

Abandoning Female Genital Mutilation/Cutting

AN IN-DEPTH LOOK AT PROMISING PRACTICES



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Abandoning Female Genital Mutilation/Cutting

AN IN-DEPTH LOOK AT PROMISING PRACTICES

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December 2006

Acknowledgments

This publication would not have been possible without the dedication and commitment of many people and organizations, especially those working in countries where female genital mutilation/cutting remains a painful reality for millions of girls and women. The authors also want to express their gratitude to Layla Shaaban and Sandra Jordan of USAID whose vision, support, and encouragement contributed to the successful culmination of this project. Thanks go also to long-time development experts, Nancy Yinger and Sarah Harbison, whose insightful review and recommendations sharpened the final product; and to Dr. Abdelhadi Eltahir for his valuable feedback.

In addition, many in-country staff from Population Council gave generously of their time, including: Ian Askew, Kenya; Nahla Tawab, Gihan Hosny, and Mona Bur, Egypt; Nafy Diop and Lamine Mbengue, Senegal; and Zachary Congo, Burkina Faso.

And a special thanks goes to the staff members of our three highlighted interventions—Navrongo, IntraHealth, and Tostan—who were incredibly patient with our repeated questions and requests.

Disclaimer

This publication was produced by the Population Reference Bureau with funds provided by the United States Agency for International Development (USAID) under the BRIDGE Project (No.GPO-A-00-03-00004-00).

The views expressed in this publication do not necessarily reflect the views of the Population Reference Bureau, the United States Agency for International Development or the United States Government.

Cover photos: Clockwise from left: Women singing human rights songs (courtesy of Tostan); Ethiopian woman at an anti-FGC rally (courtesy of IntraHealth); Ghana women singing and clapping (courtesy of Navrongo).

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CHAPTER 1

Introduction

In December 2002, as efforts toward abandonment of female genital mutilation/cutting (FGM/C)¹ continued to gain momentum worldwide, the Female Genital Cutting Interagency Working Group of the U.S. Agency for International Development (USAID) realized that the field had entered a new stage. While previously the focus had been primarily on defining FGM/C, on determining where it existed, what forms it took, even what terminology to use, it became clear to all the organizations represented in the working group that attention needed to shift to managing the information that was available and filling whatever information gaps still existed. And most importantly, more information was needed on interventions that successfully promote the abandonment of FGM/C.

After nearly four years and numerous surveys, questionnaires, in-country interviews, intermediate products, and the collaborative efforts of many groups, the result is this publication.² In it, the authors present an in-depth look at three promising interventions identified through collaboration by five organizations: the Population Reference Bureau, Family Health International, PATH, Population Council, and The Manoff Group.

Because so much excellent material has been published in the last ten years on defining FGM/C, describing the four types of cutting,³ and exploring the various approaches used and prevalence by country, this publication will not replicate those efforts. Its objective is to meet the primary information need identified by hundreds

of organizations and individuals working toward the abandonment of FGM/C: information on case studies that illustrate what is working and why.

Identifying Best Practices

In July 2005, the five collaborating organizations began researching all interventions that promote the abandonment of FGM/C in an organized attempt to learn from the experience of others and ultimately identify best practices (see Best Practices box on page 2). The groups defined such practices as those that have a demonstrable and tangible impact, are socially, culturally, and economically sustainable, and have the potential for replication.⁴

Over the next six months, hundreds of questionnaires, in French and English, were widely distributed using various databases, listservs, and contacts from in-country partners. The questionnaires asked for background information on each of the FGM/C projects, including their objectives, staff size, budget, where they work, description of the intervention, and especially details of any project evaluation (see questionnaire in Appendix 2).

In the end, approximately 100 responses were received, representing 19 countries: Burkina Faso, Egypt, England, Ethiopia, France, Gambia, Ghana, Guinea, Indonesia, Kenya, Mali, Niger, Nigeria, Senegal, Sierra Leone, Somalia, Sudan, Tanzania, and Uganda. Thirty respondents indicated that their interventions had been evaluated. Upon fur-

1 For purposes of this publication, this term will be used in the general references. But because so much emotion is attached to the various descriptive terms—female genital cutting, female genital mutilation, female circumcision—in the chapters of the three case studies chosen as promising practices and in the appendices where various interventions are listed, the preferred terminology of each of the projects will be used.

2 The collaboration of the last four years and the products it has produced provide an interesting case study in and of themselves and are described in detail in Appendix 1.

3 See World Health Organization, 1996, *Female Genital Mutilation: Report of a Technical Working Group*.

4 While this began as a “Best Practices” publication, along the way it would become clear that the title itself was becoming a problem and the groups agreed to label the highlighted cases “Promising Practices.”

ther investigation, some were found to have defined evaluation more loosely than this project's criteria and this number was trimmed to 27 (see Appendix 4 for a list of Evaluated Interventions).

What Is a Best Practice?

The term "Best Practice" is widely used and there is no universally accepted definition of what constitutes a Best Practice.

The United Nations and the international community at large define best practices as successful initiatives which:

- Have a demonstrable and tangible impact on improving people's quality of life;
- Are the result of effective partnerships between the public, private, and civic sectors of society;
- Are socially, culturally, economically, and environmentally sustainable.

It is essential that, to qualify as Best Practices, the activities in question be evaluated in terms of the criteria of innovation, success and sustainability by both experts and the people concerned. (www.unesco.org/most/bphome.htm#1)

Narrowing the Field

The task before the five collaborating organizations was intimidating: to determine which three interventions met the criteria for best practices. As the five organizations met repeatedly between December 2005 and May 2006, they struggled to answer the following questions on each of the interventions:

- 1) Was there indeed evaluation?
- 2) Did the intervention succeed in achieving its objective?
- 3) Did the intervention impact behavior and not just knowledge?
- 4) Was it replicable?
- 5) Did it display cultural sensitivity?

Evaluation

Early on, the team decided that for a project to be considered a best practice, it had to have undergone some form of evaluation. The term *evaluation* is clearly open to interpretation. While nearly a third of the respondents had indicated that their project had been evaluated, in reality very few interventions had undergone rigorous scientific analysis. However, the collaborating partners determined that the evaluated interventions examined in this effort represent the strongest evidence available to date on approaches for abandoning FGM/C. (See Interventions to Watch, page 5, for descriptions of new projects currently underway that do have an evaluation component built in to the project design.)

Not surprisingly, the most frequently cited reasons for the lack of project evaluation were related to funding shortages and time constraints. Nevertheless, as Ian Askew stresses in *Methodological Issues in Measuring the Impact of Interventions Against Female Genital Cutting*,⁵ well-designed projects that are informed by empirical evidence and designed to allow strong scientific evaluation are crucial if valid conclusions are to be made regarding their effectiveness. His article provides invaluable insight into the challenges and considerations related to designing and implementing FGM/C abandonment interventions.

Achieving Objectives

The questionnaires asked if an intervention was successful in reaching its objectives. This was done for two reasons. First, if an intervention is well designed, the evaluation and subsequent results should relate to its initial objectives. Second, the authors recognize that different settings require different approaches. In some situations, such as in a community where FGM/C awareness is very low and the health and human rights

5 Askew, 2005.

aspects of the practice have never been openly discussed before, it may not be feasible for a project to expect FGM/C to be eliminated. In these instances the intervention may be considered successful if it meets its objectives in raising awareness, increasing knowledge, and creating a social environment where people can discuss FGM/C as an important issue.

Impacting Behavior

In defining promising practices and establishing the criteria for selecting case studies, the collaborating partners discussed at length the significance of interventions showing an impact on behavior versus those resulting in positive changes in attitudes or intentions toward FGM/C. While it is recognized that different assumptions are made about behavior change and the way it occurs, the group concluded that promising practices for the abandonment of FGM/C should look beyond attitude and knowledge change. Best practices and promising practices should be able to demonstrate impact on behavior, ideally as a reduction in the incidence of FGM/C, or, at least, sustained positive social change.

Projects that limit their scope to attitude change, especially those that concentrate solely on negative health effects or the criminalization of the practice, leave communities open to the medicalization of FGM/C,⁶ the lowering of the age at which girls are cut,⁷ and other attempts to hide the practice.

Replicability

Since the motivation for this publication has been the expressed need for more information about best practices and evaluation results, an important consideration in the selection of case studies was replicability. The authors felt it was important to highlight case studies that represented a range of locations, contexts, approaches, and evaluation methods, as well as other important factors such as the number of staff involved, budget size, and project duration. Detailed information has been included in the hope that other organizations, although smaller or with less funding, may learn from the case studies and adapt them as is appropriate.

Cultural Sensitivity

Cultural sensitivity was an important criteria in choosing the case studies. In the examples of promising practices provided here, attempts to change the practice are being led by members of the communities themselves. Furthermore, as other programs, organizations, and cultures adapt the approaches described here, they will need to be mindful of the specific objectives of the programs as well as what is similar and different about their own social organization, reasons for the practice, human and financial resources, organizational structure, and development environment.

6 While medicalizing the procedure might seem like a rational response by communities wishing to protect their daughters from the immediate health consequences, medicalization fails to acknowledge the long-term reproductive, sexual, and mental health complications that may result from FGM/C. Whether performed by a health professional or not, according to the WHO, FGM/C still constitutes a violation of a girl's right to bodily integrity (see WHO, *Female Genital Mutilation: Policy Guidelines for Nurses and Midwives*, 2001).

7 The trend toward cutting girls at younger and younger ages is of great concern to those working in the field. Demographic and Health Survey data indicate that in 9 of the 16 countries where data are collected on FGM/C, the average age at which girls undergo FGM/C has been declining. Substantial declines have been observed in Mali, Burkina Faso, Côte d'Ivoire, and Kenya (Yoder et al., 2004).

Arriving at Three Cases

Once the five criteria were applied to all the interventions received, the group took the decision process one step further. Nearly two dozen FGM/C experts in the field and at various agencies and organizations were asked to review the evaluated interventions that best met those criteria and to respond to the following questions: Did we miss anything? Are these interventions good examples of best practices? Are there any others that meet all the criteria?

Feedback: From Best Practices to Promising Practices

This process yielded valuable feedback on which interventions should be included. It also revealed that the issue of best practices was a contentious one. Representatives of the original five collaborating groups and of USAID met to discuss the feedback and concluded that “best practices” should be discarded in favor of “promising practices” for two reasons. First, all involved were concerned that the important information that had been gathered would be lost in an acrimonious debate on what constitutes a best practice. Second, many of the final interventions were excellent and the group did not want to denigrate their worth by deeming them “not best practices” (see Appendix 4, Evaluated Interventions).

The Final Three

Based on the information received and the feedback from the various experts, the group decided to highlight the following three interventions:

- ***The Navrongo FGM Experiment***—Navrongo Health Research Center, Ghana
- ***A Five-Dimensional Approach for the Eradication of Female Genital Cutting in Ethiopia***—IntraHealth International, Ethiopia
- ***The Community Empowerment Program***—Tostan, Senegal

Each of these interventions has very different strengths and each adds invaluable knowledge and lessons learned in working toward FGM/C abandonment. Navrongo is noteworthy for the quality of its evaluation. IntraHealth stands out for the multiplicity of approaches and stakeholders it employed in its two-year intervention. And Tostan is a leader in the field for the community empowerment approach it has pioneered and its emphasis on cultural change rather than behavior change.

Navrongo Health Research Center: The Navrongo FGM Experiment is unusual for its experimental design, which furthers the project’s dual objectives: accelerating the abandonment of FGM/C while at the same time measuring and comparing the impact of three different intervention strategies to determine which approach is most effective in reducing FGM/C. This project’s unique contribution, however, is undoubtedly its use of robust evaluation techniques, made possible by the systematic application of operations research principles throughout the design, implementation, and evaluation phases of the project.

IntraHealth International: IntraHealth International’s Five-Dimensional Approach for the Eradication of Female Genital Cutting in Ethiopia is remarkable for several reasons, particularly for its well-informed multi-faceted approach to changing FGM/C knowledge and behavior, its demonstrated commitment to building capacity and transferring project ownership, and its attention to nurturing long-term sustainability at all phases of project design and implementation. These factors, along with the extensive advocacy, training, empowerment, and community mobilization activities, combine to make this project valuable to others interested in utilizing information, education, and communication (IEC)/community mobilization approaches.

Tostan: Perhaps the best known of all the FGM/C abandonment efforts, Tostan combines a democracy and human rights education program with an almost spiritual belief that community empowerment must be the cornerstone of all enduring change. Tostan's lengthy process (usually two to three years of education modules in the villages) addresses such issues as hygiene, health, literacy, development, and management skills. Although much of its visibility has come from large, well-publicized Public Declarations in which FGC abandonment is declared, Tostan's *raison d'être* is to empower villagers to take charge of their own development and to participate fully in society.

Innovative Approaches or Tools

Several other interventions that submitted completed questionnaires, while not included in the final three, added significantly to the wealth of knowledge about specific approaches in ending FGM/C. These are:

Maendeleo Ya Wanawake Organization (MYWO), Kenya—for its communication for social change initiatives and its use of alternative rites of passage that embrace positive traditional values and exclude FGM/C;⁸

Deutsche Gesellschaft für Technische Zusammenarbeit's (GTZ) Supra-regional Project, Promotion of Initiatives to End FGM—for its incorporation of policy dialogue and its promotion of capacity- and organizational development, research, and training in inter-generational dialogue;⁹

The FGM Abandonment Program (FGMAP), introduced in Egypt by The Centre for Development and Population Activities (CEDPA)—for building upon the Positive Deviance Approach of identifying and mobilizing individuals who have challenged conventional societal expectations to act as role models for the abandonment of FGM/C;¹⁰

Inter-African Committee on Traditional Practices Affecting the Health of Women and Children (IAC)—for its influential and far-reaching networks and advocacy efforts.¹¹

Interventions to Watch

As the work to abandon FGM/C continues to mature and spread, new approaches and projects will undoubtedly emerge. Even as this publication goes to press, several new developments in the field must be noted.

First, there are several ongoing evaluations that are expected to shed new light on some interventions. A final evaluation of CARE's FGC Abandonment in Somaliland project, which focuses on community awareness, local capacity building, and advocacy at the national government level, is planned for the end of 2006. In Mali, the Organizational Strengthening, Women's Credit, and Irrigated Agriculture in Macina (ROCAM) Project, also implemented by CARE in partnership with three local NGOs, aims to reduce the prevalence of FGM/C as part of a broader development initiative that is scheduled to continue through 2008.¹² The IAC in Gambia (GAMCOTRAP) is currently evaluating a program that targets FGM/C

8 An assessment of MYWO's alternative rite of passage program conducted by the Population Council is available at www.popcouncil.org/pdfs/frontiers/FR_FinalReports/Kenya_FGC.pdf.

9 For more information, see GTZ's website at www.gtz.de/en/weltweit/afrika/regionale-themen/9121.htm.

10 For more information, see CEDPA's website at www.cedpa.org.

11 See IAC's website at www.iac-ciaf.org.

12 See CARE's website at www.care.org.

FGM/C Abandonment and Media/Communication Interventions

FGM/C abandonment initiatives are increasingly incorporating media campaigns into their strategies as the power of radio, television, and film, in particular, are harnessed to disseminate information, increase awareness, and promote advocacy around FGM/C abandonment. Media messages can be particularly effective in helping to create a social environment conducive to change.

Of the projects reviewed, three organizations in particular exhibited diverse and extensive use of media techniques to promote the abandonment of FGM/C:

- The extensive media campaigns of the Tanzania Media Women's Association (TAMWA) use radio, television, newspapers, and other print media such as posters to "defend and advocate for women and children's rights through educating, mobilising and pressurising for cultural, policy and legal changes in the society."¹ In 2002, as part of the STOP FGM (www.stopfgm.org) campaign, TAMWA launched a nationwide information, education, and communication initiative to prompt public debate and action to stop FGM/C.
- In Mali, Sini Sanuman² and its U.S.-based sister organization, Healthy Tomorrow, have complemented their FGM/C eradication efforts with innovative pop music. Since 2000, Sini Sanuman and Healthy Tomorrow have produced several albums and music videos featuring well-known Malian artists who sing about the negative effects of FGM/C and promote its abandonment. The songs, produced in five local languages and French, air frequently on national and local radio and are broadcast on cable television in ten West Africa countries. This strategy has been credited with inspiring an influential female government minister to pledge funds for the production of a new music video.
- A third innovative project, designed to harness the potential of community-based media, has been implemented in Guinea by Communication for Change³ and its local NGO partner CPTAFE,⁴ the Guinean affiliate of the Inter-African Committee for the Prevention of Harmful Traditional Practices. The primary aim of the *Video Sabou et Nafa* project is to promote dialogue and reflection among community members. One of the many accomplishments of the project involves youth members of a video team performing and filming an open-air drama entitled "Halte à L'Excision" ("Stop Excision"). The video has been shown at several schools, reaching approximately 500 students, and has also been aired on Guinean national television.

1 From the TAMWA Women's Media Association mission statement, www.tamwa.org/mission.asp, accessed online Oct. 1, 2006.

2 See Sini Sanuman/Healthy Tomorrow website at www.stopexcision.net.

3 For more information, visit the Communication for Change website at www.c4c.org.

4 La Cellule de Coordination Sur les Pratiques Traditionnelles Affectant la Santé des Femmes et des Enfants.

through reproductive health advocacy and awareness creation programs for youth and adolescents. An evaluation was begun in early 2006 of the FGMAP initiative by CEDPA in Egypt, which has used the Positive Deviance Approach, focusing on families with "girls at risk."

Moreover, the first phase in the evaluation of a five-year FGM-Free Village Model project led by the United Nations Development Program (UNDP) and National Council for Childhood and Motherhood (NCCM), with funding from eight international donors, began this year. The project, which runs until the end of 2008, adopts a participatory IEC and human rights approach to address FGM within a comprehensive developmental package aimed at all community members.¹³

In addition, new information is being produced about existing approaches, such as communication initiatives and the harnessing of mass media (see media box).

Promising New Research

Perhaps most important for gaining the attention of policymakers interested in public health outcomes, recent new research has identified a link between FGM/C and obstetric complications, including increased infant and maternal mortality. Experts in the field have frequently speculated on the possibility that these consequences result from FGM/C; however a 2006 study by the World Health Organization is the first large-scale, multi-country study to investigate the association between FGM/C and obstetric complications.¹⁴

13 The mid-term evaluation has already begun and, according to UNDP, results will be available in early 2007.

14 WHO, 2006.

The study, which involved over 28,000 women in Burkina Faso, Ghana, Kenya, Nigeria, Senegal, and Sudan, compared the effects of different types of FGM/C on obstetric outcomes. The researchers conclude that “deliveries to women who have undergone FGM are significantly more likely to be complicated by caesarean section, postpartum hemorrhage, episiotomy, extended maternal hospital stay, resuscitation of the infant, and inpatient perinatal death, than deliveries to women who have not had FGM.”¹⁵ Furthermore, the study suggests a “causal relationship,” where risk of negative outcomes rises with increasingly severe forms of FGM/C.

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15 WHO, 2006.

CHAPTER 2

The Navrongo FGM Experiment

While community mobilization is the focus of many FGM interventions, the Navrongo FGM Experiment is unique. In addition to developing strategies to accelerate the abandonment of the practice, this project used rigorous scientific analysis to test which strategies work best: Is education alone enough? Does livelihood training have a greater impact? Or, could a combination of both activities be the most effective way to bring about changes in FGM attitudes and behavior? The successes and challenges met in pursuit of answers to these questions offer valuable lessons to others wishing to implement strategies for fostering social change in FGM practice.

Objectives and Organizational Description

The Navrongo Health Research Center (NHRC) was established in northern Ghana in 1988 as a field site for a child survival study. In 1992 the Ministry of Health adopted the facility and since then its mandate has broadened to include population and health problems with a focus on the major causes of illness in Ghana's northern regions, and the related concerns of high fertility and maternal morbidity.

In 1999 NHRC collaborated with local government and non-governmental organizations to launch a dual program of action and research. The objective of the program was to accelerate the abandonment of FGM in the Kassena-Nankana district of Northern Ghana as well as to measure the impact of various strategies on reducing FGM in this traditional rural society where the practice is long-standing and prevalent.¹⁶

Although different strategies were implemented and tested for their impact on reducing FGM, the underlying approach used in this project was community engagement and mobilization.

Ghana. Kassena-Nankana District outlined and the project area highlighted.



CIA, *The World Factbook*

Background

Prevalence

According to the 2003 Demographic and Health Survey, five percent of women in Ghana have undergone FGM;¹⁷ however, prevalence varies considerably by region and ethnicity. Many more women are affected in the north of the country

¹⁶ Akweongo et al., forthcoming.

¹⁷ Ghana Statistical Service et al., 2004.

The Navrongo FGM Experiment

Project partners:	Community members, National Commission on Women and Development (NCWD), Ghanaian Association of Women's Welfare (GAWW), ActionAid Ghana, Maata N Tudu, The District Assembly, USAID, Population Council, Gia/Nabio Agro Forestry Development Organization (GNADO), The Swiss Embassy, Accra
Staff:	10 full-time staff members
Community workers:	85 change agents
Budget range:	US\$ 116,000–238,200 (covering survey research and intervention activities for the five-year period)
Funding sources:	USAID, ActionAid Ghana, Maata N Tudu, Swiss Embassy Accra, GNADO
Working languages:	Nankam and Kassem
Project duration:	5 years (1999-2003)

where the practice has cultural roots, compared to other regions where FGM mostly occurs in migrant communities from the north or neighboring Burkina Faso and Mali.¹⁸

In 1995 the NHRC started collecting data on FGM as part of an ongoing surveillance system that records demographic events in the entire Kassena-Nankana district. This initial survey found that FGM is practiced by the two largest ethnic groups in the area, the Nankana and Kassena, and prevalence among women ages 15-49 was high at 77 percent.¹⁹ The following year a clinic-based study of pregnant women seeking prenatal care confirmed that all three types of FGM (clitoridectomy, excision, and infibulation) were practiced, the most common being excision.²⁰ The majority of women (62 percent) stated they had been cut between the ages of 15 and 19 years old. By age 20, 80 percent of respondents had undergone some form of FGM.²¹

All forms of FGM were made illegal in Ghana in 1994 and those who perform the operation face a prison sentence of at least three years.²² However, the practice is still widespread in the north, and, as in many other countries that have passed anti-FGM legislation, there have been only a handful of prosecutions in the decade since the law was introduced.

Rationale for FGM

In most west African communities where the practice persists, the most frequently cited reason for its continuation is FGM as a rite of passage to womanhood, and that is the case in the Kassena-Nankana region.

While mothers may recognize some health risks of FGM, maternal duty and the belief that they are acting in their daughter's best interests, particularly with regard to her marriage prospects, are powerful influencing factors. Eldest daughters are often under more pressure to adhere to the practice as they are required to undergo FGM in order to play an important role in their mother's funeral rites.²³

Navrongo researchers were also told by community members of the importance of FGM to cultural and gender identity. The practice is thought to instill morals and social values in girls, which are necessary for their respect and acceptance as adult women, especially by co-wives and mothers-in-law who may pressure young wives into being cut if they are not already. A middle-aged woman in the project area said: "I feel the impact to circumcise is greater from the peer group. If you are married, [pressure is from] your fellow wives. If you are a girl, from your colleagues."²⁴

18 Who 1998, cited in Akweongo et al., forthcoming.

19 Akweongo et al., forthcoming.

20 Akweongo et al., forthcoming.

21 Mbacke et al., 1998, in Akweongo et al., forthcoming.

22 Inter-Parliamentary Union, www.ipu.org/wmn-e/fgm-prov-g.htm, accessed online Oct. 1, 2006.

23 NHRC, vol. 1, no.4, 2004.

24 NHRC, vol. 1, no.5, 2004.

Project Audience

The Navrongo FGM Experiment took place in six villages in the eastern zone of the Kassena–Nankana district, where social support for the practice remains strong. This area was chosen as the study site due to the higher than average prevalence of FGM among adolescent girls during the 1995 survey. Of the 15 to 19 year age group, 34 percent of girls had already undergone FGM, compared to 23 percent in the rest of the district.²⁵

This project gave researchers a rare opportunity to test and compare anti-FGM interventions and included strategies that focus on different groups within the community. For example, one of the interventions focused on the empowerment of girls and women, while another aimed to inform all community members, including men and boys, of the harmful effects of FGM. While the majority of the project's activities were focused in six villages, it is estimated that some strategies, such as radio programs, reached the entire district—a total of 141,000 people.

Methodology

From the outset the NHRC took a scientific approach to planning and implementing their FGM experiment. Prior to designing the different strategies, in-depth research was conducted to understand and assess FGM in the region. This valuable information helped researchers develop a project that is culturally sensitive, sustainable, and specifically tailored to the local context in which FGM occurs.

Because the objectives of this project are not only to reduce FGM, but also to measure the impact of the different strategies, Navrongo researchers employed a systematic approach to documenting project activities and data collection throughout the experiment.

A 1999 baseline survey of 3,221 girls collected information about their background, FGM status, attitudes, and beliefs. The girls interviewed were ages 12 to 19 years old, representing those considered most at risk of

FGM. This was an “open” cohort so in subsequent years new girls reaching age 12 were interviewed and their data added. Surveys were conducted each year from 1999 to 2003, resulting in five rounds of data collected from a total of 19,000 interviews.

Using this methodology NHRC monitored change in the FGM status of individual girls over the duration of the project. These data, along with demographic information gathered during the baseline survey, permitted the use of a statistical method—Cox proportional hazard regression—that allowed researchers to gauge the impact of different FGM abandonment strategies.

The regression model compared FGM incidence rates in communities where abandonment strategies were introduced with those in a control community where no activities were implemented. Other factors that may affect FGM incidence, such as a girl's age, marital status, education, religion, parental religion and location, were also taken into consideration in the model to rule out their role in the observed decreases in FGM.



Adolescent girls at a training session on reproductive health during the Navrongo FGM education intervention (Photo courtesy of NHRC).

²⁵ Akweongo et al., forthcoming.

Project Activities

Following the baseline survey, communities in the project area were randomly designated to either receive an FGM abandonment intervention or become the control community.

A strategic planning phase was implemented in the intervention villages and informal discussions were held to explain the harmful effects of FGM and to build consensus around the need for its eradication. Communities were engaged and mobilized through an approach known locally as *Alagube*, a Nankam term “connoting the process by which people solve a common problem by pooling their individual and community social resources.”²⁶ In the early stages of the project there was some community resistance to the discussion of FGM and the clitoris, but this changed as people observed the involvement of key community leaders and other community members in the project’s development. There was also apprehension among the communities that the project’s personnel would arrest those who continued to practice FGM, a fear that had to be allayed.

Appropriate Alagube activities were identified through a series of meetings with key community stakeholders, including chiefs, elders, grandmothers, mothers, mothers-in law, excisors, and adolescents, both in and out of school. The groups proposed the use of community members as change agents and in each village three representatives (a woman, a man, and an adolescent) were given the responsibility of reinforcing the Alagube concept of FGM eradication.

The Four-Cell Experimental Design

The Navrongo FGM Experiment utilized a four-cell experimental design, allowing researchers to compare the effects of different strategies on FGM incidence. In this experiment the cells represent the different communities in the project area.

In three of the four communities a different strategy designed to reduce FGM was implemented. In the fourth community no strategy was introduced, making it the comparison group. By comparing the FGM incidence in the four communities, the researchers believed they could determine which strategy had the most impact on decreasing FGM.

The community-led Alagube approach was used to implement the three abandonment strategies described below. Figure 1 illustrates how the interventions were distributed among the communities, and shows that the only community not to receive an intervention is the one in Cell 4. The occurrence of FGM in the comparison cell represents what would most likely have occurred in all four locations if there had not been strategies implemented to reduce FGM. Therefore, researchers concluded that reductions in the number (or proportion) of girls undergoing FGM in the other three communities are in all probability attributable to the strategies being tested.

FIGURE 1
Navrongo FGM Experiment: The 4-Cell Project Design

The 4-Cell Project Design		Communities (Cells) receiving Alagube* + FGM Education Activities	
		No	Yes
Communities (Cells) receiving Alagube* + Livelihood and Development Activities	No	Cell 4 (Comparison)	Cell 1
	Yes	Cell 2	Cell 3 (Combined)

* A Nankam term connoting collective action.
Adapted from Akweongo et al., forthcoming.

26 Akweongo et al, 2006.

FGM education activities (Cell 1)

The focus of activities in this community was explicitly on FGM education and prevention within a reproductive health and socio-cultural framework. Intervention strategies were primarily directed toward adolescent girls not attending school and women, who met for twice-monthly meetings in groups with approximately 70 of their peers. The meetings, led by a reproductive health professional, lasted for at least two hours and addressed FGM through such topics as adolescence, the menstrual cycle, marriage, pregnancy, childbearing and child-care, and social and economic support. Lessons incorporated discussion around cultural expectations regarding adolescent girls and women that sought to reinforce positive expectations and provide lessons for discarding the negative ones. A total of 1,190 girls and 1,190 women were reached through these meetings in 17 different locations.

Additional activities included:

- *Night education programs:* FGM videos were shown at various central locations chosen by the community and were usually followed by an interactive discussion.
- *Clinic programs:* FGM education was provided to women attending antenatal and child welfare clinics.
- *School health education programs:* These were aimed at children in primary, junior secondary, and secondary schools who were otherwise not exposed to the project's activities. In each of the schools, films about FGM were shown and followed by education on the effects of FGM.
- *Singing competitions:* Adolescent girls and boys and women's groups composed anti-FGM songs for competitions often held at grand durbars (large village meetings) and attended by influential elders, powerful women's groups, and local dignitaries and political leaders.
- *Drama competitions:* These engaged the communities in creative expression about FGM that sparked intense dialogue and renewed interest in ideas surrounding the abandonment of FGM.



Examples of the arts and crafts adolescent girls are taught to make in the Navrongo livelihood and development intervention (photo courtesy of NHRC).

- *Radio programs:* a 30-minute drama about FGM was produced in the local dialect and broadcast on local radio at night when most people were at home.

Livelihood and development activities (Cell 2)

Activities in this community were designed primarily to empower girls and women through a program of livelihood skills training that included the production of crafts, marketing, micro-lending to women's groups, and other life skills as well as autonomy-building programs focusing on human rights. As with the FGM education activities, girls and women met in large groups – about 70 at each meeting – for at least two hours, twice a month. A total of 1,120 women and the same number of girls (those not attending school) participated in this training in 16 different locations. The livelihood activities were also aimed at adolescent boys no longer at school. However, compared to girls, most boys were in school and over time boys who started the training withdrew from the program, typically to travel.

In addition to these activities, girls received reproductive health education and training in domestic tasks such as the preparation of local dishes and weaving of mats and baskets. These activities were designed to replace the livelihood and family education that girls traditionally receive as part of the FGM rite of passage.

Unforeseen Challenges

According to Navrongo researchers, two of the unforeseen challenges in this project included lower than expected prevalence and inconsistent reporting by girls.

The prevalence of FGM recorded in the baseline survey was considerably lower than had been anticipated when the study was designed. Since the "power" or statistical accuracy of the study is dependent on a large enough sample of girls relative to the incidence of FGM, it was necessary to expand the project area. In 2002 an additional 1,073 girls were interviewed and data on their FGM status was collected retrospectively and linked to the original surveys to establish incidence rates.

The second challenge faced by researchers related to high levels of response reversal, where girls who initially reported they had undergone FGM reversed their answers in later surveys to report they had not. In 2001, 74 percent of respondents denied their previously reported FGM status. An extensive investigation was conducted to understand why this was happening.¹

Researchers found that women who denied their FGM status were significantly younger, more likely to be educated, and less likely to practice traditional religion than those who reported they had been cut. Among the possible explanations for such high rates of response reversal were: exposure to anti-FGM campaigns and interventions, and the enforcement of laws prohibiting the practice, which may have affected local attitudes towards FGM and women's willingness to reveal their FGM status. Investigators postulated that repetitive questions on FGM status may have confused respondents and drew from this the importance of using appropriate and qualified interviewers to maximize the reliability of self-reported data. Following improvements to data collection practices, the rate of denial dropped to 49 percent in 2003.

To assess whether or not inconsistent reporting of FGM status was biasing results, an appropriate statistical method (maximum likelihood logistic regression) was used to investigate any connections between the three different FGM abandonment strategies and response reversal. No association was found between any of the strategies and girls' denial of their FGM status, leading researchers to suggest that response reversal did not bias results relating to the effects of the FGM abandonment strategies.²

1 For more information see Jackson et al., 2003, "Inconsistent Reporting of Female Genital Cutting Status in Northern Ghana: Explanatory Factors and Analytical Consequences." A downloadable PDF is available at: <http://www.popcouncil.org/pdfs/councilarticles/sfp/SFP343Jackson.pdf>

2 Naik et al. in Akweongo et al., forthcoming.

Activities in the women's groups included:

- Basic book keeping and managerial skills;
- Identification of income-generating activities;
- Identification of sources of finance;
- Rules and procedures for financing companies;
- Skills necessary to produce items that could sell within the community; and
- Research and marketing skills.

Combining FGM education and livelihood and development activities (Cell 3)

The two strategies described above were also combined and implemented as a third intervention in Cell 3. A total of 1,260 women (18 groups of 70 women), 1,260 girls (18 groups of 70 girls), and 60 boys (3 groups of 20 boys) participated in the combined activities.

Timeline

The project was implemented over five years:

- 1999:** Qualitative and quantitative surveys are conducted to collect baseline data.
- 2000-1:** The combined FGM education and livelihood and development strategies are introduced in Cell 3. The FGM problem-focused strategy is introduced in Cell 1.
- 2002:** Livelihood and development strategy activities begin in Cell 2.
- 2003:** Evaluation.

Evaluation/Results

The final project evaluation was conducted in 2003 by a team of researchers from NHRC and the Population Council/New York.

In all, 8,473 individuals were interviewed at least once during the project, and 4,761 girls who reported that they had not undergone FGM were interviewed at least twice.

Quantitative analysis based on Cox proportional hazard regression indicated that:

- When all the other factors that could affect FGM incidence (age, marital status, education, and religion) were taken into consideration, one year of the Alagube and FGM education strategy was associated with a **93 percent decrease** in the risk of FGM, and one year of the combined Alagube, education, and livelihood strategy was associated with a **94 percent decrease** in the risk of FGM, compared to that in the control group.
- All three FGM abandonment strategies were associated with a reduction in FGM, but only girls in communities where the FGM education strategy and the combined strategy were implemented had a “statistically significant”²⁷ reduced risk of FGM.²⁸
- Marital status was the only demographic variable found to be associated with FGM incidence. Girls who had ever been married were four times more likely to report that they had undergone FGM than were those who had never been married. What remains unclear, however, is whether girls who have undergone FGM are more likely to marry early, or whether girls who marry early are more likely to have undergone FGM.²⁹

In their evaluation, researchers noted that “while the addition of livelihood activities had no independent effect, livelihood activities may have been contaminated by FGM problem-focused activities.”³⁰ During a regional singing contest it was noted that women from the communities receiving only Alagube + livelihood activities did sing anti-FGM songs, even though the intervention in their community did not explicitly focus on FGM. However, researchers maintain that while this possible unintentional overlap of interventions may have reduced the differences between the effects of the different interventions on FGM incidence, “there is clear evidence that interventions pursued in this project had an impact.”³¹

Survival Analysis

Researchers also did an analysis of data from 4,761 girls ages 12-23 to understand the chances of girls remaining uncut for the duration of the project—Cox proportional hazard regression was used to perform this “survival” analysis. Figure 2 illustrates the impact of the three FGM abandonment strategies on the probability of girls remaining uncut over time.

The analysis began with a hypothetical “baseline” of 15-year-old girls who have never attended school, are not married, practice traditional religion, live in the comparison area, and receive no FGM abandonment strategy. The reason these characteristics were made uniform in the model is because they may influence FGM incidence. Researchers reasoned that by keeping them the same, any differences seen in the probability of remaining uncut when FGM abandonment strategies were added to the model could be attributed to the strategy.

27 When all three abandonment strategies were added to the statistical model and compared, only the effects of the FGM education strategy and the combined FGM education and livelihood strategy were found to be statistically significant. In this case researchers were 95 percent confident that the reduction in FGM due to these two abandonment strategies was true and not due to chance.

28 Akweongo et al., forthcoming.

29 Akweongo et al., forthcoming.

30 Akweongo et al., forthcoming.

31 Akweongo et al., forthcoming.

The “baseline survivor function” line on the graph shows the probability of remaining uncut over time for girls in the baseline group. The other three lines on the graph show how the probability of remaining uncut changes for girls in the baseline group, when the only difference is adding one year of living in an area with an FGM abandonment strategy.

The figure shows that almost 100 percent of girls “survived” when any of the three FGM abandonment strategies were introduced – that is, they remained uncut for the four-year period. The differences between the three strategies were extremely small; suggesting the impact on reducing FGM incidence was the same.

As the figure illustrates, incidence of FGM in the project area was very low. Even among the baseline group not receiving an FGM abandonment strategy, the proportion remaining uncut is 96 percent. Some of this low incidence, however, may be attributable to girls’ denial of their FGM status³²(see Unforeseen Challenges on page 14).

Lessons Learned

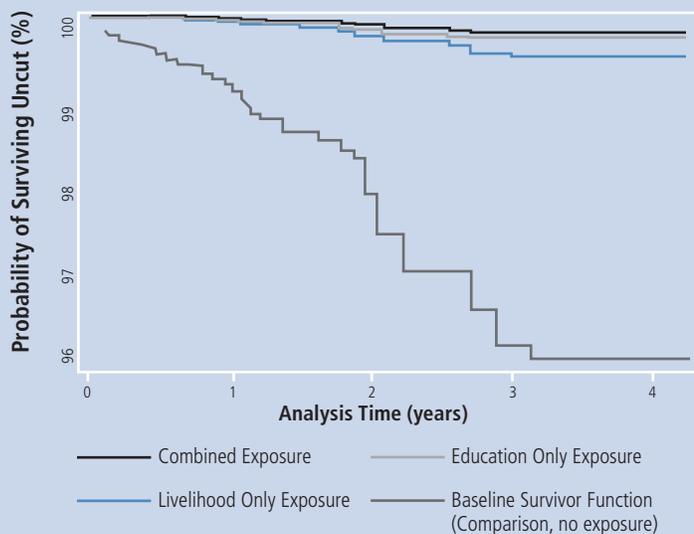
The successes and challenges experienced during the implementation of the Navrongo FGM Experiment offer valuable lessons to others wishing to implement strategies for fostering social change in FGM practice. A few of the design features that make this project stand out include its:

- **Multi-phased approach:** A diagnostic phase to understand and assess the level of FGM and its underlying rationale; a pilot phase in which the community was involved through participatory learning techniques in the planning of intervention strategies; and an experimental phase, where interventions were introduced to randomly selected communities over time.
- **Systematic intervention:** All the major lines of social support for the practice were identified during the diagnostic phase and program components developed for each one.³³ For example, activities were directed towards community leaders and community mobilization (through traditional gatherings known as durbars), parental involvement, women’s network mobilization, and peer leadership among both boys and girls.
- **Scientific evaluation:** The project design allowed for the application of robust statistical techniques to measure changes in incidence resulting from intervention strategies.

According to Navrongo staff, the project yielded two overarching lessons:

- Through community discussion and participation, it is possible to create and normalize discussion of sensitive issues such as FGM; and
- Although this project experienced design problems and some unexpected outcomes, building in a rigorous monitoring and evaluation (M&E) system allowed the researchers to modify and adapt their approaches to achieve a successful outcome.

FIGURE 2
Survival Analysis: The Probability of Not Undergoing FGM Over Time



Adapted from Akweongo et al., forthcoming.

³² Akweongo et al., forthcoming.

³³ NHRC, *Can the Sun Set Faster?*, vol. 1, no. 2, 2004.

In conclusion, Navrongo believes that its findings underscore that culturally sensitive, community-led educational interventions can reduce FGM. Although the impact of the livelihood and development strategy was not found to be statistically significant, in their final evaluation researchers stated: “It is entirely possible that a combination of livelihood and education methods could have a more sustainable impact in the long run than a less intensive community educational approach.”³⁴

While the project may have benefited in part from broader social changes that have encouraged a decline in FGM incidence in the project area, nonetheless, Navrongo researchers concluded that their findings substantiate the belief that relatively low cost and replicable strategies for FGM eradication can effectively hasten behavior change.

The Navrongo FGM Experiment adds an important chapter to the FGM abandonment literature by measuring actual changes in FGM behavior, rather than changes in FGM beliefs, attitudes, and intentions. This is an important distinction given widespread disagreement about whether intention is a reliable indicator of future behavior change. Given the obvious ethical obstacles to physically verifying FGM status, NHRC’s experiment relies on self-reporting. While this is not without its problems, the project’s results do suggest that the FGM abandonment strategies tested have successfully changed behavior and led to a reduction in FGM.



Adolescent girls weaving baskets during a Navrongo livelihood training session (photo courtesy of NHRC).

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34 Akweongo et al., forthcoming.

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CHAPTER 3

IntraHealth International: A Five-Dimensional Approach for the Eradication of Female Genital Cutting (FGC) in Ethiopia

What makes this project for FGC abandonment in Ethiopia both successful and impressive is its extensive range of activities and its multi-faceted approach to changing FGC knowledge and behavior. Although bridging knowledge gaps, especially among different groups in the community, is a key component of the approach, it is more than just an education program. Generating dialogue, empowering women and communities to advocate against FGC, involving influential religious and political leaders, and creating networks of anti-FGC groups from the grassroots to the national level are just some of the activities that have contributed to its success and sustainability. This project was implemented by IntraHealth International with the National Committee on Traditional Practices of Ethiopia.

Objectives and Organizational Description

Founded in 1979 as INTRAH (Program for International Training in Health) at the University of North Carolina at Chapel Hill School of Medicine, IntraHealth International became an independent nonprofit corporation in 2003, with the stated purpose of “improving the health and well-being of vulnerable women and their families around the world.”³⁵

The National Committee on Traditional Practices of Ethiopia (NCTPE) was founded in 1997 as a chapter of the Inter-African Committee on Traditional Practices Affecting the Health of Women and Children (IAC). The NCTPE has two objectives: 1) to promote and encourage positive traditional practices that are beneficial to society and 2) to eradicate traditional practices that negatively impact health and well-being, particularly those affecting women and children.³⁶ IntraHealth International, which worked alongside NCTPE to implement this FGC project, has experi-

Ethiopia. Showing project sites: Harari Region (Harar City, Jegol ancient town, Awomer Farmers Association, Burqa Farmers Association, and Miyay Farmers Association); Somali Region (Jiligar City, Jijiga town, and Fafem Farmers Association); Oromia Region (2 communities in Jima Zone)



CIA, *The World Factbook*, and Wikimedia Commons, 2006

35 IntraHealth International, “Who We Are,” at www.intrahealth.org, accessed on Oct. 1, 2006.

36 The Human Rights Databank, www.hri.ca/organizations/viewOrg.asp?ID=2539, accessed on Oct. 1, 2006.

A Five-Dimensional Approach for the Eradication of FGC in Ethiopia

Project type:	Non-governmental
Partners:	National Committee on Traditional Practices of Ethiopia (NCTPE), and the Women's Affairs Bureaus in Harari, Somali and Oromia.
Paid staff:	2.5
Budget range:	US\$ 80,000 per year
Funding sources:	USAID
Working languages:	Amharic, English and local languages, including Somali, Harari and Oromiffa
Project duration:	2 years (2003–2005)

ence with FGC abandonment projects in Ethiopia, Kenya, and Mali and currently works in 19 countries in Africa, Asia, Latin America, Eastern Europe, and the Middle East.³⁷ Throughout the project some activities were led by IntraHealth and others by the NCTPE; however, it was essentially a team initiative with the goal of building the capacity to transfer all aspects of the approach to local NGOs by the end of the project.

Through a five-dimensional approach that focuses on health, gender, religion, human rights/law, and access to information, the project aimed to encourage FGC abandonment by closing knowledge gaps, strengthening communication links among policymakers and different groups within the community, and empowering women to change their attitudes and behavior toward FGC.

According to IntraHealth Ethiopia's former country director, Christina Ruden (now country director in Senegal), the project's four primary objectives were to:

- Identify the current knowledge, attitudes, and practices of FGC in selected sites;
- Develop the capacity for community leaders to advocate against FGC;
- Increase knowledge and change the attitudes of community members regarding FGC; and
- Monitor and evaluate the impacts of interventions to identify knowledge gaps in FGC practice.

Background

Prevalence

A 1998 survey by the NCTPE found that 73 percent of Ethiopian women had undergone some form of FGC. This figure was found to be even higher in the 2000 Ethiopian Demographic and Health Survey (DHS), which estimated national prevalence at 80 percent.³⁸

All four types of FGC, as classified by the World Health Organization, are performed in Ethiopia. In a 2003 study to identify knowledge, attitudes, and practices (KAP) related to FGC in the project communities, respondents indicated that in recent years there had been a trend away from infibulation, the most severe form of FGC, toward less extreme types.³⁹

Widespread support was shown for the practice of "Sunna" or partial clitoridectomy,⁴⁰ believed by many to be an Islamic religious obligation. However, misunderstanding of what actually constitutes Sunna, especially among women, frequently results in more severe forms of FGC being conducted in its name.⁴¹

37 From the IntraHealth International website, www.intrah.org/index.php?option=com_content&task=blogsection&id=4&Itemid=103 accessed on Oct. 1, 2006.

38 Central Statistical Authority [Ethiopia] and ORC Macro, 2000. Editors Note: While the 5-D project based its information on the 2000 DHS numbers, the newly published 2005 Ethiopia DHS estimates that 74 percent of women in Ethiopia have experienced FGC. While it is beyond the scope of this publication to try to attribute this decrease of nearly six percent since the 2000 DHS, it is interesting to note that, while in 2000 52 percent of women with a daughter reported having at least one of their daughters cut, this number is 38 percent in the 2005 DHS.

39 Redwan et al., 2004.

40 The removal of the hood of the clitoris (prepuce), Redwan et al., 2004.

41 Redwan et al., 2004.

Rationale for FGC

In Ethiopia, FGC is not traditionally performed as a rite of passage. The 2000 Ethiopian DHS found that over 50 percent of girls who undergo FGC do so before their first birthday, and by 10 years of age 88 percent of those undergoing FGC have already been cut.

Most people at the project sites stated that they support FGC for religious reasons. In addition, many men believe that FGC is necessary to control women's sexuality, and that women who have undergone FGC are less emotional and more obedient and respectful of their husband's perceived higher status in the family.⁴² Generally, women in Ethiopia demand FGC, as it is one of the few socially defined areas over which they have any control. They continue to support FGC primarily to protect their daughters' reputations and marriage prospects, based on extreme gender inequities and a lack of information. A commonly held belief in Ethiopia is that FGC is necessary to stop the clitoris from growing. This opinion is even shared by some nurses, midwives, traditional birth attendants, and doctors in the country.

"The reason why infibulation is practiced is because the girl will be insulted and will be looked at as something open and used. But, in reality, it is not good and it is against our religion."

Married Woman from Jijiga City, January 1, 2004.

"In our society FGC takes place mainly to reduce high sexual desire of a woman and to develop high confidence during marriage. Because with the women who are circumcised and stitched together, it is like packing the confidential resource that will be opened by the owner. The base assumption for circumcision in the society is to protect them from sex before marriage."

Married Woman from Harar City, October 18, 2003.

Project Audience

The IntraHealth project was introduced across eight sites in regions with higher than average prevalence of FGC: Oromia (90 percent), Somali (99 percent), and Harari (94 percent)⁴³. While the project was designed to include all community members with a stake in the practice of FGC, specific groups were identified and targeted through tailored interventions. More than 4,200 community members, both men and women, gained "five-dimensional knowledge" through the project's training, information, education, and communication (IEC) materials, and community mobilization activities. Many more people were reached through related national and local media programs, including broadcasts on television and radio, and printed materials in local languages. Advocacy efforts by community and regional teams, and public anti-FGC declarations by more than 120 religious and political leaders and influential elders, helped to increase the project's audience and impact.



Adolescent girls at a Public Declaration against FGC held by the Awomer Farmers Association, Harari Region (photo courtesy of IntraHealth).

Project Design

The initial step in this project was a rapid appraisal study, using interviews and focus group discussions to collect information about FGC practice, and knowledge. In addition, the study identified communication channels and gaps, particularly among men and women, and community leaders and the larger community.

42 Redwan et al., 2004.

43 Central Statistical Authority [Ethiopia] and ORC Macro, 2001.

The communities' perceived benefits of FGC, including the preservation of a girl's virginity until marriage, control of women's sexual desire, and fulfillment of religious obligation, were acknowledged as some of the "obstacles" the project needed to overcome in order to be successful. The negative consequences identified, such as health problems associated with giving birth and fear of HIV transmission, became "platforms of opportunity" for the project to build upon to increase support for FGC abandonment.

IntraHealth's partnership with the NCTPE and local Women's Affairs Bureaus focused on decreasing demand for FGC through the five-dimensional model for FGC knowledge and capacity building, while at the same time creating vertical networks of anti-FGC teams from the national level to the grassroots level (see Figure 3). This multi-faceted approach was designed to bridge FGC knowledge gaps in the areas of health, gender, religion, human rights/law, and information, and to engage community members in dialogue and advocacy activities against FGC, leading to behavior change. By engaging community leaders, including health providers, law enforcers, and

influential religious and political figures, the project aimed to create a social, legal, and religious environment conducive to abandoning FGC.

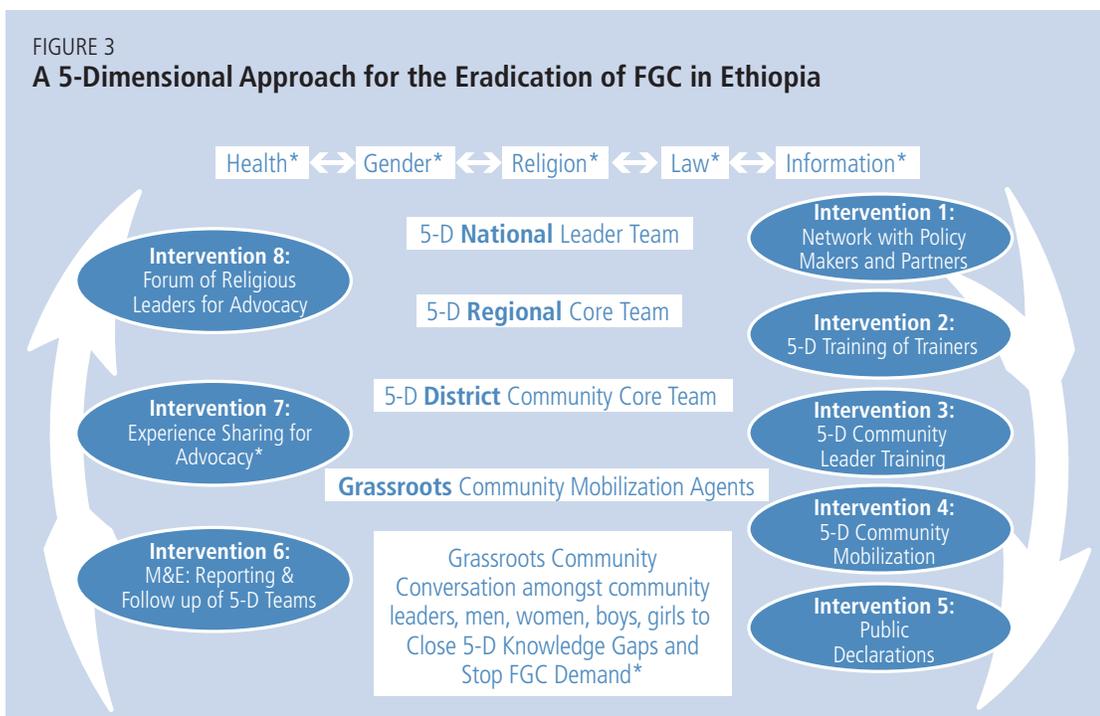
Interventions

Strategies for women's empowerment and initiation of community dialogue on FGC were approached systematically and were based on the findings of the 2003 rapid appraisal study. The approach was designed to focus specifically on communication channels, cultural and religious values, and the social roles of men and women in the community. Interventions included national and regional workshops, training of trainers, community leadership training, community mobilization, Public Declarations, and a religious leaders' forum.

National and Regional Sensitization Workshops

The project was officially launched at a national sensitization workshop in Addis Ababa on December 11 and 12, 2003, which was attended by 40 senior government officials, and representatives of government and non-governmental organizations involved in FGC abandonment. A simultaneous regional

launch of the project took place at each project site for decision makers and community leaders. One of the aims of the workshops was to identify and engage already empowered women to use their voices to raise awareness and gain support from men with political, religious or legal influence, and to encourage them to lead community dialogue in their own districts and villages.



Model courtesy of IntraHealth.

As a result of the national sensitization workshop, a national Anti-FGC Women Leaders Team was founded. Attendees suggested four prominent women leaders to make up the team, who were all present at the launch: the Minister of Women's Affairs, State Minister of Information, Head of the Family Health Department within the Ministry of Health, and Deputy Chairperson of the Women's Affairs Standing Committee. IntraHealth and the project team regularly updated the Women Leaders Team on the strategies, implementation, and results over the course of the project and received guidance and feedback from the team.

“The issue (FGC) is now becoming like a hot thing to discuss. Though the community doesn't like to talk about it, they are compelled to hear and discuss about it for it is a new idea where they started to hear it even in the Mosques. It was then that they commenced to talk and ask each other and whether FGC is the command of Quran or not.”

Focus group discussion participant, 2005.

Training of Trainers

A training of trainers workshop, designed to educate and mobilize regional leaders, established four regional core teams, made up of equal numbers of men and women, which included health providers, gender specialists, lawyers/judges, religious leaders, and teachers/journalists. Trainers experienced in FGC elimination provided six days of instruction in reproductive health, gender, community mobilization techniques, communication skills, advocacy, and monitoring and evaluation methodologies. The group included professionals from all sectors included in the 5-D approach who were available to answer questions of participants. According to one gender specialist at the Harar City training, “Although it was a challenge, and many arguments came up, for every question that people had and for every argument that people presented, there was a specialist ready with a response.”



Women attending the International Women's Day celebrations organized by IntraHealth, NCTPE, and the Harari Women's Affairs Bureau in Harar town (photo courtesy of IntraHealth).

Community Leader Training

The regional core teams went on to train district community core teams made up of 20 community leaders, both men and women, at each of the project sites. In addition to providing information on behavior change and community mobilization techniques, they also assisted in drafting FGC elimination action plans and establishing teams of grassroots community mobilization agents.

Community Mobilization

Each of these grassroots teams was then assigned to mobilize 100 community members representing mothers, fathers, and young unmarried men and women. The community mobilization aimed to close knowledge gaps in the five-dimensions of FGC, help form grass roots action plans, and initiate discussion within families and the community to encourage anti-FGC behavior change.

Activities initiated through community mobilization included: public demonstrations, anti-FGC cultural shows (such as music, drama, singing, and poetry), traditional ceremonies such as slaughtering of sheep, and public anti-FGC declarations. In addition, men and women at the grassroots level initiated and facilitated community dialogue.



The first Anti-FGC Mothers Association created by mothers of 35 non-circumcised girls, Harari Region (photo courtesy of IntraHealth).

A booklet and educational talk show video on the five dimensions of FGC were produced in local languages, to be used primarily as job aids for community education by the regional and district community core teams. The materials focus on health complications, sexual health, human rights, the religious scriptures, gender inequity, access to information, and community dialogue.

Public Declarations

At each site a public declaration to ban FGC was organized by the mobilized community members. Over 2,200 community members participated in the ceremonies. Journalists who were members of the core teams broadcast the public events and project results on national and local radio in the Somali, Harari, and Oromiffa languages.

Forum of Religious Leaders for Advocacy

Given the widespread belief that FGC is required by Islam, the support of influential religious leaders was key to the success of this project. A forum of Muslim and Christian religious leaders, the first of its kind in Ethiopia, was convened to discuss FGC and reach consensus both nationally and locally on

the need to publicly ban FGC. The majority of attendees were Islamic religious leaders and included the Grand Mufti of Islamic Affairs, Higher Islamic Sharia Court; the Imams of prominent mosques; representatives from local Sharia courts; and religious leaders from each of the project sites.

Evaluation/Project Results

In 2005 IntraHealth began the project evaluation by collecting qualitative data from focus group discussions with community members. In addition, the impact of the community mobilization interventions and lessons learned were recorded at an experience-sharing workshop organized by IntraHealth and the NCTPE. District community core teams from each project site attended the workshop, and participants were invited from regional and international organizations involved in the abandonment of FGC in Ethiopia, for the purpose of presenting the project's results and sharing experiences and lessons learned.⁴⁴

Unfortunately, the call for national elections during the final phase of the project impeded IntraHealth's plans to collect quantitative data, as the project's partners and associated women's groups and the communities themselves were involved in preparations for the election. While the lack of quantitative data leaves obvious gaps in measuring impact, IntraHealth has made a considerable effort to provide a detailed picture of how the project has influenced community attitudes and action against FGC. They have recorded details of the project's far-reaching activities, including national and local level advocacy efforts, media coverage, and community mobilization activities, that provide a detailed picture of how the project has influenced community attitudes and action against FGC. In addition, three focus group discussions with the regional core teams were held at the close of the project to discuss knowledge change and capacity building among the project communities.

⁴⁴ Redwan, 2005.

⁴⁵ Phone conversation with Amal Redwan on April 20, 2006.

The project manager for the 5-D Project, Amal Redwan, outlined the following highlights and successes of the project:⁴⁵

- Penal code making FGC punishable by law, drafted by a member of the Anti-FGC Women Leaders' Team, was enacted by the Ethiopian parliament in July 2004;
- A consensus by 83 prominent national and religious leaders in June 2004 to unanimously criminalize and ban clitoridectomy, excision, and infibulation;
- More than 4,200 community members gaining five-dimensional FGC knowledge via the project's workshops, training events, community mobilization activities, public declarations, or information, education, and communication interventions and materials;
- Public promises to cease performing FGC by seven well-known circumcisers who had practiced FGC for more than 15 years; and
- 2,252 community members agreeing to ban FGC at public declarations.

In addition,

- More than 120 religious leaders, political leaders, and influential elders made public anti-FGC declarations.
- The Imams at each of Jijiga's 13 mosques made anti-FGC religious proclamations at Friday prayers and sent an official circular to all nine zones of the Somali region urging religious leaders at all levels, including mosques and district Islamic Affairs and Sharia courts to apply the religious law against FGC immediately;
- Regular media coverage of community mobilization activities appeared on national radio and television, and in print throughout the project. IntraHealth and the five-dimensional approach continue to receive media coverage as new events resulting from the project occur. In April



At top: Sister Entisar Ahmed training community leaders on the health aspects of FGC. **At bottom:** A member of the local women's association participating in training of local community leaders in Jijiga town, Somali Region (photos courtesy of IntraHealth).

2006, a program describing the five-dimensional FGC initiative was broadcast on national television during "Women's Perspectives" for two consecutive Saturdays; and

- Anti-FGC rules and penalties were written and publicly declared at three sites (Jijiga City, Manna District, Awemer Peasant Association) and FGC was publicly banned by political leaders at two sites (Harar City and Burqa Peasant Association).



International Women's Day celebrations organized by IntraHealth, NCTPE, and the Harari Women's Affairs Bureau in Harar town, Harari Region (photo courtesy of IntraHealth).

While all these findings are pointed to as important indicators of the project's success, another impressive achievement of the five-dimensional approach is its sustainability and adoption by other organizations. In an effort to maintain and build upon the successes of the five-dimensional approach when its funding ended, IntraHealth created a number of linkages to encourage sustainability of the projects goals, including:

- In October 2005, a 5-D Board Team was created, which established itself as an NGO called Somali Women Development Organization (SOWDO). This grassroots organization, run by a midwife, a lawyer, a religious leader, two gender experts, and a communication expert—all from the Somali region—continues to provide training on the five-dimensional approach for FGC eradication to other groups and community members.
- In the Harari region the project led to the formation of the first Anti-FGC Mothers' Association. These women have stated they want to be role models for other mothers wishing to protect their

daughters from FGC. Their daughters, who numbered 35 at the association's inception, formed the first Association of Non-Circumcised Girls. By the end of the project membership had risen to 70. Both mothers' and girls' associations are supported by a United Nations Development Programme (UNDP) micro-finance program in conjunction with the Harari Women's Affairs Bureau.

- IntraHealth also linked with the Somali Women Self-Help Association (SOWSHA) located in Jijiga town. Founded by a Somali midwife several years prior to the introduction of IntraHealth's FGC project, this association trains former excisors to become traditional birth attendants, or helps them to become financially independent in other ways, for example, through training in the production and sale of handicrafts. SOWDO, the local NGO established by the 5-D Board Team, has trained SOWSHA's members in the five-dimensional approach and seven former excisors have publicly declared they have stopped practicing FGC and now act as advocates for FGC abandonment by conducting anti-FGC trainings with excisors from other districts.
- The NCTPE, co-implementer of this project, has continued to expand the 5-D approach nationwide and is implementing a three-year project on FGC and other harmful traditional practices in partnership with the national Women's Affairs Bureau, the Ethiopian Women Lawyers Association, and UNICEF.
- The African Development and Aid Association has also adopted the five-dimensional approach and is preparing to use IntraHealth's training manuals and 5-D FGC booklet in other Oromia regions in Ethiopia. In addition, several other regional, nation and international organizations have asked Regional Core Teams to provide training to groups in other communities.

Lessons Learned

Feedback from the focus group discussions with the Regional Core Teams and the end of project experience-sharing workshop helped IntraHealth and the NCTPE to identify a number of key components, which they believe are crucial to the success of the Five-Dimensional Approach for the Eradication of FGC in Ethiopia:

- Design intervention activities based on community needs, strengths, and recommendations;
 - Provide information from a multi-dimensional perspective;
 - Ensure the transfer of project ownership and leadership;
 - Provide audiovisual and interactive training materials and job aids;
 - Focus on stopping the demand for FGC;
 - Bridge information and communication gaps simultaneously among fathers, mothers, young women, and young men to minimize misunderstandings. Encourage intra-familial/community discussion of FGC; and promote understanding and support for community behavioral change;
 - Respect socio-cultural values and settings when implementing activities;
 - Mobilize and train teams of individuals from the local community with expertise, such as health providers, traditional birth attendants, gender specialists, lawyers, religious leaders, journalists, and teachers;
 - Use traditional information and communication channels; and
- Join with government and non-governmental organizations, such as Regional Health Bureaus and Women's Affairs Bureaus, which are generally respected and trusted by the community, to implement common activities, share information on FGC eradication, strengthen cooperation, and avoid competition and duplication.

"I was highly motivated by the chance to break the ice on FGC and start community dialogue on a topic that was kept taboo for more than a millennium in Ethiopia. I feel rewarded to see that FGC, which was a "women's issue" and was neglected by men for so long, now concerns both men and women who finally talk about their reproductive and sexual health openly even on national television!"

Amal Redwan, IntraHealth Project Manager

Although IntraHealth no longer oversees the Five-Dimensional Approach to FGC Eradication in Ethiopia, it has clearly left a strong legacy. Not only did the project have a considerable impact on knowledge and attitudes toward FGC in the project communities, it also achieved much wider success. By motivating and organizing political and religious leaders to speak out and take action against FGC, the project contributed to the passing of a new law against FGC. In addition, the large number of ongoing activities and numerous organizations that continue to implement the 5-D approach are further testimony to the achievement and sustainability of this project.

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CHAPTER 4

Tostan: The Community Empowerment Program

There is probably no intervention anywhere that is better known for its impact on female genital cutting than the Community Empowerment Program (CEP) developed by the NGO Tostan. But, ironically, FGC abandonment is not the stated objective of this cross-cutting program. In fact, the program, in which democracy and human rights education provide a foundation for community development, also addresses hygiene, health, literacy, and management skills over the course of two to three years. Above all else, Tostan is a learning organization that is constantly evolving. “If someone were to take a look at our program eight years ago and take another look at it today, they would see a program that has changed a lot, based on the lessons we have learned,” according to Molly Melching, Tostan’s director.

Objective and Organizational Description

Tostan, which means “breakthrough” (as in the hatching of an egg) in the Wolof language, focuses on empowering villagers to take charge of their own development and to participate fully in society. Established in 1991, Tostan’s Community Empowerment Program started in Senegal and has since expanded to six other African countries. Tostan’s mission is “to empower African communities to bring about positive sustainable development through a comprehensive non-formal education program in local languages.”

Tostan has *directly* reached more than 130,000 African people, and perhaps more than a million if all those impacted by the Public Declarations are counted. It has been a critical voice in the movement to abandon female genital cutting.

Background

The Tostan Basic Education Program has its roots in a center created for Senegalese children in 1976, the *Demb ak Tey* (“Yesterday and Today”) Resource Center in Dakar. The center promoted non-formal education for Senegalese children through books, theater, puppetry, games and art activities based on African traditions and in the national language

Senegal



From CIA, *The World Factbook* www.cia.gov/cia/publications/factbook/geos/sg.html

spoken by 71% of the population, Wolof. Bollé Mbaye, a Senegalese actor and specialist in oral traditions, and Molly Melching, an American educator who received her Master’s Certificate from the University of Dakar and subsequently joined the Peace Corps, started the Center under the auspices of the Ministry of Culture of the Government of Senegal.

Tostan—The Organization

Number of people

involved in the project: 59 paid staff, multiple partners, 500+ community facilitators

Budget range: Typically between \$3,000 and \$5,000 per year in each direct implementation community

Funding sources: Hundreds of private contributors, government partners, foundations, and multilateral organizations, including American Jewish World Service, the Swedish International Development Agency, UNICEF, and USAID

Working languages: Wolof, Fulani (Senegal), Fulani (Guinea), Mandinka (Senegal), Malinke (Guinea), Serere, Bambara, Soninke, Diola, Moore, Soussou, and Arabic

Part of the Center’s activities involved a one-hour weekly children’s radio program in Wolof that reached thousands from 1978 through 1982. Messages on health, the environment and other community development issues were included in the stories, songs, games, and plays. This popular program not only attracted children but also adults by using cultural traditions to present new knowledge. It soon became a catalyst for discussions in many rural villages of Senegal.

From there, the project moved to a small village of 300 people, Saam Njaay. Using cultural traditions to provide information, they worked with the villagers to improve living conditions—what is now popularly labeled “participatory development.” The sessions developed with the villagers were later incorporated into a comprehensive community education program funded by USAID and, in 1987, implemented by eight non-governmental organizations (NGOs) in the region of Kaolack. Over the next few years, the success of this program led UNICEF/Senegal to support further development and extension of this program to hundreds of other communities in many regions of the country. In 1991, Tostan was established as an NGO.

Prevalence and Impact

While Tostan is headquartered in Senegal, it has also worked in other African countries, including Burkina Faso, Mali, and the Sudan, and is currently actively moving into Guinea.

According to the most recent DHS data, the total prevalence of FGC among women ages 15-49 in Senegal in 2005 is 28.2 percent (in urban areas it is 21.7 percent and in rural areas 34.4 percent).⁴⁶ When broken down by age group, the prevalence among 15-19 year olds is 24.8 percent and gradually increases by age groups (20-24, 25-29, etc.) up to a prevalence of 30.6 percent for 45-49 year olds, a trend that could be interpreted as demonstrating that FGC abandonment efforts in Senegal are having an effect. In many of the regions in Senegal where Tostan works, the prevalence rate is generally about 90 percent. The Kolda region, for example, has a prevalence of about 93.8 percent, according to the DHS.⁴⁷

FGC in Senegal has typically involved Type 1, Type 2, and Type 3 (the most severe type—similar to infibulation, but with a slight deviation where the vaginal opening is sealed rather than sewn). The average age of the girls who undergo FGC varies by ethnic group, with 1/3 of the girls cut just after birth, another third before the age of six, and the remaining third cut by adolescence.⁴⁸

Tostan faces an even greater challenge as it moves into Guinea. According to 2005 DHS figures, 95.6 percent of girls in Guinea have undergone FGC.⁴⁹

46 Senegal 2005, DHS Final Report (www.measuredhs.com); see also UNICEF, *Female Genital Mutilation/Cutting: A Statistical Exploration* (New York, 2005).

47 See www.measuredhs.com/pubs/pdf/FR177/13Chapitre13.pdf, accessed online Oct. 1, 2006.

48 GTZ, *Female Genital Mutilation in Senegal*, www.gtz.de/de/dokumente/en-fgm-countries-senegal.pdf, accessed online Oct. 1, 2006.

49 See www.measuredhs.com/pubs/pdf/FR162/14Chapter14.pdf, accessed online Oct. 1, 2006.

Project Audience

To date, Tostan has worked mainly in rural communities, although there are test programs currently underway to adapt the model to large urban areas. In Senegal, while some men may participate, Tostan has worked predominantly with women. In Guinea, the classes are divided 50/50 between men and women. Tostan's classes in both countries are typically composed of participants of all ages, from adolescents to elders. In Senegal, each community now has an adult class and a separate adolescent class.

While it is difficult to put an exact number on how many people have participated in Tostan's projects in the last decade, Tostan estimates that it has been an average of 60 participants per community and the Tostan Community Empowerment Project has been carried out in approximately 2,000 villages.

As of July 2006, Tostan estimated that its work has led to the abandonment of FGC by 1,748 communities or over 33 percent of the 5,000 communities in Senegal that practiced FGC in 1997.⁵⁰

Rationale for FGC

Asked to rank the reasons given for the continuation of this harmful traditional practice, Tostan representatives have said the main reasons people give are marriage prospects, religion, and preservation of virginity. However, Tostan believes that the true cause of the practice is that it is a social convention carried out to ensure membership in the community.

This belief is based on the social convention theory of FGC advanced by Dr. Gerry Mackie, a professor at the University of California San Diego. In 1996, Mackie, while an Oxford research fellow, argued in an *American Sociological Review* article, that FGC, though centuries old, would end very quickly once people began abandoning the practice collectively.



Fulani women at an inter-village meeting (photo courtesy of Tostan).

Mackie stated that FGC is analogous to the practice of foot-binding in China, which ended abruptly at the close of the 20th century when a coordinated movement allowed intra-marrying groups to collectively pledge to end the practice. Mackie believes that this coordinated abandonment was the only way for Chinese parents to ensure the marriageability of their daughters. (see box on page 34). In the same way, Mackie argues that FGC is a social convention which can only end when intra-marrying groups pledge to collectively abandon the practice.

The Tostan Method

The Tostan Method consists of over 200 sessions in five modules taught over a two- to three-year period. Molly Melching emphasizes the importance of the modules' sequence because the sessions build on one another and are inter-related.

The modules are divided into two parts: The *Kobi* and the *Aawde*. The *Kobi*, which means "to prepare the field for planting" in Mandinka, is composed of the following modules:

⁵⁰ Interview with Gannon Gillespie and Molly Melching in Washington, DC, April 6, 2006.



Girls at a Public Declaration in Senthieu Malem in December 2004 (photo courtesy of Tostan).

- Democracy, Human Rights, and Responsibilities (48 sessions);
- The Problem-Solving Process (7 sessions); and
- Hygiene and Health (48 sessions).

The three modules in the Kobi include specific sessions for discussions on child marriage, childbearing, STIs, and FGC.

The *Aawde*, which means “to plant the seed” in Fulani, generally takes place in the second and third years. It consists of modules on:

- Literacy, Math, and Management Skills; and
- Reinforcement of themes from the Kobi through interactive literacy workbooks.

There are two workbooks: *“From Knowledge to Action 1: Democracy, Human Rights and Problem Solving”* and *“From Knowledge to Action 2: Hygiene and Health.”*

If 60 people participate in the Tostan program in each community, the group is normally divided into two classes of about 30. Each session lasts two to three hours and sessions are held every other day. The class arrangements (classroom, lodging, food for the facilitator, etc.) are decided and arranged by the participants. The facilitator is generally 20-40

years old and may be a man or a woman.

These details are a very critical part of the Tostan method, which is based on community ownership and the following six essential characteristics:

- Trustworthy—credible information is provided to participants, who test and verify the reliability of the information throughout the program, creating an environment of trust;
- Trusting—the program believes people will make the right decision when given good information;
- Learner-centered—involves participants with little or no formal schooling through theater, games, song, etc.;
- Holistic—the comprehensive program covers areas from hygiene and health to literacy training and micro-credit;
- Practical—participants use knowledge gained to solve problems and implement projects together;
- Respectful—teaching methods are based on African tradition of respectful consultation of all those concerned.

Tostan’s main focus is on helping communities achieve their goals, not on “targeting” a single development issue or opposing individual harmful traditional practices. “Tostan’s program is holistic—it addresses many issues, from human rights to health, and from literacy to small projects. It doesn’t start with or focus on FGC,” according to Molly Melching.

Even Tostan’s insistence on the use of the term “female genital cutting,” rather than mutilation, is reflective of its philosophy. Tostan avoids language or images which could humiliate, shock or upset people. “Words are important in the Tostan program. We use excision or FGC instead of mutilation because ‘mutilation’ is judgmental and implies an intent to harm, which is not the case,” she says. Tostan also rejects the use of shocking images or negative messages, preferring instead to speak of

“promoting” health and human rights not “fighting against” a harmful tradition.

Organized diffusion

Over the past 20 years Tostan has developed a system whereby knowledge from its program radiates out to encompass wider circles of people via a process called *organized diffusion*. Class participants share their new-found knowledge with others through an “adopt a learner” strategy. This can be a friend, relative, husband or village leader. Participants and adopted learners use theater, songs, and events to share with the rest of their community. This new knowledge is then passed on to surrounding villages, particularly those with whom they intermarry, are close to, or share space with, such as at wells or markets. Tostan helps to facilitate intervillage meetings that allow further discussion and consensus building on issues that require interdependent decisions such as ending FGC and child marriage.

In Tostan’s experience, communities often make the choice to abandon these harmful traditional practices and organize Public Declarations to mark the change in convention. The Public Declarations, which have received much publicity through NGO networks and media, only came about after the development of a human rights and women’s health module in 1996, when participants in the Tostan program themselves insisted on the addition of sessions addressing FGC to the module. Upon initial implementation of this module in 1997, the communities of Malicounda Bambara and Nguerigne Bambara decided to stop practicing FGC.

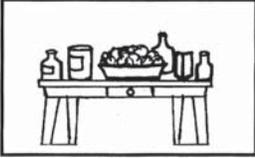
This historic decision quickly became a movement in large part due to the efforts of one local Imam, or religious leader: Demba Diawara. After hearing of the women in neighboring villages who had abandoned FGC, Demba was inspired to learn more about the practice that was rarely discussed in the presence of men. Although swayed by the suffering of the women, the Imam was concerned that if parents in one village were to abandon FGC, their daughters would be unable to marry

FIGURE 4
Tostan Workbook

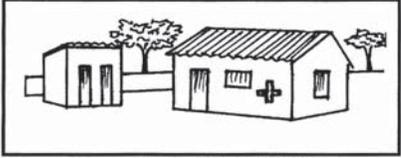
JOJJANDE E CELLAL

Nat doo natal kolliroowal ndee jojjannde.

Wonande tuugnorde adunayanƙooje jowitiide e jojjandi aadee, kala biɗɗo leydi ina jogii jojjannde e cellal. Duum ina soomi :



safaara



nokkuuji cafrordi



waawde yimbe ɓe ɓof yottaade nokkuuji cafrordi

Rewɓe ɓe kadi ina poti waawde yottaade nokkuuji cafrordi di so ɓe cowiima, so ebe njibina e caggal nde ɓe njibini (hay so tawii ɓe mbaawaa yofde yo ɓe newnane). Eɓe poti kadi heɓde ɓaamde timmunde so ɓe cowiima e so ɓe muynina. Eɓe njogii kadi jojjannde e heɓde kabaruuji peewtudi e palaaniin familiyaal ngam reende cellal mumen e cellal sukaaɓe mumen.

safaara : ɓaawndoode
nokkuuji cafrordi : cuudi ɓaawndirdi

49

Page in the Pulaar language from a Tostan workbook on the human right to health.

men from another, unless that village also abandoned. Demba walked to 10 villages where his community marries and discussed the issue with traditional and religious leaders, health care workers, men, and women. His visits resulted in 13 communities organizing the first Public Declaration for collective FGC abandonment, the Diabougou Declaration of February 14, 1998. Since that time, more than 1,700 communities

Ending Footbinding and FGC

What do footbinding in China and FGC in Africa have in common? Quite a bit, according to Gerry Mackie, a professor at the University of California in San Diego. As he describes in his article "A Way to End Female Genital Cutting" (1998):

"Footbinding and FGC are essentially equivalent practices, and originate from similar causes.... Footbinding and FGC persist because of the same convention mechanism. Footbinding lasted for a thousand years, was universal among all "decent" Chinese, and was undented by liberal agitation and imperial prohibition in the 19th century. However, footbinding ended in less than a generation. ...[I]t ended suddenly and universally, just as the convention model predicts. Therefore, the methods used to end footbinding in China should work to end FGC in Africa."

There were three critical factors in ending footbinding, according to Mackie: an education campaign; information about the negative health consequences; and the formation of natural-foot societies, whose members "publicly pledged not to bind their daughters' feet nor to let their sons marry women with bound feet."

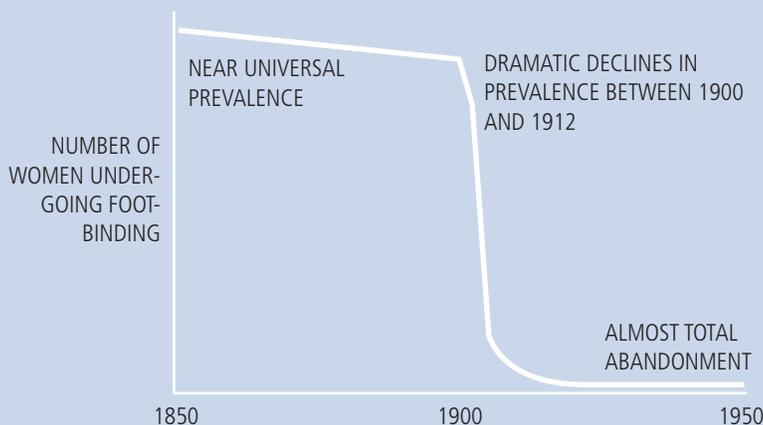
The first anti-footbinding society was founded in 1874, but a larger movement didn't begin until 1895, with the Anti-footbinding Society in Shanghai. "The pledge societies, and the cessation of footbinding, spread like a prairie fire." After 1,000 years of tradition, footbinding ended in one generation. By 1908, Chinese public opinion was decisively anti-footbinding, and by 1911 urban children no longer had their feet bound.

"Footbinding and FGC are each a special kind of convention such that either nearly everyone does it or no one does it," Mackie says, "so that when it ends it must end quickly."

Mackie also uses game theory, the Schelling Diagram and the Nash Equilibrium theory to explain the concepts behind organized diffusion. Perhaps the clearest demonstration of inter-dependent decisionmaking is the shift in Sweden in 1967 from driving on the left side of the road to the right. As explained by Gannon Gillespie, while this is a convention shift, you cannot change the convention one individual at a time as the consequences would be obvious. "All need to change. None could change without coordinated abandonment."

Gerry Mackie adds, "That's why FGC programs in Africa have often changed attitudes but not behaviors." It is Tostan's process of coordinated abandonment among intra-marrying villages that has led to the end of FGC through Public Declaration in communities throughout Senegal.

Model 1: The Decline of Foot-binding in China, 1850–1950



have publicly abandoned FGC after participating in the Tostan education program or ensuing social mobilization activities.

However, the Public Declaration is not the end of the process. Tostan has learned in the eight years of Public Declarations that, while these celebrations are important events for establishing a shift of convention, they do not always immediately lead to 100 percent abandonment by a community. Rather they demonstrate that a critical mass of people are abandoning and are publicly encouraging others to do the same for the first time. "New ideas always have early adopters and resisters," according to Tostan's director. "If 40 percent in the community do abandon after the Public Declaration, that may constitute enough people to influence others and lead to a tipping point where all will abandon."

"What matters is that everyone is watching this happen. The Public Declaration wipes out the concerns about the consequences of abandonment and shows a new way to go, a new alternative."

Evaluations

Tostan's work in Senegal has undergone a number of evaluations, including: by FRONTIERS from 2000 to 2003, by the Government of Senegal in 2004, by the Swiss Tropical Institute in early 2006, and one currently being undertaken by UNICEF and Measure DHS/Macro, with Population Council/FRONTIERS and the Center for Research on Human Development. This current evaluation, which ends in December 2006 and will be published in 2007, is measuring impact in those communities of the Kolda and Thies region of Senegal where the first declarations were held more than eight years ago. While shedding some much needed light on the long-term impact of the Tostan approach, it will also be measuring the impact of an approach and content that has changed considerably over the last eight years.

FRONTIERS' Evaluation

From 2000 to 2003, Population Council/FRONTIERS carried out an evaluation of the effect of Tostan's community-based education program on awareness, attitudes, and behavior regarding reproductive health and female genital cutting. The respondents were men and women in 20 villages in the intervention area (some of whom had participated in the program as well as some who had not). The comparison group consisted of men and women in 20 non-intervention villages. FRONTIERS measured changes using pre- and post-intervention surveys as well as qualitative interviews with key community members. They also assessed, pre- and post-intervention, the number of girls under 10 who had been cut.

Tostan's education program was found to have had a significant effect on knowledge about human rights and gender-based violence. As for its effect on FGC, the evaluation concluded that as a result of the Tostan program:

1. Knowledge about FGC increased;
2. The proportion of girls aged 10 and under NOT cut increased; and
3. Approval of FGC and intent to cut girls decreased significantly (see table 1).

This evaluation predated the addition of a second phase by Tostan that includes a greater focus on literacy, math, and project management skills. It took place not long after the Public Declaration of 300 villages in the Kolda region in 2002.

TABLE 1
Attitudes of Women and Men toward FGC

	Intervention group			Comparison group	
	Baseline	Endline		Baseline	Endline
		Participant	Nonparticipant		
Women (n)	576	333	200	199	200
Approve of FGC	72	16*	28*	89	60*
Will cut daughters in the future	71	12*	23*	89	54*
Men (n)	373	82	185	184	198
Will cut daughters in the future	66	13*	32*	78	56*
Prefer a woman who has been cut	—	20	40	—	63

* $p < 0.05$

From *Senegal: Community Education Program Increases Dialogue on FGC. FRONTIERS OR Summary 54*. Washington, DC: Population Council, 2005.

Evaluation by Government of Senegal

This evaluation of Tostan's non-formal education program in the regions of Ziguinchor, Tambacounda, Kolda, and Matam was conducted by the Government of Senegal from December 1 to 30, 2004.

The evaluation had very specific objectives, including:

- To estimate the level of knowledge acquired in relation to the materials supplied (workbooks one and two);
- To evaluate the effects and impacts of the program; and
- To identify insufficiencies in the implementation of the program, with the hope of improving the programs implementation and management.

The methodology used included a sampling of 24 sites, taken from the 110 project sites in the region under evaluation. Researchers developed focus group interview guides and a total of 693 students participated in the focus groups. In addition, social mobilization was evaluated through interviews with 168 leaders in community focus groups and 288 participants in focus groups of Community Management Committees.



Class participants presenting posters on human rights and responsibilities (photo courtesy of Tostan).

The Senegal Government's evaluation concluded that:

- About 83 percent of the 24 communities visited had abandoned excision and forced/child marriages. Only two communities did not;⁵¹
- The functional literacy classes reached 693 participants in the four regions;
- 50 percent of participants successfully completed workbook one and 67 percent successfully completed workbook two (which included sections on hygiene and health); and
- Literacy program attendance among the female target group was high; participants attended 80 percent of the classes.

“These results are very satisfactory for Tostan's non-formal education program,” the government's evaluation stated. “Tostan can affirm that its objectives have been largely met, and that its program has had a real impact on participating communities. Social changes in participating communities have resulted not only in improvements in health for women and children, but also in a greater respect for human rights. The noted effects of the program are largely due to the motivation and organization of participants, the devotion of Tostan, and the involvement of administrative and local authorities in the program.”

Evaluation of Tostan in the Matam and St. Louis Regions of Senegal

This evaluation was undertaken in January 2006 by a member of the Swiss Centre for International Health of the Swiss Tropical Institute, Claudia Kessler. The main purpose of this evaluation was to assess Tostan's effectiveness, based on mid-term data, in a project covering 40 communities of the Matam and St. Louis regions in Northern Senegal since 2004. Kessler used a mainly qualitative approach, engaging in interviews and discussions with Tostan staff at various levels, as well as local authorities, program participants, and other villagers.

In a 2004 baseline study conducted by Tostan, it appeared that all 40 villages targeted by the project interventions had limited infrastructure and difficult access to health services and educational opportunities. Knowledge of health, human rights, and problem solving was weak, and FGC and early marriage (from 12 years of age) were universal.

The Kessler evaluation credited the Tostan program with the abandonment of FGC and child marriage by 70 villages in November 2005 through the Public Declaration of Sedo Abass. Discussions with villagers, authorities, associations, and former cutters “confirmed that in the villages that had joined the declaration a definite change in attitudes has been achieved, particularly with

51 There is no indication in the Government's written evaluation of how the government reached this determination. The table containing this information merely indicates 'yes' or 'no' to abandonment by community without any indication of population size, etc.

regard to gender-based violence, FGC, and early marriage.” The evaluation found no consensus on FGC abandonment in the project villages that had not participated in the declaration, but discussion about it seemed to be more widespread.

Outcomes noted by Kessler include positive results in health, education, and the environment; for example, during the Tostan program 13,459 vaccinations occurred, 1,300 women went for antenatal consultations, and 2,326 children obtained birth registration papers. From the interviews, it was clear that knowledge of human rights and women’s status had been elevated, particularly in the villages surrounding one of the participating communities, Sedo Abass. Moreover, interviews showed that many of the Tostan participants had opened bank accounts for the first time and engaged in income-generating activities. Many village participants now have basic writing and calculation skills, and school enrollment has improved for both boys and girls.

No final impact data had yet been collected, the evaluator points out, since the project does not end until mid-2007.

Lessons Learned

Tostan’s staff has learned many valuable lessons from the many years the organization has implemented its non-formal education program, and has constantly revised and updated program content and methodology based on learner feedback.

“We’ve learned that it’s important to begin the program with a year of consciousness-raising sessions that allow all the community to be involved in discussions and dialogue about human rights and responsibilities,” according to Molly Melching. “Women in particular need time and space to reflect and analyze before taking action and the classes allow this opportunity. The literacy and management classes for economic empower-

ment are only introduced in the second year after participants are confident, active, and anxious to continue learning.”



The reading of the declaration in French at the Kidira Public Declaration in March 2006 (photo courtesy of Tostan).

Other lessons include:

- *Adolescents:* Previously, Tostan mainly worked with adult learners in participating communities. The young people of the community who often are not able to attend formal school were left out, causing a gap in communication and understanding between the older and younger generations. Even in villages that had decided to abandon the practice of FGC, young girls were asking to be cut because they had not been part of the process. Tostan now opens one adult and one adolescent class in every community to ensure intergenerational dialogue and consensus around these important issues. Since this change two years ago, the adolescents in the classes appear to be more engaged and empowered, particularly when it comes to the human rights issues, and have gone on to organize around certain issues, holding national adolescent forums to support ending FGC and child marriage.

- *Public Declarations:* The Public Declarations must involve the whole community, from youth to elders and traditional and religious leaders. Moreover, some of the villages that have been represented at the Public Declarations have not actually undergone the Tostan program and need further educational support to reinforce their community's decision. Tostan now sends evaluation teams to be certain that all communities signed up for the declaration are fully aware of what the declaration signifies.
- *Tipping Point:* While a public declaration may not achieve 100 percent abandonment in a given community, this is not necessarily critical in a social movement of this type, Gerry Mackie underscores. What is important is that at some point the change will reach a critical mass of people who support abandonment and influence others' attitudes. This can lead to a "tipping point" in which a convention shift occurs and FGC quickly becomes a thing of the past.
- *Mapping of Communities:* Tostan now works with villagers to map their networks of locally connected communities before project implementation. This can yield important information such as where the villages intra-marry, which communities come to the same markets, and who the influential political and religious leaders are in the area.

Next Steps

Tostan is now strengthening its organization and finalizing its program content in order to respond to requests for training from other organizations and countries. In 2006, Tostan has already extended its program in West and East Africa in collaboration with UNICEF and other international partners such as the Swedish International Development Agency. Tostan is partnering with UNICEF to bring its comprehensive program to more than 80 communities in The Gambia and Somalia, reaching about 4,000 participants directly, and impacting more than 50,000 people indirectly through organized diffusion. In each new country, Tostan partners with local NGOs to coach them through program implementation so that they may continue independently after the first training cycle.

Tostan is also now conducting research in three cities in Guinea to assess the ways in which people make decisions in urban centers. This will allow Tostan to adapt its program strategies for non-rural populations.

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CHAPTER 5

Conclusion

The goal of this publication is to provide detailed information on the FGM/C abandonment interventions that meet the four criteria set forth by the collaborating partners in this project. These criteria are that the interventions:

- Have a positive tangible impact
- Have potential for replication
- Foster effective partnerships
- Demonstrate sustainability

While much has already been written about the three highlighted interventions, it is the hope of the authors that both the detailed descriptions of the interventions and the evaluations measuring their impact will be useful to program planners and managers. Those working in the field have asked repeatedly for information on well-designed projects from which valid conclusions concerning their effectiveness can be drawn. And while, as we pointed out in Chapter 1, not all of the cases highlighted here have employed the most stringent measures in their evaluations, the authors believe that they do add significantly to the body of knowledge.

Lessons Learned

IntraHealth, Navrongo, and Tostan are different in many ways, and those differences will no doubt yield further discussion. IntraHealth focuses on FGM/C specifically, while Tostan makes it a point not to. IntraHealth bridges information and communication gaps simultaneously among fathers, mothers, young women, and young men, while Tostan has learned that having youth-specific groups is very important. Navrongo had a project duration of five years, while IntraHealth's was two years, and Tostan's duration varies with the region in which it is working.

Yet, their commonalities provide many important lessons and perhaps the most important of these commonalities is that all three of these interventions emphasize community involvement. Some of the sub-lessons of community involvement include:

- An intervention must be centered on community needs, strengths, and recommendations;
- Project ownership must be transferred to the community;
- Individuals from the communities should be employed as trainers and agents of change;
- Socio-cultural values and settings should be respected when implementing activities; and
- Organizations must earn communities' trust in order to overcome resistance to sensitive discussions of FGM/C.

Other lessons drawn from the successes of these interventions are:

- Information should be multi-dimensional;
- Creative materials and methods are often effective, including media and the arts;
- Development champions may be indispensable to social change; and
- Long-term funding is needed if interventions that result in FGM/C abandonment are to lead to sustainable changes.

Unexpected Outcomes

Experience has shown that interventions that focus solely on the negative health consequences of FGM/C, or laws that ban FGM/C without any accompanying information, education, and communication, may well have the effect of changing people's attitudes toward FGM/C, but in ways that are not desirable or conducive to the abandonment of the practice.

The possible consequences of such approaches may include medicalization of FGM/C, the lowering of the age at which girls are cut, taking girls to neighboring countries for the procedure, and other attempts to hide the practice. It is important for program managers to monitor these changes and incorporate strategies to address these issues in the design of new interventions.

Lessons Learned on Evaluation

Navrongo's evaluation was the most scientifically rigorous and Navrongo researchers offer the following lessons pertaining to evaluation:

- A multi-phased approach is useful and should include:
 - A diagnostic phase to understand and assess the level of FGM and its underlying rationale;
 - A pilot phase in which the community is involved through participatory learning techniques in the planning of intervention strategies; and
 - An experimental phase, where interventions are introduced to randomly selected communities over time.
- Inconsistent or inaccurate reporting by girls (or their mothers) on whether they had been cut can be an impediment to an accurate evaluation of effectiveness.

Problems with Data Collection

This last point, regarding the problem of inconsistent or inaccurate reporting, is one that many interventions focusing on FGM/C abandonment

have encountered. The definitive indication of successful abandonment strategies is a sustained decrease in the prevalence of FGM/C. However, given the personal nature of the practice there are obvious ethical and practical limitations to the way FGM/C incidence can be measured. Researchers usually rely on questionnaires that ask mothers about the FGM/C status of their daughters or, if the practice takes place during adolescence, girls may be asked to indicate their own status. The problem with this method is that girls and mothers may inaccurately report or deny having ever been cut for several reasons, including fear of prosecution where the practice has been made illegal; recognition that the elimination of FGM/C is the desired outcome; and awareness that societal norms around FGM/C may be changing and the practice is no longer favored by community leaders.

Nevertheless, it is imperative that researchers continue in their efforts to measure impact. As stated by Ian Askew in his article on methodological issues in measuring FGM/C, "concerted behaviour change efforts to encourage abandonment of the practice need to be informed by empirical evidence, and to be evaluated using strong research designs. A better understanding of research methods, and operations research in particular, can contribute to this end."⁵²

Resources

Askew, I. "Methodological Issues in Measuring the Impact of Interventions Against Female Genital Cutting" in *Culture, Health & Sexuality* 7, no. 5 (2005): 463-477.

Population Council/Frontiers. *Using Operations Research to Strengthen Programmes for Encouraging Abandonment of Female Genital Cutting: Report of the Consultative Meeting on Methodological Issues for FGC Research, April 9 – 11 2002*. Nairobi, Kenya. Accessible online at: http://www.popcouncil.org/pdfs/frontiers/nairobi_fgcmgtg.pdf

⁵² Askew, I. 2005, p. 475.

APPENDIX I

A Collaboration: Filling the Gaps

In December 2002, the Female Genital Cutting Interagency Working Group of the U.S. Agency for International Development (USAID) threw down the gauntlet to organizations working on abandonment of female genital mutilation/cutting: focus on managing the information available and filling whatever information gaps exist. In the nearly five years since then, five groups—the Population Reference Bureau, Population Council, PATH, the Manoff Group, and Family Health International—have been working together to meet that challenge. Following numerous surveys, questionnaires, and in-country interviews, three products have been produced. “Information on Female Genital Cutting: What Is Out There? What Is Needed?” was released in July 2004. In August 2005, a CD-ROM entitled “Abandoning Female Genital Mutilation/Cutting: Information From Around the World” was produced. And finally, this publication takes an in-depth look at three promising approaches.

What Is Out There? What Is Needed?

From July 2003 to July 2004, PRB, FHI, PATH, Population Council, and The Manoff Group, researched the availability and accessibility of information, as well as the information gaps. The five groups sent out hundreds of queries using an innovative internet tool, Survey Monkey, in addition to conducting face-to-face interviews and focus groups in eight African countries where FGM/C is

practiced: Burkina Faso, Egypt, Ethiopia, Guinea, Kenya, Mali, Senegal, and Uganda. Dozens of websites and databases were reviewed. In the end, nearly 300 completed surveys were received from individuals and organizations working around the world toward the abandonment of FGM/C.

The resulting assessment, “Information on Female Genital Cutting: What Is Out There? What Is Needed?”⁵² revealed that there was nearly universal consensus among those answering the survey that more information is needed about all aspects of the practice of FGM/C, but especially regarding best practices and evaluation results. Respondents repeatedly called for more networking on “successful attempts and strategies,” “exchange of experiences and good practices in order to create synergy,” and “case studies to illustrate what is working and what is not.”

Information From Around the World: A CD-ROM

One information gap that respondents revealed was that existing publications and Internet resources were often not reaching them. Many of the websites that had been assessed by the five groups were not user friendly, and many of those working on this issue had difficulty accessing the Internet. As a result, a USAID-funded CD-ROM, *Abandoning Female Genital Mutilation/Cutting: Information From Around the World* was produced

52 This report is available in English, French, and Arabic at <http://www.prb.org/Template.cfm?Section=PRB&template=/ContentManagement/ContentDisplay.cfm&ContentID=13789>.

by PRB.⁵³ This product gathered information about specific approaches and practices from 20 countries, in addition to statistical and policy information. It was widely distributed and created an important database for the next endeavor: to respond to the request for more information on interventions that have been proven effective in bringing about the abandonment of FGM/C.⁵⁴

Identifying Best Practices

In July 2005, the five groups turned to creating this publication. With its publication, the collaborative process has resulted in in-depth descriptions of Promising Practices that will, it is hoped, prove useful to organizations working toward the abandonment of FGM/C.

⁵³ A description of this CD-ROM can be found at http://www.prb.org/Template.cfm?Section=By_Topic&template=/Ecommerce/ProductDisplay.cfm&ProductID=407 and can be ordered by emailing prborders@prb.org.

⁵⁴ While this began as a “Best Practices” publication, along the way it would become clear that the title itself was becoming a problem and we would later decide to rename the highlighted cases as “Promising Practices.”

APPENDIX II

Questionnaire

Questionnaire

Initiatives Promoting the Abandonment of Female Genital Mutilation/Cutting

Name of organization:

Location of the FGM/C abandonment project:

Country:

Region:

City/Town/Village:

Project name:

Contact person:

Postal address:

E-mail address:

Telephone number:

Background Information

Please indicate the prevalence of FGM/C in the:

Country:

Region:

Project audience:

Which type of FGM/C is most commonly practiced in the project audience?

__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 and stitching and/or narrowing of the vaginal opening.

__Type 4 or Unclassified: All other operations on the female genitalia.

__Unknown

Please describe the rationale for the continued practice of FGM/C in the project audience.

(If several of the following reasons are applicable, please try to indicate the order of importance by numbering the reasons: 1 = most commonly cited reason for the continued practice of FGM/C)

- Religion
- Health
- Marriage prospects
- Sanitation
- Rite of passage
- Other (please provide details)

Have there been any other recent activities contributing to the abandonment of FGM/C in the same geographical location? If yes, please provide a brief description.

(Media campaigns, new legislation, local/national initiatives, religious campaigns, alternative rites, retraining of excusers, public declarations, girls'/women's education programs etc.)

Project Description

Project type:

(Governmental, non-governmental, municipal, partnership)

Number of people involved in the project:

Paid staff:

Partners:

Community workers:

Budget range:

Funding source(s):

Working language(s):

Intended project audience:

Number of participants/geographical area covered:

Duration of the project:

(Please include information about all phases)

What is the main approach used in the project?

(You may select more than one approach but if relevant please indicate the order of priority:
1 = primary approach)

- Alternative rituals
- Collective abandonment
- Health workers as change agents
- Human rights
- Information, education, and communication
- Positive deviance
- Targeting excisors
- Other approaches (please specify)

Please state the main objectives of the project:

Please provide a description of the project (or send existing documentation):

Project Evaluation

Please describe the strengths of the project:

What are the main obstacles the project has encountered?

Has there been any evaluation of the project? ____yes ____no

If yes, please describe how it was evaluated and the key findings.

APPENDIX III

Interventions on FGM/C

In an effort to share the wealth of valuable information collected during this undertaking, the following table provides a brief description and contact details for 92 projects/organizations from which we received completed questionnaires. While a total of 102 questionnaires were returned, five were duplicates of questionnaires already received and five lacked sufficient information, including contact details.

Country	Organization/Project name	Comments	Contact Information
Burkina Faso	Association Burkinabé des Sages Femmes (ABST) (Association of Burkinabe Wise Women)	Contributes to the sensitization of FGC and provides support for girls and women in the aftermath of excision.	Association Burkinabe Des Sages-Femmes 01 BP 4686 Ouagadougou 01, Burkina Faso +226 30 72 59
Burkina Faso	Association des Femmes Pag-la-Yiri de Zabre (AFZ)	Uses IEC techniques to sensitize local leaders and chiefs against the practice of excision.	Mme Wage Zuzane 09 BP 335, Ouagadougou 09, Burkina Faso paglayiri@fasonet.bf +226 50 36 34 00 +226 40 71 42 00
Burkina Faso	Association Nasongb-Zanga	Volunteer organization that targets excisors with IEC.	Kombassie TONUOMA Madeleine BP 569, Ouagadougou 01, Burkina Faso +226 76 69 72 72
Burkina Faso	Direction de l'Éducation en Matière de Population (DEMP) : Integrating the Fight Against the Practice of Excision in the Teaching of Primary and Secondary Schools of Burkina Faso	Schools-based IEC program, which also sensitizes parents, produces teaching materials, and trains teachers.	Lazare Bakyono 01 BP 4901, Ouagadougou 01, Burkina Faso baklaz2003@yahoo.fr +226 50 39 40 97 +226 50 31 76 54 +226 70 24 64 05
Burkina Faso	Femme en Action (Women in Action): Involved Youth	Alternative rituals and visits to homes and movie theatres.	M. Yoméoyo Alexis 04 BP 8282, Ouagadougou 04, Burkina Faso celestepoule@yahoo.fr +226 50 43 15 00
Burkina Faso	Mouvement Burkinabé des Droits de l'Hommes et des Peuples (MBDHP): Division of Women and Children	Facilitates FGM/C sensitization activities including theatre, forums/debates, meetings/conferences, and videos.	Na Koulma Angèle 01 BP 2055, Ouagadougou 01, Burkina Faso mbdhp@cenatin.bf +226 50 31 31 50

Country	Organization/Project name	Comments	Contact Information
Burkina Faso	Mwangaza Action: Expérience d'un programme d'éducation à base communautaire	An operational research project based on the Community Empowerment Program by Tostan.	M. Djingri Ouoba 06 BP 9277, Ouagadougou 06, Burkina Faso mwangaz@fasonet.bf, + 226 50 36 07 70 + 226 50 36 33 85 www.mwangaza-action.org/
Burkina Faso	National Museum: Excision and its Consequences	A photo and audio-visual exhibition showing the harmful nature of excision and sensitizing audiences to abandon the practice in the future.	Mme. Compaoré Rose 06 BP 9815, Ouagadougou 06, Burkina Faso +226 50 36 50 50 +226 50 39 19 34
Burkina Faso	Promo-Femme: Promo-Femme Project70	Focuses on empowerment of women and young girls.	Mme Ouedissa Clematine 01 BP 2532, Ouagadougou 01, Burkina Faso promo.femmes@river.bf +226 50 36 96 94 http://promofemme.courantsdefemmes.org/
Burkina Faso	Radio Evangile Développement (Gospel Development Radio): PIC/LPE Project	Focuses on collective abandonment and IEC activities	M. Kiemde Etienne/Congo Pascal 04 BP 8050, Ouagadougou 04, Burkina Faso redbf@laposte.net/red@red-br.org +226 50 43 51 56 +226 50 43 15 90 http://www.autre.net/red/
Burkina Faso	Radio Maria: Excision Project	Advocacy through IEC including theatre, forums, video, radio, and sports matches.	Mathieu Djiguemdé 01 BP 90, Ouagadougou 01, Burkina Faso +226 50 31 70 70 +226 76 60 22 44 www.radiomaria.org
East and West Africa	Deutsche Gesellschaft fuer Technische Zusammenarbeit (GTZ) (German Technical Cooperation): Supra-regional Project: Promotion of Initiatives to End FGM	Participative "listen and dialogue" approaches, policy dialogue; advisory services for the development of methods and programs; promotion of capacity- and organizational development; training and upgrading; research; experience exchange and networking.	Marion Fischer/Emanuela Finke P.O. Box 5180, 65726 Eschborn, Germany marion.fischer@gtz.de emanuela.finke@gtz.de + 49 6196-791545 www.gtz.de/en/weltweit/afrika/regionale-themen/9121.htm
Egypt	Al-Khishaba Organisation for Development and Graduate Projects in Al-Minya: National Project for Fighting FGM/C	FGM/C awareness-raising for all members of the community. Activities also target medical doctors to discourage medicalization of the practice. Skills training to empower mothers and girls and provide a forum for approaching FGM/C in an indirect way.	Magdi Yousef 32 Al-Shahid Atef Mousa St. Al-Khashaba, Al-Minya, Egypt El-Khashaba_minia@yahoo.com +20 86 2372535

Country	Organization/Project name	Comments	Contact Information
Egypt	Anba Mousa Organisation for Community Development: Project For Fighting FGM/C	Literacy classes, as a platform for discussing FGM/C; health seminars; and the Older Daughter Project, which trains and educates older daughters to be able to offer advice and raise awareness among younger sisters.	Suzan Elia Tahouna St. Ezbet Khairalla Al-Zahra, Misr Al-Qadima, Egypt +20 2 7162677
Egypt	The Centre for Development and Population Activities (CEDPA) (in partnership with six local NGOs and UNICEF): Female Genital Mutilation Abandonment Program (FGMAP)	A three-phase project that involves the introduction and identification of positive deviants, community mobilization activities, and home visits to families with “girls at risk” of FGM/C by active positive deviants.	Egypt Mrs. Amel Gamal, Mrs. Roula El-Saady 53, El-Manial St., Manial El-Roda, Cairo 11451, Egypt agamal@cedpa.org.eg relsaady@cedpa.org.eg +20 2 3654567 +20 2 3654566 +20 2 3654565 U.S.A Kathrin Tegenfeldt ktegenfeldt@cedpa.org +1 202 667 1142 www.cedpa.org/ www.cedpa.org/files/714_file_egypt_tech_seminar5_5_5.pdf (Pages 57-64) www.cedpa.org/content/publication/detail/751/
Egypt	Center for Egyptian Women’s Legal Assistance: Resisting FGM Through A Public Theater	Project aims to increase awareness and facilitate dialogue among youth in an innovative way using public theatre.	Yasmin Adel 5 El Kawsar St., off Gamat El Dawal El Arabia, Mohandeseen, Cairo, Egypt info@cewla.org +20 2 7154557 +20 2 7316585 www.cewla.org/en/projects/04/fgm.html
Egypt	Coptic Evangelical Organization for Social Services (CEOSS): Reproductive Health Project	Focuses on IEC, women’s empowerment, and income-generation activities.	Margaret Sarofine Eman Mamdouh 13310 Dr. Ahmad Zaki’s Quarter, behind Petrogate Al-Nozha Al-Gadida, Egypt margrice.saroufin@ceoss.org.eg +20 121039051 +20 2 6221425 www.ceoss.org.eg/
Egypt	Coptic Evangelical Organization for Social Services (CEOSS): Project for Fighting FGM/C	A human rights and IEC intervention targeting mothers with daughters at risk of FGM/C.	Magda Ramzy 15 Nasr St. - Ard Sultan - Wabour El Nor, Egypt dev_head2_m@ceoss.org.eg +20 86 2347793 www.ceoss.org.eg/

Country	Organization/Project name	Comments	Contact Information
Egypt	Coptic Organisation for Services and Training (COST): "A Village Free from FGM/C," The National Project for Fighting FGM/C	Educational programs for girls and women incorporating human rights and positive deviance.	Dr. Johanna Salib 1 Al-Arwam Church St., Maqbal, Bani Soueif, Egypt Post Box 30, Bani Soueif, Egypt joannasalib@yahoo.com +20 82 2329114
Egypt	Egyptian Fertility Care Foundation: Training of Physicians to Raise Awareness About the Problem of FGC	Anti-FGM/C training for practicing physicians.	Prof. Ezzeldin Osman Hassan P.O. Box 147 Orman, Giza, Egypt EFCF@link.net +20 2 3441573 +20 2 3441574
Egypt	Egyptian Organisation for Community Initiatives and Development: National Project for Fighting FGM/C	IEC activities targeting mothers and women approaching marriageable ages.	Fardos Mahmoud Mahmoud 82 Abtal Al-Tahrir St., Misr Insurance Building, Flat no. 41, Egypt eacid_@hotmail.com, fgm_@hotmail.com +20 97 2301525
Egypt	Egyptian Organisation for Reproductive Health and Family Planning, Port Said: Al-Da'wa Project, Addressing Youth's Needs	Focus on human rights and IEC related to the needs of youth, through expert led seminars.	Ashraf Al-shinnawy ashalshnawy1802@yahoo.com +20 66 3341991
Egypt	Egyptian Society for the Prevention of Harmful Practices	An educational program designed to change FGM/C attitudes and practice.	Aziza Kamel, Executive Director P.O. Box 84 El Cala, Cairo, Egypt mtobgui@idsnet.eg +20 2 7005325 +20 2 3914339
Egypt	Family Planning Organisation in Munufiya: Project for Addressing Needs of Young People in the Field of Reproductive Health and Family Planning	Seminars led by local leaders and doctors for young men and women to teach them the dangers and problems of FGM/C, and awareness raising seminars in schools and young people's clubs.	Abdalla Shatla Shibeen Al-Kom, 4 Cultural Palace, Qasr Al-Thaqafa St., Egypt +20 48 2225818
Egypt	Fatayat Al-Ghad (Future Girls Organisation): Project for Fighting FGM/C	Focuses on recruiting and training women, especially grandmothers to mobilize other women against FGM/C.	Randa Mahmoud Burg Al-Atiba, fourth floor, flat no 22, Malek Faysal St.-Giza, Egypt dor.fugad2004@hotmail.com +20 2 5829662
Egypt	Jesuit and Frere Association: Development for Education and Learning Skills	IEC activities targeting mothers and grandmothers, which address FGM/C and wider reproductive health issues, awareness raising around FGM/C for girls in schools, and positive deviants as role models.	Amal Samy 1 El Homiaat Hospital St. - Jesuit and Frere Association El Menia, Egypt gpanin@yahoo.com +20 2 086 2363687
Egypt	Ministry of Social Affairs, Population and Family Planning Division: Training of Medical Members with Patients, Nurses, and Raidat Rifiyat	FGM/C IEC aimed at medical staff.	Maha Hemmeda MOH, 3, Majlis El-Shaab, 5th floor Cairo, Egypt

Country	Organization/Project name	Comments	Contact Information
Egypt	Muslim Female Young Woman's Organisation in Bani Souief: National Project for Fighting FGM/C	IEC activities directed toward young unmarried women and newly-wed women.	Mr. Gamal Fathy shapaad@yahoo.com +20 82 2320100 www.shapaad.com
Egypt	Nadim Centre for Rehabilitation and Psychological Treatment: Nadim Centre	Rehabilitation and psychological treatment for women and girls.	Ashgan Abdel-Hamid 3 A Suleiman Al-Halabi St, Ramses, Egypt Nadeem@link.com +20 2 578 7089
Egypt	National Council for Childhood & Motherhood (NCCM): National Project for Fighting FGM/C	This project involves a large number of NGOs working under the umbrella of NCCM, which focuses on mothers, new wives, girls ages 8 to 14, grandmothers, and young men.	Viviane Fouad 1103 Cornishe El Nile St. Tahrir, Cairo, Egypt vivianfahmy@hotmail.com +20 25240288 www.nccm.org.eg/
Egypt	New Woman Foundation: Celebrating 10 years of Deir El-Barsha's Declaration Against FGM	Focus on human rights and collective abandonment.	Amal Abdel-Hadi amalhadi99@yahoo.com +20 23464901
Egypt	Organisation for Community Development in Aqab Kubra: Project for Fighting FGM/C	The project exclusively targets women (mothers and grandmothers) in the belief that FGM/C is a purely female issue that should not involve men.	Hamdiyya Uthman Bishir Aswan Governorate - Aqab Kubra, Egypt hosman_363@yahoo.com +20 97 2380415
Egypt	Organisation for Comprehensive Care and Services: National Project for Fighting FGM/C	IEC targeting young women and men.	Dr. Mahmoud Rifqi mrefky@yahoo.com +20 10 4659621
Egypt	Organisation for Development of Community for Rural and Urban Woman: Project for Fighting Bad Practices (FGM/C)	IEC and human-rights based activities targeting young women, mothers, and grandmothers.	Amal Ebeid Qina Governorate, Hod 10 Port Said St. next to Abu Bakr Sidiq Mosque, Egypt cdaru@yahoo.com +20 96 5342340
Egypt	Organisation for Family Planning in Assiut: The Collaboration of Youth in Fighting FGM/C	Focuses on training families to become positive deviant role models to educate and mobilize other families against FGM/C.	Sana Al-Qassas Organisation for Family Planning in Assiut Al-Arba'een, Ma'unet Al-Shita Buildings No2, Assiut, Egypt +20 2 6170690 +20 88 2293007
Egypt	Organisation for Male Muslim Youth: National Project for Fighting FGM/C	Human rights and IEC activities targeting all family members, especially decisionmakers and young people who will become future decisionmakers.	Ahmad Al-Husseiny 32 Port Said St. Al-Minya +20 86 3627730

Country	Organization/Project name	Comments	Contact Information
Egypt	Organisation of Fayoum Women: Reproductive Health and FGM/C Project	Seminars and illiteracy eradication classes targeting mothers and grandmothers as the key FGM/C decisionmakers.	Organisation of Fayoum Women Ard Sayed Sadeq, Al-Aboudy Station, Masalla, Haj Ali Abdel Salam House, Egypt +20 84 6355858
Egypt	Organisation of Upper Egypt for Development: Project for Fighting FGM/C	Targets literacy and handicraft classes engage young women and mothers and serve as entry points to discussing FGM/C.	Ikram Mousa Organisation of Upper Egypt for Development 16 Ahmad Shawky St. Qalta Co., Egypt akoo2003@yahoo.com +20 88 2331064 +20 12 5957007
Egypt	Population Council and Save the Children/ USA in partnership with The Centre for Development and Population Activities (CEDPA) and Caritas Egypt: ISHRAQ, In-School Adolescent Program	Supports a healthy and active transition to adulthood for disadvantaged rural girls, and prepares them to make informed, positive decisions about life issues such as schooling, marriage, and careers.	Abeer Salem Population Council 59 Misr Helwan Agricultural Road, Maadi, Cairo, Egypt asalem@pccairo.org +20 2 5255967 www.popcouncil.org/projects/TA_EgyptIshraqRI.html Mona Moneer Save The Children 25 B, El-Minya, 43, Sharia el-Kholafa St, Cairo, Egypt mmoneer@Savechildren.org.eg +20 86 2366667
Egypt	Red Crescent Organisation in Aswan: National Campaign for Fighting FGM/C With Collaboration of NCCM	IEC activities targeting school girls, young women, and mothers. Summer camps offering cultural seminars designed to change traditional opinions around FGM/C away from the village atmosphere.	Egyptian Red Crescent Organisation Ahmad Hassanien Mubarak City post, Assiut, 71783, Egypt rca_2003@yahoo.com +20 88 2333367
Egypt	The Association for the Development and Enhancement of Women: Girls' Dreams	Working with adolescent girls in the squatter areas of Cairo to abandon FGM/C.	Rania Hasanen 8/10 Mathaf El Manial St., 5th Fl, Apt 12, Cairo, Egypt rhasanen@adew.org.eg +20 2 363-6345
Egypt	The Egyptian Center for Women's Rights: The Four Illiteracies for East Africa	A five-phase project designed to tackle a multiplicity of issues affecting women, including human rights, illiteracy, economic empowerment, FGM, and early marriage.	Ahmed Elewa The Egyptian Center for Women's Rights 135 Misr-Helwan El Zeraay, 2nd Floor, Suite 3 Hadayak El Maadi, Cairo, Egypt ecwr@link.net aelewa_82@hotmail.com +20 2 5271397 +20 2 5282176

Country	Organization/Project name	Comments	Contact Information
Egypt	United Nations Children's Fund (UNICEF): FGM/C Abandonment Project	Project targets 45 communities in rural and urban areas in Cairo and Alexandria to decrease the incidence of FGM/C by mobilizing community leaders and parents with girls at risk of FGM/C to abandon the practice	Nadra Zaki, Project Officer - Child Protection Yasmine Wahba, Assistant Project Officer, Child Protection, FGM/C Abandonment 86 Misr Helwan Agricultural Road, Maadi, Cairo, Egypt nzaki@unicef.org ywahba@unicef.org +20 2 5265083 ext. 89 http://www.unicef.org/egypt/
Egypt	United Nations Development Program (UNDP) and National Council for Childhood and Motherhood (NCCM): The FGM-Free Village Model project	A participatory IEC and human rights approach which addresses FGM within a comprehensive developmental package, aimed at all community members. Additional components respond to medicalization of the practice and encourage positive deviants to act as role models.	Simona Galbiati, UNDP Programme Officer 1191 Corniche El Nil, World Trade Center, Boulac, Cairo, Egypt simona.galbiati@undp.org +20 02 5253349 http://www.undp.org.eg/default.aspx Mona Amin, National Programme Director National Council for Childhood and Motherhood 1191 Corniche El Nil, World Trade Center, Boulac, Cairo, Egypt nccm_fgm@yahoo.com +20 2 5784840
Egypt	USAID and The Ministry of Health and Population, Egypt: Healthy Mother/Healthy Child and Tahseen Projects	Training and IEC activities aimed at health providers and outreach workers	Dr. Mohamed Ismail Sabry msabry@tahseen.com Tahseen office +20 2 5325065
England	Guy's and St. Thomas Hospital: African Well-Woman's Clinic	Educating professionals and the general public; providing support, information, and surgical reversals to women and girls.	Comfort Momoh African Well Woman Clinic C/O Admin Office, 10th Floor North-Wing, London SE1 7EH, U.K. comfort.momoh@gstt.sthames.nhs.uk cmomoh@hotmail.com +44 20 7955 2381 +44 795 654 2576
Ethiopia	Adventist Development and Relief Agency (ADRA)/Ethiopia: Female Genital Cutting Prevention Project	Training health workers as change agents; introducing and strengthening counseling services to women and couples; introducing alternative rituals; intensifying IEC and behavior-change campaigns; using the positive deviance inquiry; placing emphasis on educating religious leaders, traditional leaders, and the general public; and facilitating inter-generational dialogue.	Dr. Mesfin Hailemariam ADRA Ethiopia hmesfin@adra.org.et Erin Anastasi ADRA International 12501 Old Columbia Pike Silver Spring, MD 20904 U.S.A. +1 301 680 6380 erin.anastasi@adra.org http://www.adra.org

Country	Organization/Project name	Comments	Contact Information
Ethiopia	CARE International in Ethiopia: Afar Female Genital Cutting Elimination Project	Advocacy and health and awareness-raising activities to improve the health and social status of Afar women and girls by eliminating FGC and improving access to health services.	Marcy Vigoda, Country Director Dawn Wadlow, Program Director Fahee Khan, Rural livelihood Program Coordinator Tamirat Lonseko, Project Area Coordinator P.O. Box 4710, Addis Ababa, Ethiopia carefgc@telocom.net.et careawash@ethionet.et +251 1 5538040 +251 22 2240454 http://www.careinternational.org/
Ethiopia	IntraHealth International: A 5-Dimensional Approach for the Eradication of Female Genital Cutting in Ethiopia	Focuses on bridging knowledge gaps, generating dialogue, empowering women and communities to advocate against FGC, involving influential religious and political leaders, and creating networks of anti-FGC groups from the grassroots to the national level.	Cristina Ruden, Country Director, Ethiopia P.O. Box 9658 BISELEX Building, 1st, 2nd and 3rd floor Kebele 02, House No. 784, Addis Ababa, Ethiopia cruden@intrahealth.org +251 1 627480 www.intrah.org/
Ethiopia	Pathfinder International, Ethiopia: Harmful Traditional Practices (HTPs) Affecting Family Planning and Reproductive Health	Focuses on expanding advocacy to eradicate HTPs; building capacity through training of trainers; developing, translating, and adopting existing training materials; and expanding activities in schools and youth organizations.	Tilahun Giday tgiday@pathfind.org +251 1 661 33 30 www.pathfind.org
France	Commission pour l'Abolition des Mutilations Sexuelles (CAMS)	Participates in mother and child care units and takes part in legal trials related to FGM/C. Prevention tools include an anti-FGM/C film, song, and comic strip aimed at children.	Linda Wiel-Curiel C.A.M.S 6 Place Saint-Germain-des-Près, 75006, Paris, France +33 1 45490400 w113111@club-internet.fr http://www.cams-fgm.org/
Gambia	BAFROW	Focus on women's health, economic empowerment, and the environment through a functional literacy program and alternative rite of passage that excludes FGM/C.	http://www.bafrow.org
Gambia	Inter-African Committee (IAC) Gambia (GAMCOTRAP): Youth and Adolescent Reproductive Health	Focuses on the provision of information on sexual and reproductive health and rights for adolescents and youth.	Berhane Ras-Work 145, Rue de Lausanne CH-1202 GENEVA, Switzerland cominter@iprolink.ch +41 22 7320821 http://www.iac-ciaf.org

Country	Organization/Project name	Comments	Contact Information
Ghana	Navrongo Health Research Center: The Navrongo FGM Experiment	An experimental project design which measures and compares the impact of three interventions: an FGM education strategy, a livelihood and development strategy, and a combined strategy.	Patricia Akweongo Navrongo Health Research Centre Health Service, P. O. Box 114, Navrongo, Ghana pakweongo@navrongo.mimcom.net +233 742 22310 www.navrongo.org/
Ghana	The Ghanaian Association for Women's Welfare (GAWW): Alternative Employment for Excisors	Focuses on identifying and registering excisors to sensitize them to the serious consequences of their practice; providing grants and training for alternative sources of income; and training to become peer educators to assist GAWW in anti- FGM educational activities.	Berhane Ras-Work 145, rue de Lausanne CH-1202 Geneva, Switzerland cominter@iprolink.ch +41 22 7320821
Guinea	CHU de Donka: Abandon Excision	Development-oriented approach to behavior change communication focusing on rights, education, the environment, and health, including excision.	Thierno Mariama Barry BP 234 Conakry, Guinea desoria56@yahoo.fr +224 34 22 21
Guinea	Communication for Change and CPTAFE: Video Sabou et Nafa (Community Voices Joined in a Common Cause)	A community-based media project.	Communication for Change 423 Atlantic Avenue, # 3L Brooklyn, New York 11217 USA +1 718 624 2727 info@c4c.org http://www.c4c.org/guinea.html
Guinea	Ministère de la Santé Publique (Ministry of Public Health): Reduction of FGM Practiced by Health Professionals	Focuses on educating and reinforcing the capacity of the health sector in Guinea in order to reduce the level of FGM/C practiced by health professionals.	Dr. Salématou Toure BP 422 Conakry, Guinea saletatou2003@yahoo.fr +224 29 48 61
Guinea	Ministry of Social Affairs and the Promotion of Women and Children/National Direction of the Promotion of Women: Abandon Excision in Guinea	Focuses on enabling populations to take charge of their problems, including rights, health, and community development.	Mme N'Diaye Diénabou Fofana BP 527 Conakry, Guinea fofanadiénabou@yahoo.fr +224 41 22 19
Guinea	Tostan: Community Empowerment Program	Community development through a holistic program involving adults and youths, decisionmakers, traditional leaders, and religious leaders.	Guinea Mohammed El Kebir Basse, National Coordinator BP 241, Labe, Guinea +224 512486 +224 543596 BP 3235, Conakry, Guinea +224 420600 tostan.guinea@gmail.com U.S.A. Gannon Gillespie 777 N Capitol St., NE Washington, DC 20002, U.S.A. Tostan.dc@gmail.com +1 202 408 9300 ext 105

Country	Organization/Project name	Comments	Contact Information
Indonesia	Population Council, Jakarta: Female Circumcision: Extent, Implications and Possible Interventions to Uphold Women's Health Rights	A quantitative and qualitative assessment of FGM/C designed to inform an appropriate national campaign to end harmful FGM/C practices.	Lila Amaliah (Mitra Inti Foundation) Jl. Tebet Barat Dalam VII C No. 5B Jakarta Selatan 12810, Java, Indonesia lila@mitrainti.org lila_amaliah@yahoo.com +62 21 8295136 +62 21 8319458 http://www.popcouncil.org/asia/indonesia.html
Kenya	CARE International in Kenya: Participatory & Integrated Approach on Combating GBV, FGC, and Prevention of HIV/AIDS Transmission in Refugee Camps	Focuses on IEC and advocacy efforts to increase the interest and ability of communities, NGOs, Ministries of Health, and local Ministries to combat gender-based violence, FGM/C, and HIV/AIDS transmission in Kenyan refugee camps.	Mohammed Qazilbash Senior Programme Manager, Emergency & Refugee Operations, CARE Kenya. CARE Kenya, P.O. Box 43864 00100 Off Ngong Road, Mucai Drive, Nairobi, Kenya mohammedq@care.or.ke +254 2 2729451 +254 2 2710069 +254 2 2712374 www.care.or.ke/
Kenya	Girl Child Network: Eradication of FGM/C	IEC campaigns primarily aimed at mothers and adolescent daughters focusing on girls' education as an entry point to discuss FGM/C.	Mercy M. Musomi Executive Director – Girl Child Network P. O. Box 2447-00200 City Square Nairobi, Kenya gcn@girlchildnetwork.net mercymusomi@yahoo.com +254 20 604510 +254 20 607137
Kenya	Julikei International Women and Youth Affairs: Elimination of FGM in Gusiland	Community sensitization activities including participatory dialogue/exchange of ideas, collective abandonment, human rights education, and engaging health workers as change agents.	Julie Kemunto Maranya P.O. BOX 57019 - 00200, Nairobi, Kenya julikeiintl@swiftkenya.com +254 20 2715134
Kenya	Maendeleo Ya Wanawake Organization (MYWO)/PATH: Alternative Rites of Passage	Alternative rites of passage that embrace positive traditional values and exclude FGM/C.	Maendeleo Ya Wanawake Organization Maendeleo House, Loita / Monrovia Street, P.O. Box 44412, Nairobi, Kenya +254 2 222095 +254 2 221136 +254 2 252210
Kenya	Northern Aid Hosts the National Focal Point on the Eradication of Female Genital Mutilation in Kenya: Strengthening Coordination of Anti-FGM Activities in Kenya	Focuses on creating awareness on the extent and effects of FGM/C in Kenya through IEC campaigns, intensive media outreach, and the involvement of policymakers, anti-FGM advocates, national religious leaders, and the leaders of civil society organizations.	Joyce Isika naid@africaonline.co.ke +254 20 6750969

Country	Organization/Project name	Comments	Contact Information
Kenya	Pokot Kiletat Women Group Consumer Cooperative Society Limited	Addresses women's vulnerability and marginal status through a program of activities focusing on women's health, education, economic independence, participation in decisionmaking, human rights, and citizenship.	Dinah C.Katina P.O. BOX (30600) 265, Kapenguria, Kenya pokilewg@africaonline +254 54 62202
Kenya	UNICEF Kenya Country Office: Abandonment of Female Genital Mutilation/Cutting (FGM/C) in North-Eastern Province of Kenya	Focuses on community dialogue, mobilizing religious leaders to speak out against FGM/C, IEC campaigns, and human rights education leading to the collective abandonment of FGM/C.	Mrs. Zeinab A. Ahmed UNICEF Kenya Country Office P.O. Box 44145 Nairobi, Kenya 00100 Zeahmed@unicef.org +254 20 462492 +254 20 463076
Mali	AMSOPT (Association Malienne pour le suivi et l'Orientation des pratiques traditionnelles): Information – Sensibilisation Pour L'abandon des MGF/Excision	Focus on collective, familial, and individual abandonment through IEC, community dialogue, development of community laws, and internal monitoring of FGM by communities.	Mme. SIDIBE Kadidia Aoudou AMSOPT BP : E1543, Hamdallaye ACI 2000 Route de Lafiabougou Bamako, Mali amsopt@datatech.toolnet.org +223 229 58 95 +223 672 70 76 http://amsopt.over-blog.com/
Mali	Association de Soutien au Développement des Activités de Population (ASDAP): Programme intégré de santé de la reproduction (Integrated reproductive health program)	Intervention activities focus on communication for behavior change through communication workshops directed at community leaders, health agents, NGOs, excisors, and key communicators.	Traoré Fatoumata Touré, Présidente ONG and Dr Sylla Habibatu Diallo, Chargée de Programmes BP 951 Faladié Sema, Rue 876 porte 29 Bamako, Mali asdap@datatech.toolnet.org +223 220 27 69 +223 220 38 43
Mali	CARE: ROCAM II : Renforcement Organisationnel, Crédit et Aménagement au Mali, 2eme phase	An integrated approach to development focusing on women's access to credit and income-generating activities; capacity building of NGOs, women's groups, agricultural associations and other partners; and behavior change communication (BCC) aimed at improving reproductive health, including the abandonment of FGM/C.	Monsieur Aliou Bâh BP 1766, Bamako, Mali +223 232 15 16 +223 232 20 90 +223 224 55 01 abah@afribone.net.ml Madame Karakodio Fadimata Mahamane +223 232 15 16 +223 232 20 90 fmahamane@caremali.org Monsieur Younoussou Tangara +223 224 55 01 +223 224 22 62 +223 224 91 37 ytangara@caremali.org www.care.org/careswork/countryprofiles/78.asp?

Country	Organization/Project name	Comments	Contact Information
Mali	IntraHealth International: Expanding the Role of Primary Providers in Eliminating Female Genital Cutting (FGC) in Mali, West Africa	Focuses on increasing the capacity of the Ministry of Health to support primary providers in the elimination of FGC, providing training and support related to FGC abandonment, and community education.	Dr Cheick Oumar TOURE Immeuble TOUNKARA, ACI 2000 Hamdallaye BP 2243, Bamako, Mali ctoure@intrrahealth.org +223 229 62 52 +223 674 08 80 www.intrahealth.org
Mali	Sini Sanuman (Healthy Tomorrow): Project Stop Excision	Community outreach and mobilization efforts including a Pledge Against Excision signatures campaign and the production of anti-FGM pop-songs and videos by well-known local artists, which air frequently on national and local radio and cable television in 10 West Africa countries.	Mali Siaka Traore Sini Sanuman, BP:E 3885, Bamako, Mali Traorefr@yahoo.fr +223 222 54 50 USA Susan McLucas Healthy Tomorrow 14 William Street Somerville, MA 02144 SusanMcL@StopExcision.net/Siaka +1 617 776 6524
Niger	UNICEF: The Fight Against Female Genital Mutilation in the Diffa Region	Sensitization and community mobilization activities to raise awareness, promote the law against FGM/C, and encourage behavior change and alternative livelihoods for excisors.	Mme Salmey Bebert UNICEF Niger PB: 12 481, Niamey, Niger sbebert@unicef.org Niamey@unicef.org +227 72.30.08 +227 72.29.04 +227 72.28.40
Nigeria	Girls' Power Initiative (GPI), Nigeria: Combating Female Genital Mutilation	Community IEC through video screenings, seminars, publications, weekly media programs, lessons for girls, community social work by graduating GPI girls, and public seminars.	Professor Bene E. Madunagu 44 Ekpo Abasi Street P. O. Box 3663 UNICAL Post Office Calabar, Nigeria +234 87 230929 gpi@fordwa.linsve.org gpibn@alpha.linkserve.com gpi_hqcal@yahoo.co.uk
Nigeria	Johns Hopkins University/Center for Communication Programs: Ndukaku (Health is Better than Wealth)	An IEC campaign that uses a non-confrontational, multi-channel approach; combines community capacity strengthening and mobilization with targeted advocacy and mass media interventions.	Anna Helland/Stella Babalola 111 Market Place - Ste 310 Baltimore, MD 21202, USA sbalalol@jhuccp.org +1 410 659 6300 www.jhuccp.org/

Country	Organization/Project name	Comments	Contact Information
Nigeria	Nigeria Society for the Improvement of Rural People (NSIRP): Replication of Best Practices of a Targeted Education, Communication, and FGM Training Programme in Five Communities of Enugu State in Nigeria (Phase I)	Utilizes the linkage between HIV/AIDS and FGM as an entry point for project implementation.	Chris .N. Ugwu P.O. Box 3125, University of Nigeria Nsukka, Nigeria nsirp@yahoo.com +234 42 259761
Nigeria	Women's Health and Action Research Centre (WHARC): Female Genital Mutilation and Obstetric Sequelae	In collaboration with the World Health Organization, evaluates the relationship between different types of FGM/C and obstetric complications.	Professor F. E. Okonofua P.O. Box 10231, Ugbowo Benin City, Edo State, Nigeria, West Africa wharc@warri.rcl.nig.com wharc@hyperia.com +234 52 600151 +234 52 602334 wharc.freehosting.net/
Senegal	COSEPRAT (Senegalese Committee on Harmful Traditional Practices for Mothers and Children)	Awareness-raising activities and retraining of former excisors.	COSEPRAT Hôpital Le Dantec, B.P. 3001 Dakar, Senegal coseprat@sentoo.sn +221 825 42 87
Senegal	Deutsche Gesellschaft fuer Technische Zusammenarbeit (GTZ) (German Technical Cooperation): Fankanta	Focuses on long-term sensitization campaigns, IEC activities including theater and peer education, training health workers as change agents, and collaboration with traditional practitioners.	Susanne Bieberbach, Dr. Maria-Laura Mastrogiacommo-Mbow, Dr. Gerd Eppel BP 3869, Dakar, Senegal Gerd.Eppel@gtz.de Susanne.Bieberbach@gtz.de beira@coopi.org http://www.gtz.de/en/weltweit/afrika/regionale-themen/9121.htm
Senegal	Forum for African Women Educationalists (FAWE) Senegal: Extension dans l'éducation formelle de la lutte contre la pratique de l'excision des filles au Sénégal (Extension of Formal Education in the Fight Against the Excision of Girls in Senegal)	Uses the formal education system to train teachers and inform students, future parents, and decisionmakers about FGM/C through human rights IEC campaigns and positive deviant role models.	Laurence Maréchal, National Coordinator of FAWE/Senegal BP:6646 Dakar Etoile, Senegal fawesenegal1@yahoo.fr +221 822 41 77 www.fawe.org/content/Chapters/fawesen4.html
Senegal	Ministry of Women, Family, and Social Development: Promotion of the Abandonment of FGM	Focuses on introducing FGM/C awareness into formal education and on communication for behavior change activities.	Mme. Dia Awaniang 3, rue Berenger Ferroud Dakar, Senegal sadiodio@yahoo.fr +221 823 84 85 +221 595 18 58

Country	Organization/Project name	Comments	Contact Information
Senegal	Tostan: Community Empowerment Program	A socially and economically empowering non-formal education program focusing on human rights. Incorporates community-based education in local language, inter-village meetings, information and social mobilization activities, and public declarations.	Senegal: Molly Melching BP 29371, Dakar-Yoff, Senegal mjmelching@gmail.com +221 820 55 89 U.S.A. Gannon Gillespie 777 N Capitol St., NE Washington, DC 20002, U.S.A. Tostan.dc@gmail.com +1 202 408 9300 ext 105
Sierra Leone	Inter-African Committee (IAC) Sierra Leone (CESMYCO): Training and Information Campaign for Empowering Women, Changing the Mindsets of Women From Prestige of FGM Towards an FGM-Free Environment	Focuses on the empowerment of women through two initiatives: engaging youth in the fight against FGM through training and information campaigns, and funding alternative employment opportunities for former excisors.	Berhane Ras-Work 145, Rue de Lausanne CH-1202 Geneva, Switzerland cominter@prolink.ch +41 22 7320821
Somalia	CARE Somalia/South Sudan: FGC Abandonment in Somaliland Project (FASP)	Focuses on community awareness, local capacity building, and advocacy at the national government level.	Salina Sanou (Sector Coordinator) Johanna Dellantonio (technical advisor) P.O. Box 2039, KNH 00202 Nairobi, Kenya sanou@ci.or.ke Johanna.dellantonio@gmx.at +254 20 2807143 www.care.org/
Sudan	Ahfad University for Women	Focuses on capacity building, training, and outreach programs.	Ahfad Reproductive Health Centre P.O.Box 167, Omdurman, Sudan +249 24 553 363 www.ahfad.org/
Sudan	Entishar Charity Society: Community Empowerment Program	A three-phase project that focuses on training, social mobilization, and public declarations against FGM/C	Dr.Emad Mamoun Abdeen P.O.Box 640, Khartoum, Sudan emad.abdeen@gmail.com Emad_abdeen@hotmail.com +249 91 2346252 +249 91 2444094, +249 91 2698697
Sudan	Sudan National Committee on Traditional Practices (SNCTP): Community Together Against FGM/HTPs/GBV/HIV/AIDS	Focuses on FGM/C and child marriage. Programs include: training of trainers, community dialogue, community media events, competitions and sports, and income-generation activities for former excisors.	Dr. Amna A.R Hassan - SNCTP Ex. Sec. & IAC Vice President P.O. Box 10418 Khartoum, Sudan snctpiac5@hotmail.com +249 183 460546 www.snctp.org/

Country	Organization/Project name	Comments	Contact Information
Tanzania	Anti-Female Genital Mutilation Network (AFNET): Fight Against FGM	Focuses on sensitization, support, and training activities at the community level, in addition to alternative rites and lobbying and advocacy activities.	Sarah Daimon Mwaga Plot 2 Bk P Kuu Street, P.O. Box 1763, Dodoma, Tanzania afnetdodoma@yahoo.com sarahmwaga@yahoo.com +255 26 2321513 +255 744 294901
Tanzania	Tanzania Media Women's Association (TAMWA): Stop FGM Campaign	Mass media campaigns	Ananailea Nkya Tanzania Media Women's Association P.O. Box 8981, Dar es Salaam, Tanzania. +255 22 2115278, tamwa@raha.com info@tamwa.org www.tamwa.or.tz/
Uganda	Community That Cares, Uganda: Community Initiatives Project to Eradicate FGM/FGC	Focuses on girls' formal education, networking and empowerment of faith-based organizations, and the formation of male anti-FGC pressure groups.	Jane Frances Kuka P.O. Box 29518, Kampala, Uganda cothacu@lycos.com +256 77 495 837
Uganda	Reproductive Educative and Community Health (REACH) Program: REACH	A multi-faceted approach that includes training health workers, former excisors, and FGM/C victims as change agents; supporting alternative livelihoods for former excisors; and IEC campaigns aimed at children, especially girls.	Mrs. Beatrice Chelangat Mella Road, P.O. Box 156, Kapchorwa, Uganda chelangatbeatrice2004@yahoo.com +256 45 51190

APPENDIX IV

Evaluated Interventions

Country	Organization/Project name	Evaluation
Burkina Faso	Direction de l'Éducation en Matière de Population (DEMP) : Integrating the Fight Against the Practice of Excision in the Teaching of Primary and Secondary Schools of Burkina Faso	Surveyed project participants
Burkina Faso	Femme en Action (Women in Action): Involved Youth	Questionnaires
Burkina Faso	Mouvement Burkinabé des Droits de l'Hommes et des Peuples (MBDHP): Division of Women and Children	Surveys and interviews
Burkina Faso	Mwangaza Action: Expérience d'un programme d'éducation à base communautaire	Baseline survey, post-intervention survey and end-line survey two years post-completion of the intervention. For more information see: www.popcouncil.org/pdfs/frontiers/FR_FinalReports/BurkinaFaso_FGC.pdf
Egypt	The Centre for Development and Population Activities (CEDPA) (in partnership with six local NGOs and UNICEF): Female Genital Mutilation Abandonment Program (FGMAP)	Baseline and post-intervention KAP studies involving focus groups and in-depth interviews. Ongoing monitoring of "girls at risk" and their families. For more information see: www.cedpa.org/files/714_file_egypt_tech_seminar5_5_5.pdf (Pages 57-64)
Egypt	Center for Egyptian Women's Legal Assistance: Resisting FGM Through A Public Theater	Questionnaires and in-depth interviews.
Egypt	Coptic Evangelical Organization for Social Services (CEOSS): Project for Fighting FGM/C	Surveys and interviews.
Egypt	Egyptian Society for the Prevention of Harmful Practices	A control-intervention design with pre- and post-intervention questionnaires.
Egypt	Population Council and Save the Children/USA in partnership with The Centre for Development and Population Activities (CEDPA) and Caritas Egypt: ISHRAQ, In-School Adolescent Program	Monitoring and evaluation throughout all phases of the project and baseline and end line surveys.
Ethiopia	CARE International in Ethiopia: Afar Female Genital Elimination Project (FGC)	Baseline, mid-term, and final evaluation; final evaluation comprised 400 individual questionnaires, 72 people in focus group discussions, key informants' interviews, document review, and field observation.
Ethiopia	IntraHealth International: A 5-Dimensional Approach for the Eradication of Female Genital Cutting in Ethiopia	Pre-intervention rapid appraisal study, using interviews and focus group discussions; post-intervention focus group discussions and experience-sharing workshop.

Country	Organization/Project name	Evaluation
Ethiopia	Pathfinder International Ethiopia: Harmful Traditional Practices (HTPs) Affecting Family Planning and Reproductive Health	Mid-term evaluation conducted 2006, final evaluation due 2008.
Ghana	Navrongo Health Research Center: The Navrongo FGM Experiment	A control-intervention design incorporating qualitative and quantitative data collection; baseline survey of cohort in 1999 and follow-up surveys yearly to 2003.
Kenya	Julikei International Women and Youth Affairs: Elimination of FGM in Gusiland	Internal evaluation; no additional information provided.
Kenya	Maendeleo Ya Wanawake Organization (MYWO)/PATH	Population Council evaluation (2001); qualitative and quantitative methods focus group discussions, in-depth interviews, family case studies. For more information see: www.popcouncil.org/pdfs/frontiers/FR_FinalReports/Kenya_FGC.pdf PATH evaluation (2003) using same data.
Mali	AMSOPT (Association Malienne pour le suivi et l'Orientation des pratiques traditionnelles): Information – Sensibilisation Pour L'abandon des MGF/Excision	Evaluation by external consultants; no additional information provided.
Mali	Association de Soutien au Développement des Activités de Population (ASDAP): Programme intégré de santé de la reproduction (Integrated reproductive health program)	Individual interviews and focus group discussions.
Mali	IntraHealth International: Expanding the Role of Primary Providers in Eliminating Female Genital Cutting (FGC) in Mali, West Africa	Baseline and post-intervention data.
Nigeria	Girls' Power Initiative (GPI), Nigeria: Combating Female Genital Mutilation	Questionnaires targeting specific groups.
Nigeria	Johns Hopkins University/Center for Communication Programs: Ndukaku (Health is Better than Wealth)	A control-intervention design with pre- and post-intervention surveys. For more information see: www.jhuccp.org/pubs/ci/18/18.pdf
Senegal	Deutsche Gesellschaft fuer Technische Zusammenarbeit (GTZ) (German Technical Cooperation): Fankanta	Focus group discussions (2000), baseline KAP study (2001), and end line KAP study 2005.
Senegal	Forum for African Women Educationalists (FAWE) Senegal: Extension dans l'éducation formelle de la lutte contre la pratique de l'excision des filles au Sénégal (Extension of Formal Education in the Fight Against the Excision of Girls in Senegal)	Internal evaluation: KAP survey using focus group discussions and a structured questionnaire.

Country	Organization/Project name	Evaluation
Senegal	Tostan: Community Empowerment Program	--Population Council/Frontiers evaluation (2000-2003): A control-intervention design using questionnaires and group discussions at baseline, immediately following the intervention and 2 years post intervention. For more information see: http://www.popcouncil.org/pdfs/frontiers/FR_FinalReports/Senegal_Tostan%20FGC.pdf ; --Government of Senegal evaluation (2005): Focus groups and surveys; --Swiss Tropical Institute (Jan. 2006); --UNICEF/DHS evaluation currently underway.
Sudan	Entishar Charity Society: Community Empowerment Program	Baseline and follow-up questionnaires and field visits.
Sudan	Sudan National Committee on Traditional Practices (SNCTP): Community Together Against FGM/HTPs/GBV/HIV/AIDS	Mid-term evaluation 2002, Impact assessment due 2006. No additional information available.
Tanzania	Anti-Female Genital Mutilation Network (AFNET): Fight Against FGM	Baseline survey and ongoing data collection through follow-up visits, physical examinations, and community monitoring and reporting.
Uganda	Reproductive Educative and Community Health (REACH) Program	Questionnaire indicates surveillance of FGM/C prevalence is ongoing as results from 1996 and 2004 are referenced, but no further details are available.



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