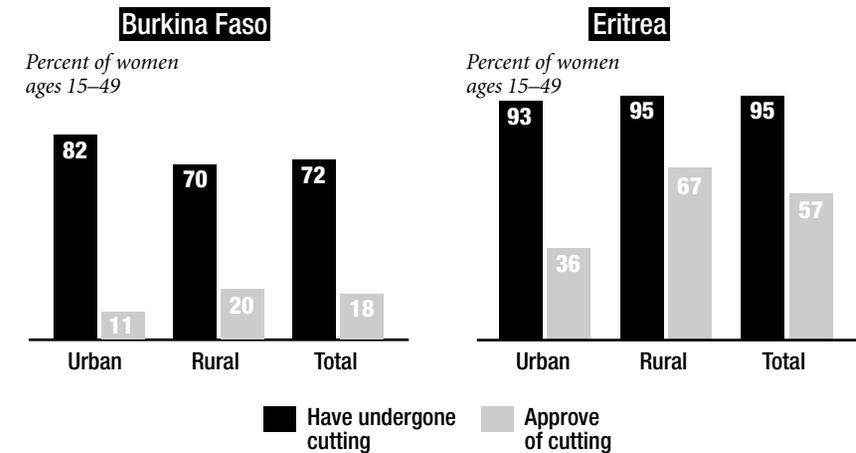
Figure 8
Women Who Support Female Genital Cutting, by Urban or Rural Residence



Note: No data on attitudes are available for Tanzania.

Source: Special tabulations of Demographic and Health Survey data for 1989–2000 by Principia International, Inc. (Chapel Hill, NC) and published data from ORC Macro (Calverton, MD).

Figure 9
Women's Attitudes Toward Female Genital Cutting by Urban or Rural Residence, Burkina Faso and Eritrea



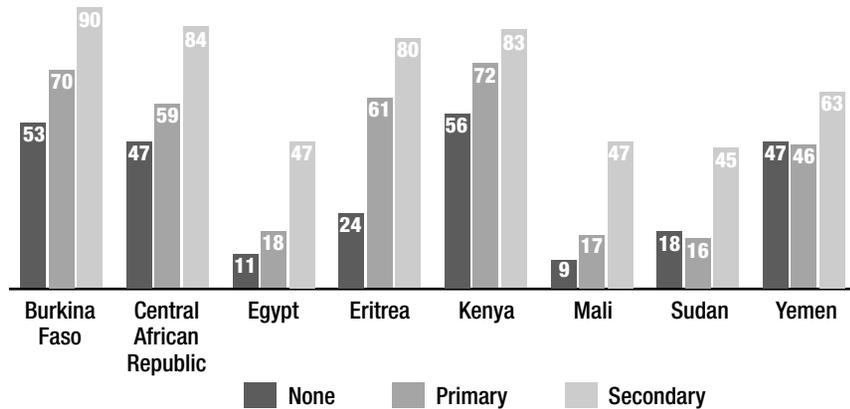
Note: Approval is shown for all women ages 15 to 49, whether or not they have been cut.

Source: Special tabulations of Demographic and Health Survey data for 1995 (Eritrea) and 1998–1999 (Burkina Faso) by Principia International, Inc. (Chapel Hill, NC) and published data from ORC Macro (Calverton, MD).

Figure 10

Women Who Oppose Female Genital Cutting, by Educational Level

Percent of women ages 15–49



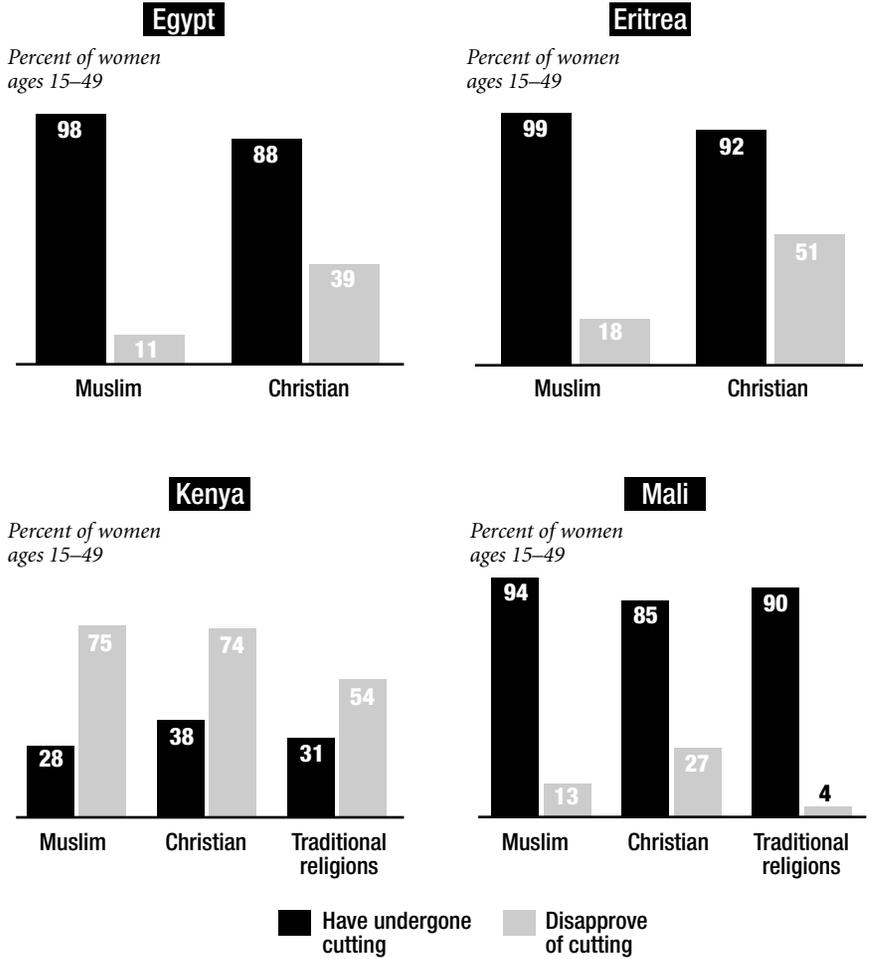
Note: No data on attitudes are available for Tanzania. In Egypt, primary education refers to primary incomplete. Data for Egypt are from the 1995 DHS. Source: Special tabulations of Demographic and Health Survey data for 1989–2000 by Principia International, Inc. (Chapel Hill, NC) and published data from ORC Macro (Calverton, MD).

In half the countries surveyed, women with secondary education exhibit high levels of disapproval for FGC. In Eritrea, Kenya, CAR, and Burkina Faso, 80 percent to 90 percent of women with secondary education oppose of the practice. By contrast, 45 percent to 63 percent of more educated women in Sudan, Egypt, Mali, and Yemen do not support FGC. Figure 10 shows a breakdown of the percentage of women by education level in Burkina Faso, CAR, Egypt, Eritrea, Kenya, Mali, Sudan, and Yemen.

While many religious groups practice FGC, women’s attitudes reflect the cultural rather than religious nature of the practice. Figure 11 provides a picture of the different perspectives on FGC held by women who practice various religions in Egypt, Eritrea, Kenya, and Mali. In three largely Islamic countries (Egypt, Eritrea, and Mali), Muslim women are less likely than their Christian counterparts to oppose FGC. In Kenya, which has a large Christian population, however, Muslim women are as likely as Christian women to oppose the practice.

Figure 11

Women Who Oppose Female Genital Cutting, by Religion



Note: Data for Egypt are from the 1995 DHS. Source: Special tabulations of Demographic and Health Survey data for 1995–1998 by Principia International, Inc. (Chapel Hill, NC) and published data from ORC Macro (Calverton, MD).

Among women who have had one or more of their daughters circumcised, there is significant variation in the extent of approval for the practice. Women in three countries (Egypt, Mali, and Sudan) who have had one or more daughters circumcised are highly supportive of FGC. In Kenya and Eritrea, around two-thirds of mothers who have had at least one daughter cut approve of the practice. In Burkina Faso, however, only 28 percent of such mothers approve (see Figure 12).

Conditions and Health Consequences

In all of the countries surveyed, traditional practitioners perform the majority of FGC procedures.

Traditional practitioners typically have no medical training and include traditional birth attendants (traditional midwives), barbers, and circumcisers (see Figure 13).

While most female circumcisions are still performed by traditional practitioners, in Egypt and Tanzania, there appears to be greater medicalization—using nontraditional practitioners (e.g., medical professionals such as doctors, nurses, and trained midwives) to perform FGC rather than abandoning the practice altogether.³⁴

Medicalization is partly the result of programs over the past 20 years

that have encouraged abandonment of FGC by emphasizing the “health risk” or the “harmful traditional” nature of the practice. Using health professionals to deliver health messages about the physical complications of FGC, such as bleeding or infection, and risk to the child during delivery or to the mother—rather than the need to reduce the prevalence of FGC—may have encouraged greater medicalization of the practice.

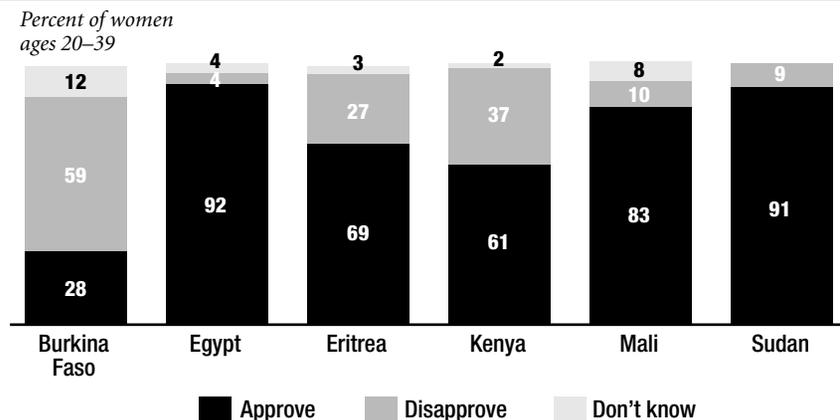
In all of the countries, there is little difference in the use of traditional versus nontraditional practitioners in urban and rural settings.

FGC can cause harmful health effects for women, including hemorrhage, infection, pain, fever, difficulty urinating, and shock.

Twenty-seven percent of women in CAR reported side effects after cutting and 5 percent in Egypt. In CAR, of the 27 percent of women who reported side effects, 65 percent reported bleeding, 40 percent cited pain, and 17 percent indicated that they had experienced a fever. In Egypt, of the 5 percent of women who reported side effects, 70 percent cited bleeding as the most pronounced side effect, pain was the second most common complication followed by infection and fever.

Figure 12

Attitudes Toward Female Genital Cutting of Women Who Have Had at Least One Daughter Cut

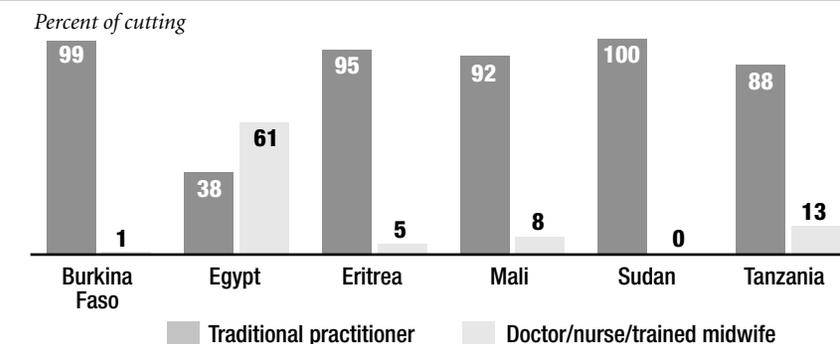


Note: Data for Egypt are from 1995. No 2000 data for Egypt are available for the 20–39 age group. The 20–39 age group was chosen to assess women who would be most likely to have daughters eligible for circumcision. Percentages for Burkina Faso, Eritrea, and Mali are rounded and do not add to 100.

Source: Special tabulations of Demographic and Health Survey data for 1989–1999 by Principia International, Inc. (Chapel Hill, NC) and published data from ORC Macro (Calverton, MD).

Figure 13

Female Genital Cutting Performed by Traditional Practitioners and Nontraditional Practitioners



Note: Data are not available for the Central African Republic, Kenya, and Yemen. Data for Sudan include only traditional birth attendants; no data are available on other FGC practitioners. “Traditional practitioners” include FGC practitioners and traditional birth attendants (TBAs).

Source: Special tabulations of Demographic and Health Survey data for 1989–2000 by Principia International, Inc. (Chapel Hill, NC) and published data from ORC Macro (Calverton, MD).

OVERVIEW OF APPROACHES TO ABANDON FGC

The Foundations for FGC Abandonment Efforts

Ending FGC will be a long and difficult process, requiring long-term commitment to establishing a foundation for sustained behavior change. A report by the Program for Appropriate Technology in Health (PATH) and the World Health Organization (WHO) identifies six critical elements that must be emphasized if efforts to abandon FGC are to succeed.³⁵ The report draws on an

extensive literature review, survey data from 88 agencies with anti-FGC programs, and field assessments of five countries with strong programs. The six elements are

- strong and capable institutions implementing abandonment programs at the national, regional, and local levels;
- a committed government that supports FGC abandonment with strong policies, laws, and resources;
- institutionalization of FGC issues into national reproductive health and development programs;
- trained health providers who can recognize and treat the complications of FGC;
- coordination among governmental and nongovernmental organizations; and
- advocacy efforts that foster a positive policy and legal environment, increased support for programs, and public education.

The report notes that innovative behavior-change interventions are at the heart of ending FGC, as they can address its cultural roots. For these interventions to succeed, however, the foundation described above must be in place. While laws and clear policy declarations prohibiting the practice may help provide an overall framework for ending FGC, more comprehensive efforts are also needed.³⁶

A judge in Mali who campaigns against FGC holds a newspaper article “Is Circumcision a Crime?”

FGC Abandonment Approaches: What Has Worked and What Hasn’t

Over the past two decades, national governments, local organizations, and donor agencies have used various approaches to encourage abandonment of FGC. Approaches that have relied on outside authorities or financial incentives have been less successful than those that have focused on community-based behavior change. One of the oldest and most widely used strategies to date is the “health risk” or “harmful traditional practice” approach discussed on page 16.³⁷ Despite its longstanding use, little evidence exists that the strategy used in isolation of other educational efforts has reduced the incidence of FGC. In fact, using the health approach alone has led to a number of problems, including medicalization of the practice.

Another controversial anti-FGC strategy has focused on educating circumcisers and training them for alternative sources of income thus reducing the supply of FGC practi-

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tioners. This strategy, which has been applied in many countries for more than ten years, has not been generally effective in influencing the demand for circumcisions. Projects such as one in Ghana, which trained circumcisers to become traditional birth attendants, and another in Ethiopia, which provided instruction to FGC practitioners in sandal-making and bread-baking, initially yielded positive results.³⁸ However, more recent studies have indicated that this approach faces many challenges. One evaluation study completed in 1998 in Mali determined that this strategy failed because parents continued to seek out excisors. The low social status of excisors gave them no power to end FGC and the excisors received community recognition, in addition to payment, for their work.³⁹ The study indicated that future programs should focus on reducing demand for FGC from the community instead of seeking to restrict the supply of excisors. In addition, future efforts need to encourage broad, community-based education campaigns for diverse audiences (men, opinion leaders, religious leaders, and traditional midwives) and promote discussion about FGC and urge local leaders to publicly decry the practice.

The most effective programs have focused on community-based behavior change. Community-based projects have used one or several of the five following approaches. These

approaches are not mutually exclusive and may overlap with one another. These approaches appear to be more successful when used in conjunction with other types of interventions; using any one approach in isolation may reduce its effectiveness.

1. Integrating FGC abandonment into a range of social and economic development initiatives that focus on women's empowerment.

This long-term approach focuses on women who are becoming heads of households for a variety of reasons, including their husbands emigrating abroad or migrating internally to earn money. It includes initiatives such as income generation, the provision of health services, and literacy training. At the end of the program, all groups in the community (including the traditional midwives and barbers who act as circumcisers) sign a declaration stating that they will abandon FGC. This strategy has achieved success in some settings in Egypt, such as the villages of Al Tayeba and Deir El Bersha, which have relatively large Christian populations and where circumcision has stopped. Some progress has also been made in largely Muslim communities in other parts of the country.⁴⁰ This approach provides an environment in which women are able to exercise greater decisionmaking power.

A study of Deir El Bersha used household surveys and in-depth

Photo removed for copyright reasons.

Efforts to abandon female genital cutting can be integrated into a range of initiatives focused on women's empowerment.

interviews with key people in the community (e.g., women leaders and the first young woman to be married who was not cut) to determine why FGC had declined markedly from one generation to another in the village (from 95 percent among women surveyed to 50 percent among their daughters). Findings indicated that three main factors were associated with the decrease in circumcision: 1) one or more individuals in the household were involved in development activities; 2) the husband was working outside of the country and the wife was head of the household; and 3) various Christian churches in the community had all spoken out against the practice.⁴¹

2. Developing alternative rituals to substitute for the traditional cutting ceremonies.

Community-based NGOs consult with family and community members such as tribal and religious leaders to create coming of age celebrations that exclude cutting but embrace other aspects of the ritual including seclusion, information sharing, and celebration (e.g., gift-giving). Some view the ceremonies as a public declaration of abandoning FGC. Girls initiated into the program report that the training has helped raise their self-esteem and confidence to resist community pressure to undergo FGC. Furthermore, initiates in all participating districts have formed support groups; this strengthens their new role in community culture.⁴²

Although this approach has not been fully evaluated, preliminary findings from Kenya suggest that it is a promising strategy for reducing FGC in some communities.⁴³ One of the keys to its success lies in its involvement of family and community members in designing the project.

3. Empowering women through participatory techniques to collectively decide about FGC and to negotiate community support.

This participatory approach provides women with literacy training and information (e.g., related to health, human rights, problem solving) to give them the information and self-confidence to abandon FGC. The women and other community members then decide to make a public declaration to end the practice. In Senegal, this strategy has been successfully applied through the Tostan program, which uses a model formulated by sociologist Gerry Mackie. It involves a three-stage process of shifting conventions regarding cultural practices, such as foot binding in China and FGC in Africa, through basic education, public discussion, and public declaration.⁴⁴

This methodology was used to end foot binding (the act of wrapping a young girl's feet to push the heel and toe together) in China in the early 1900s. This cultural practice, like FGC, had existed for thousands of years and was required for a

proper marriage, for the virtue of the women, and for the honor of the family. The campaign to abandon foot binding had three aspects:

- development of a modern education campaign that explained that the rest of the world did not bind women's feet;
- explanation of the benefits of natural feet and the detriments of bound feet in Chinese cultural terms; and
- formation of natural-foot societies and pledges by members not to bind their daughters' feet or to let their sons marry women with bound feet.⁴⁵

The Tostan project also applies Mackie's three stages to change the convention of FGC. By fostering "informed dialogue" among women, men, and community and religious leaders about women's rights, health, and FGC, this approach establishes a foundation for women's participation in other aspects of community life and decisionmaking. The approach aids in shifting power relationships in families and communities and enhances women's ongoing needs for

In general, there has been greater success raising awareness about FGC than in changing behavior.

information and skills and serves their long-term interests.⁴⁶

The public declaration appears to have been pivotal in causing rapid and universal abandonment of FGC in various villages in Senegal. Once enough families pledge to end FGC, they are vested in keeping their pledge and convincing others to oppose the practice.⁴⁷ The public declaration also plays a critical role in encouraging dialogue about FGC, resolving conflicts, and building consensus among diverse parties.

This programmatic approach, like the one implemented in Egypt, emphasizes women's empowerment and the involvement of the community. Both strategies culminate in a public declaration which all community members sign or to which they are sworn.⁴⁸

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4. Using an intensive social marketing approach to involve community stakeholders in evaluating the costs and benefits of continuing or abandoning FGC.

In this context, social marketing is defined broadly as a process for increasing the acceptability of ideas or practices in a target group.⁴⁹ This outreach approach is based on delivering a message to the power holders or chiefs of a community or tribes through a cost-benefit analysis about the negative effects of FGC on the community and persuading them to publicly decry the practice. It includes an alternative ritual (similar to that described in the second approach), a cultural day that affirms community identity and positive aspects of the culture, and an awards ceremony for the leaders who urge girls to end circumcision.⁵⁰

In Uganda, this approach has been introduced in the Sabiny community, where girls are typically circumcised between the ages of 15 and 22 just prior to marriage, in ceremonies each December of every even-numbered year to coincide with the timing of male circumcision rites. As a result of the program, the majority of girls stopped the practice the first year. Recent reports, however, indicate that FGC has persisted in later years because the leaders' opposition to the practice has not been sustained. Furthermore, many girls have said that they want to be

circumcised because they were not involved in the decision to end FGC and felt that they were being denied a privilege.⁵¹

5. Identifying individuals who have challenged or “deviated” from conventional societal expectations and explored successful alternatives to cultural norms, beliefs, or perceptions in their communities.

This approach identifies individuals who oppose FGC in communities and promotes them as role models. Role models may include families, teachers, religious figures, and others who have abandoned the practice, urged others to reject it, or publicly declared their opposition to it. The strategy’s effectiveness is enhanced through efforts to document the stories of individuals who rejected FGC and how they dealt with confusion, opposition, and taking a stand against the majority. These individuals then recount their experiences at community forums.

The Egypt country office of the Centre for Development and Population Activities (CEDPA) implemented a pilot project from 1998 to 1999 in an endeavor to understand the factors that enable some families to decide against circumcising their daughters. CEDPA/Egypt staff identified nine positive role models and organized partnerships with four NGOs: the Coptic Organization for Services and

Training (COST) and the NGO Manshiet Nasser, both in Beni Suef; the Center for Egyptian Women’s Legal Assistance (CEWLA) in Cairo; and Caritas in Minya. These NGOs represent urban, rural, Christian, and Muslim populations from various educational backgrounds and carry out activities in literacy, skills training, health and family planning, legal aid, and substance abuse.

The project involved orientation workshops focused on FGC practices, past efforts to address the issue, an overview of the process, and interviews with the nine role models. Skills training focused on effective communication skills and interviewing and information recording techniques. Once the interviews had been conducted, community leaders, CEDPA staff, and the NGOs met to analyze the information recorded. This analysis became the foundation for proposed strategies and activities to abandon FGC in participating communities.

Through its work, CEDPA/Egypt trained 31 women and 13 men and developed a guidebook for others interested in replicating the project. Presently, 83 role models have been identified and interviewed in local communities.

Women in Cairo, Egypt, learn to knit at a home economics class run by the Coptic Evangelical Organization for Social Services (CEOSS).

Both communities and local development organizations in Egypt have praised this project, and it has been replicated in eight other countries. Efforts to evaluate the project are presently underway.

Many approaches to abandoning FGC have been attempted and others will be developed until the practice ends. While rigorous evaluation data are lacking, there is growing evidence about the impact of community-level anti-FGC activities. Efforts are presently underway to allocate more resources for data collection and analysis and to pay more attention to the need for high-quality



research to evaluate the effectiveness of FGC interventions.

In general, there has been greater success in raising awareness about the issue than in changing behavior. For instance, in many countries, FGC is no longer a taboo subject and opinion, religious, and traditional leaders are supporting abandonment of the practice. In addition, civil society, including the media, is becoming more involved in promoting dialogue and education about the issue. Organizations involved in FGC abandonment are becoming more skilled in advocating for the cause, implementing programs, and developing appropriate messages and materials.

There is growing recognition that female genital cutting violates human rights, damages the sexual health of women, and incurs a public health burden. Anti-FGC laws have been passed in 10 African countries, and other countries have imposed decrees or general medical legislation regulating or outlawing FGC.⁵² Finally, community-based efforts have demonstrated that changes can occur on a small scale and begin to reduce FGC among certain groups in regions of practicing countries.

Promising Projects

This section provides brief descriptions of four promising community-based projects in Egypt, Senegal, Kenya, and Uganda. Evaluation studies are presently underway and preliminary data suggest that these may be success stories. The lessons from these community-based projects are discussed in greater detail in the PATH/WHO report.

Egypt: The Coptic Evangelical Organization for Social Services (CEOSS)

The Coptic Evangelical Organization for Social Services, which has existed for 50 years and is renowned for its programs to empower rural women in the Coptic Christian community, established an anti-FGC program in 1995. This educational program targets all family members and focuses special attention on girls ages 7 to 13 at risk of excision and their mothers.

This approach has a number of components. First, a local leaders committee, comprised of an *omda* (mayor), a sheik, and a priest, is established. CEOSS program implementers, typically a male/female team, live with a designated family and are appointed to work directly with local leaders. They begin their work on FGC by registering girls ages 7 to 13 and gradually introducing them to issues regarding health and literacy, followed by the sensitive

topic of FGC. Timing is critical and the implementers regularly monitor the readiness of participants before introducing new topics or advancing in the program. This approach has been most successful in homogeneous communities, such as in villages with a Christian majority, where people are easily influenced by one another and there is pressure to conform. According to PATH/WHO, positive results have also been seen in villages with Muslim majorities but these villages have not yet matched the success of villages such as Al Tayeba and Deir El Bersha.

The CEOSS program divides the community according to the number of leaders available, with each assuming responsibility for a defined geographic area. Each leader develops an annual work plan and monitors about 10 girls every year using specially designed monitoring charts. If, according to the monitoring chart, a girl reaches the age of 13 and remains uncircumcised, she is viewed as out of risk and a successful case.

The PATH/WHO review found that the CEOSS had succeeded in reducing the rate of excisions in eight of 22 communities in Minya Governorate; the FGC abandonment rate was more than 70 percent in these eight villages. These positive changes occurred over seven years (see Box 4, page 13).

Several factors contributed to the project's effectiveness: a focus on

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A village imam reads from the Koran in the village of Tatin Bambara, near Dakar, Senegal, where FGC is still practiced. The woman on the right is the president of the village women's association. Informed dialogue about FGC among women, men, and community and religious leaders establishes a foundation to change the practices of FGC.

young girls who are most at risk of FGC; the use of clear and positive information regarding FGC abandonment; and support from local community leaders which contributes to sustainability. Efforts are underway to assess the longer-term sustainability of the effort.

Senegal: The Tostan Experience and Community Education

Tostan is an international, educational nongovernmental organization established in 1991 and based in Senegal. Tostan, which means "breakthrough" in the Senegalese language of Wolof, empowers people through education and knowledge to enhance their personal and community development. Its specific objectives are to reduce illiteracy, promote self-development through the use of adapted educational materials, and to offer a model

educational program that can be replicated. It provides women and adolescents with a one-year educational program on topics such as bookkeeping techniques, human rights, project planning and implementation, child health, and women's health (including FGC) in their own languages.

After learning about the negative health consequences of FGC, in 1996 women in the village of Malicounda Bambara gradually began to discuss the practice openly with their husbands, the male village chief, and the imam, a recognized leader or a religious leader. After one year, the women mobilized and declared that they would end the practice. The village chief supported this decision and no circumcision ceremonies were held that year. Due to the efforts of this one community, neighboring villages

also began to speak out against FGC. The project received support from the Senegalese president who urged other communities to follow Malicounda Bambara’s example and began proceedings to implement legislation banning FGC. The imam from the Bambara village of Keur Simbara, who was highly committed to ending FGC, visited all of the Bambara villages over a three-month period. His efforts and the consensus of religious, health, and government representatives culminated in the Diabougou Declaration which pledged the Bambara community’s commitment to end the practice of FGC. Presently, 274 villages (of more than 250,000 people) have agreed to give up the practice. Monitoring of the project is ongoing.⁵³

The Tostan process has been successful because it has provided basic education vital for empowering villagers, a forum for villagers to meet with each other to discuss the practice of FGC, and the involvement of village leaders (especially religious leaders) who can address peoples’ concerns about Islam’s position on the practice. Ninety-five percent of Senegalese are Muslim and religion plays a significant role in their lives. Furthermore, it has made people aware of alternatives (i.e., not everyone excises their daughters); provides information about the health benefits of not performing FGC; and enables people to agree collectively to halt the

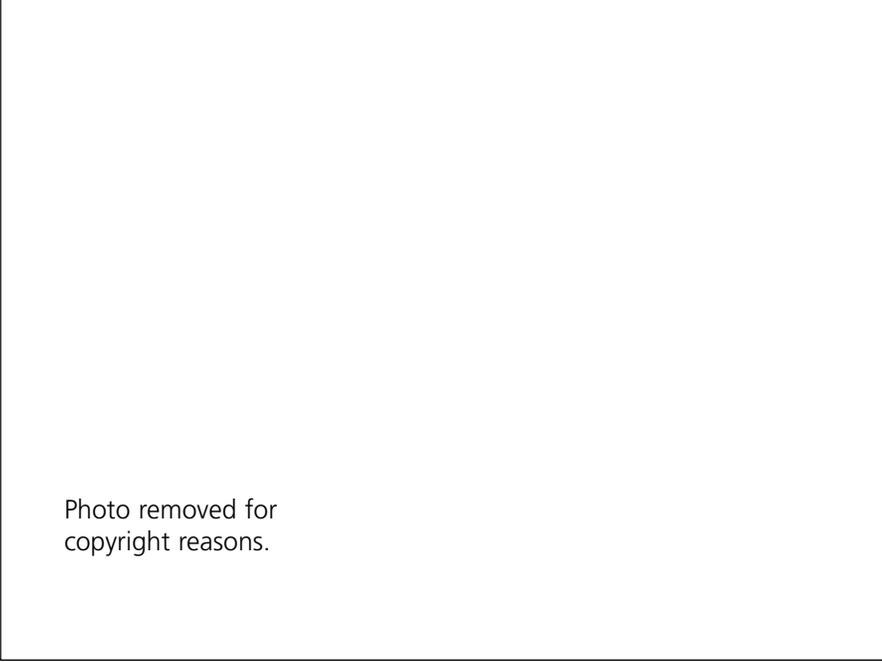


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The Tostan process allows people to agree collectively to halt the practice of FGC so that no one family stands out or no one is socially stigmatized.

“We pray God that our decision will be an inspiration to other communities across the world. Yesterday there was one village, then there were 10, today there are more than 100, tomorrow there will be millions of us in Senegal and across Africa who seek to preserve and assure the well-being of all people.”

—*Woman village participant reading from the Declaration to End Female Genital Cutting, written and approved by 105 villages in Kolda, the southern region of Senegal.*

practice so that no one family stands out or no one person becomes socially stigmatized and thus unmarried. Publicity and press coverage

have aided the movement in encouraging dialogue about the issue and helping the message spread beyond the initial villages.

Kenya: Alternative Rites of Passage

The Maendeleo Ya Wanawake Organization (MYWO) was formed in 1952 with the objective of improving the living standards of families and communities in Kenya. MYWO used the Alternative Coming of Age Program to encourage FGC abandonment in seven of Kenya’s 63 districts.⁵⁴ The first alternative rites of passage program “Ntanire Na Mugambo” (“Circumcision by Words” in Swahili), developed by MYWO and PATH, took place in Meru, Kenya in 1996. The program collects the traditional wisdom imparted to girls when they are circumcised, adapts these messages to encourage positive female traditional values without the physical and psychological damage caused by FGC, and includes a five-day seclusion period to teach girls adult values and behaviors (see Box 5). This culminates in a one-day, coming-of-age ceremony that includes feasting, gift giving, and the presentation of graduation certificates.

Alternative rites of passage are gaining community acceptance and are endorsed both by community elders and the Kenya Medical Association. The “circumcision with words” ceremony has grown rapidly, beginning with only 12 families in Gatunga (a village in Tharaka Nithi District) and growing to 200 families in three divisions in the district after

one year. According to PATH/WHO, none of the girls who participated in alternative ceremonies has been circumcised; they and their families are a core group strongly motivated to recruit others.⁵⁵ According to PATH-Kenya, 14 alternative rites of passage have taken place in Kisii, Meru, Narok, and Tharaka Nithi Districts. Four years after the first ceremony in 1996, nearly 3,000 girls have gone through alternative rite-of-passage ceremonies. In 1999, evaluation research indicated changes in attitudes and behavior in both men and women.⁵⁶

Earlier community outreach activities had raised awareness about FGC, allowing the alternative rites-of-passage initiative to focus on fostering decisionmaking to abandon the practice. Significant media coverage helped to promote both awareness and interest. The Ministry of Health is planning to replicate the effort in other areas such as the TansMara district with funding from the German Development Agency (Deutsche Gesellschaft für Technische Zusammenarbeit—GTZ).

The alternatives program has been successful in part because of the larger strategy—it builds on the positive community values underlying FGC. The program provides an entry point to promote dialogue among family members in rural communities about family, life education, and sexuality issues. Various stakeholders,

Box 5

Kenya's Alternative Rite-of-Passage Course Content

- Self-esteem: coping with criticism
- Responsibility for own decisions
- Dating and courtship
- Coping with peer pressure
- Personal hygiene
- Marriage
- Pregnancy and prevention of sexually transmitted infections (STIs) including HIV/AIDS
- Contraception
- Female genital cutting, early marriage, and gender empowerment, including rights of the girl child
- Respect for the community and for elders

Note: United States Agency for International Development, Intra-Agency Working Group on FGC, *Female Genital Cutting: The Facts and the Myths*, USAID Final Report (Washington, DC: USAID, 1999): 13.

including girls (particularly those initiated to FGC between the ages of 12 and 19), mothers, aunts, grandmothers, godmothers, community leaders, and fathers, explore the feasibility of adopting the alternative ritual. Each person suggests whether and how to implement the program, what information is needed, what type of celebration is necessary, what kind of gifts should be given, and

who should participate. Trained peer educators play a critical role in recruiting mothers and girls for the program and educating them about the harmful effects of FGC.

Uganda: The Reproductive, Education, and Community Health (REACH) Program

Uganda's Sabin community in Kapchorwa, with the support of the United Nation's Population Fund, developed the REACH program in 1995. The program sensitized members of the Sabin Elder's Association and clan leaders in Uganda's Kapchorwa district to the harmful effects of FGC. As a result of the program, the male elders resolved to replace the actual cutting with symbolic gift giving and other festivities to mark the passage into adulthood. The REACH project has several outreach components:

- using community seminars and workshops for target groups within the community, including elders;
- selecting and training adolescents to serve as peer educators for fellow students in school and at homes during the holidays;
- training traditional birth attendants and health workers in basic maternal and child health, and family planning and delivery skills,

and about the negative effects of FGC; and

- establishing a district cultural day designed to celebrate cultural values and dispel taboos and harmful practices.

The project successfully involved community leaders in the decision-making process and in the design and implementation of the project. It addressed the basic reproductive health needs of the community while also targeting abandonment of FGC. The project drew on close collaboration with many different partners from international donor agencies (e.g., the International Planned Parenthood Federation and the Norwegian Agency for Development) and in-country organizations (e.g., Family Planning Association of Uganda). Finally, it used a culturally sensitive and "persuasive" approach to FGC rather than a more condemnatory one.

Since its inception in 1996, the REACH project has had a positive impact on the Kapchorwa community. According to statistics compiled by REACH staff, the percentage of girls and women who have been cut decreased by 36 percent in two years (544 girls and women were circumcised in 1996, as compared with 854 girls and women in 1994). Other favorable results have been greater dialogue on FGC and reproductive health; an increase in the number of

adolescents involved in creating awareness of the harmful effects of FGC; and greater demand for awareness-raising seminars about FGC and its associated effects. The Sabinu Elders were awarded UNFPA's Population Award in 1998 for their role in the REACH project. This approach is being replicated in other countries such as Mali.

In several countries, the strong participation of men has been instrumental in encouraging an end to the practice. This is particularly notable in the Tostan and REACH projects. Traditional male leaders, after becoming sensitized to the harmful effects of FGC, advocate for abandonment of the practice throughout their community, and initiate and collaborate on innovative projects to preserve the important ceremonial aspects of FGC while eliminating the actual cutting (see Box 6).

Box 6 The Role of Men in Abandoning Female Genital Cutting

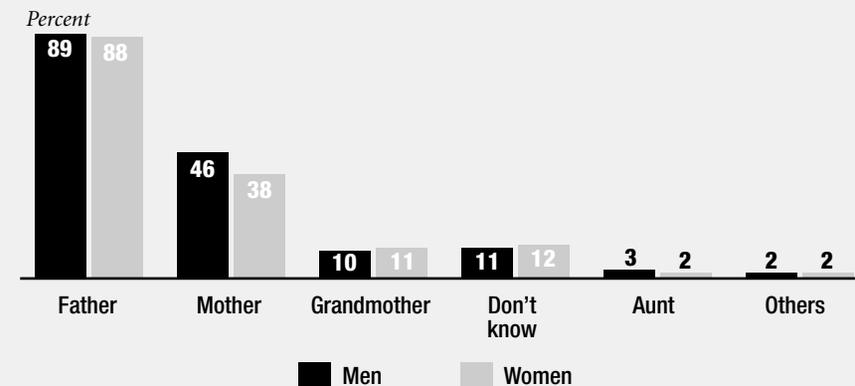
In two FGC-practicing countries with Demographic and Health Survey data on men—Guinea and Eritrea—the results indicate that men are less likely than women to support continuation of FGC. For instance, in Guinea, 68 percent of women favor FGC, as compared with 52 percent of men.¹ This is also the case in Eritrea where more women (57 percent) than men (46 percent) support continuation of the practice.²

Male involvement is critical in encouraging the abandonment of FGC. Men, however, have not always been the target of information, education, and communication campaigns. Qualitative studies conducted in Mali and Burkina Faso by the Population Council indicate that men recognize that the practice will not be abandoned without their involvement. In Burkina Faso, fathers play the most critical role in determining whether to have their daughter cut.³

Notes:

1. P. Stanley Yoder, Papa Ousmane Camara, and Baba Soumaoro, *Female Genital Cutting and Coming of Age in Guinea* (Calverton, MD: Macro International, 1999).
2. 1995 Eritrea Demographic and Health Survey (Calverton, MD: Macro International, 1995).
3. Population Council/Africa OR/TA, *Strengthening Reproductive Health Services in Africa Through Operations Research*. Final Report of the Africa Operations Research and Technical Assistance Project II (Nairobi, Kenya: Population Council, 1999): 87.

Who is Involved in the Decision to Cut Girls? Evidence from Bazèga, Burkina Faso



Note: Women and men were asked “Who is involved in the decision to cut girls?” These are the answers they gave. Source: Population Council/Africa OR/TA, *Strengthening Reproductive Health Services in Africa Through Operations Research*. Final Report of the Africa Operations Research and Technical Assistance Project II (Nairobi, Kenya: Population Council, 1999).

RECOMMENDED ACTIONS TO END FGC

Data on attitudes, practices, and prevalence can provide important background information on opportunities for intervention. In addition, lessons from program experiences provide an important context for formulating abandonment campaigns. PATH and WHO developed the following recommendations for policymakers and program managers.

Recommendations for Policymakers

Policymakers are those who are in a position to influence policies and provide funding related to FGC.

1. Governments and donors need to support the groundswell of agencies involved in FGC abandonment with financial and technical assistance. An increasing number of agencies, especially NGOs, are involved in efforts to end FGC. However, programs tend to be small, rely heavily on volunteers and funds from foreign donors, and reach a small proportion of the people in need. Additional support is needed to make the grow-

ing network of agencies more effective and expand their reach.

In Egypt, 15 NGOs, including the Egyptian Fertility Care Society, the Task Force Against FGM, the Cairo Institute for Human Rights Studies, and CEOSS have been instrumental in advocating the abandonment of FGC. In order to become more effective, these groups need to collaborate with one another, enhance training in advocacy and communications skill building, and evaluate the impact of their programs.⁵⁷

2. Governments must enact and use anti-FGC laws to protect girls and educate communities about FGC and human rights.

Passing anti-FGC legislation is one of the most controversial aspects of the FGC abandonment movement. It is extremely difficult to enforce anti-FGC laws. There is fear that heavy-

handed enforcement may drive the practice underground. In fact, this has occurred in some countries. Still, most program planners and activists agree that anti-FGC legislation can demarcate right from wrong, provide official legal support for project activities, offer legal protection for women, and ultimately, discourage circumcisers and families for fear of prosecution. The key is to use the law in a positive fashion—as a vehicle for public education about and community action against FGC.

3. National governments need to be active both in setting policy and in expanding existing programs. A key role for governments is to “scale up” successful community-based FGC abandonment activities. To date, most governments have provided support in the form of in-kind contributions to NGOs working in

The excellent program models that NGOs have carried out on a pilot basis need to be expanded, either by direct government interventions or by increased support for the NGO networks.

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In Egypt, NGOs have been instrumental in advocating the abandonment of FGC.

the communities. The excellent program models that NGOs have carried out on a pilot basis need to be expanded, either by direct government interventions or by increased support for the NGO networks.

4. To sustain programs, governments need to institutionalize FGC abandonment efforts in all relevant ministries.

Currently, none of the anti-FGC efforts underway are sustainable over the long run, in part because they have failed to change the social norms underlying FGC. The integration of FGC issues into government programs, however, has met with some success. In Burkina Faso, the National Committee to Fight Against the Practice of FGC has effectively promoted FGC abandonment through participation in national events such as the international day of population, by integrating FGC

abandonment into all of the relevant ministries, and through training and awareness raising activities.

Efforts in other countries, such as Mali, have encountered more difficulties. While various ministries have expressed their support for anti-FGC activities, they have not been integrated into the relevant ministries, particularly in programs carried out by Mali's Ministry of Health. The primary nursing and medical schools in Mali do not include FGC as an adverse health practice in their curricula.⁵⁸ Presently, PRIME II, a partnership of U.S.-based organizations, is working with the Ministry of Health to develop a national curriculum integrating FGC.⁵⁹

Governments have a responsibility to make political decisions and place FGC abandonment in the mainstream of reproductive health and development programs. Limited success has been achieved through increased fundraising, greater integration of anti-FGC activities into government and civil society programs, and through solicitation of community support.

5. Health providers at all levels need to receive training and financial support to treat FGC complications and to prevent FGC.

A key foundation for FGC abandonment is to make health providers aware of the extent and severity of FGC-related complications and to

give them the skills and resources to treat these problems. Health providers often encounter women and girls suffering from FGC-related complications, yet they are often not prepared to treat and counsel women, or to prevent recurrence of the circumcision practice. Because there is limited training on clinical treatments for circumcised women or counseling women suffering from psychological or sexual problems, women lack access to high quality, relevant services in most countries.

A 1998 operations research study in Mali sought to assess the use of health personnel to address FGC. The study, which was conducted by an NGO, Association de Soutien au Développement des Activités de Population (ASDAPO), and the Ministry of Health, evaluated the

effectiveness of a three-day training course on identifying and treating medical complications related to FGC and counseling patients about the problem. The study focused on 14 urban and rural health centers in Bamako and the Ségou region and included 107 health providers from experimental and control sites. Results indicated that the course was highly effective in changing provider attitudes toward FGC. After receiving training, three in four trained providers knew at least three immediate and long-term complications of FGC. The study also indicated that providers felt they had limited competence in caring for FGC complications (even after receiving training) and needed further training in how to discuss FGC with their clients.⁶⁰

6. Governments, donors, and NGOs working on FGC abandonment should continue to coordinate their efforts. Findings from field assessments reveal an impressive array of cooperative efforts and exchanges of information and resources among NGOs, government institutions, and donors. Agencies typically invite each other to meetings and training activities and coordinate at program sites to avoid duplication of efforts. Although occasional conflicts arise over funding and strategies, they should not discourage agencies from continuing to coordinate and build on each other's strengths.

7. International agencies should assist staff of NGOs and government to develop their advocacy skills.

Advocacy is essential to ensuring that FGC abandonment programs are established and maintained until the practice of FGC ceases. Agencies involved in abandonment efforts increasingly use advocacy for public education and to influence legislation, but they need to improve their skills.

Box 7

Theater Script from Tostan

Poolel was a young girl eight years old. One day, her father's sister came to get her, accompanied by a traditional circumciser. Poolel, along with her other girl friends of the same age, was to undergo the ancient rite of circumcision practiced by her ethnic group. This operation would help her to become "a real woman" and give her dignity and value in her society. Unfortunately, something terrible happened! Poolel bled profusely and the family was quite worried. They went to visit the nurse in their village. The nurse was angry because the family had circumcised Poolel and tried to get the bleeding to stop. Poolel continued to bleed and was suffering terribly. Finally, they evacuated her to the regional hospital where the doctors tried to save her life. It was too late. Poolel died the next day.

Source: Tostan, *Breakthrough in Senegal: The Process that Ended Female Genital Cutting in 31 Villages* (Nairobi, Kenya: Population Council, 1999).

Recommendations for Program Managers

Program managers are those who design and implement programs.

1. Implementers of FGC abandonment programs should include all stakeholders in the design, implementation, and evaluation of programs.

Although program assessments show that agencies have included a wide range of participants in program planning, few have involved the intended beneficiaries—young girls and women—in designing activities. Participatory approaches are essential to success.

2. Programs to end FGC need to use sound research to design programs and materials tailored for specific target audiences.

Many groups have developed and implemented their anti-FGC efforts without conducting country-specific field research. Each community's perceptions on FGC must be the foundation of information and abandonment campaigns. Efforts should also be made to ensure that programs and materials use symbols understood by low-literate audiences, employ neutral visual images, convey nonjudgmental messages, and include current information.

3. Programs should particularly focus on youth, both because youth are key change agents and because they are potentially more likely to be cut.

Findings from DHS and other research show that a high percentage of adolescent girls ages 15 to 19 have already undergone FGC. Despite the high prevalence of the practice, young girls (particularly in urban areas) are more likely than their parents to oppose the practice. As a result of this generation gap in approval for FGC, anti-FGC program implementers regard adolescents as one of their most critical target audiences. Outreach activities for this group can be carried out through formal (e.g., schools) and informal means (e.g., youth associations). Peer education programs and alternative rites-of-passage programs are especially important in changing attitudes, knowledge, and future practices of youth.

4. Urban and educated men and women should be included in programs.

FGC occurs among all socioeconomic groups. In fact, in countries with high prevalence of FGC, there are only small differences in levels of the practice among women according to their educational status and residence. In these countries, younger women, in general, are also nearly as likely to be circumcised as their mothers are. Urban and educated woman in Egypt,

Eritrea, Mali, and Sudan are more inclined to disapprove of FGC, as compared with their rural and less educated counterparts. Despite these less favorable attitudes toward genital cutting, a significant number of women opposed to FGC have had or intend to have their daughter circumcised. According to PATH/WHO, urban and educated communities may have been forgotten in FGC abandonment programs, which have traditionally focused on youth, and rural and uneducated communities. Programs should reach out to urban and educated groups who may have reservations about the practice of female circumcision.

5. Programs need to assess and build on the positive community values that underlie FGC, while working with the population to abandon the practice. Anti-FGC programs should be developed primarily by the communities where FGC is practiced, rather than by outside policymakers, educators, or health professionals. The programs outlined in this report are promising interventions based on community empowerment, consensus building, and collective decision-making.

6. Programs should expand their work with the mass media, particularly in creative areas such as folk media and drama (see Box 7).

More than 60 percent of groups working to abandon FGC cite collaboration with the media as a program strategy. Accurate media coverage helps to desensitize the issue of FGC and encourage dialogue. Thirty percent to 40 percent of agencies surveyed produced both traditional and modern educational programs including folk media and drama. These types of media strategies can be used to examine the traditions and myths surrounding FGC in a non-threatening and entertaining way.

7. Anti-FGC training efforts for program implementers need to be comprehensive both in the range of people trained and in the topics covered.

Training is a critical component of FGC abandonment efforts. It enhances the ability of program implementers to design, implement, evaluate, and monitor multidimensional, national and community-based behavior change programs and to develop an overall infrastructure to ensure sustainability. For instance, the Kenya–Maendeleo Ya Wanawake Organization and PATH–Kenya program includes a comprehensive three- to four-week course for program implementers, health care providers, and other resource per-

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The experience of community-based programs suggests that the practice of FGC may be waning. While community-based programs are at the core of efforts to abandon FGC, national and international laws, policies, and resources are also needed to create a supportive environment for these local initiatives.

sons. It provides participants with the information and skills required to plan and implement an effective community-based, anti-FGC intervention.

8. Programs should prioritize and implement evaluations to measure the effectiveness of programs.

Rigorous evaluation data are rarely available to help improve and expand anti-FGC programs. The PATH/WHO review indicated that less than 30 percent of organizations surveyed had evaluated their projects; lack of funds or lack of expertise were the reasons cited. Most of the groups surveyed stated that they had been more successful in raising awareness about FGC than in changing behavior.

Progress is being made in encouraging and promoting the abandonment of FGC, but efforts are still at an early stage. In some settings in a handful of countries, the practice of FGC has declined and attitudes toward the practice appear to be changing. The experience of community-based programs suggests that the practice of FGC may be waning. While community-based programs are at the core of efforts to abandon FGC, national and international laws, policies, and resources are also needed to create a supportive environment for these local initiatives.

APPENDIX TABLE

Implementing Agencies for Demographic and Health Surveys

Country	Year of survey	Number of Women ages 15–49 surveyed	Implementing agency
Burkina Faso	1998–1999	6,445	Institute National de la Statistique et de la Démographie, Ministère de l'Economie et des Finances
Central African Republic	1994–1995	5,884	Direction des Statistiques Démographiques et Sociales, Division des Statistiques et des Etudes Economiques, Ministère de l'Economie, du Plan et de la Coopération Internationale
Egypt	1995 2000	14,779* 15,573*	National Population Council
Eritrea	1995–1996	5,054	National Statistics Office, Department of Macro Policy and International Economic Cooperation, Office of the President
Kenya	1998	7,881	National Council for Population and Development, Central Bureau of Statistics, Office of the Vice President and Ministry of Planning and National Development
Mali	1995–1996	9,704	Cellule de Planification et de Statistique, Ministère de la Santé, de la Solidarité et des Personnes Agées; Direction Nationale de la Statistique et de l'Informatique
Sudan	1989–1990	5,860	Department of Statistics, Ministry of Economic and National Planning
Tanzania	1996	8,120	Bureau of Statistics Planning Commission
Yemen	1991–1992 1997	5,687* 10,414*	Central Statistical Organization

*Indicates ever-married women.

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